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THE RISK REPORT

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Coverage Evolution

Virtual-First Health Care Plans Hit the Market

IN THE continuing quest to reduce health care costs and make care more accessible, a new type of health plan has been taking shape: The virtual-first health plan.

These evolving plans integrate virtual care delivery models into a comprehensive health plan that encourages enrollees to access virtual care with their doctors before resorting to an in-person visit. These plans are coming to market as Americans have gotten use to virtual visits with their doctors during the last three years of the COVID-19 pandemic and virtual care becomes more common even in traditional health plans.

While the uptake is still quite small – 6% of employers surveyed in 2022 offered these plans – it's expected to grow quickly over the next few years. Most of the major health insurers have already announced various tie-ups with virtual care providers and tech vendors to improve their telemedicine offerings.

A recent survey by Mercer found that, among organizations with 500 or more employees:

- 52% planned to offer virtual behavioral health care in 2023.
- 40% planned to offer a virtual primary care physician network or service in 2023.
- 21% already offer virtual specialty care, like for dermatology or diabetes.

Plan benefits

There are a number of benefits to virtual-first primary care:

Reduced costs – Telemedicine visits cost less than in-person visits, and they can yield additional savings through technological efficiencies.

Convenience and easier access – Patients don't have to drive to the doctor's office, check in, or sit in the waiting room. They can meet with their doctor from their home.

Better health outcomes – Virtual-first plans may often put a premium on health record integration across the care spectrum to ensure that all care team members have access to them.

How they work

Virtual-first health plans include the same coverage as traditional health plans, including fee-for-service, health maintenance organizations and preferred provider organizations, but they focus on directing enrollees to telemedicine options for their doctor's visits.

The key difference is that they aim to significantly reduce costs by incentivizing enrollees to seek out virtual care first through plan design, incentives and advocacy.

Sessions can often be performed virtually, saving both the patient and doctor time, while reducing the costs for each visit.

Virtual-first plans incorporate the same arrangements as traditional health plans, except that most doctor's visits will be online, or via a smartphone app.

When a patient needs to see their doctor, they'll schedule the visit on their account and they need to opt out of a virtual visit if they feel that they need to see the doctor in person.

Additionally, if possible, specialist visits can also be conducted on the app or website.

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Legislative Action

Bill Would Pave Way for Stand-Alone Telehealth Coverage

A BIPARTISAN BILL of House legislators in February reintroduced legislation from 2022 that would pave the way for employer-sponsored, stand-alone telehealth benefits plans.

The bill is important as the current law allowing health insurers to cover telehealth benefits sunsets at the end of 2024, which would be difficult for many patients and providers who have grown accustomed to telehealth visits with their physicians.

The legislation, however, takes a different approach by instead making telehealth benefits separate from a health plan.

A similar measure died in committee last year due to congressional inertia during an election year. The current legislation has bipartisan support with sponsorship by Rep. Angie Craig, D-Minnesota, Rep. Ron Estes, R-Kansas, Rep. Mikie Sherrill, D-New Jersey, and Rep. Rick Allen, R-Georgia.

The bill

The goal of the Telehealth Benefit Expansion for Workers Act would be to make stand-alone telehealth benefits separate, and not a replacement for a group health plan. Instead, employers would be able to offer them under a group health plan or group health insurance coverage as excepted benefits.

Excepted benefits are additional coverages that employers can, but are not required to, offer, like vision or dental insurance. Federal law dictates what qualifies as an excepted benefit, which necessitates the legislation to add telehealth services to the mix.

Why is the legislation needed?

Prior to the COVID-19 pandemic, health plans were unable to cover telehealth services under the law. But, when the outbreak first started, followed by lockdowns, telemedicine was sometimes the only option patients had to get face time with their physicians.

As a result, lawmakers enacted legislation that allows health plans to cover patients' video and phone visits with their doctors. Those laws were set to sunset 151 days after the COVID-19 public health emergency expires.

But the budget bill signed into law at the end of 2022 extends and expands telehealth flexibilities under the law through Dec. 31, 2024. Those flexibilities include:

- Expanding originating sites to include any sites where patients are located, including their homes.
- Extending coverage and payment for audio-only telehealth services.

What's next

This measure has only just been introduced, but since it was crafted by Democrats and Republicans, and considering the eventual sunsetting of telehealth provisions, there is some urgency in getting permanent legislation on the books.

However, as telemedicine grows in use and popularity, elected representatives may feel pressured to make permanent the current law that allows health plans to cover video and telephone visits with their physicians. ❖

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Look for Strong Member Engagement, Seamless Integration

The takeaway

Virtual-first care plans are an evolving product and it's important to find a plan that can truly save you money while not sacrificing quality of care.

These plans are still in their infancy and are hitting the market in increasing numbers. But because they are new, there is no uniform standard for them. The most important aspects to look for in these plans are strong member engagement and seamless integration to ensure quality of care.

Give us a call if you have questions about these plans and if carriers in the area are offering them, and whether they are a good fit for your organization. ❖

Employers 'Unwavering' in Providing Insurance: Study

EMPLOYERS ARE unwavering in their plans to continue offering group health plans to their workers instead of funding individual reimbursement accounts that would allow them to buy coverage on exchanges, according to new research.

