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MEMORANDUM

TELEMEDICINE ARRANGEMENTS: BEWARE OF INADVERTENTLY DIALING UP AN EXCISE TAX

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In an effort to save money and provide employees with more convenient health care delivery options, a growing number of employers are adding telemedicine arrangements to their overall benefits package. Telemedicine generally refers to the provision of medical care by physicians or other health care professionals via the Internet or phone-video system, rather than in-person. Patient consultations using a telemedicine vehicle operate like a virtual doctor's office visit, with the physician providing a diagnosis and treatment plan and even issuing a prescription if necessary. There obviously is no opportunity for the doctor to palpate any part of the patient, but then again, the patient doesn't have to sit in a waiting room for hours on end reading three-year-old issues of *Field and Stream*.

As one might expect, there is a broad array of legal pitfalls dotting the landscape of these telemedicine arrangements. It is our understanding that most program sponsors have done a good job addressing issues like physician state licensure requirements and informed consent rules. Our primary concern, though, is for the sponsoring employers. Unless the telemedicine arrangement is structured in just the right way, employers may find themselves on the hook for excise taxes of $100/day ($36,500/year) per participant. Moreover, depending on how the program is offered, participants enrolled in both the telemedicine arrangement and a high deductible health care plan may be precluded from making (or receiving) contributions to their Health Savings Account. In short, there is much that can go wrong. It is critical, therefore, that employers proceed with caution.

I. – Potential Imposition of Excise Taxes Under the Affordable Care Act

One of the most significant concerns for employers offering telemedicine arrangements is the potential imposition of excise taxes. The basic problem is that a telemedicine program is, by definition, a "group health plan" under ERISA, the Internal Revenue Code (the "Code"), and the Public Health Service Act ("PHSA"). Unless it is

properly structured – a very difficult task in light of the underlying objective of telemedicine programs – the plan will not satisfy all of the market reform requirements (e.g., the prohibition on annual and lifetime limits, the prohibition on cost sharing for preventive health services, etc.) of the Affordable Care Act ("ACA"), which in turn could trigger enormous excise taxes.

The preventive services mandate is particularly problematic for telemedicine plans. Under the final regulations, preventive health services include immunizations, screenings, and other tests that realistically can only be performed through an in-person visit to the doctor's office. If such services are performed by an in-network provider, there can be no cost sharing. Moreover, if a plan does not have an in-network provider that can provide such services, then the plan cannot impose any cost-sharing for the services to be performed out-of-network. *It is difficult to see how any telemedicine arrangement can comply with this mandate on its own*.

An employer whose group health plan fails to satisfy any of the ACA's market reforms is subject to excise taxes of $100/day "with respect to each individual to whom such failure relates." In other words, an unwitting plan sponsor could be exposed to excise taxes up to $36,500/year for *every single participant in the plan*! That's enough to ruin not only Christmas, but every other holiday that falls on a day ending in the letter Y.

The fact that the employer is offering to its employees some other fully compliant major medical plan does not, in and of itself, negate the telemedicine plan's obligation to meet all the ACA's market reform requirements. The market reform mandates apply to *every group health plan* that is not a HIPAA-excepted benefit. A stand-alone telemedicine plan is no different.

The Code does state that the excise tax does not apply where the employer's compliance failure was not discovered despite its exercise of reasonable diligence. Further, if the "failure was due to reasonable cause and not to willful neglect," and the failure is promptly corrected, then the tax may be greatly reduced or even avoided altogether. But it is a well settled legal doctrine that mere ignorance of the law is no excuse.

Nor, technically, can an employer wait for the feds to come knocking before paying the excise tax. Indeed, the IRS treats the tax as a *self-reporting* obligation. Employers are supposed to complete a Form 8928 by the due date for filing their personal tax returns. Penalties and interest await them if they do not.

Even non-federal governmental employers cannot bask in a penalty-free zone. While the Code's excise tax provisions do not apply to such employers, the PHSA empowers the U.S. Department of Health & Human Services ("HHS") to impose civil penalties of up to $100/day "with respect to each individual to whom such failure relates" for a failure to comply with the ACA's market reforms. The PHSA contains the

same penalty limitations and relief as the Code. Non-federal governmental employers should tread even more lightly, though, because one would suspect that HHS currently has more resources and agents to enforce this mandate than does their IRS counterparts.

