118TH CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPT. 118–132
Part 1

TELEHEALTH BENEFIT EXPANSION FOR WORKERS ACT OF 2023

JUNE 30, 2023.—Ordered to be printed

Ms. FOXX, from the Committee on Education and the Workforce, submitted the following

R E P O R T

together with

MINORITY VIEWS

[To accompany H.R. 824]

[Including cost estimate of the Congressional Budget Office]

The Committee on Education and the Workforce, to whom was referred the bill (H.R. 824) to amend title XXVII of the Public Health Service Act, the Employee Retirement Income and Security Act of 1974, and the Internal Revenue Code of 1986 to treat benefits for telehealth services offered under a group health plan or group health insurance coverage as excepted benefits, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Telehealth Benefit Expansion for Workers Act of 2023".

SEC. 2. TREATING BENEFITS FOR TELEHEALTH SERVICES OFFERED UNDER A GROUP HEALTH PLAN OR GROUP HEALTH INSURANCE COVERAGE AS EXCEPTED BENEFITS.

(a) ERISA.—

(1) IN GENERAL.—Section 733(c)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(c)(2)) is amended—

(A) by redesignating subparagraph (C) as subparagraph (D); and

(B) by inserting after subparagraph (B) the following new subparagraph: "(C) Benefits for telehealth services.".

(2) MAINTAINING APPLICATION OF CERTAIN PROVISIONS.—Section 732(c)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191a(c)(1)) is amended—

(A) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively, and adjusting the margins accordingly;

(B) by striking "The requirements" and inserting the following:

"(A) IN GENERAL.—Except as provided in subparagraph (B) and subject to subparagraph (C), the requirements."; and

(C) by adding at the end the following new subparagraphs:

"(B) APPLICATION OF PROVISIONS.—The requirements of sections 2704, 2705, and 2712 of the Public Health Service Act, as applied under section 715, shall apply to any group health plan or group health insurance coverage in relation to its provision of excepted benefits described in section 733(c)(2)(C).

"(C) REQUIREMENT FOR PROVISION OF NOTICE WITH RESPECT TO TELEHEALTH EXCEPTED BENEFITS.—Subparagraph (A) shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 733(c)(2)(C) unless such plan or coverage (as applicable) provides to each participant or beneficiary enrolled under such plan or coverage (and to each individual seeking to enroll under such plan or coverage) a notice that distinguishes between the benefits provided under a group health plan or group health insurance that meets the requirements of this part and the benefits provided under a group health plan or group health insurance coverage that provides only excepted benefits described in section 733(c)(2)(C).".

(3) CONFORMING AMENDMENT TO APPLICATION PROVISION.—Section 715(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185d(a)) is amended—

(A) in paragraph (1), by inserting ", other than section 2722 of such Act," after "Affordable Care Act)"; and

(B) in paragraph (2), by inserting "(other than such section 2722)" after "a provision of such part A".

(b) PHSA.—

(1) IN GENERAL.—Section 2791(c)(2) of the Public Health Service Act (42 U.S.C. 300gg–91(c)(2)) is amended—

(A) by redesignating subparagraph (C) as subparagraph (D); and

(B) by inserting after subparagraph (B) the following new subparagraph:

"(C) Benefits for telehealth services.".

(2) LIMITATION ON EXCEPTION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.—Section 2722(c)(1) of the Public Health Service Act (42 U.S.C. 300gg–21(c)(1)) is amended—

(A) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively, and adjusting the margins accordingly;

(B) by striking "The requirements" and inserting the following:

"(A) IN GENERAL.—Except as provided in subparagraph (B), the requirements."; and

(C) by adding at the end the following new subparagraph:

"(B) APPLICATION OF PROVISIONS IN THE CASE OF INDIVIDUAL HEALTH INSURANCE COVERAGE FOR CERTAIN EXCEPTED BENEFITS.—The requirements of subparts I and II shall apply to any individual health insurance coverage in relation to its provision of excepted benefits described in section 2791(c)(2)(C).".

(c) IRC.—Section 9832(c)(2) of the Internal Revenue Code of 1986 is amended—

(1) by redesignating subparagraph (C) as subparagraph (D); and

(2) by inserting after subparagraph (B) the following new subparagraph:

"(C) Benefits for telehealth services.".

(d) PUBLICATION OF MODEL NOTICE.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Labor, in consultation with the Secretary of Health and Human Services and the Secretary of the Treasury and taking into account input from the public, shall publish a model notice that may be used by a group health plan or group health insurance coverage (as such terms are defined in section 733 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b)) for purposes satisfying the requirement of section 732(c)(1)(C) of such Act, as added by subsection (a).

(e) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after the date of the enactment of this Act.

PURPOSE

H.R. 824, the *Telehealth Benefit Expansion for Workers Act of 2023*, amends the *Employee Retirement Income Security Act of 1974* (ERISA)[1] and the Internal Revenue Code of 1986 (Code)[2] to expand coverage, lower costs, and promote a healthy workforce by allowing for telehealth excepted benefit plans.

COMMITTEE ACTION

116TH CONGRESS

Second Session—Hearing

On January 28, 2020, the Committee on Education and the Workforce's Subcommittees on Health, Employment, Labor and Pensions (HELP) and Workforce Protections (WP) held a joint hearing entitled "Expecting More: Addressing America's Maternal and Infant Health Crisis," which examined trends in maternal and infant mortality in the United States and related policy proposals, including expanding access to health care through telehealth. Testifying before the subcommittees were Ms. Stacy Stewart, President and CEO, March of Dimes, Washington, D.C.; Ms. Nikia Sankofa, Executive Director, United States Breastfeeding Committee, Washington, D.C.; and Ms. Joia Crear-Perry, Founder and President, National Birth Equity Collaborative and Black Mamas Matter, Washington, D.C.

117TH CONGRESS

First Session—Hearings

On April 15, 2021, the HELP Subcommittee held a hearing entitled "Meeting the Moment: Improving Access to Behavioral and Mental Health Care," which examined, among other things, the benefits of telehealth services. Testifying before the Subcommittee were Mr. James Gelfand, Senior Vice President, ERIC, Washington, D.C.; Dr. Meiram Bendat, Founder, Psych-Appeal, Santa Barbara, California; Dr. Christine Yu Moutier, Chief Medical Officer, American Foundation for Suicide Prevention, New York, New York; and Dr. Brian D. Smedley, Chief of Psychology in the Public Interest, American Psychological Association, Washington, D.C.

On June 9, 2021, the Committee held a hearing entitled "Examining the Policies and Priorities of the U.S. Department of Labor," which examined the Department of Labor's (DOL) Fiscal Year 2022 budget priorities. The Committee was interested in whether the Department would extend existing telehealth relief, including standalone telehealth benefits. The sole witness was the Honorable Martin J. Walsh, Secretary of DOL, Washington, D.C.

On June 16, 2021, the Committee held a hearing entitled "Examining the Policies and Priorities of the U.S. Department of Health and Human Services," which examined the Department of Health and Human Services' (HHS) Fiscal Year 2022 budget priorities. The sole witness was the Honorable Xavier Becerra, Secretary of HHS, Washington, D.C. Secretary Becerra was questioned about the Trump administration's telehealth policies.

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[1] 29 U.S.C. § 1001 *et seq*.
[2] 26 U.S.C. § 1 *et. seq*.

Second Session—Hearings

On February 17, 2022, the HELP Subcommittee held a hearing entitled "Exploring Pathways to Affordable, Universal Health Coverage" which examined, among other things, the benefits of expanding telehealth services. Testifying before the Subcommittee were Dr. Brian Blase, President, Paragon Health Institute, Ponte Verde, Florida; Dr. Georges C. Benjamin, Executive Director, the American Public Health Association, Washington, D.C.; Ms. Katie Keith, Center on Health Insurance Reforms, Georgetown University, Washington, D.C.; and Mr. Robert B. Reich, Carmel P. Friesen Professor of Public Policy, Goldman School of Public Policy, University of California, Berkley, California.

On April 6, 2022, the Committee held a hearing entitled "Examining the Policies and Priorities of the U.S. Department of Health and Human Services," which examined HHS' Fiscal Year 2023 budget priorities. The sole witness was the Honorable Xavier Becerra, Secretary of HHS, Washington, D.C. The hearing included a discussion about expanding access to telehealth.

