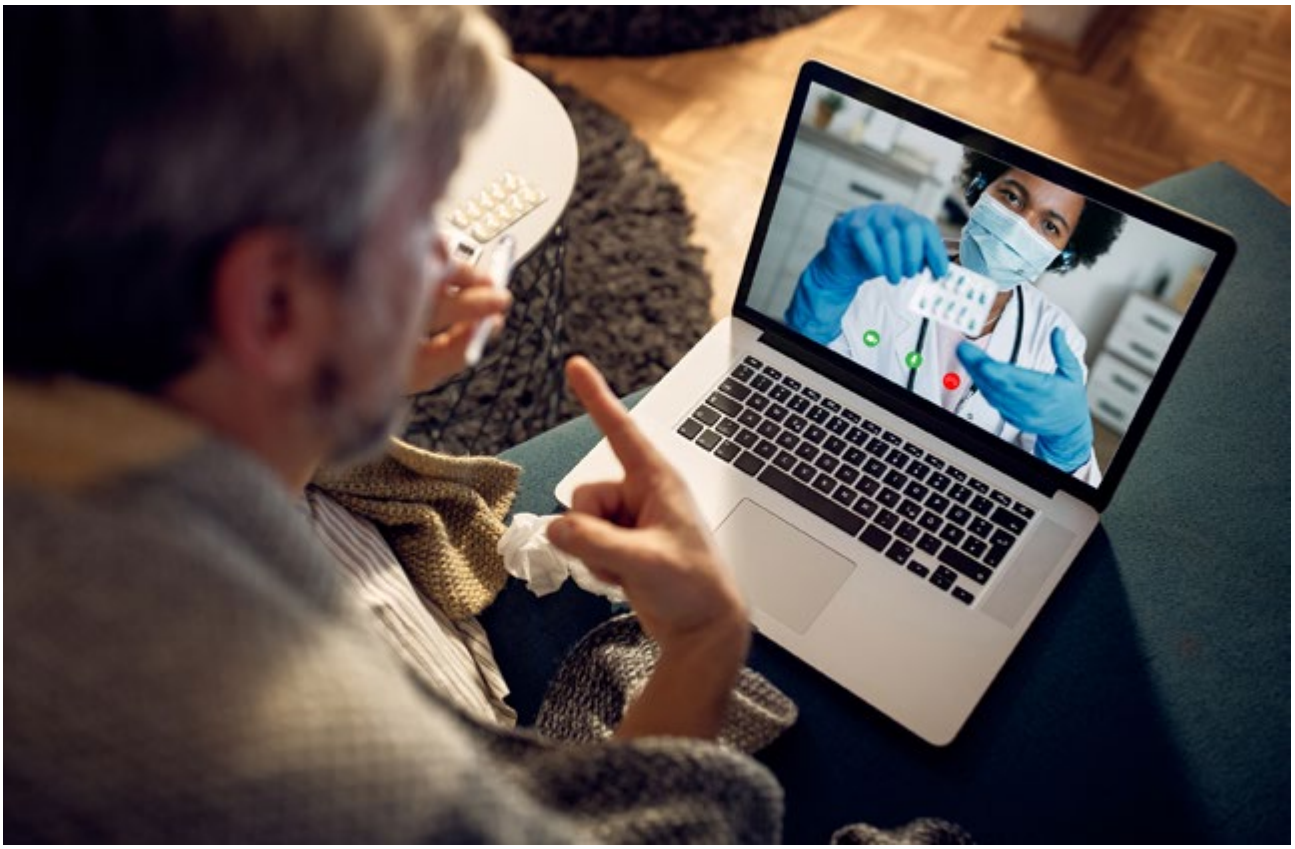

EXTENDED TELEHEALTH RELIEF FOR HSA PLANS

Written By Andrew Silverio, Esq.

The COVID-19 pandemic has given rise to many practical and regulatory challenges for self-funded plans and those that serve them. Most of these regulatory changes create important protections for plan participants but create significant burdens and potential exposure for plans – this includes significant expansions to COBRA rights under the American Rescue Plan Act of 2021, vaccine and testing mandates under the FFCRA and CARES Act, and the extension of various plan deadlines relating to claim submission, appeals, enrollment, and COBRA.

There is an important allowance in the CARES Act which benefits both plans and participants, however – under this, high deductible health plans (HDHPs) may provide benefits for telehealth services without application of any cost-sharing and without regard to whether any deductible has been met without impacting the plans' ability to be paired with a health savings account (HSA).

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Without this allowance, an HDHP providing any "first-dollar" coverage for non-preventive services would destroy the plan's HSA compatibility, having serious tax consequences for all participants utilizing the HSA. This allowance was set to expire at the end of 2022; however, the passage of the Consolidated Omnibus Appropriations Act (2023) extends it through the end of 2024.

This means that HDHPs using HSAs may (but are not required to) continue to offer first-dollar coverage for telehealth and telemedicine services, whether preventive, through the end of plan years beginning on or before December 31, 2024.

It's important to note, however, that this relief does not include an extension of a waiver that currently allows providers to prescribe controlled substances via telehealth for substance abuse treatment. Because of this, most telehealth providers will default back to existing regulations which severely limit their ability to prescribe controlled substances for patients they haven't treated in person.

The need for this relief is attributable to the severe restrictions imposed on HDHPs by the regulations governing HSAs. In order to utilize an HSA, an individual must be covered under an HDHP which complies with strict limitations, most notably that the plan applies at least a minimum required deductible to almost all non-preventive services ($1,500 for individual coverage in 2023).

Additionally, an individual using an HSA must have no other health coverage besides that HDHP. These requirements in tandem severely limit HDHPs' ability to create steerage within the plan benefit structure, and thus their ability to utilize many popular cost-containment techniques.

For example, an HDHP cannot exempt certain high-cost non-preventive drugs from its deductible to steer individuals toward a specialty management program without bumping up against the "first-dollar" coverage requirement, while it also can't create parallel coverage for those drugs outside the plan without bumping up against the "other coverage" problem.

These challenges are the major trade-off HDHP sponsors make in return for the tax benefits of making an HSA available. ■