Telemedicine, On-Site Clinics and Other New Plan Options: Avoid the Traps for the Unwary

Jay Kirschbaum, J.D., LLM, FLMI
Vice President Compliance Services
Lockton
St. Louis, Missouri
Lineup

- Background.
- Wellness programs.
- Telemedicine.
- Second opinion services.
- On-site clinics.
- Concierge medicine.
- Health FSAs.
- HRAs (health reimbursement arrangements).
- HSAs (health savings accounts).
- Opt-out incentives.
- Supplemental coverage.
- EAPs.
Why the fuss?

- Background
  - These are arcane points of law, the stuff that lawyers (but nobody else) love to discuss.
  - The enforcement risk is modest, but more than zero.
    - Demonstrate compliance when/if investigation occurs.
  - Most often comes up in mergers/acquisitions context.
Wellness programs
Wellness programs

What are they?
- Employer programs that encourage healthy behaviors/lifestyles.
  - Participatory: incentives to partake in activities irrespective of impact on specific health measures.
  - Outcomes-based: incentives to partake in activities dependent on factors attributable to healthy outcomes. Typically includes biometric screening and diagnostic information.

ERISA
- Applies to all medical plans.
- If it includes biometrics, diagnosis—wellness is a medical plan.
- Consolidate with an underlying medical plan or need a separate document, etc.

COBRA
- Applies to group medical plans.
- Wellness plan is subject to COBRA.
  - Availability.
  - Notices.
  - Cost.
  - Incentives.
Wellness programs

- **HIPAA**
  - Self-funded—must comply with HIPAA privacy, nondiscrimination, etc.
  - Fully insured—maintain “hands-off” policies.

- **ACA**
  - Standard ACA requirements apply.
    - 30 percent/50 percent incentive possible.
    - Reasonable alternative standard.
  - Stand-alone program (or permitting employees who do not participate in group medical plan) does not meet ACA/PHSA requirements.

- **ADA/GINA- regulations due to be vacated in 2019.**
  - 30 percent of self-only coverage for incentive.
  - GINA restrictions on spousal participation if health questions are asked.
Telemedicine programs

- **What are they?**
  - Medical plan options whereby participants can obtain medical advice from a medical professional remotely either telephonically or via other electronic means.
  - The medical professional may be able to offer a diagnosis from self-reported symptoms and prescribe treatment. If not, he/she may have to refer the patient to other professional.
  - Typically very cost effective for routine issues.

- **ERISA**
  - Typically includes sufficient care (more than first aid) so it is a medical plan.
  - Subject to ERISA and plan document requirements.
  - Includes eligibility and coverage requirements.

- **COBRA**
  - Applies to group medical plan.
    - Availability.
    - Notices.
    - Cost.
Telemedicine programs

- **HIPAA**
  - Self-funded—must comply with HIPAA privacy, nondiscrimination, etc.
  - Fully insured—maintain “hands-off” policies.

- **ACA**
  - NOT excepted benefits.
  - Stand-alone program (or permitting employees who do not participate in group medical plan) does not meet ACA/PHSA requirements.
  - $100/day for each incident of noncompliance (up to $500,000).
  - Mandates
    - Preventive care.
    - Patient protections.
    - Clinical trials.
    - SBC Distribution.

- **HSA coordination**
  - Must require full payment of “fair market value” for services used below HDHP deductible levels.
Second opinion services
Second opinion services

- What are they?
  - Medical plan options whereby the medical plan can participants or the plan itself will obtain a second opinion from an unrelated physician.
  - The goal is to avoid unnecessary, costly and invasive treatments or provide assurance regarding the diagnosis and recommended treatment.
Second opinion services

- **ERISA**
  - Typically includes sufficient care (more than first aid) so it is a medical plan.
  - Subject to ERISA and plan document requirements.
  - Includes eligibility and coverage requirements.

- **COBRA**
  - Applies to group medical plan.
    - Availability.
    - Notices.
    - Cost.
Second opinion services

- HIPAA
  - Self-funded—must comply with HIPAA privacy, nondiscrimination, etc.
  - Fully insured—maintain “hands-off” policies.

- ACA
  - NOT excepted benefits.
  - Stand-alone program (or permitting employees who do not participate in group medical plan) does not meet ACA/PHSA requirements.
  - $100/day for each incident of noncompliance (up to $500,000).
  - Mandates
    - Preventive care.
    - Patient protections.
    - Clinical trials.
    - SBC Distribution.