On June 10, 2022, the Committee held a hearing entitled "Examining the Policies and Priorities of the U.S. Department of Labor," which examined DOL's Fiscal Year 2023 budget priorities. The sole witness was the Honorable Martin J. Walsh, Secretary of DOL, Washington, D.C. Secretary Walsh was questioned about whether DOL would extend existing telehealth flexibilities.

118TH CONGRESS

First Session—Hearing

On April 24, 2023, the HELP Subcommittee held a hearing entitled "Reducing Health Care Costs for Working Americans and Their Families," which examined the continuing negative impact of the *Affordable Care Act* (ACA) on employer-sponsored health coverage and lowering costs by extending telehealth services. Testifying before the Subcommittee were Mr. Joel White, President, Council for Affordable Health Coverage, Washington, D.C.; Mrs. Tracy Watts, Senior Partner, Mercer, Washington, D.C.; Ms. Marcie Strouse, Partner, Capitol Benefits Group, Des Moines, Iowa; and Ms. Sabrina Corlette, Senior Research Professor, Center on Health Insurance Reforms, Georgetown University's Health Policy Institute, Washington, D.C.

Legislative Action

On February 2, 2023, Rep. Tim Walberg (R–MI) introduced the *Telehealth Benefit Expansion for Workers Act of 2023* (H.R. 824), with Rep. Rick Allen (R–GA), Rep. Angie Craig (D–MN), Rep. Susan DelBene (D–WA), Rep. Ron Estes (R–KS), and Rep. Mikie Sherrill (D–NJ) as original cosponsors. On June 13, 2023, the Committee considered H.R. 824 in legislative session and reported it favorably, as amended, to the House of Representatives by a recorded vote of 21–14. The Committee adopted an Amendment in the Nature of a Substitute (ANS) offered by Rep. Walberg, which reaffirmed that plans cannot discriminate against individuals with preexisting conditions or discriminate against participants based on health status, and that rescissions of coverage are prohibited. The ANS to H.R. 824 also required a disclosure informing the bene-

ficiary that the coverage is not major medical coverage. Rep. Mark DeSaulnier (D–CA) offered an impede coordination of care or result in reduced access to in-person care. This amendment failed by a recorded vote of 15–18.

COMMITTEE VIEWS

INTRODUCTION

Background on employer-sponsored insurance coverage

Since World War II, employers have offered health care benefits to recruit and retain talent and to ensure a healthy and productive workforce. Employer-sponsored health insurance is one of the primary means by which Americans obtain health care coverage. According to the Kaiser Family Foundation, almost 159 million American workers and family members are covered by a health benefit plan offered by their employer.[3] The U.S. Census Bureau reports that 54.3 percent of Americans were covered by employment-based health coverage in 2021.[4] When given the option for employment-based health coverage, 77 percent of workers accept coverage.[5] Almost all businesses with at least 200 or more employees offer health benefits.[6] According to the Kaiser Family Foundation, however, smaller firms (with 3 to 199 employees) are significantly less likely to offer health benefits.[7] As a result, in 2022, just over half of all employers offered some health benefits.[8]

Employer-provided health benefits are regulated by a number of laws, including ERISA, as amended by the ACA. DOL implements and enforces ERISA. By virtue of its jurisdiction over ERISA, the Committee has jurisdiction over employer-provided health coverage.

Telehealth

Generally, "telehealth" and "telemedicine" are not defined in ERISA, the *Public Health Service Act* (PHSA), or the Code.[9] The Kaiser Family Foundation focused on telehealth as a rapidly expanding form of health care delivery in its Employer Health Benefits 2022 Annual Survey (2022 Survey).[10] For that purpose, the 2022 Survey defined "telemedicine" as "the delivery of health care services through telecommunications to a patient from a provider who is at a remote location, including video chat and remote monitoring."[11]

Before the COVID–19 pandemic, telehealth comprised a very small but growing percentage of health care expenditures and re-

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[3] Kaiser Family Found., *Employer Health Benefits: 2022 Annual Survey, 2022 Employer Health Benefits Survey*, Sec.3, 58, available at http://files.kff.org/attachment/Report-Employer-Health-Benefits-2022-Annual-Survey.pdf.

[4] U.S. CENSUS BUR., U.S. DEP'T OF COM., HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2021, http://census.gov/content/dam/Census/library/publications/2022/demo/p60-278.pdf.

[5] Kaiser Family Found., *supra* note 3, Summary of Findings, at 12.

[6] *Id.*

[7] *Id.*

[8] *Id.*

[9] Telehealth is defined in Title 42 of the U.S. Code as "the use of electronic information and telecommunications technologies to support long distance clinical care, patient and professional health-related education, public health, and health administration." 42 U.S.C. § 254c–16(a)(4). That definition is narrowly applicable to a specific provision of the U.S. Code directing the HHS Secretary to award grants to establish demonstration projects for the purpose of providing remote mental health care.

[10] Kaiser Family Found., *supra* note 3, Telemedicine, at 191.

[11] *Id.*

imbursements.[12] In Fiscal Year 2019, the Centers for Medicare and Medicaid Services (CMS) recorded 840,000 telehealth visits.[13] A recent Department of Health and Human Services (HHS) report showed a 63-fold increase in Medicare telehealth use during the pandemic, with 52.7 million visits in 2020.[14]

During the COVID–19 pandemic, DOL, HHS, and the Treasury (the Departments) allowed employers to offer coverage for telehealth and other remote care services to employees who were not eligible for any other group health plan offered by their employer.[15] As a result, the Departments provided "relief for a group health plan (and health insurance offered in connection with a group health plan) that solely provides benefits for telehealth or other remote care services from the group market reforms under part 7 of ERISA, title XXVII of the [PHSA], and chapter 100 of the [Code]."[16] The Departments' relief was limited to telehealth and other remote care service arrangements sponsored by large employers (very generally, employers with more than 50 employees) for employees (or their dependents) who were ineligible for coverage under any of their employer's other group health plans.[17] Notably, the Departments continued to include telehealth and remote care services as "group health plans" rather than as excepted benefits.[18] As such, the Departments stated that some market reforms would continue to apply to telehealth, including prohibitions on pre-existing condition exclusions or other discrimination based on health status, prohibitions on rescissions, and mental health or substance use disorder parity.[19] The relief provided by the Departments applies only to plan years beginning before the end of the public health emergency (PHE) related to COVID–19 (May 11, 2023).[20]

Congress recognized the importance of telehealth by providing a safe harbor allowing employees who were eligible participants for Health Savings Account (HSA) high deductible health plan (HDHP) to receive telehealth services on a "first-dollar basis." Under the *Coronavirus Aid, Relief, and Economic Security Act* (CARES Act), these employees (and their dependents) were given relief from the requirement to meet their deductible under the HDHP before receiving telehealth services paid for by their employer (or their employer-provided insurance coverage).[21]

Congress extended the "first dollar basis" telehealth relief for the period from April 1, 2022 to December 31, 2022, in the *Consolidated Appropriations Act*, 2022.[22] Congress further extended the

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[12] *See generally*, VICTORIA ELLIOTT, CONG. RESEARCH SERV., R46239, TELEHEALTH AND TELEMEDICINE: FREQUENTLY ASKED QUESTIONS (2020).

[13] Press Release, Ctrs. for Medicare & Medicaid Serv., New HHS Study Shows 63-Fold Increase in Medicare Telehealth Utilization During the Pandemic (Dec. 3, 2021), https://cms.gov/newsroom/press-releases/new-hhs-study-shows-63-fold-increase-medicare-telehealth-utlization-during-pandemic.

[14] *Id.*

[15] FAQs ABOUT FAMILIES FIRST CORONAVIRUS RESPONSE ACT AND CORONAVIRUS AID, RELIEF, AND ECONOMIC SECURITY ACT IMPLEMENTATION PART 43, at 11 (Jun. 23, 2020), https://www.cms.gov/files/document/FFCRA-Part-43-FAQs.pdf.

[16] *Id.*

[17] *Id.*

[18] *See generally Id.*

[19] *Id.*

[20] *Id.*

[21] CARES Act, Pub. L. No. 116–136, § 3701 (2020). President Trump signed the CARES Act into law on March 27, 2020. The "first-dollar basis" telehealth relief for HSA-eligible HDHP participants extended to plan years beginning before Dec. 31, 2021.

[22] Pub. L. No. 117–103, § 307 (2022).

"first dollar basis" telehealth relief through December 31, 2024, under the *Consolidated Appropriations Act, 2023*.[23]

However, Congressional relief has not yet extended to allowing employers to provide stand-alone telehealth to employees (and their dependents) who may not otherwise be covered under an employer's group health plan. The Departments' relief ends at the beginning of an employer's plan year that begins after May 11, 2023.[24] As a result, there is a critical need to extend relief through Congressional action.

Telehealth coverage for employees not covered by a group health plan

The Kaiser Family Foundation reports that while almost all employers with 200 or more employees offer group health coverage, only 39 percent of employers with three to nine employees, and only 51 percent of all employers, offer health care coverage.[25] More than 20 percent of employees offered group health insurance by their employers did not take up coverage in 2022.[26] Allowing employers to offer telehealth, telemedicine, or other remote care services to employees (even employees not covered by an employer-sponsored group health plan or group health insurance) will provide critical coverage that may be lacking when the Departments' relief expires.

H.R. 824, as reported by the Committee, ensures that beneficiaries are informed that this coverage is an additional benefit and not full major medical coverage. This benefit in no way alleviates large employers from their obligations under the employer mandate of the ACA to offer full medical coverage to employees.

Support for creating options and flexibility for small businesses

The Council for Affordable Health Coverage; the Self-Insurance Institute of America, Inc.; ERIC; the Partnership for Employer Sponsored Coverage; the Alliance to Fight for Health Care; Mercer; the Society for Human Resources Management; the U.S. Chamber of Commerce; the American Telemedicine Association; and other employer and telehealth companies support H.R. 824 because it provides flexibility for all employers to offer stand-alone telehealth services. The legislation will expand access to affordable benefits that best meet the needs of workers and their families.

With the end of the COVID–19-designated PHE, legislation is necessary to allow employees who do not qualify for group health plans to continue enjoying access to stand-alone telehealth benefits. In testimony before the HELP Subcommittee, Mr. Joel White, President of the Council for Affordable Health Coverage, stated that after the PHE, "this flexibility will end. Seasonal and part-time workers will also lose access to telehealth services in many cases."[27] Tracy Watts, Senior Partner of Mercer, testified that "this is a benefit that is hugely valued by employees—but employers

[23] Pub. L. No. 117–328, § 4151 (2022).
[24] FAQs Part 43, *supra* note 15.
[25] Kaiser Family Found., *supra* note 3, Health Benefits Offer Rates, Fig. 2.2, at 45.
[26] Kaiser Family Found., *supra* note [4]. Take-Up Rate, at 62.
[27] *Reducing Health Care Costs for Working Americans and Their Families: Hearing Before the H. Subcomm. on Health, Employment, Labor, and Pensions*, 118th Cong. (2023) (statement of Joel White, President, Council for Affordable Health Coverage).

need permanent legislation for this coverage to be restored."[28] Echoing the importance of stand-alone telehealth in testimony before the Committee, HHS Secretary Becerra, stated, "the sooner that Congress moves forward to change the statutes on telehealth, to give us that flexibility in the areas where we've seen tremendous success, the better off the American people will be."[29] Unless stand-alone telehealth benefits are extended and remain separate from traditional group health plans, many workers across industries like retail, hospitality, and health care will lose access to key services on which they have come to rely.

H.R. 824, THE TELEHEALTH BENEFIT EXPANSION FOR WORKERS ACT OF 2023

H.R. 824, the *Telehealth Benefit Expansion for Workers Act of 2023*, amends ERISA and the Code to preserve and expand employee access to services delivered by telehealth and to lower costs. The bill promotes a healthy workforce by treating benefits for telehealth, telemedical, or other remote care services (including services for medical, mental health, or substance use disorders) as an excepted benefit. The bill permits an employer of any size to offer telehealth, telemedical, or other remote care services to any or some of its employees as a stand-alone benefit separate from a group health plan or group health insurance, whether or not the employees are covered by an employer-sponsored group health plan or group health insurance. H.R. 824 reaffirms that plans may not discriminate against individuals with preexisting conditions, discriminate against participants based on health status, and it prohibits recissions. It also requires a disclosure informing the beneficiary that the coverage is not major medical coverage.

CONCLUSION

H.R. 824, the *Telehealth Benefit Expansion for Workers Act of 2023*, preserves and expands employee access to telehealth and lower costs. The Act promotes a healthy workforce by treating benefits for telehealth, telemedical, or other remote care services (including services for medical, mental health, or substance use disorders), as an excepted benefit when provided separately from an employer sponsored group health plan or employer provided group health coverage.

SUMMARY

H.R. 824 SECTION-BY-SECTION SUMMARY

Section 1. Short title

Section 1 provides that the short title is "Telehealth Benefit Expansion for Workers Act of 2023."

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[28] *Id.* (statement of Tracy Watts, Senior Partner, Mercer).

[29] *Examining the Policies and Priorities of the U.S. Department of Health and Human Services: Hearing before the Comm. On Education and the Workforce, 117th Cong. (2022) (statement of the Honorable Xavier Becerra, Secretary, U.S. Department of Health and Human Services).*

Section 2. Treating benefits for telehealth services offered under a group health insurance plan or group health insurance coverage as excepted benefits

Section 2 amends ERISA and the Code to preserve and expand employee access to telehealth and to lower costs. Section 2 treats benefits for telehealth, telemedical, or other remote care services (including services for medical, mental health, or substance use disorders) as an excepted benefit. Section 2 also permits an employer of any size to offer telehealth, telemedical, or other remote care services to any of its employees as a standalone benefit separate from a group health plan or group health insurance, whether or not such employees are covered by an employer-sponsored group health plan or group health insurance. This will allow employers to offer standalone telehealth coverage to any employee and ensure that employees currently enjoying increased access to telehealth services can maintain access to this benefit after the end of their plan year.

In addition, Section 2 reaffirms that plans may not discriminate against individuals with preexisting conditions or discriminate against participants based on health status, and it prohibits recissions. It also requires plans to include a disclosure informing the beneficiary that the coverage is not major medical coverage. The Secretary of Labor is directed to create model disclosure language with input from the public.

EXPLANATION OF AMENDMENTS

The amendments, including the amendment in the nature of a substitute, are explained in the body of this report.

APPLICATION OF LAW TO THE LEGISLATIVE BRANCH

Section 102(b)3 of Public Law 104–1 requires a description of the application of this bill to the legislative branch. H.R. 824 takes important steps to preserve and expand employee access—including access for any eligible employees of the Legislative Branch—to telehealth services and to preserve and expand employer flexibility to offer telehealth coverage after the expiration of the PHE by treating such coverage as an excepted benefit.

UNFUNDED MANDATE STATEMENT

Section 423 of the Congressional Budget and Impoundment Control Act (as amended by Section 101(a)(2) of the Unfunded Mandates Reform Act, P.L. 104–4) requires a statement of whether the provisions of the reported bill include unfunded mandates. This issue is addressed in the CBO letter.

EARMARK STATEMENT

H.R. 824 does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9 of House rule XXI.

ROLL CALL VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee Report to include for each record vote

on a motion to report the measure or matter and on any amendments offered to the measure or matter the total number of votes for and against and the names of the Members voting for and against.

Date: 6/13/23

COMMITTEE ON EDUCATION AND THE WORKFORCE RECORD OF COMMITTEE VOTE

Roll Call: 1 Bill: H.R. 824 Amendment Number: 2

Disposition: Defeated 15-18

Sponsor/Amendment: DeSaulnier_H824_AMD_02_hml

Name & State	Aye	No	Not Voting	Name & State	Aye	No	Not Voting
Mrs. FOXX (NC) (Chairwoman)		X		Mr. SCOTT (VA) (Ranking)	X		
Mr. WILSON (SC)			X	Mr. GRIJALVA (AZ)	X		
Mr. THOMPSON (PA)		X		Mr. COURTNEY (CT)			X
Mr. WALBERG (MI)		X		Mr. SABLAN (MP)	X		
Mr. GROTHMAN (WI)		X		Ms. WILSON (FL)			X
Ms. STEFANIK (NY)		X		Ms. BONAMICI (OR)	X		
Mr. ALLEN (GA)			X	Mr. TAKANO (CA)	X		
Mr. BANKS (IN)		X		Ms. ADAMS (NC)	X		
Mr. COMER (KY)		X		Mr. DESAULNIER (CA)	X		
Mr. SMUCKER (PA)			X	Mr. NORCROSS (NJ)			X
Mr. OWENS (UT)		X		Ms. JAYAPAL (WA)	X		
Mr. GOOD (VA)		X		Ms. WILD (PA)	X		
Mrs. MCCLAIN (MI)		X		Mrs. MCBATH (GA)	X		
Mrs. MILLER (IL)		X		Mrs. HAYES (CT)	X		
Mrs. STEEL (CA)			X	Ms. OMAR (MN)			X
Mr. ESTES (KS)			X	Ms. STEVENS (MI)	X		
Ms. LETLOW (LA)		X		Ms. LEGER FERNÁNDEZ (NM)	X		
Mr. KILEY (CA)		X		Ms. MANNING (NC)			X
Mr. BEAN (FL)		X		Mr. MRVAN (IN)	X		
Mr. BURLISON (MO)		X		Mr. BOWMAN (NY)	X		
Mr. MORAN (TX)			X				
Mr. JAMES (MI)			X				
Ms. CHAVEZ-DEREMER (OR)		X					
Mr. WILLIAMS (NY)		X					
Ms. HOUCHIN (IN)		X					

TOTALS: Ayes: 15 Nos: 18 Not Voting: 12

Total: 45 / Quorum: 33 / Report:

(25 R - 20 D)

Date: 6/13/23

COMMITTEE ON EDUCATION AND THE WORKFORCE RECORD OF COMMITTEE VOTE

Roll Call: 2 Bill: H.R. 824 Amendment Number: N/A

Disposition: Adopted 21-14

Sponsor/Amendment: Motion to Report

Name & State	Aye	No	Not Voting	Name & State	Aye	No	Not Voting
Mrs. FOXX (NC) (Chairwoman)	X			Mr. SCOTT (VA) (Ranking)		X	
Mr. WILSON (SC)			X	Mr. GRIJALVA (AZ)		X	
Mr. THOMPSON (PA)	X			Mr. COURTNEY (CT)		X	
Mr. WALBERG (MI)	X			Mr. SABLAN (MP)		X	
Mr. GROTHMAN (WI)	X			Ms. WILSON (FL)			X
Ms. STEFANIK (NY)	X			Ms. BONAMICI (OR)		X	
Mr. ALLEN (GA)			X	Mr. TAKANO (CA)		X	
Mr. BANKS (IN)	X			Ms. ADAMS (NC)		X	
Mr. COMER (KY)	X			Mr. DESAULNIER (CA)		X	
Mr. SMUCKER (PA)			X	Mr. NORCROSS (NJ)			X
Mr. OWENS (UT)	X			Ms. JAYAPAL (WA)		X	
Mr. GOOD (VA)	X			Ms. WILD (PA)	X		
Mrs. MCCLAIN (MI)	X			Mrs. MCBATH (GA)		X	
Mrs. MILLER (IL)	X			Mrs. HAYES (CT)		X	
Mrs. STEEL (CA)			X	Ms. OMAR (MN)			X
Mr. ESTES (KS)			X	Ms. STEVENS (MI)		X	
Ms. LETLOW (LA)	X			Ms. LEGER FERNÁNDEZ (NM)		X	
Mr. KILEY (CA)	X			Ms. MANNING (NC)			X
Mr. BEAN (FL)	X			Mr. MRVAN (IN)	X		
Mr. BURLISON (MO)	X			Mr. BOWMAN (NY)		X	
Mr. MORAN (TX)			X				
Mr. JAMES (MI)	X						
Ms. CHAVEZ-DEREMER (OR)	X						
Mr. WILLIAMS (NY)	X						
Ms. HOUCHIN (IN)	X						

TOTALS: Ayes: 21 Nos: 14 Not Voting: 10

Total: 45 / Quorum: 35 / Report:

(25 R - 20 D)

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

In accordance with clause (3)(c) of House rule XIII, the goal of H.R. 824 is to preserve and expand employee, including any eligible employees of the Legislative Branch, access to telehealth services and to preserve and expand employer flexibility to offer telehealth coverage after the expiration of the PHE by treating such coverage as an excepted benefit.

DUPLICATION OF FEDERAL PROGRAMS

No provision of H.R. 824 establishes or reauthorizes a program of the Federal Government known to be duplicative of another Federal program, a program that was included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139, or a program related to a program identified in the most recent Catalog of Federal Domestic Assistance.

STATEMENT OF OVERSIGHT FINDINGS AND RECOMMENDATIONS OF THE COMMITTEE

In compliance with clause 3(c)(1) of rule XIII and clause 2(b)(1) of rule X of the Rules of the House of Representatives, the committee's oversight findings and recommendations are reflected in the body of this report.

REQUIRED COMMITTEE HEARING AND RELATED HEARINGS

In compliance with clause 3(c)(6) of rule XIII the following hearings held during the 118th Congress were used to develop or consider H.R. 824: on April 24, 2023, the HELP Subcommittee held a hearing entitled "Reducing Health Care Costs for Working Americans and Their Families." In addition, on January 28, 2020, the HELP and WP Subcommittees held a joint hearing entitled "Expecting More: Addressing America's Maternal and Infant Health Crisis;" on April 15, 2021, the HELP Subcommittee held a hearing entitled "Meeting the Moment: Improving Access to Behavioral and Mental Health Care;" on June 9, 2021, the Committee held a hearing entitled "Examining the Policies and Priorities of the U.S. Department of Labor;" on June 16, 2021, the Committee held a hearing entitled "Examining the Policies and Priorities of the U.S. Department of Health and Human Services;" on February 17, 2022, the HELP Subcommittee held a hearing entitled "Exploring Pathways to Affordable, Universal Health Coverage;" on April 6, 2022, the Committee held a hearing entitled "Examining the Policies and Priorities of the U.S. Department of Health and Human Services;" and on June 10, 2022, the Committee held a hearing entitled "Examining the Policies and Priorities of the U.S. Department of Labor."

NEW BUDGET AUTHORITY AND CBO COST ESTIMATE

With respect to the requirements of clause 3(c)(2) of rule XIII of the Rules of the House of Representatives and section 308(a) of the Congressional Budget Act of 1974 and with respect to requirements of clause 3(c)(3) of rule XIII of the Rules of the House of Representatives and section 402 of the Congressional Budget Act of 1974, a cost estimate was not made available to the Committee in time for

the filing of this report. The Chairwoman of the Committee shall cause such estimate to be printed in the Congressional Record upon its receipt by the Committee.

COMMITTEE COST ESTIMATE

Clause 3(d)(1) of rule XIII of the Rules of the House of Representatives requires an estimate and a comparison of the costs that would be incurred in carrying out H.R. 824. However, clause 3(d)(2)(B) of that rule provides that this requirement does not apply when, as with the present report, the committee adopts as its own the cost estimate of the bill being prepared by the Director of the Congressional Budget Office under section 402 of the Congressional Budget Act.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, and existing law in which no change is proposed is shown in roman):

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

* * * * * * *

TITLE I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

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SUBTITLE B—REGULATORY PROVISIONS

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PART 7—GROUP HEALTH PLAN REQUIREMENTS

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SUBPART B—OTHER REQUIREMENTS

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SEC. 715. ADDITIONAL MARKET REFORMS.

(a) GENERAL RULE.—Except as provided in subsection (b)—

(1) the provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act)*, other than section 2722 of such Act,* shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart; and

(2) to the extent that any provision of this part conflicts with a provision of such part A *(other than such section 2722)* with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.

(b) EXCEPTION.—Notwithstanding subsection (a), the provisions of sections 2716 and 2718 of title XXVII of the Public Health Serv-

ice Act (as amended by the Patient Protection and Affordable Care Act) shall not apply with respect to self-insured group health plans, and the provisions of this part shall continue to apply to such plans as if such sections of the Public Health Service Act (as so amended) had not been enacted.

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SUBPART C—GENERAL PROVISIONS

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SEC. 732. SPECIAL RULES RELATING TO GROUP HEALTH PLANS.

(a) GENERAL EXCEPTION FOR CERTAIN SMALL GROUP HEALTH PLANS.—The requirements of this part (other than section 711) shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year if, on the first day of such plan year, such plan has less than 2 participants who are current employees.

(b) EXCEPTION FOR CERTAIN BENEFITS.—The requirements of this part shall not apply to any group health plan (and group health insurance coverage) in relation to its provision of excepted benefits described in section 733(c)(1).

(c) EXCEPTION FOR CERTAIN BENEFITS IF CERTAIN CONDITIONS MET.—

(1) LIMITED, EXCEPTED BENEFITS.—[The requirements]

(A) IN GENERAL.—Except as provided in subparagraph (B) and subject to subparagraph (C), the requirements. of this part shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 733(c)(2) if the benefits—

[(A)] *(i)* are provided under a separate policy, certificate, or contract of insurance; or

[(B)] *(ii)* are otherwise not an integral part of the plan.

(B) APPLICATION OF PROVISIONS.—The requirements of sections 2704, 2705, and 2712 of the Public Health Service Act, as applied under section 715, shall apply to any group health plan or group health insurance coverage in relation to its provision of excepted benefits described in section 733(c)(2)(C).

(C) REQUIREMENT FOR PROVISION OF NOTICE WITH RESPECT TO TELEHEALTH EXCEPTED BENEFITS.—Subparagraph (A) shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 733(c)(2)(C) unless such plan or coverage (as applicable) provides to each participant or beneficiary enrolled under such plan or coverage (and to each individual seeking to enroll under such plan or coverage) a notice that distinguishes between the benefits provided under a group health plan or group health insurance that meets the requirements of this part and the benefits provided under a group health plan or group health insurance coverage that provides only excepted benefits described in section 733(c)(2)(C).

(2) NONCOORDINATED, EXCEPTED BENEFITS.—The requirements of this part shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 733(c)(3) if all of the following conditions are met:

(A) The benefits are provided under a separate policy, certificate, or contract of insurance.

(B) There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.

(C) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.

(3) SUPPLEMENTAL EXCEPTED BENEFITS.—The requirements of this part shall not apply to any group health plan (and group health insurance coverage) in relation to its provision of excepted benefits described in section 733(c)(4) if the benefits are provided under a separate policy, certificate, or contract of insurance.

(d) TREATMENT OF PARTNERSHIPS.—For purposes of this part—

(1) TREATMENT AS A GROUP HEALTH PLAN.—Any plan, fund, or program which would not be (but for this subsection) an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that such plan, fund, or program provides medical care (including items and services paid for as medical care) to present or former partners in the partnership or to their dependents (as defined under the terms of the plan, fund, or program), directly or through insurance, reimbursement, or otherwise, shall be treated (subject to paragraph (2)) as an employee welfare benefit plan which is a group health plan.

(2) EMPLOYER.—In the case of a group health plan, the term "employer" also includes the partnership in relation to any partner.

(3) PARTICIPANTS OF GROUP HEALTH PLANS.—In the case of a group health plan, the term "participant" also includes—

(A) in connection with a group health plan maintained by a partnership, an individual who is a partner in relation to the partnership, or

(B) in connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the self-employed individual,

if such individual is, or may become, eligible to receive a benefit under the plan or such individual's beneficiaries may be eligible to receive any such benefit.

SEC. 733. DEFINITIONS.

(a) GROUP HEALTH PLAN.—For purposes of this part—

(1) IN GENERAL.—The term "group health plan" means an employee welfare benefit plan to the extent that the plan provides medical care (as defined in paragraph (2) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

Such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of the Internal Revenue Code of 1986).

(2) MEDICAL CARE.—The term "medical care" means amounts paid for—

(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

(B) amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and

(C) amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).

(b) DEFINITIONS RELATING TO HEALTH INSURANCE.—For purposes of this part—

(1) HEALTH INSURANCE COVERAGE.—The term "health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

(2) HEALTH INSURANCE ISSUER.—The term "health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2)). Such term does not include a group health plan.

(3) HEALTH MAINTENANCE ORGANIZATION.—The term "health maintenance organization" means—

(A) a federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act (42 U.S.C. 300e(a))),

(B) an organization recognized under State law as a health maintenance organization, or

(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

(4) GROUP HEALTH INSURANCE COVERAGE.—The term "group health insurance coverage" means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

(c) EXCEPTED BENEFITS.—For purposes of this part, the term "excepted benefits" means benefits under one or more (or any combination thereof) of the following:

(1) BENEFITS NOT SUBJECT TO REQUIREMENTS.—

(A) Coverage only for accident, or disability income insurance, or any combination thereof.

(B) Coverage issued as a supplement to liability insurance.

(C) Liability insurance, including general liability insurance and automobile liability insurance.

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for on-site medical clinics.

(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(2) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED SEPARATELY.—

(A) Limited scope dental or vision benefits.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Benefits for telehealth services.

[(C)] *(D)* Such other similar, limited benefits as are specified in regulations.

(3) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS INDEPENDENT, NONCOORDINATED BENEFITS.—

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(4) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS SEPARATE INSURANCE POLICY.—Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.

(d) OTHER DEFINITIONS.—For purposes of this part—

(1) COBRA CONTINUATION PROVISION.—The term "COBRA continuation provision" means any of the following:

(A) Part 6 of this subtitle.

(B) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines.

(C) Title XXII of the Public Health Service Act.

(2) HEALTH STATUS-RELATED FACTOR.—The term "health status-related factor" means any of the factors described in section 702(a)(1).

(3) NETWORK PLAN.—The term "network plan" means health insurance coverage offered by a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the issuer.

(4) PLACED FOR ADOPTION.—The term "placement", or being "placed", for adoption, has the meaning given such term in section 609(c)(3)(B).

(5) FAMILY MEMBER.—The term "family member" means, with respect to an individual—

(A) a dependent (as such term is used for purposes of section 701(f)(2)) of such individual, and

(B) any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual or of an individual described in subparagraph (A).

(6) GENETIC INFORMATION.—

(A) IN GENERAL.—The term "genetic information" means, with respect to any individual, information about—

(i) such individual's genetic tests,

(ii) the genetic tests of family members of such individual, and

(iii) the manifestation of a disease or disorder in family members of such individual.

(B) INCLUSION OF GENETIC SERVICES AND PARTICIPATION IN GENETIC RESEARCH.—Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual.

(C) EXCLUSIONS.—The term "genetic information" shall not include information about the sex or age of any individual.

(7) GENETIC TEST.—

(A) IN GENERAL.—The term "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detects genotypes, mutations, or chromosomal changes.

(B) EXCEPTIONS.—The term "genetic test" does not mean—

(i) an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or

(ii) an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(8) GENETIC SERVICES.—The term "genetic services" means—

(A) a genetic test;

(B) genetic counseling (including obtaining, interpreting, or assessing genetic information); or

(C) genetic education.

(9) UNDERWRITING PURPOSES.—The term "underwriting purposes" means, with respect to any group health plan, or health insurance coverage offered in connection with a group health plan—

(A) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the plan or coverage;

(B) the computation of premium or contribution amounts under the plan or coverage;

(C) the application of any pre-existing condition exclusion under the plan or coverage; and

(D) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

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PUBLIC HEALTH SERVICE ACT

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TITLE XXVII—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

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PART A—INDIVIDUAL AND GROUP MARKET REFORMS

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Subpart 2—Exclusion of Plans; Enforcement; Preemption

SEC. 2722. EXCLUSION OF CERTAIN PLANS.

(a) LIMITATION ON APPLICATION OF PROVISIONS RELATING TO GROUP HEALTH PLANS.—

(1) IN GENERAL.—The requirements of subparts 1 and 2 and part D shall apply with respect to group health plans only—

(A) subject to paragraph (2), in the case of a plan that is a nonfederal governmental plan, and

(B) with respect to health insurance coverage offered in connection with a group health plan (including such a plan that is a church plan or a governmental plan).

(2) TREATMENT OF NONFEDERAL GOVERNMENTAL PLANS.—

(A) ELECTION TO BE EXCLUDED.—Except as provided in subparagraph (D) or (E), if the plan sponsor of a nonfederal governmental plan which is a group health plan to which the provisions of subparts 1 and 2 otherwise apply makes an election under this subparagraph (in such form and manner as the Secretary may by regulations prescribe), then the requirements of such subparts insofar as they apply directly to group health plans (and not merely to group health insurance coverage) shall not apply to such governmental plans for such period except as provided in this paragraph.

(B) PERIOD OF ELECTION.—An election under subparagraph (A) shall apply—

(i) for a single specified plan year, or

(ii) in the case of a plan provided pursuant to a collective bargaining agreement, for the term of such agreement.

An election under clause (i) may be extended through subsequent elections under this paragraph.

(C) NOTICE TO ENROLLEES.—Under such an election, the plan shall provide for—

(i) notice to enrollees (on an annual basis and at the time of enrollment under the plan) of the fact and consequences of such election, and

(ii) certification and disclosure of creditable coverage under the plan with respect to enrollees in accordance with section 2701(e).

(D) ELECTION NOT APPLICABLE TO REQUIREMENTS CONCERNING GENETIC INFORMATION.—The election described in

subparagraph (A) shall not be available with respect to the provisions of subsections (a)(1)(F), (b)(3), (c), and (d) of section 2702 and the provisions of sections 2701 and 2702(b) to the extent that such provisions apply to genetic information.

(E) ELECTION NOT APPLICABLE.—The election described in subparagraph (A) shall not be available with respect to the provisions of subparts I and II.

(F) SUNSET OF ELECTION OPTION.—

(i) IN GENERAL.—Notwithstanding the preceding provisions of this paragraph—

(I) no election described in subparagraph (A) with respect to section 2726 may be made on or after the date of the enactment of this subparagraph; and

(II) except as provided in clause (ii), no such election with respect to section 2726 expiring on or after the date that is 180 days after the date of such enactment may be renewed.

(ii) EXCEPTION FOR CERTAIN COLLECTIVELY BARGAINED PLANS.—Notwithstanding clause (i)(II), a plan described in subparagraph (B)(ii) that is subject to multiple agreements described in such subparagraph of varying lengths and that has an election described in subparagraph (A) with respect to section 2726 in effect as of the date of the enactment of this subparagraph that expires on or after the date that is 180 days after the date of such enactment may extend such election until the date on which the term of the last such agreement expires.

(b) EXCEPTION FOR CERTAIN BENEFITS.—The requirements of subparts 1 and 2 and part Dshall not apply to any individual coverage or any group health plan (or group health insurance coverage) in relation to its provision of excepted benefits described in section 2791(c)(1).

(c) EXCEPTION FOR CERTAIN BENEFITS IF CERTAIN CONDITIONS MET.—

(1) LIMITED, EXCEPTED BENEFITS.—[The requirements]

(A) IN GENERAL.—Except as provided in subparagraph (B), the requirements. of subparts 1 and 2 and part Dshall not apply to any individual coverage or any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 2791(c)(2) if the benefits—

[(A)] *(i)* are provided under a separate policy, certificate, or contract of insurance; or

[(B)] *(ii)* are otherwise not an integral part of the plan.

(B) APPLICATION OF PROVISIONS IN THE CASE OF INDIVIDUAL HEALTH INSURANCE COVERAGE FOR CERTAIN EXCEPTED BENEFITS.—The requirements of subparts I and II shall apply to any individual health insurance coverage in relation to its provision of excepted benefits described in section 2791(c)(2)(C).

(2) NONCOORDINATED, EXCEPTED BENEFITS.—The requirements of subparts 1 and 2 and part Dshall not apply to any individual coverage or any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 2791(c)(3) if all of the following conditions are met:

(A) The benefits are provided under a separate policy, certificate, or contract of insurance.

(B) There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.

(C) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor or, with respect to individual coverage, under any health insurance coverage maintained by the same health insurance issuer.

(3) SUPPLEMENTAL EXCEPTED BENEFITS.—The requirements of this part and part Dshall not apply to any individual coverage or any group health plan (and group health insurance coverage) in relation to its provision of excepted benefits described in section 27971(c)(4) if the benefits are provided under a separate policy, certificate, or contract of insurance.

(d) TREATMENT OF PARTNERSHIPS.—For purposes of this part and part D—

(1) TREATMENT AS A GROUP HEALTH PLAN.—Any plan, fund, or program which would not be (but for this subsection) an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that such plan, fund, or program provides medical care (including items and services paid for as medical care) to present or former partners in the partnership or to their dependents (as defined under the terms of the plan, fund, or program), directly or through insurance, reimbursement, or otherwise, shall be treated (subject to paragraph (2)) as an employee welfare benefit plan which is a group health plan.

(2) EMPLOYER.—In the case of a group health plan, the term "employer" also includes the partnership in relation to any partner.

(3) PARTICIPANTS OF GROUP HEALTH PLANS.—In the case of a group health plan, the term "participant" also includes—

(A) in connection with a group health plan maintained by a partnership, an individual who is a partner in relation to the partnership, or

(B) in connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the self-employed individual,

if such individual is, or may become, eligible to receive a benefit under the plan or such individual's beneficiaries may be eligible to receive any such benefit.

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PART C—DEFINITIONS; MISCELLANEOUS PROVISIONS

SEC. 2791. DEFINITIONS.

(a) GROUP HEALTH PLAN.—

(1) DEFINITION.—The term "group health plan" means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) to the extent that the plan provides medical care (as defined in paragraph (2)) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise. Except for purposes of part C of title XI of the Social Security Act (42 U.S.C. 1320d et seq.), such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of the Internal Revenue Code of 1986).

(2) MEDICAL CARE.—The term "medical care" means amounts paid for—

(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

(B) amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and

(C) amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).

(3) TREATMENT OF CERTAIN PLANS AS GROUP HEALTH PLAN FOR NOTICE PROVISION.—A program under which creditable coverage described in subparagraph (C), (D), (E), or (F) of section 2701(c)(1) is provided shall be treated as a group health plan for purposes of applying section 2701(e).

(b) DEFINITIONS RELATING TO HEALTH INSURANCE.—

(1) HEALTH INSURANCE COVERAGE.—The term "health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

(2) HEALTH INSURANCE ISSUER.—The term "health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974). Such term does not include a group health plan.

(3) HEALTH MAINTENANCE ORGANIZATION.—The term "health maintenance organization" means—

(A) a Federally qualified health maintenance organization (as defined in section 1301(a)),

(B) an organization recognized under State law as a health maintenance organization, or

(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

(4) GROUP HEALTH INSURANCE COVERAGE.—The term "group health insurance coverage" means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

(5) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The term "individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

(c) EXCEPTED BENEFITS.—For purposes of this title, the term "excepted benefits" means benefits under one or more (or any combination thereof) of the following:

(1) BENEFITS NOT SUBJECT TO REQUIREMENTS.—

(A) Coverage only for accident, or disability income insurance, or any combination thereof.

(B) Coverage issued as a supplement to liability insurance.

(C) Liability insurance, including general liability insurance and automobile liability insurance.

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for on-site medical clinics.

(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(2) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED SEPARATELY.—

(A) Limited scope dental or vision benefits.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Benefits for telehealth services.

[(C)] *(D)* Such other similar, limited benefits as are specified in regulations.

(3) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS INDEPENDENT, NONCOORDINATED BENEFITS.—

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(4) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS SEPARATE INSURANCE POLICY.—Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.

(d) OTHER DEFINITIONS.—

(1) APPLICABLE STATE AUTHORITY.—The term "applicable State authority" means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State involved with respect to such issuer.

(2) BENEFICIARY.—The term "beneficiary" has the meaning given such term under section 3(8) of the Employee Retirement Income Security Act of 1974.

(3) BONA FIDE ASSOCIATION.—The term "bona fide association" means, with respect to health insurance coverage offered in a State, an association which—

(A) has been actively in existence for at least 5 years;

(B) has been formed and maintained in good faith for purposes other than obtaining insurance;

(C) does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

(D) makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

(E) does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

(F) meets such additional requirements as may be imposed under State law.

(4) COBRA CONTINUATION PROVISION.—The term "COBRA continuation provision" means any of the following:

(A) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines.

(B) Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, other than section 609 of such Act.

(C) Title XXII of this Act.

(5) EMPLOYEE.—The term "employee" has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974.

(6) EMPLOYER.—The term "employer" has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974, except that such term shall include only employers of two or more employees.

(7) CHURCH PLAN.—The term "church plan" has the meaning given such term under section 3(33) of the Employee Retirement Income Security Act of 1974.

(8) GOVERNMENTAL PLAN.—(A) The term "governmental plan" has the meaning given such term under section 3(32) of the Employee Retirement Income Security Act of 1974 and any Federal governmental plan.

(B) FEDERAL GOVERNMENTAL PLAN.—The term "Federal governmental plan" means a governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of such Government.

(C) NON-FEDERAL GOVERNMENTAL PLAN.—The term "non-Federal governmental plan" means a governmental plan that is not a Federal governmental plan.

(9) HEALTH STATUS-RELATED FACTOR.—The term "health status-related factor" means any of the factors described in section 2702(a)(1).

(10) NETWORK PLAN.—The term "network plan" means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the issuer.

(11) PARTICIPANT.—The term "participant" has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974.

(12) PLACED FOR ADOPTION DEFINED.—The term "placement", or being "placed", for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

(13) PLAN SPONSOR.—The term "plan sponsor" has the meaning given such term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

(14) STATE.—The term "State" means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(15) FAMILY MEMBER.—The term "family member" means, with respect to any individual—

(A) a dependent (as such term is used for purposes of section 2701(f)(2)) of such individual; and

(B) any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual or of an individual described in subparagraph (A).

(16) GENETIC INFORMATION.—

(A) IN GENERAL.—The term "genetic information" means, with respect to any individual, information about—

(i) such individual's genetic tests,

(ii) the genetic tests of family members of such individual, and

(iii) the manifestation of a disease or disorder in family members of such individual.

(B) INCLUSION OF GENETIC SERVICES AND PARTICIPATION IN GENETIC RESEARCH.—Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual.

(C) EXCLUSIONS.—The term "genetic information" shall not include information about the sex or age of any individual.

(17) GENETIC TEST.—

(A) IN GENERAL.—The term "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detects genotypes, mutations, or chromosomal changes.

(B) EXCEPTIONS.—The term "genetic test" does not mean—

(i) an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or

(ii) an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(18) GENETIC SERVICES.—The term "genetic services" means—

(A) a genetic test;

(B) genetic counseling (including obtaining, interpreting, or assessing genetic information); or

(C) genetic education.

(19) UNDERWRITING PURPOSES.—The term "underwriting purposes" means, with respect to any group health plan, or health insurance coverage offered in connection with a group health plan—

(A) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the plan or coverage;

(B) the computation of premium or contribution amounts under the plan or coverage;

(C) the application of any pre-existing condition exclusion under the plan or coverage; and

(D) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

(20) QUALIFIED HEALTH PLAN.—The term "qualified health plan" has the meaning given such term in section 1301(a) of the Patient Protection and Affordable Care Act.

(21) EXCHANGE.—The term "Exchange" means an American Health Benefit Exchange established under section 1311 of the Patient Protection and Affordable Care Act.

(e) DEFINITIONS RELATING TO MARKETS AND SMALL EMPLOYERS.—For purposes of this title:

(1) INDIVIDUAL MARKET.—

(A) IN GENERAL.—The term "individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(B) TREATMENT OF VERY SMALL GROUPS.—

(i) IN GENERAL.—Subject to clause (ii), such terms includes coverage offered in connection with a group health plan that has fewer than two participants as current employees on the first day of the plan year.

(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of a State that elects to regulate the coverage described in such clause as coverage in the small group market.

(2) LARGE EMPLOYER.—The term "large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average

of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(3) LARGE GROUP MARKET.—The term "large group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer.

(4) SMALL EMPLOYER.—The term "small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employees on the first day of the plan year.

(5) SMALL GROUP MARKET.—The term "small group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.

(6) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of this subsection—

(A) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(C) PREDECESSORS.—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

(7) STATE OPTION TO EXTEND DEFINITION OF SMALL EMPLOYER.—Notwithstanding paragraphs (2) and (4), nothing in this section shall prevent a State from applying this subsection by treating as a small employer, with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

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INTERNAL REVENUE CODE OF 1986

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Subtitle K—Group Health Plan Requirements

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CHAPTER 100—GROUP HEALTH PLAN REQUIREMENTS

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Subchapter C—GENERAL PROVISIONS

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SEC. 9832. DEFINITIONS.

(a) GROUP HEALTH PLAN.—For purposes of this chapter, the term "group health plan" has the meaning given to such term by section 5000(b)(1).

(b) DEFINITIONS RELATING TO HEALTH INSURANCE.—For purposes of this chapter—

(1) HEALTH INSURANCE COVERAGE.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the term "health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

(B) NO APPLICATION TO CERTAIN EXCEPTED BENEFITS.—In applying subparagraph (A), excepted benefits described in subsection (c)(1) shall not be treated as benefits consisting of medical care.

(2) HEALTH INSURANCE ISSUER.—The term "health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974, as in effect on the date of the enactment of this section). Such term does not include a group health plan.

(3) HEALTH MAINTENANCE ORGANIZATION.—The term "health maintenance organization" means—

(A) a federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act (42 U.S.C. 300e(a))),

(B) an organization recognized under State law as a health maintenance organization, or

(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

(c) EXCEPTED BENEFITS.—For purposes of this chapter, the term "excepted benefits" means benefits under one or more (or any combination thereof) of the following:

(1) BENEFITS NOT SUBJECT TO REQUIREMENTS.—(A) Coverage only for accident, or disability income insurance, or any combination thereof.

(B) Coverage issued as a supplement to liability insurance.

(C) Liability insurance, including general liability insurance and automobile liability insurance.

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for on-site medical clinics.

(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(2) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED SEPARATELY.—(A) Limited scope dental or vision benefits.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Benefits for telehealth services.

[(C)] *(D)* Such other similar, limited benefits as are specified in regulations.

(3) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS INDEPENDENT, NONCOORDINATED BENEFITS.—(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(4) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS SEPARATE INSURANCE POLICY.—Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.

(d) OTHER DEFINITIONS.—For purposes of this chapter—

(1) COBRA CONTINUATION PROVISION.—The term "COBRA continuation provision" means any of the following:

(A) Section 4980B, other than subsection (f)(1) thereof insofar as it relates to pediatric vaccines.

(B) Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.), other than section 609 of such Act.

(C) Title XXII of the Public Health Service Act.

(2) GOVERNMENTAL PLAN.—The term "governmental plan" has the meaning given such term by section 414(d).

(3) MEDICAL CARE.—The term "medical care" has the meaning given such term by section 213(d) determined without regard to—

(A) paragraph (1)(C) thereof, and

(B) so much of paragraph (1)(D) thereof as relates to qualified long-term care insurance.

(4) NETWORK PLAN.—The term "network plan" means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care are provided, in whole or in part, through a defined set of providers under contract with the issuer.

(5) PLACED FOR ADOPTION DEFINED.—The term "placement", or being "placed", for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

(6) FAMILY MEMBER.—The term "family member" means, with respect to any individual—

(A) a dependent (as such term is used for purposes of section 9801(f)(2)) of such individual, and

(B) any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual or of an individual described in subparagraph (A).

(7) GENETIC INFORMATION.—

(A) IN GENERAL.—The term "genetic information" means, with respect to any individual, information about—

(i) such individual's genetic tests,

(ii) the genetic tests of family members of such individual, and

(iii) the manifestation of a disease or disorder in family members of such individual.

(B) INCLUSION OF GENETIC SERVICES AND PARTICIPATION IN GENETIC RESEARCH.—Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual.

(C) EXCLUSIONS.—The term "genetic information" shall not include information about the sex or age of any individual.

(8) GENETIC TEST.—

(A) IN GENERAL.—The term "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detects genotypes, mutations, or chromosomal changes.

(B) EXCEPTIONS.—The term "genetic test" does not mean—

(i) an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes, or

(ii) an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(9) GENETIC SERVICES.—The term "genetic services" means—

(A) a genetic test;

(B) genetic counseling (including obtaining, interpreting, or assessing genetic information); or

(C) genetic education.

(10) UNDERWRITING PURPOSES.—The term "underwriting purposes" means, with respect to any group health plan, or health insurance coverage offered in connection with a group health plan—

(A) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the plan or coverage;

(B) the computation of premium or contribution amounts under the plan or coverage;

(C) the application of any pre-existing condition exclusion under the plan or coverage; and

(D) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

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MINORITY VIEWS

INTRODUCTION

Committee Democrats oppose H.R. 824, the *Telehealth Benefit Expansion for Workers Act of 2023*. This misguided legislation would create loopholes in important consumer protections, put individuals at risk of misleading marketing practices and substandard coverage, and undermine access to quality, coordinated health care for workers and their families.

GROUP HEALTH PLAN CONSUMER PROTECTIONS AND "EXCEPTED BENEFITS"

Group health plans and health insurance issuers are subject to a number of requirements that protect consumers and ensure health coverage meets minimum standards. These laws include the *Health Insurance Portability and Accountability Act* (HIPAA),[1] the *Mental Health Parity and Addiction Equity Act* (MHPAEA),[2] *the Genetic Information Nondiscrimination Act* (GINA),[3] and the *Patient Protection and Affordable Care Act* (ACA).[4] More than 164 million workers and their dependents[5] rely on these consumer protection laws to ensure that the coverage they receive through a job-based health plan is adequate and affordable. These standards apply to group health plans and issuers primarily through Part 7 of the *Employee Retirement Income Security Act* (ERISA),[6] Title 27 of the *Public Health Service Act* (PHSA),[7] and *Chapter 100 of the Internal Revenue Code* (IRC)[8] and are enforced by the Departments of Labor, Health and Human Services, and the Treasury, respectively.

Although these consumer protections apply broadly to insurance and group health plans sponsored by both private entities and non-federal governments, federal law enumerates certain categories of "excepted benefits" that are exempt from these requirements.[9] Excepted benefits include insurance products that are distinct from health coverage—such as liability insurance, disability benefits, and workers' compensation—as well as certain health expenses that historically have been treated separately from group health coverage—such as long-term care, limited scope dental or vision

[1] Pub. L. No. 104–191 (1996).
[2] Pub. L. No. 110–343 (2008).
[3] Pub. L. No. 110–233 (2008).
[4] Pub. L. No. 111–148 (2010).
[5] Kaiser Family Found., Health Insurance Coverage of the Total Population (2021), https://www.kff.org/other/state-indicator/health-insurance-coverage-of-the-total-population-cps.
[6] 29 U.S.C. Part 7.
[7] 42 U.S.C. Subch. XXV.
[8] IRC Chap. 100.
[9] 29 U.S.C. § 1191a, IRC § 9831, 42 U.S.C. § 300gg–21.

benefits, and hospital indemnity or fixed indemnity insurance.[10] Status as an excepted benefit provides the plan or coverage with a sweeping exemption from all requirements of Part 7 of ERISA, Title 27 of PHSA, and Chapter 100 of IRC.

H.R. 824 COULD UNDERMINE IMPORTANT CONSUMER PROTECTIONS

H.R. 824 amends ERISA, PHSA, and IRC to provide that standalone telehealth-only plans offered by an employer would be treated as excepted benefits. This would exempt these plans from consumer protections and lower the quality of health coverage provided to workers and their dependents. The Republican Amendment in the Nature of a Substitute (ANS) that was adopted at the Committee's markup applied three limited consumer protections that prohibit rescissions of coverage, preexisting condition exclusions, and discrimination based on preexisting conditions or health status. However, the ANS fails to address the overwhelming majority of other loopholes created by this legislation that could leave workers vulnerable. As an excepted benefit, all telehealth-only plans would be exempt from critical ACA consumer protections, including:

- prohibition on annual or lifetime dollar limits on the amount of care provided;
- prohibition on waiting periods for coverage;
- right to external review of benefit denials; and
- medical loss ratio standards that require insurers to spend at least 80 percent (85 percent in the large group market) of premium dollars on health claims.

Telehealth-only plans in the small-group market would also be exempt from state and federal review of large premium hikes, could raise premiums for older workers beyond the 3:1 ratio permitted under the ACA, and would not have to provide coverage of essential health benefits.

In addition, H.R. 824 would severely undermine the requirement of MHPAEA that plans and issuers that cover mental health and substance use disorder benefits do so at parity with medical and surgical benefits. Under current law, there is no federal requirement that self-insured small employer plans or large employer-sponsored plans (whether self-insured or fully insured) provide any behavioral health benefits, only that, if they do so, they comply with MHPAEA. Therefore, under H.R. 824, an employer could opt not to cover behavioral health care in their traditional group health plan and instead carve out a separate behavioral health benefit delivered through a telehealth-only policy. As an excepted benefit, the telehealth-only plan would be exempt from MHPAEA, therefore allowing the plan sponsor to impose otherwise impermissible treatment limitations on patients. Because of this loophole, major organizations that advocate for mental health and substance use disorder care oppose H.R. 824, including American Psychological Association, Kennedy Forum, National Alliance on Mental Illness, Mental Health America, and Eating Disorders Coalition.[11]

[10] 29 U.S.C. § 1191b, IRC § 9832, 42 U.S.C. § 300gg–91.

[11] Letter from Mental Health and Substance Use Disorder Organizations to Chair Virginia Foxx and Ranking Member Bobby Scott, H. Comm. on Educ. & the Workforce, Full Committee Markup (June 6, 2023) (*on file with author*).

H.R. 824 COULD REDUCE QUALITY BY SEGMENTING TELEHEALTH FROM IN-PERSON CARE

Telehealth can be a useful tool in delivering certain health services and can offer convenience and the ability to provide care to people with mobility limitations.[12] However, making standalone telehealth policies an excepted benefit would encourage the segmentation of an important modality of delivering care to patients. Consumer advocates and health care providers have expressed serious concerns that this approach could make accessing important health services more difficult and could severely lower the quality of care that patients receive.[13]

Currently, the vast majority of employers already provide coverage for telehealth as part of their traditional group health plan. In 2022, 96 percent of large employer plans and 87 percent of small employer plans included telehealth coverage as part of an integrated health benefit.[14] However, rather than expanding coverage of telehealth as part of a comprehensive benefit package that includes both in-person and virtual care, H.R. 824 would simply encourage employers to carve out telehealth from their group health plan. This could lead to segmentation of care and potentially worse outcomes for patients. In a recent letter, more than 30 leading patient groups—including American Cancer Society Cancer Action Network, American Heart Association, American Lung Association, March of Dimes, Susan G. Komen, and the Leukemia & Lymphoma Society—wrote:

> Even in the best-case scenario, where an individual enrolls in a comprehensive employer plan and the telehealth-only policy, we are concerned that a telehealth- only policy could create significant frustration and confusion for consumers who need in-person care to diagnose and treat their symptoms . . . [T]he telehealth provider and in-person provider may be two different providers within two different medical systems. As a result, the telehealth provider would not necessarily have access to the patient's medical history and thus would be hampered in their ability to adequately treat and diagnose the patient.[15]

Studies have shown that telehealth can benefit patients when it is part of integrated care that improves coordination between in-person and telehealth providers.[16] However, telehealth also suffers

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[12] Stephanie Watson, *Telehealth: The advantages and disadvantages*, Harvard Health Publ'g (Oct. 12, 2020), https://www.health.harvard.edu/staying-healthy/telehealth-the-advantages-and-disadvantages.

[13] Elizabeth Rosenthal, Telemedicine Is a Tool. Not a Replacement for Your Doctor's Touch, NY Times (Apr. 29, 2021), https://www.nytimes.com/2021/04/29/opinion/virtual-remote-medicine-covid.htm.

[14] Gary Claxon et. al., *2022 Employer Health Benefits Survey, Kaiser Family Found.* (Oct. 27, 2022), at 191, https://files.kff.org/attachment/Report-Employer-Health-Benefits-2022-Annual-Survey.pdf.

[15] *Patient Community Concerns About the Detrimental Impact of Policies Included in HR 2868, the Association Health Plans Act; HR 824, the Telehealth Benefit Expansion for Workers Act; and HR 2813, the Self-Insurance Protection Act,* Letter to Chair Virginia Foxx and Ranking Member Bobby Scott, H. Comm. on Educ. & the Workforce, Full Committee Markup (June 6, 2023) (*on file with author*).

[16] *See, e.g.,* Holly D. McKissick, et al., *The Impact of Telehealth and Care Coordination on the Number and Type of Clinical Visits for Children with Medical Complexity*, 31 J. Pediatric Health Care 452 (Dec. 22, 2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5481493/.

from numerous limitations and is frequently inappropriate because it does not offer the ability of a provider to perform examinations, evaluations, treatments, and other health services that can only be provided in-person.[17] Regrettably, by encouraging employers to remove telehealth from their comprehensive group health plans in favor of standalone policies, H.R. 824 would exacerbate the segmentation of care and increase the risk that telehealth is used as an inappropriate substitute for in-person care.

H.R. 824 COULD PLACE CONSUMERS AT RISK OF DECEPTIVE MARKETING PRACTICES

H.R. 824 could expose consumers to deceptive marketing practices that could lead to individuals enrolling in telehealth-only plans under the mistaken impression that they are receiving comprehensive coverage. Navigating health coverage is extremely complex for consumers and health policy experts have identified the marketing of excepted benefits as a growing area of concern for individuals covered by job-based health plans.[18] As Sabrina Corlette, