The Affordable Care Act - International Implications
March 2013

Below is a white paper prepared at the request of Olympus Managed Health Care that addresses potential issues, which may arise under the Patient Protection and Affordable Care Act (“PPACA”) in connection with inpatiate and expatiate employees. While the paper was commissioned primarily to address certain concerns about the potential impact of PPACA on the non-US international insurance market, many of the issues that are of concern to that industry may be of concern to employers generally.

Background

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (“PPACA”), which provided a comprehensive regulatory overhaul of the health care system in the U.S. The Health Care and Education Reconciliation Act of 2010 (together with PPACA, collectively referred to herein as, the “Act”), signed into law by President Obama on March 30, 2010, reconciled and amended certain provisions of PPACA.

While many aspects of the Act are slowly coming into focus, the implications of the Act for the international medical insurance industry remain largely unclear. The focus of this paper is medical insurance products which are not marketed or sold directly in the U.S., but which provide coverage to individuals who may access the U.S. health care system (“International Products”). These International Products may be offered in the individual market through products such as travel insurance and other products covering treatment in the U.S. for non-U.S. residents (“Travel for Treatment Products”) or in connection with a program maintained by a non-U.S. employer for its employees who will be working in the U.S.

Two of the primary enforcement mechanisms under the Act are penalties imposed on individuals and employers for failing to obtain or provide “minimum essential coverage” and potential excise taxes imposed on an employer and/or insurer for providing coverage that fails to comply with various market reform requirements under the Act (e.g., the prohibition on preexisting exclusions, extension of dependent coverage, coverage of preventative health services, etc.). In other instances, there are separate potential requirements and prohibitions for employers and insurers.

While there is some commonality in the penalties under the Act, because of the way the Act is structured, it is necessary to look...
at each specific prohibition or requirement to determine the potential international impact. Further, the implications of the Act for International Products may vary depending on the type of product involved (e.g., travel insurance vs. inpatient coverage), the time the individual remains in the U.S., or the employment status of the individual involved in the case of inpatients (i.e., whether he or she is employed locally by a U.S. employer, or remains an employee of a non-U.S. affiliate).

As noted in this paper, many of the more thorny issues arising under the Act in the context of International Products center on coverage provided to "inpatients" while working in the U.S. A typical example might be an employee of a Japanese company who is sent on international assignment to one of the company's U.S. subsidiaries. The employee continues to be employed by the Japanese parent and while he is located in the U.S. he is covered by an International Product purchased and offered by his Japanese employer.

Ostensibly, the two key areas of concern for the international insurance industry are: (i) whether International Products can be used to meet the individual and employer mandates under the Act, and (ii) whether International Products will be subject to the Act's various coverage requirements by virtue of covering individuals located in the U.S.

Key Questions

Since the enactment of the Act, the various agencies charged with implementing the Act have begun to provide regulations, rules, and guidance for interpreting the Act. However, guidance on the application of the Act with respect to internationally mobile employees is limited. In all likelihood, many aspects of the international impact of the Act were probably not even considered.

Below are certain questions and answers raised by members of the international insurance industry regarding some key international issues under the Act. The responses to the questions below assume that the employer is an "applicable large employer" under the Act (i.e., generally has more than 50 full-time employees).

1. Will International Products be recognized for the purposes of minimum essential coverage?

The Act does not specifically address this issue and the relevant agencies have not provided regulations or guidance on this matter, but based on a technical reading of the law, the likely answer is "no."

As background, two of the major healthcare reform components encompassed in the Act include the "Individual Mandate" and the "Employer Mandate," each going into effect in 2014. In general, the Individual Mandate provides that all "applicable individuals" must obtain and maintain a certain level of health care coverage, referred to as "minimum essential coverage" or face a penalty. The Employer Mandate (often referred to as the "pay-or-play" requirement) provides that if an "applicable large employer" fails to offer its full-time employees (and their dependents) the opportunity to enroll in "minimum essential coverage," the employer may be subject to a penalty tax.

