AssuredPartners

Telehealth Overview

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Healthcare consumers and plan sponsors alike are increasingly turning to remote care options to address both cost and access issues. A wide array of telehealth plans is available in today's healthcare market and can vary regarding both the types of services provided and the cost-sharing strategies implemented. Some telehealth benefits are offered as part of a larger group medical plan, while other times it is offered as a stand-alone arrangement. The compliance requirements applicable to a telehealth plan vary in accordance with the details of the specific plan.

ERISA

Any group plan maintained by an employer for the purpose of providing medical care or benefits for its employees is subject to ERISA. For these purposes, medical care is defined as *"amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body."* Most telehealth plans provide access to licensed healthcare professionals who may perform diagnostic assessments, recommend treatment options, and write prescriptions. Therefore, most telehealth plans provide medical care and are subject to ERISA. NOTE: Certain employers are exempt from ERISA regardless of what type of benefits they offer. Telehealth benefits offered by government or church employers are NOT subject to ERISA. In addition, telehealth benefits offered by tribal employers are sometimes exempt depending on who is allowed to participate.

Group Health Plan Status

We are aware that many telehealth vendors argue that they are a medical provider, not a health plan. However, when the employer coordinates and pays for the arrangement on behalf of its employees and their family members, it creates a group health plan.

ERISA requires plans to name fiduciaries (typically the plan administrator(s) or employer) who are responsible for carrying out certain fiduciary duties in accordance with ERISA. The overarching requirement is for plan fiduciaries to act in the best interests of plan participants. Such duties include, amongst other things, selecting appropriate vendors and setting and following plan terms such as benefit inclusions/exclusions, eligibility for coverage, and claims procedures. As an ERISA-covered benefit, there must be plan documentation and a summary plan description (SPD). One document could potentially serve both purposes. Alternatively, the telehealth benefits could be included in a WRAP document along with the employer's other benefits that are subject to ERISA. In addition, a Form 5500 is required annually if the telehealth benefit has 100 or more

participants, or if the telehealth is part of a bundled ERISA plan via a WRAP document, the telehealth benefits should be included on the Form 5500 that is filed on behalf of the bundled ERISA plan.

ACA

The Affordable Care Act (ACA) requires health plans to set limits on the amount that a participant can be required to pay for in-network essential health benefits (EHBs) by requiring that OOP maximums for health plans not exceed a particular amount. In addition, health plans are required by the ACA to cover items that are considered preventive without imposing any copayments, coinsurance, deductibles, or other cost-sharing requirements. As telehealth plans generally do not comply with these requirements, telehealth plans should be integrated with a major medical plan (i.e., available only to those enrolled in a major medical plan) to ensure compliance with these requirements. In other words, plan sponsors should consider limiting telehealth eligibility to those who are enrolled in the employer's major medical plan or another employer's group health plan, e.g. that of a spouse or parent. That being the case, we appreciate that there are many employers currently offering stand-alone arrangements with no real enforcement occurring. Further guidance on stand-alone telehealth benefits (those not integrated with a major medical plan) would be helpful.

COBRA

Federal COBRA (the Consolidated Omnibus Budget Reconciliation Act) applies to employers with 20 or more employees in the preceding calendar year, but not to government or church plans. Federal COBRA continuation requirements apply more broadly than just to the major medical plan. COBRA applies to employer-sponsored group health plans that provide medical care, utilizing the same definition of medical care described above for purposes of ERISA application. Therefore, most telehealth plans will be subject to COBRA, requiring covered employers to offer continuation coverage for the applicable maximum coverage period (e.g., 18, 29 or 36 months) to qualified beneficiaries when they experience a COBRA qualifying event (e.g., termination of employment, reduction in hours, or loss of dependent status). If the telehealth plan is integrated with the major medical plan, COBRA can be offered on the two plans on an integrated basis as well. But if the telehealth plan is offered to employees who are not enrolled on the major medical plan the telehealth plan will have to be offered on a stand-alone basis to all employees and dependents who experience a COBRA qualifying event.

Health Savings Account (HSA) Eligibility

Only eligible individuals can make contributions to their HSA account. To be eligible to contribute to an HSA, an individual:

- Must be enrolled in a qualifying high-deductible health plan (HDHP);
- May not have any other "disqualifying coverage"; and
- Cannot be claimed as a tax dependent by another individual.

Most medical coverage available to an individual prior to meeting the minimum statutory HDHP deductible will cause HSA ineligibility. However, there is an exception for preventive coverage, as well as for permitted insurance and permitted coverage. Most telehealth plans will be disqualifying other coverage unless the telehealth plan charges a fair market value fee for each use at least until the employee incurs medical expenses equal to the minimum required HDHP deductible.

Telehealth Relief

To encourage individuals to avoid hospitals when appropriate during the COVID-19 health crises, Congress passed relief permitting coverage for telehealth and other remote care services outside the HDHP and before satisfying the deductible of the HDHP while maintaining HSA eligibility. Since that time, such relief has been extended on multiple occasions. However, employers who intend to ensure that their employees remain HSA eligible during the 2025 plan year and beyond may need to prepare to make changes to their telehealth benefit offerings to preserve such eligibility. The simplest solution may be to remove access to telehealth programs entirely for those enrolled in the employer's qualified HDHP. Alternatively, employers could choose to offer a telehealth program which charges fair market value until the minimum HDHP deductible is met.

Mental Health Parity and Addiction Equity Act (MHPAEA)

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans offering mental health (MH) or substance use disorder (SUD) benefits to provide such benefits "in parity" with (equal to or better than) the medical/surgical coverage available under the group health plan. MHPAEA does not require group health plans to provide MH or SUD benefits, but if they do offer such benefits beyond what is considered preventive under the ACA, the parity requirements apply. MHPAEA applies to group health plans, but not excepted benefits or retiree-only plans. For purposes of compliance with the parity rules, the term "group health plan" includes not only a major medical plan offering, but also other benefits providing MH/SUD benefits such as telehealth benefits.

If an employer or organization has multiple arrangements by which it provides health care benefits, and any participant can simultaneously receive coverage for medical/surgical benefits and MH/SUD benefits, such combination of arrangements is treated as a single group health plan subject to the parity requirements. Therefore, plan sponsors will generally be required to consider the telehealth plan in conjunction with their other health care benefits when determining whether parity exists between its MH/SUD and medical/ surgical benefits. It may violate MHPAEA requirements to offer telehealth solely for medical/surgical benefits or to offer a $0 copay for medical/surgical benefits while requiring a higher copay for MH/SUD benefits. On the other hand, if material differences in access related to network composition are discovered between a plan's MH/SUD and medical/ surgical benefits, the rules suggest it may be appropriate to expand telehealth benefits to remedy the issue.

HIPAA Privacy & Security

As a group health plan, a telehealth arrangement is subject to HIPAA privacy and security requirements. The covered entity (the telehealth plan) is prohibited from using or disclosing protected health information (PHI) except as required or permitted by the privacy rule, and the covered entity must have appropriate administrative, technical, and physical safeguards to protect the privacy of any PHI. In addition, any service providers/vendors used to administer or facilitate the telehealth benefits and who may have access to PHI in connection with the arrangement would likely be business associates and should be required to enter into a business associate agreement (BAA) with the plan. It would be appropriate to inquire as to whether any such service providers/vendors have appropriate administrative, technical and physical safeguards in place, especially for any electronic communications.

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