- HSA coordination
  - Must require full payment of “fair market value” for services used below HDHP deductible levels.
On-site clinics
On-site clinics

- **What are they?**
  - An employer offering of health and wellness services from licensed medical professionals. They may be on the premises of the employer (i.e., on-site) or in a nearby location (sometimes referred to as "near-site"). The services range from first aid and treatment of minor illnesses to ongoing medical services including vaccine administration and other health and wellness services.

- **ERISA**
  - Applies, unless restricted to first aid, minor illnesses or injuries.
  - Limit participation to those enrolled in group medical plan or must comply with ERISA requirements as a stand-alone plan.

- **COBRA**
  - Applies unless restricted to first aid.
  - If employer is not part of larger group plan, employer must comply with all COBRA obligations.
    ▶ Availability.
    ▶ Notices.
    ▶ Cost.
  - Alternatives to having former employees seek treatment on site:
    ▶ Offer the same services at another clinic nearby.
    ▶ Do not end services until after the COBRA period to avoid the necessity of alerting former employees.
On-site clinics

- **HIPAA**
  - Are excepted benefits for portability and nondiscrimination.
  - Privacy and security still apply.
    - Self-funded plans—must comply with privacy and security.
    - Fully insured plans—must maintain a hands-off stance.

- **ACA**
  - They are excepted benefits so they are not subject to PHSA benefit mandates.
  - Not considered MEC, so they will not avoid ESRP penalties.

- **HSA coordination**
  - Must require full payment of “fair market value” for services used below HDHP deductible levels.
Concierge medicine
Concierge medicine

- **What is it?**
  - There are different models that generally include an annual fee permitting a subscriber to have access to a primary care physician. Since the physician limits the number of subscribers, access is intended to be much more available than a typical fee-for-service offices. It may or may not include some additional services as part of the annual fee.

- **ERISA**
  - Voluntary benefit exception might apply.
  - “Enhanced” access to care, but no other discounts, so an exception might apply.
  - Most include some “free” or included services; if so, ERISA applies.
    - Incorporate in larger group plan or would require.
    - Plan documents.
    - 5500s.
    - SPDs, etc.

- **COBRA**
  - Applies if employer offers medical care.
  - If they are not part of larger group plan, employer must comply with all COBRA obligations.
    - Availability.
    - Notices.
    - Cost.
Concierge medicine

- HIPAA
  - Self-funded—must comply with HIPAA privacy, nondiscrimination, etc.
  - Fully insured—maintain “hands-off” policies.

- ACA
  - Stand-alone program (or permitting EES who do not participate in group medical plan) does not meet ACA/PHSA requirements.
  - $100/day for each incident of noncompliance (up to $500,000).
  - Mandates.
    - Preventive care.
    - Patient protections.
    - Clinical trials.
    - SBC distribution.

- HSA coordination
  - Issue if “premium” includes medical service at no additional cost.
  - Must require full payment of “fair market value” for services used below HDHP deductible levels.
Health FSAs

What are they?

- Notional (unfunded bookkeeping) accounts reimbursing out-of-pocket medical expenses.
- Small self-insured healthcare plan.
  - Ongoing administrative scheme.
  - Claim substantiation.
  - Plan documents/SPDs, etc.
- Typically funded by employee pretax contributions, employer contributions are possible (don’t go north of $500).
- Essential features of health FSAs:
  - “Uniform availability” rule:
    - FSA election for the year must be fully available on day 1, and
  - “Use it or lose it rule”:
    - Any residual year-end balance forfeited unless FSA has either “grace period” or “carryover” feature.
Health FSAs

- **ERISA**
  - ERISA (including its 5500 requirement) applies.
  - ERISA (but not the tax code) restricts use of unused account balances at year end, i.e., forfeitures.
    - Use to pay plan expenses, increase benefits or distribute pro rata.

- **COBRA**
  - Generally applies, unless:
    - Is the FSA an “excepted benefit” for HIPAA purposes or
    - Account was “underspent” on date of qualifying event.
  - Excepted benefit - COBRA doesn’t extend beyond end of plan year; if excepted benefit and account overspent COBRA doesn’t apply at all.
  - If COBRA applies the FSA must comply with all COBRA obligations.
    - Availability, notices, cost.
    - BTW, what is the COBRA rate?
Health FSAs

- **HIPAA**
  - HIPAA privacy and security apply.
  - HIPAA portability/nondiscrimination do not apply—the FSA is “excepted benefit”—if employer doesn’t contribute more than $500 to participant’s account, and FSA not made available to employees not also eligible for medical coverage.