The poll of 26 health benefits decision-makers at large firms by the Commonwealth Fund and the Employee Benefits Research Institute (EBRI) found that despite rising premium and care costs, they felt obligated to offer coverage to their workers.

Employers since 2019 have been allowed to fund individual coverage health reimbursement accounts (ICHRAs) with pre-tax dollars for their employees to satisfy the Affordable Care Act's employer mandate. Workers use their ICHRA funds to purchase a plan on government-run exchanges.

The health benefits decision-makers at large firms told researchers that jettisoning their group health insurance benefits would make it more difficult to attract and retain talent.

Why Firms Are Standing Pat

- They felt they could offer their workers a better deal. *"We liked to have control. We can do a better job with design than the exchanges."* – **Health care company benefits executive**
- They felt they simplified insurance for their staff, who would possibly feel overwhelmed by the choices on exchanges. *"We don't want [workers] out shopping on their own, [exchange plans] aren't easy to understand."* – **Financial services company benefits executive**
- They said their firms have a responsibility to help workers make better insurance decisions. *"It would make workers feel like you were cutting and running."* – **Benefits executive at a manufacturing firm**
- They didn't want to be the first to completely disrupt the group health benefits paradigm. *"A big part was trepidation. Nobody wanted to be first."* – **Benefits executive at an insurance company**

Some of the interviewees said that funding ICHRAs and sending their workers to ACA exchanges would rob the company of the opportunity to help workers manage expensive health conditions.

For example, under IRS rules, employers may cover some drugs and services on a pre-deductible basis for workers who are enrolled in HDHPs with attached health savings accounts.

Employee satisfaction

But likely the biggest reason for not taking the ICHRA leap is the effect on employee satisfaction. Executives told the researchers that the workers expect them to provide a "suitable menu of health benefits options" and that they trust that their employer has shopped around for the best deal that doesn't reduce quality.

Additionally, they felt that their workers would not be happy about being shunted to an exchange and having to take it on themselves to sift through the myriad of plans available to them at different cost and benefit structures.

"[Employees] don't really take the time or energy to really understand, and they don't want to. They trust us to make the decision for them," one benefits executive told the researchers.

The takeaway

While this survey was only of large employers, market indications are that most mid-sized and smaller firms have also been sticking to providing their employees with health insurance coverage.

Offering a comprehensive group health plan is still the best way to retain and attract talent while satisfying the employer mandate under the ACA. Even for employers not subject to the mandate, to be competitive in the job market, offering health insurance is still a priority.

Finally, treading into ICHRA territory requires foresight and planning and companies have to prepare for possible blowback if the employees don't like the exchange experience or can't get the same coverage at the same out-of-pocket costs as they did before.

Doing it incorrectly, such as not funding the accounts with enough money, could open your organization up to fines. ❖

Most Employees Spend Little Time Choosing Their Health Plan

A NEW STUDY has found that individuals enrolled in high-deductible health plans (HDHPs) are more engaged than their traditional plan counterparts during open enrollment, spending more time on choosing plans and using employer-provided tools to help them make their choices.

Despite their higher engagement though, overall, 72% of group health plan enrollees spent less than an hour on their plan during last year's open enrollment, according to the "2022 Consumer Engagement in Health Care Survey" by the Employee Benefits Research Institute and Greenwald Research. Also, one in five didn't spend any time researching or tending to their health plan and were just automatically re-enrolled.

The study's authors said there are likely a few reasons U.S. workers are not spending a significant amount of time researching health plans during open enrollment.

Why employees are zipping through the open enrollment process

Satisfaction with their plan – The study found that 90% of employees were satisfied or somewhat satisfied with their employer's open enrollment process. As mentioned, 20% of participants auto-renewed, indicating they are likely satisfied with their plan.

More choices – Employees that have more plans to choose from may find the process of comparing and contrasting plans overwhelming.

Too many obligations – Many employees likely want to spend more time researching plans, but everyday work, family, social and community obligations can get in the way.

Source: Consumer Engagement in Health Care Survey

HDHP enrollees more engaged

HDHP enrollees on most metrics were more involved in plan selection and research during open enrollment than their traditional plan counterparts.

For example, 29% of HDHP enrollees spent more than an hour researching plans during open enrollment, compared to 23% of those enrolled in traditional plans.

They were also more likely to use employer-provided tools to choose a plan, such as employee benefits guides, online portals and educational videos.

One of the driving factors for plan choice was whether the plan covered preventative care for chronic conditions pre-deductible.

Nearly one-half (45%) of HDHP enrollees said that pre-deductible coverage of preventative care for chronic conditions affected their decision to select the HDHP to a great extent.

Additionally, 25% of traditional plan enrollees said they would be extremely or very likely to select an HDHP if it covered preventative care for chronic conditions before they reach their deductible.

The takeaway

With so few employees spending more than an hour researching plans during open enrollment, some of your workers may be choosing the wrong coverage for their life circumstances.

While open enrollment only happens during the last few months of the year, you can still provide educational resources to your staff during the rest of the year to educate them on their plan choices and how to choose the best one for their life situation.

You can also encourage them to use the resources you and we provide them to help make educated decisions about their coverage. ❖