Notwithstanding appearances to the contrary, the phrase "minimum essential coverage" has little to do with the level of benefits provided under a medical plan. Instead, it deals with the vehicle under which coverage is provided. Under Section 5000A(f)(1) of the Internal Revenue Code of 1986, as amended (the "Code")¹, "minimum essential coverage" (hereinafter referred to as "MEC") means coverage under (i) government-sponsored programs; (ii) eligible employer-sponsored plans (discussed further below); (iii) a health plan offered within the individual market within a State; (iv) grandfathered group health plans; and (v) other coverage recognized by regulation.³

As noted above, the Individual Mandate requires "applicable individuals" to maintain MEC in order to avoid certain penalties. With some exception, as discussed below in Question 3, "applicable individuals" include just about anyone lawfully present in the U.S.
Where an International Product covers an individual and that coverage is unrelated to the individual’s employment, it seems clear that the coverage under the International Product would not constitute MEC for purposes of the Individual Mandate (e.g., travel insurance or Travel for Treatment Products). Where an International Product is being provided by an individual’s home country employer, the issue of whether that coverage constitutes MEC is unclear.

Using the Japanese inpatient example as described above, the issue of whether that coverage would constitute MEC would turn on whether that International Product is providing coverage under an “eligible employer-sponsored plan.” Eligible employer-sponsored plans include, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee that is a governmental plan or “any other plan or coverage offered in the small or large group market within a State.” The Act defines “small and large group market” as the health insurance market under which individuals obtain health insurance coverage through a group health plan maintained by a large employer or by a small employer.

Thus, whether the coverage provided by the Japanese employer described above would constitute MEC would turn on whether the coverage could be considered to be “offered” within a state by virtue of covering inpatients located in a state. At this point the answer to that is unclear.

2. What rules will apply to individuals who are employed by a U.S. company but who leave the U.S. to work abroad?

Individual Mandate

With respect to the Individual Mandate, applicable individuals residing in a foreign country are treated as having MEC, and thus exempt from the Individual Mandate penalty, for any month during which the individual’s foreign residency qualifies them for the foreign earned income exclusion. However, U.S. individuals sent on international assignment do not typically immediately qualify for the foreign earned income exclusion. Thus, there is a potential gap period employers and individuals need to consider. For example, if an individual is employed by a U.S. company and (i) leaves to work abroad on an expatriate assignment, (ii) is not covered by his or her U.S. employer’s health plan, and (iii) does not yet meet the foreign earned income exclusion requirements, it appears possible that the employee could potentially be subject to the penalty under the Individual Mandate. Thus, there is a question as to how that potential gap issue could be eliminated.

Normally, if neither a governmental or employer plan is available to an individual, such individual would generally acquire health coverage under the new U.S. state-based health insurance systems (referred to as “Exchanges”). However, the provision of the Act that addresses the new Exchanges, indicates that only “qualified individuals” may purchase health coverage through an Exchange.

A “qualified individual” means, with respect to an Exchange, an individual who is seeking to enroll in a qualified health plan in the individual market offered through the Exchange and “who resides in the State that established the Exchange.” Thus, that option will likely not be available to the outbound U.S. expat if he is deemed to be not residing in a state. As noted above in Question 1, even if the outbound U.S. expat were to be covered by an International Product in the host country during that gap period it may not constitute MEC.

Applying the Individual Mandate in the foregoing context would seem unreasonable. However, as with many international aspects of the Act, the solutions to the potential gap issue remain unclear.

Employer Mandate

Penalties for failing to comply with the Employer Mandate under Code Section 4980H are triggered only if an employee enrolls in coverage through an Exchange and receives a premium tax credit or cost-sharing reduction. Thus, assuming an outbound expatriate employee is not eligible for coverage under the Exchange (i.e., because they do not reside in the state that established the Exchange), the exclusion of that employee from coverage would not, in itself trigger a penalty. What the exclusion arguably does potentially impact is whether the employer is considered to be properly offering MEC to all its employees if some other employee were to enroll in coverage through an Exchange and receive a premium tax credit or cost-sharing reduction.
Under Code Section 4980H(a) a employer who fails to offer MEC to “full-time employees” is subject to a potential penalty of 1/2 of $2,000 per month per full-time employee if any one employee enrolls in coverage through an Exchange and receives a premium tax credit or cost-sharing reduction. Under Code Section 4980H(b) an employer who offers MEC to “full-time employees” is subject to a potential penalty of 1/2 of $3,000 per month per full-time employee that actually enrolls in coverage through an Exchange and receives a premium tax credit or cost-sharing reduction. Thus, the question is whether the exclusion of an expatriate employee (or group of expatriate employees) is sufficient to cause the employer to be viewed as failing to offer MEC to all its full-time employees potentially subjecting the employer to the harsher penalty under Code Section 4980H(a).