- **ACA**
  - If “excepted benefit” FSA is not subject to ACA mandates, like cost-free preventive care . . .
  - . . . but neither is it “minimum essential coverage” for purposes of Tier 1 of ACA employer mandate.

- **HSAs**
  - Disqualifying coverage, for HSA purposes, unless reimburses only dental, vision or preventive care (“limited purpose FSA”), or is high deductible FSA.
  - Health FSA grace periods and carryover rules can have adverse HSA eligibility implications.

- **Nondiscrimination**
  - Health FSA is subject to section 105(h) nondiscrimination rules.
  - **Practical tip:** Look to disparity in eligibility rather than disparity in elected benefit amounts.
HRAs (health reimbursement arrangements)
HRAs (health reimbursement arrangements)

**What are they?**

- Notional (unfunded bookkeeping) accounts reimbursing out-of-pocket medical expenses.
  - Using funded accounts raises ERISA issues.
- Small self-insured healthcare plan.
  - Ongoing administrative scheme.
  - Claim substantiation.
  - Plan documents/SPDs, etc.
- Funded only by employer contributions.
- HRAs are amazing, under-utilized programs.
  - No “use it or lose it” rule.
  - Employer decides what benefits are reimbursable, what is forfeited, what can be carried over and for how long.
  - Forfeited amounts return to the employer, as long as the HRAs are not “funded,” as through a trust account.
  - Recently proposed IRS rules would re-invigorate HRAs as a vehicle to reimburse individual market premium for larger employers.
HRAs (health reimbursement arrangements)

- **ERISA**
  - ERISA applies.
    - Plan document/SPD.
    - Form 5500.

- **COBRA**
  - COBRA applies: availability, notices, cost.
  - The COBRA premium . . . it’s not 102 percent of the benefit made available for the year (it’s less than that).

- **HIPAA**
  - HIPAA privacy, security, nondiscrimination and portability all apply.
  - It is not a HIPAA nondiscrimination problem that an employee’s available balance for subsequent years may be lower, on account of claims experience, than another employee’s balance.
HRAs (health reimbursement arrangements)

- ACA
  - Old regs—HRAs for active employees (unless there’s just one employee) must “integrated” with medical coverage, unless the HRA is a qualifying small employer HRA (QSEHRA); HRAs for retirees need not be integrated. “Integration” means:
    ▶ The employer offers other group coverage beyond mere “excepted benefits” (e.g., dental, vision, typical health FSA).
    ▶ The individual covered by the HRA is actually enrolled in other group coverage through this or another employer (e.g., spouse’s employer).
    ▶ The HRA doesn’t reimburse essential health benefits unless the other group coverage is at least minimum value.
    ▶ Annual opt-out right.
  - If the HRA reimburses premium under the employer group plan, the HRA benefit can be taken into account for affordability purposes under the employer mandate.
  - If it can only be used to pay out-of-pocket medical expenses under the employer’s group medical plan, can be taken into account for minimum value purposes.
  - Need not report coverage on a Form 1095-C, Part III if the employee’s medical coverage through the employer is reported on a 1095-C or -B.
  - If the HRA reimburses expenses of dependents (of active employees) not covered under the employer’s medical plan:
    ▶ The dependents must be enrolled in other group medical coverage, and
    ▶ ACA reporting applies; employer must supply a Form 1095-C reflecting months of the dependents’ self-insured coverage under the HRA.
HRAs (health reimbursement arrangements)

- ACA
  - New regs—Allow larger employers (those subject to the ACA employer mandate) to use HRAs to integrate with individual market coverage, beginning in 2020.
    - Individual coverage HRA—ICHRA.
    - Excepted benefit HRA—EBHRA.
ICHRA

- Reimburse premiums or other unreimbursed health care expenses
- Cannot also offer traditional coverage
  - May offer to different groups of permissible classifications:
    - Full-time employees.
    - Part-time employees.
    - Salaried employees.
    - Non-salaried (e.g., hourly) employees.
    - Seasonal employees.
    - Temporary employees of staffing firms.
    - Bargaining unit employees.
    - Non-resident aliens with no US-source income.
    - Employees working the same geographic location (generally, the same insurance rating area, state or multi-state region).
    - Employees who have not met the employer’s waiting period for medical coverage.
    - Any group of employees formed by combining two or more of these classes.
  - Classes must be at least:
    - 10 employees if employer < 100 employees
    - 10% if employer is 100-200 employees
    - 20 is employer >200 employees.
HRAs (health reimbursement arrangements)

- **ICHRA**
  - Individuals must actually enroll in individual coverage (or Medicare A&B or C).
  - Must have opportunity to opt out at least annually.
  - Employer notice obligations (model is 6 pages long).

