ERIC

The ERISA Industry Committee

July 29, 2016

Internal Revenue Service
Attention: CC:PA:LPD:PR (REG–135702–15)
P.O. Box 7604
Washington, DC 20044

RE: Proposed Rule – 'Expatriate Health Plans and other issues'

To whom it may concern:

The ERISA Industry Committee ("ERIC") is pleased to comment on the proposed rule issued by the Departments of Health and Human Services ("HHS") and Labor (DOL), and the Internal Revenue Service (IRS) (collectively, "the Departments") on June 10th, 2016, concerning "Expatriate Health Plans, Expatriate Health Plan Issuers, and Qualified Expatriates; Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Plans."

ERIC'S INTEREST IN EXPAT PLANS AND OTHER EXCEPTED BENEFITS

The ERISA Industry Committee (ERIC) is the only national trade association advocating solely for the employee benefit and compensation interests of the country's largest employers. ERIC supports the ability of its large employer members to tailor retirement, health, and compensation benefits for millions of workers, retirees, and their families. ERIC's members provide comprehensive health and retirement benefits to millions of active and retired workers and their families.

ERIC's member companies employ millions of Americans, including Americans who are stationed abroad for periods of time, as well as non-citizens who are stationed within the U.S. and its territories for periods of time. As such, ERIC has an interest in maintaining the ability of companies to offer flexible benefits to these varying employee populations.

ERIC members also offer many health-related and financial benefits in addition to their traditional group health plans, including supplemental benefits, financial support for those who are exposed to certain medical costs, disease-specific benefits, and more. These additional benefits offer employees financial security when faced with high medical costs, improved care for those suffering from complex or chronic illnesses, coordinated care for those who will see numerous medical providers, and more. Continuing to offer these benefits is in the best interest of both employers and employees, and ERIC is committed to promoting policy and regulations that will preserve employers' flexibility to do so.

COMMENTS

I. FLEXIBILITY IS NEEDED TO ENSURE EXPAT PLANS CAN CONTINUE TO BE A VIABLE OPTION FOR EMPLOYEES

ERIC appreciates the Departments' proactive affirmation that expat plans are not subject to many of the new insurance rules required under the Patient Protection and Affordable Care Act (ACA). Some ERIC member companies' expat plans cover employees from more than 100 countries, and these individuals often have expectations of very generous plans due to the health care systems in the countries from which they hail. Other employer plans cover just a small number of

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individuals, often times Americans consulting on projects being primarily conducted by foreign companies. The situations in which expat coverage is needed are as varied as the companies that sponsor these plans, and the individuals that enroll within them.

To the extent that new requirements may be placed on expat issuers, those requirements should be reasonable and not increase costs for plan sponsors or enrollees. If, in seeking to prevent abuse of expat plans, the Departments cause it to be more expensive and less viable for an employer to purchase coverage for employees abroad or within the U.S., this will frustrate the purpose of the ACA, as well as unnecessarily impede the already complicated situation faced by expat families.

As such, ERIC questions the necessity of the 95% threshold for an expatriate plan issuer – requiring that 95% of primary enrollees be expatriates is counter to the goals of the Expatriate Health Coverage Clarification Act (EHCCA), which was meant to encourage coverage of Americans overseas in the kind of quality, affordable plans that U.S. carriers and plan sponsors offer. Choosing 95% seems arbitrary when the statute specified "substantially all," given that the Departments, in other contexts, have used lower thresholds. If this standard leads to fewer U.S.-based plans being qualified as expat plans, that could lead to more employers either (1) dropping coverage for expats, or (2) enrolling them in plans offered by foreign carriers, which might be well below the level of coverage available in American issuers' products. How does this benefit plan beneficiaries?

The issue is complicated further by the way the Departments have defined "qualified expats". Category A expats have to travel outside the U.S. every year in order to qualify, yet events could transpire in such a way that the employer might not foresee, which could mean an assumption at the beginning of a year that an individual would be travelling back and forth might prove to be mistaken. There are also cases in which expat plans are needed to cover dependents outside the country who will not be travelling to the U.S., in which case problems arise as to who the primary enrollee would be in the expat plan. Further, in some cases an employer or issuer has no way of knowing whether or not an individual will need coverage in multiple countries. We recommend that the Departments clarify that the plan sponsor or carrier should be given deference in the case that they reasonably expect an individual to qualify as a Category A expat.

For Category B expats, the requirement that employees must spend 180 or more days outside the country in a given plan year to qualify is problematic. What about an employee whose time outside the country is significant, but does not neatly coincide with a calendar or plan year? Here again it would be helpful for the Departments to clarify that the plan sponsor should be given deference in the case that they reasonably expect an individual to qualify as a Category B expat. Some employers have also requested that the Departments affirm that an individual, who hails from one non-U.S. country, and is working/covered in another non-U.S. country, is captured in this definition – as well as individuals who are transferred to a country in which they do not qualify for medical coverage generally offered in that country, other than the U.S.-based expat plan.

Few major employers have a significant number of Category C expats – save for some employer-related foundations and the like. However, in those limited cases, ERIC questions whether it makes sense for the expats to be required to reside in the U.S. for not more than 12 months. In the case of foreign expats inside the U.S., this would severely limit the usefulness of qualified expat plans. Again, how does this benefit anyone?

II. INDEMNITY AND DISEASE-SPECIFIC BENEFITS IMPROVE THE LIVES OF EMPLOYEES, AND FLEXIBILITY MUST BE MAINTAINED

Plan sponsors often purchase indemnity and disease-specific plans for the purpose of enhancing patient care, improving population health, and protecting employees and their families from the dire financial consequences of certain unfortunate medical events. We acknowledge that the Departments are concerned that patients might be confused, thinking that such plans constitute minimum essential coverage, or that they are comprehensive coverage. However, ERIC believes these concerns are misplaced, and especially for individuals covered by plans sponsored by major employers, there is no reason to believe they would require additional limitations on indemnity or disease-specific plans. Such concerns could easily be addressed by including notice language in already-required disclosures, and that language should be uniform. We understand that most of these plans already have standard disclosure language, and that such language is sufficient to inform enrollees.

In terms of indemnity plans, the Departments propose to radically change how many of these plans operate – requiring that instead of provide financial aid to enrollees based on the financial hardships they are facing (evidenced by their medical claims), all financial assistance should be a standard per-day amount. ERIC believes that allowing increased financial assistance in cases of increased exposure to medical costs bears virtually no risk of confusing plan enrollees about the nature of an indemnity plan – these plans do not act as payment intermediaries between providers and patients; they merely provide financial assistance in the case of certain medical costs a beneficiary incurs. Employers and consumers like these plans products because they provide income replacement when individuals incur certain medical costs, which can be tough for a family to handle when an enrollee has to miss work due to illness, operations, or recovery time.

ERIC does not believe that it is in the best interests of patients to eliminate the flexibility in plan design and force all plan beneficiaries into a one-size-fits all formula that disregards the actual financial hardship they are facing, simply to address an unlikely but perceived risk of confusion. Further, this would disadvantage plan beneficiaries who incur high medical costs, by disallowing higher financial assistance under the indemnity plan for the sickest and most unfortunate plan enrollees.

Further, this new limitation is not supported by the underlying statute. The Employee Retirement Income Security Act of 1974 (ERISA) § 732(c)(2)(C) specifically cites payments "with respect to an event" – and nowhere in statute is authority given to the Departments to redefine excepted benefits in order to exclude plans that base payments specifically on the medical event incurred, rather than on some flat daily amount. As such, ERIC respectfully requests that the Departments withdraw this requirement.

On the subject of disease-specific coverage, ERIC urges the Departments to drop the proposal to limit plans to one or only a few specific diseases. It is unclear what such a limit would mean – is cancer one disease, or would a cancer-only plan be permitted if it covered the more than 200 types of cancer? Where in the statute does it state the Departments may impose a limit on the number of diseases a disease-specific excepted benefit plan may offer? And how would this help patients and their families?

ERIC members believe that disease-specific benefits can be critical tools to assist employees facing serious illnesses. How would it accrue to the patients' benefit to limit these plans to only one or a couple diseases? ERIC believes it would lead to higher costs and more health care dollars wasted on administrative costs if employers or patients had to purchase multiple plans rather to cover multiple conditions, rather than broader disease-specific coverage. If the Departments are once again worried that patients will be confused that these plans constitute

minimum essential coverage or are comprehensive coverage, a simple disclosure included in notices or documents that plans are already required to disclose, should suffice to address the problem. Said disclosure should be succinct, short, and should not be required to contain any language likely to lead to confusion or induce fear in patients that they do not otherwise have comprehensive coverage under another plan.

New limitations on disease-specific plans, as well as new notice requirements, are likely unnecessary due to the fact that many of these disease-specific supplements once again do not serve as payment intermediaries between providers and patients, but rather provide financial assistance to beneficiaries based upon medical costs likely incurred, and to replace income lost due to sickness, missing work, etc. It is highly unlikely that a plan enrollee, especially one who is employed by (or a dependent of someone employed by) a major employer, would confuse the benefits available under a disease-specific plan with the major medical plans offered by ERIC members, all of which constitute minimum essential coverage.

III. SHORT-TERM, LIMITED DURATION PLANS SERVE AN IMPORTANT NICHE, AND THE DEPARTMENTS MUST TAKE A BALANCED APPROACH IN REGULATING THEM

ERIC members comply with the ACA's limitation on waiting periods before an individual is eligible to enroll in an employer-sponsored plan. However, one can imagine numerous instances in which it might be preferable for an individual to maintain a short-term plan longer than three months. If an individual's needs and circumstances prompt them to choose a limited duration plan for four months before enrolling in comprehensive coverage, how does limiting these plans to three months duration (thus requiring the individual to bounce around between two or more plans, and creating more hassle and costs for patients as well as administrative waste) accrue to the benefit of the patient?

It is worth noting that these plans, regulated on the state level, already are subject to oversight by the states – in the case that they purposely mislead consumers or suggest that they are a replacement for minimum essential coverage, the states would have authority to investigate and penalize the plan. The Departments have proposed a very clear and concise disclosure requirement on these plans that makes it obvious to any enrollee that they may be subject to the individual mandate penalty while enrolled in a short-term plan. If an individual freely chooses to enroll in such a plan, knowing of the risk, is it appropriate for the Departments to eliminate the option for those individual who wish to have a policy longer than three months?

ERIC agrees with the Departments that it is critical that stability comes to the state marketplaces and federally-facilitated exchanges. However, forcing people into the marketplaces by eliminating a coverage option like short-term plans, which may be the most cost-efficient and logical choice for a given individual or family at a given time, is an improper way of improving the exchanges' risk pools. Rather than eliminate options for consumers, a better approach would be to reexamine the special enrollment periods the Departments have established, examine the practices of providers and their role in enrolling individuals in coverage, and taking actions to increase the attractiveness of participation in marketplaces by both consumers and health plans.

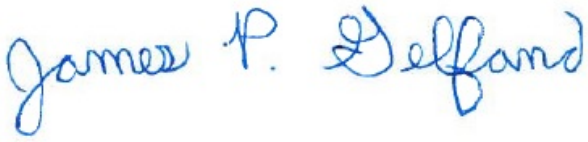
IV. EFFECTIVE DATE SHOULD BE DELAYED AS PLANNING IS ALREADY UNDERWAY FOR THE 2017 PLAN YEAR

At this point in the year, plans are already engaged in the renewal process for the 2017 plan year. As such, it seems overly burdensome to impose new requirements for plans and plan sponsors before 01/01/2018. ERIC requests the Departments to consider delaying the effective date of the

final rule to reflect that plans and plan sponsors need more time to make necessary changes to their assumptions, projections, and compliance regimes.

ERIC appreciates the opportunity to provide comments on this proposed rule. If you have questions concerning our comments, or if we can be of further assistance, please contact us at (202) 789-1400.

Sincerely,



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