Proposed regulations issued by the IRS under Code Section 4980H (the “Proposed Regulations”) provide some clarity on this issue. Under the Proposed Regulations, the determination of full-time employee status is based on an hours counting paradigm. The hours counting rules under the Proposed Regulations are very complex, but, in general, employees working at least 30 hours per week are considered full-time employees. The Proposed Regulations provide that hours of service are not counted if the compensation for those services constitutes foreign source income under U.S. Federal tax rules. Thus, employees working outside the U.S. generally will not have hours of service and will not count as full-time employees for purposes of calculating any liability under the Employer Mandate. Because the U.S. income sourcing rules differ from the rules regarding the foreign earned income exclusion described above, there should be no “gap” issue as described above with the Individual Mandate.

3. How does the Individual Mandate apply to a person who is temporarily present in the U.S. but not considered tax resident and therefore not obligated to file a return?

As noted, the Individual Mandate applies to “applicable individuals.” The phrase “applicable individual” is defined in terms of what it does not include. Specifically, it does not include an individual if the individual “is not a citizen or national of the United States or an alien lawfully present in the United States.” Thus, the determination of “applicable individual” status focuses only on legal presence.

Thus, an alien technically need only be lawfully present in the U.S. to be subject to the Individual Mandate. However, no penalty is assessed for failing to get coverage under the Individual Mandate if the period without coverage is less than three months (with only one period of three months allowed in one year). Once the period of noncoverage exceeds three months, the parameters of the Individual Mandate become less clear. Thus, many of the typical insureds under travel insurance or Travel to Treatment Products will likely be exempt from the Individual Mandate.

Furthermore, the penalty for failing to comply with the Individual Mandate is to be included with the "taxpayer's return” for the year of failure. Thus, while arguably covered by the Individual Mandate as an “applicable individual,” a nonresident alien not subject to U.S. tax with no U.S. filing requirement may have no downside for noncompliance.

4. How will the Individual Mandate and Employer Mandate apply to non-U.S. citizens who are tax resident in the United States?

Individual Mandate

As noted above in Question 3, the Individual Mandate applies to each “applicable individual” and the definition of “applicable individual” is based merely on lawful presence. Thus, being a U.S. tax resident appears to be irrelevant to the determination of whether someone is subject to the Individual Mandate. However, tax residency will likely require payment of the penalties if there is a violation of the Individual Mandate, while non-tax residents may be immune from enforcement although technically in violation.

Employer Mandate

The implications regarding non-U.S. citizens who are tax resident in the U.S. under the Employer Mandate may well turn on the details of the employment relationship. As noted above, the penalties under the Employer Mandate are only triggered when an employee enrolls in coverage through an
Exchange and receives a premium tax credit or cost-sharing reduction. Thus, as a practical matter, the U.S. inbound inpatient himself is unlikely to trigger the Employer Mandate penalty since he is not likely to attempt to get coverage through an Exchange (because the International Product providing his coverage is equal to or better than the Exchange coverage). That presupposes that (1) the inpatient is considered an employee of the U.S. subsidiary for purposes of the Employer Mandate, and (2) the inpatient could even get coverage through an Exchange (which seems likely, but is not necessarily clear).

Thus, the real question would seem to be whether the inpatient could be considered an employee of the U.S. subsidiary for purposes of the Employer Mandate penalties. That determination affects whether the inpatient could trigger the penalty (which, as noted above, seems unlikely from a practical perspective even if he is found to be an employee of the U.S. subsidiary) and whether failure to offer MEC (assuming the International Product does not constitute MEC) to the inpatient subjects the U.S. subsidiary to the more harsh penalties under Code Section 4980H(a) as described above if someone other than the inpatient ever enrolls in coverage through an Exchange and receives a premium tax credit or cost-sharing reduction (i.e., failure to offer MEC to the inpatient is a failure to offer it to all full-time employees).

From a technical perspective, the Japanese inpatient described above would not be considered an employee of the U.S. subsidiary. However, the Proposed Regulations make it clear that “employer” would mean the entity that is the employer of an employee under the U.S. common-law test. That test looks at a number of factual issues such as who has the ability to direct and control the day-to-day activities of the individual. If, under the common law test, the Japanese inpatient is actually found to be an employee of the U.S. subsidiary you would have the potential issues described above.