- **ACA implications (full guidance coming)**.
  - Adequate to purchase affordable, silver policy in individual’s market.
  - Affordability determined by premium less HRA amount.

- Not necessarily an ERISA plan.

- OK with HSA as long as only for premiums (and not other OOP expenses).
Health reimbursement arrangements/accounts

- **EBHRA**
  - Employer option to provide up to $1800 (as adjusted) in an HRA to purchase excepted benefits.
    - Dental.
    - Vision.
    - Similar excepted benefits.
  - No restriction tied to employer group coverage.
  - No obligation to enroll in individual coverage.
  - Reimburse OOP expenses including premiums except group medical and Medicare.
  - Must be offered to all similarly situated employees.
HRAs (health reimbursement arrangements)

- **HSAs**
  - Disqualifying coverage unless the HRA reimburses only dental, vision or preventive care ("limited purpose FSA") or is a high-deductible HRA.

- **Nondiscrimination**
  - Subject to section 105(h) nondiscrimination rules.

- **Ordering rule**
  - Unless the HRA document provides otherwise, it must pay before a health FSA.
HSAs (health savings accounts)
HSAs (health savings accounts)

- **What are they?**
  - Funded, trusteed accounts holding actual dollars in employee’s name.
  - Beyond control or reach of the employer.
  - Eligibility to make contributions to an HSA depends on enrollment in qualifying high-deductible medical coverage, and lack of coverage under disqualifying, low-deductible medical coverage.

- **ERISA**
  - ERISA doesn’t apply unless employer:
    - Makes HSA anything but voluntary (although the employer can deposit seed money into an HSA on a unilateral basis), or
    - Restricts the employee from moving money from one HSA to another or restricts uses of the HSA funds, or
    - Is slow in moving employee contributions to the HSA.

- **COBRA**
  - If ERISA does not apply, then COBRA does not apply.
  - The underlying high-deductible health plan is subject to COBRA.
HSAs (health savings accounts)

- HIPAA
  - No applicability unless ERISA applies.

- ACA
  - The typical HSA program is not a group health plan and is not subject to ACA requirements, nor is it MEC.

- Nondiscrimination
  - Comparability rules apply, but avoided if employees may make their own pretax contributions to their HSAs directly or via cafeteria plan.
  - Cafeteria plan nondiscrimination testing, however, will take into account pretax dollars pushed through the plan into HSAs.

- Cafeteria plan election changes
  - Cafeteria plans must permit employees to change their HSA contribution election at least monthly.
Opt-out incentives
Opt-out ("cash or coverage") incentives

- What are they?
  - Choice between health insurance coverage and additional cash compensation.

- ACA
  - Affects affordability—incidence added to employee’s premium cost-share for affordability determinations unless:
    - Incentive in place prior to Dec. 16, 2015, or
    - Incentive is “eligible opt-out arrangement”—opt-out payments only available to employees who provide reasonable evidence they have minimum essential coverage somewhere else during plan year.

- Cafeteria plans
  - Employer is offering choice between nontaxable benefit (health insurance) and taxable benefit (cash), this is a cafeteria plan or employees who elect health insurance will be taxed on the value of cash they could have received.
  - Most cafeteria plans written broadly enough to encompass the opt-out without need of plan amendment.
Medicare/Tricare

- “I know! Let’s encourage all our Medicare-eligible and military retirees to take the government’s coverage in lieu of ours . . . let’s offer a cash-or-coverage incentive just to them!”
- Opt-out incentives create issues under Medicare and TRICARE coordination rules unless they are available broadly to employees other than those who are Medicare or TRICARE eligible.

FLSA and similar state overtime rules

- Opt-out incentives have been viewed by some courts as affecting overtime calculations; incentive amount is added to basic rate of pay when determining overtime rates.
Supplemental coverage
Supplemental coverage

What is it?
- Health coverage that supplements medical coverage by paying for things like cost sharing (deductibles, copayments, etc.).

