

FAQ Regarding Expatriate Health Plans under PPACA

March 22, 2013

In an FAQ released jointly by the Departments of Labor, Treasury, and Health and Human Services (collectively, the “Departments”), expatriate health plans are granted temporary transitional relief from compliance with the requirements of subtitles A and C of Title I of the Patient Protection and Affordable Care Act (“PPACA”), including the group health mandates and market reforms such as coverage of preventive care and the restrictions on lifetime and annual limits, for plan years ending on or before December 31, 2015. For purposes of this transitional relief, an “expatriate health plan” is an *insured* group health plan with respect to which enrollment is limited to primary-insured individuals who reside outside of their home country for *at least six months* of the plan year and any covered dependents of such expatriates. In order to qualify for the transitional relief, expatriate health plans must comply with the pre-PPACA version of Title XXVII of the Public Health Service Act and other applicable law under ERISA and the Internal Revenue Code, including, for example, mental health parity provisions, HIPAA nondiscrimination provisions, and ERISA’s claims procedures, reporting requirements, and disclosure requirements. As an ancillary point, the Departments confirm in the FAQ that coverage provided under an expatriate group health plan is a form of “minimum essential coverage.” Under PPACA, an employer’s failure to offer “minimum essential coverage” to applicable employees may trigger certain shared-responsibility penalties beginning in 2014. A copy of the FAQ (“Affordable Care Act Implementation, Part XIII”) is available [here](#).