A. – Is A Telemedicine Plan an Employee Assistance Program?

In an effort to avoid the market reform requirements, some telemedicine providers have sought to characterize their plans as an "employee assistance program" ("EAP"). An EAP is a HIPAA-excepted benefit and is thus exempt from the ACA's market reform mandates. But characterizing a telemedicine arrangement as an EAP is no slam dunk. The final regulations on excepted benefits issued in October 2014 declared that, to be considered an EAP, the program must satisfy each of the following four requirements:

1. The EAP does not provide significant benefits in the nature of medical care. For this purpose, the amount, scope and duration of covered services are taken into account;

2. The benefits under the EAP are not coordinated with benefits under another group health plan, as follows:

    a. Participants in the other group health plan must not be required to use and exhaust benefits under the EAP (making the EAP a gatekeeper) before an individual is eligible for benefits under the other group health plan; and

    b. Participant eligibility for benefits under the EAP must not be dependent on participation in another group health plan;

3. No employee premiums or contributions are required as a condition of participation in the EAP; and

4. There is no cost sharing under the EAP.

As evidenced by elements three and four, if a telemedicine plan has any chance at being properly considered an EAP, it must be *completely free* to employees. No premium, deductible, co-payment, or any other form of cost sharing would be permitted.

Element one, though, is far more muddled. Federal regulators have offered little insight into what constitutes "significant benefits in the nature of medical care." The Preamble to the final excepted benefit regulations states that "employers may use a reasonable good faith interpretation" in defining this phrase. In 2013 proposed regulations, federal agencies invited comments as to whether the following types of

programs might constitute a valid EAP: a program providing no more than ten outpatient visits for mental health or substance use disorder counseling; an annual wellness checkup; immunizations and diabetes counseling with no inpatient benefits. Would a telemedicine arrangement in which employees can meet with a physician at any time (albeit over the web or by phone) to discuss some physical malady they are experiencing and possibly even receive a prescription fall within this definition? While it is impossible to say for sure without further guidance, we are very skeptical.

B. – Integration: The Path to Excise Tax Avoidance?

If the telemedicine plan cannot be legitimately treated as an EAP, another possible fix to the market reform requirements would be to integrate the telemedicine arrangement with the employer's major medical plan. Because the major medical plan presumably satisfies all of the ACA's market reform mandates, the concern over excise taxes largely vanishes.

The problem we often see, though, is that the employer makes the telemedicine program available to employees who are not participating in, or even eligible for, the medical plan. Some employers also give employees who *are* enrolled in the medical plan the opportunity to opt out of the telemedicine component (by, for example, not paying the extra premium associated with the telemedicine plan). This will not work. If participants in the medical plan can decline coverage in the telemedicine plan, then the plans are not integrated. Anything less than an "all or nothing" choice will not get the employer over the necessary threshold.

C. – If All Else Fails, Avoid Employer Plan Sponsorship

If an employer cannot (or does not want to) integrate the telemedicine arrangement into its major medical plan, and the arrangement cannot be accurately characterized as an EAP, it still may be possible for the employer to avoid the market reform mandates by adhering to the so-called "ERISA safe harbor." In other words, the employer would simply not "establish or maintain" a telemedicine group health plan. The telemedicine plan would instead be treated as a voluntary plan. To accomplish this objective, the employer would have to adhere strictly to each of the following requirements:

- *No Employer Contributions*. All premiums must be paid entirely by the employee. The employer cannot make any contribution towards the cost of the premium. This also means that employees would have to pay their premiums on an *after-tax* basis;

- *Voluntary Participation*. Participation in the program must be completely voluntary for employees;

- *No Employer Endorsement*. The employer cannot endorse the program in any way. Its role is strictly limited to allowing the telemedicine provider to publicize the program to employees and remitting employees' after-tax premiums to the provider; and

- *No Employer Benefit*. The employer must not receive any cash or consideration from the telemedicine provider for allowing such provider to offer the program to the employer's employees.

If all of these conditions are satisfied, the telemedicine arrangement would be exempt from ERISA. The employer's total absence of any contribution to, or endorsement of, the plan also would mean that the employer did not establish a group health plan for purposes of the Code or the PHSA. That, in turn, would render the market reform requirements inapplicable.

II. – Potential Impact of Telemedicine Arrangement on Health Savings Account Contributions

Even if ACA excise taxes can be circumvented, there is another potential impediment to telemedicine arrangements: depending on how they are structured, they may be incompatible with a Health Savings Account ("HSA"). In order to be eligible to contribute to an HSA during any particular month of the year, an individual must be covered under a high deductible health plan ("HDHP") as of the first day of that month. In addition, with only a handful of narrow exceptions, the individual cannot have any coverage under a *non-HDHP* that provides benefits for medical care covered by the HDHP. The IRS has clarified this prohibition to mean that any benefits under the non-HDHP coverage cannot kick in until after the individual has met the HDHP's deductible. Depending on the nature of the telemedicine plan, therefore, participants may be precluded from contributing to an HSA.