In Notice 2011-36, the IRS, among other things, requested comments as to whether there are appropriate exceptions that should be provided for under the Employer Mandate and cited “for example, an exception to permit employers not to offer coverage to nonresident alien employees, who are not required to have coverage under the Affordable Care Act.” This suggested that there may be exemptions from the coverage requirement for certain categories of employees (e.g., inpatients). However, in the Proposed Regulations the IRS opted for a percentage coverage concept rather than providing specific category exclusions.

Under the Proposed Regulations, an employer will be treated as offering coverage to its full-time employees if it offers coverage to all but five percent or, if greater, five of its full-time employees. Thus, even if the inpatient is re-characterized as an employee of the U.S. subsidiary, all may not be lost with respect to the Employer Mandate.

5. Would International Products be required to provide “essential health benefits” under the Act for coverage provided to individuals present in the U.S.?

International Products that are not offered by insurers subject to U.S. state insurance law regulation would not be required to provide “essential health benefits” as required under the Act.

As noted in Question 1, the question of whether a medical plan constitutes MEC generally has nothing to do with the level of benefits provided under the plan. However, certain health plans are required to provide “essential health benefits” under the Act. This requirement is intended to ensure that individuals with certain coverages are not denied access to needed services.

The requirement to provide essential health benefits only applies to coverages offered by a “health insurance issuer” in the individual or small group markets or through an Exchange. “Health insurance issuer” is defined as an insurance company, service or organization (including a health maintenance organization) which is licensed to engage in the business of insurance in a state and which is subject to state insurance law regulation. Since International Products are not subject to U.S. state insurance laws, International Products would not be required to provide essential health benefits.
6. **Would International Products be subject to the prohibition on preexisting condition exclusions for coverage provided to individuals present in the U.S.?**

Effective January 1, 2014, group health plans and health insurance offered in the group or individual markets may not impose preexisting condition exclusions with respect to coverage. Specifically, the Act provides that “a group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.” As noted above a “health insurance issuer” is defined as an insurance company, service or organization (including a health maintenance organization) which is licensed to engage in the business of insurance in a state and which is subject to state insurance law regulation. Thus, similar to the exclusion from the requirement to provide essential health benefits, providers of International Products are not directly affected since they are not a “health insurance issuer” for purposes of the Act.

The unanswered question would be whether International Products could be impacted indirectly through the application of the prohibition on preexisting exclusions to group health plans. For this purpose a “group health plan” is defined as an “employee welfare benefit plan” (as defined in ERISA) that provides for medical care to employees or their dependents. This would include both insured and self-insured arrangements. Under ERISA, an “employee welfare benefit plan” is a plan "established or maintained by an employer."

Currently, the potential penalty for failing to comply with the prohibition on preexisting conditions is the imposition of an excise tax under Code Section 4980D. That excise tax is imposed on the "employer."

Using the Japanese inpat example described above, the Japanese parent company is the employer. Thus, even if found to be in violation, there would likely be practical issues associated with imposing a tax on the Japanese parent. However, as noted above, the determination of who is an employee (and thus, who is an employer) is based on a facts and circumstances test. If the inpat were determined to actually be an employee of the U.S. subsidiary would that be sufficient to permit the excise tax to be imposed on the U.S. subsidiary? Arguably, the answer should be “no” since the relevant plan is not “established or maintained by an employer.” However, does that result change if the U.S. subsidiary is actually reimbursing the Japanese parent for the cost of the insurance benefit?

Furthermore, in a number of instances the Act uses a controlled group test to determine who is the relevant employer. Thus, would the fact that the Japanese parent and U.S. subsidiary are in the same controlled group be sufficient basis to impose the excise tax on the U.S. subsidiary? The answer to that would seem to be “no.” The Act appears to specifically identify the instances in which a controlled group concept is to be used and that is not addressed in the preexisting exclusion rules. Similarly, while ERISA (which provides us with the definition of “group health plan” and “employer” for purposes of the preexisting exclusion rules) uses controlled group concepts in specific instances under the statute, that concept is not built into the definition of employer.

Obviously, if an excise tax could be imposed on a U.S. subsidiary where International Products do not comply with the preexisting exclusion rules, that could have a chilling effect on the use of International Products for inbound employees. While the questions above remain unanswered, it would seem unlikely that the excise tax would be imposed in this context.