ERISA
- ERISA applies.
- Typically, supplemental coverage will be considered part of the medical plan whose benefits are supplemented so, e.g., no need for separate Form 5500 filings, for example.

COBRA
- COBRA applies.
- Can avoid a separate COBRA notice and coverage obligation if supplemental coverage is considered part of/bundled with another medical plan, and COBRA rate and election are also bundled.
Supplemental coverage

- HIPAA
  - Supplemental coverage is “excepted benefit” under HIPAA’s portability and nondiscrimination rules if meets specific requirements:
    - Is **insured** under **separate insurance policy** (cannot be self-insured; but see the discussion on next slide about HRAs).
    - Supplemental policy is issued by entity that **does not provide the primary coverage** which supplemental policy is supplementing.
    - **Fills gaps in cost sharing** (deductibles, copayments, co-insurance) under medical plan it is supplementing, and/or supplements that plan with additional nonessential health benefits.
    - Cost of supplemental coverage cannot exceed **15 percent of the cost of the primary coverage**.
    - Supplemental coverage doesn’t differentiate in eligibility, benefits or premiums based on any health status factor of an individual.
Supplemental coverage

- **ACA**
  - Supplemental coverage that is a HIPAA “excepted benefit” is not subject to the ACA’s benefit mandates.
  - Supplemental coverage that fails to meet “excepted benefits” exemption from HIPAA is potentially problematic under ACA’s mandates (e.g., preventive care mandate, ban on dollar limits, etc.).
  - A **self-insured** supplemental arrangement like an integrated HRA is permissible under separate rules for “integration” under the ACA.
Employee assistance programs
Employee assistance programs

- What are they?
  - Employee benefits that, at least, provide referrals for counseling sessions.
  - Contemporary EAPs typically provide (pay for) a certain number of counseling sessions per year.

- ERISA
  - EAPs that provide mere referrals for counseling are not ERISA benefits.
  - ERISA applies to EAPs that provide (pay for) counseling benefits.

- COBRA
  - If ERISA applies and participation is not confined to enrollees in another medical program that is already satisfying the COBRA notice and other COBRA requirements—so confining it creates other issues (see next slide)—EAP must itself satisfy COBRA obligations, including relevant COBRA notices.
  - As a practical matter—seldom accomplished by EAP vendor or enforced by federal authorities . . . few employees even contemplate COBRA rights under and EAP, and even fewer would buy it.
Employee assistance programs

- HIPAA
  - HIPAA privacy and security apply to EAPs.
  - However, most EAPs are considered "excepted benefits" under HIPAA portability and nondiscrimination rules (a fact that makes life easier for EAPs under the ACA; see next slide).
  - To be considered an excepted benefit, the EAP cannot:
    ▲ Provide significant medical care benefits.
    ▲ Coordinate with another group health plan (i.e., EAP benefits cannot be delayed until the employee exhausts counseling benefits under another group health plan, and EAP coverage can't be limited to employees enrolled in another group health plan).
    ▲ Require employees to pay premiums.
    ▲ Include cost sharing (copays, deductibles, etc.).
Employee assistance programs

- **ACA**
  - Most EAPs are “excepted benefits” under HIPAA, meaning they are not subject to ACA benefit mandates.
  - However, if EAP is **not** excepted benefit (see previous slide) and if participation is not confined to enrollees in another medical program that is already satisfying ACA mandates . . .
  - . . . EAP might itself be medical plan subject to ACA benefit mandates (such as preventive care mandate) and disclosure obligations (such as SBC requirement) but would not satisfy applicable rules, potentially triggering significant penalties.
  - Applies with respect employees who are not required to be covered by ACA because they are not full-time employees.

- **HSAs/HDHPs**
  - EAPs providing “insignificant” benefits, such as free or low-cost, short-term counseling for substance abuse, alcoholism, mental health or emotional disorders, financial or legal difficulties, or dependent care needs, are not considered disqualifying, low-deductible medical coverage.
Conclusion

- No overt enforcement activity.
- Comes up most often in due diligence.
- Employee complaints.
- Proper procedures help convince investigators that they have no enforcement concerns.
Questions?

“If you ask me anything I don’t know, I’m not going to answer.”

–Yogi Berra