But this rule is not absolute. Some non-HDHP coverage is disregarded. For example, if the non-HDHP coverage can be legitimately characterized as an EAP, the IRS has said that such coverage would likewise be compatible with HSA contributions. Further, the Code carves out an exception for "preventive" services; in other words, if the non-HDHP coverage is merely providing "preventive" care, then the HDHP participant can still contribute to an HSA notwithstanding the otherwise disqualifying coverage.

A. – Is Integration a Solution to Compatibility?

Some employers have questioned whether integrating a telemedicine arrangement with their HDHP will make the joint plan compatible with HSA contributions. As noted earlier, this integration does allow the employer to avoid imposition of excise taxes for

failure to adhere to all of the ACA market reforms. HSA compatibility, however, is a different story. Unless the telemedicine plan can be characterized as an EAP or somehow limited to providing preventive services, it is hard to see how integrating the telemedicine plan with the HDHP negates the problem of disqualifying coverage. Absent such carve-outs, the telemedicine program would be providing non-preventive service medical care coverage before the participant's HDHP's deductible had been satisfied.

Endeavoring to get around this problem, some insurers that incorporate telemedicine arrangements into their HDHP policies require participants to pay for each virtual doctor's visit until the deductible has been satisfied. Whether these efforts are successful likely will depend on the exact details of the structure. Is a participant on the hook for the full cost of the visit, or is he/she responsible only for a co-payment? If the latter, the HSA incompatibility issue may well still exist.

Particularly given the recognized utility of these programs, perhaps regulators will at some future date explicitly sanction this kind of dual coverage in tandem with HSA contributions. Until that day arrives, though, there is real risk that offering a telemedicine arrangement in conjunction with an HDHP will preclude participants from making (or receiving) contributions to their HSA.

B. – Is Telemedicine "Preventive" Care?

If the integration road is blocked, what about the "preventive" care path? It, too, looks less than promising. The big issue here is what exactly is meant by "preventive" care and does it capture the type of coverage provided by a telemedicine plan? The Code's HSA rules look to the Social Security Act's definition of "preventive services." The Social Security Act, which is as long as *War and Peace* and as penetrable as Kevlar, defines "preventive services" to include all of the following:

- Screening and preventive services;
- Initial preventive physical examinations; and
- Personalized prevention plan services.

The "screening and preventive services" referenced in the Social Security Act all appear to encompass procedures that would have to be done in person at the doctor's office. The same is likely true of "initial preventive physical examinations," which include height and weight measurements, blood tests, blood pressure exams, and other physical screenings. To be sure, there are preventive services – especially the "personalized prevention plan services" that clearly could be performed in a virtual setting. But do physicians meeting with patients over the Internet as part of a telemedicine arrangement strictly confine themselves to the type of "personalized prevention services" set forth in the Social Security Act? It's doubtful.

This makes perfect sense. After all, one of – if not *the* – main benefits of telemedicine is to enable individuals to meet promptly with a doctor upon experiencing some sort of health concern. Sure, certain preventive care may be provided in the virtual visit, but those preventive services would represent only a small component of the overall arrangement.

C. – Improper HSA Contributions Potentially Trigger Excise Taxes

This situation creates a serious dilemma for employers and employees alike. If the non-HDHP telemedicine coverage cannot be properly characterized as an EAP or "preventive" care, then any individual covered under both the HDHP and the telemedicine plan will be unable to contribute (or have contributions made on his/her behalf) to an HSA. Meanwhile, if improper contributions are made to the HSA, the HSA holder may be subject to an excise tax of 6% of the amount of the excess contribution. This could be an even bigger punch to the gut because the excise tax is cumulative; that is, if the excess HSA contribution is not distributed, a 6% tax will apply to the full amount of the excess contribution each and every year. Although the responsibility for this excise tax technically rests with the employee, any employer who inadvertently subjects its employees to the tax will be about as popular as *E. coli* at the company barbecue.

If the problem is caught early enough, the excise tax may be avoidable. The rules for doing so, however, are complicated and beyond the scope of this Alert. An employer finding itself in this situation should contact experienced benefits counsel as soon as possible to avoid making the problem even worse.

III. – Conclusion

Clearly, fitting telemedicine plans into the complex regulatory environment governing employer-sponsored health care can be a tricky endeavor. These are unchartered waters, with potential dangers lurking behind every bend. No doubt, employers will increasingly find themselves encountering similar challenges as the health care delivery system evolves and as they continue to seek novel approaches to control their escalating health care expenses. It is essential, therefore, that employers tread carefully to ensure that they do not unwittingly invite even greater costs by running afoul of obscure federal statutes and regulations. Unlike, say, a Kardashian marriage, telemedicine may well be around for a long time. But taking refuge in a non-compliant arrangement could be a cure far worse than the disease.

If you have any questions regarding telemedicine arrangements or, more generally, regarding the impact of health care reform on employers, please feel free to call Eric Namee, Brad Schlozman, or Steven Smith at (316) 267-2000.