7. **Would International Products be subject to the Cadillac Plan excise tax for coverage provided to individuals present in the U.S.?**

It is unclear how the so-called “Cadillac Plan” excise tax would apply to non-U.S. employers and more importantly offerors of International Products. To summarize, beginning in 2018, Code Section 4980I imposes a 40% excise tax on the “excess benefit” provided to the employees under any “applicable employer-sponsored coverage.” The “excess benefit” is determined by comparing the cost of the actual coverage provided (calculated using rules similar to those for determining COBRA premiums) to annual adjusted limits. For 2018, the annual limit for employee-only coverage is $10,200 per year (as adjusted by a “health cost adjustment percentage”) and the annual limit for coverage other than employee-only coverage is $27,500 per year (as adjusted). The “health cost adjustment percentage” takes into account year-to-year increases in the cost of health care...
Employers are required to calculate the amount of the excess benefit subject to the excise tax and determine each coverage provider’s “applicable share” of the excess benefit. A coverage provider’s applicable share of an employee’s excess benefit is determined by multiplying the total excess benefit for the employee by the ratio of the cost of the coverage provided to the employee by the coverage provider to the aggregate cost of all applicable coverage. The Act generally defines “coverage providers” in relevant part to include: (i) in the case of fully-insured group health plans, the health insurer, and (ii) in the case of a self-insured plan, the person that administers the plan (e.g., a TPA).

Unfortunately, the Act and the relevant agencies have not clearly provided guidance on whether “applicable employer-sponsored coverage” would include a program maintained by a non-U.S. employer which uses an International Product. However, Code Section 4980I does incorporate the controlled group concept described in question 6 above for purposes of determining who is an employer. Thus, it may well include a plan maintained by the Japanese parent in our example above. Unlike the excise tax related to preexisting condition exclusion violations, the Cadillac Tax is imposed on the insurer rather than the employer. As with any of the Act excise taxes, imposing those taxes directly on an International Products provider would seem to present a number of practical problems.

**Conclusion**

Ultimately, the impact of the Act on International Products remains unclear. Most of the provisions of the Act that could impact International Products and their providers are not yet effective. Thus, there is the possibility of more guidance prior to the effective date of those provisions.

Unfortunately, a policy analysis of the Act does not necessarily give any guidance on how some of these issues will be resolved. For example, if the ultimate policy goal is to make sure that applicable individuals have coverage, one might argue that coverage under International Products should be considered for purposes of determining MEC. However, there is also an arguable interest of driving individuals into the U.S. insurance markets in order to subsidize the overall cost of the Act. Although, the relative size of the International Products market would seem to have little impact on that objective.

As outlined above, the punitive aspects of the Act will likely not directly reach providers of International Products in most instances. However, the potential impact of the Act on global employers sponsoring programs that use International Products could have an indirect impact on the industry.

* * *

Pursuant to requirements related to practice before the Internal Revenue Service, any tax advice contained in this communication (including any attachments) is not intended to be used, and cannot be used, for purposes of (i) avoiding penalties imposed under the United States Internal Revenue Code or (ii) promoting, marketing or recommending to another person any tax-related matter.

---

1 The Act amended the Code to include the Individual Mandate.
2 For example, Medicare, Medicaid, the Children's Health Insurance Program, coverage for members of the U.S. military (including the TRICARE program), veterans' health care, health care relating to Peace Corp volunteers, and health care through the Defense Department’s Nonappropriated Fund Health Benefits Program.
3 That is, other health benefits coverage, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of the Act.
4 Within the meaning of Section 2791(d)(8) of the Public Health Service Act.
5 Code Section 5000A(f)(4).
6 42 U.S.C. § 18032(f)(1)(A)(ii). Also, the individual must be a U.S. citizen or national or an alien lawfully present in the U.S.
7 Code Sections 4980H(a) and (b).
8 In general, the premium credit is only available if the employer coverage is unaffordable of fails to provide minimum value as determined under the Act.
However, there are certainly situations in which a nonresident alien may be subject to tax and required to file a tax return (e.g., Form 1040-NR).

Note that there are instances in which a tax resident may not be required to pay U.S. taxes or file a U.S. return.

Note that this issue is inherently present in any secondment arrangement with implications in a number of areas outside the Act.

Note that the preamble to the Proposed Regulations seems to suggest that is intended as a margin of error in providing coverage rather than a specific ability to intentionally exclude a group of full-time employees from coverage.

Note that this requirement is already effective for individuals under age 19.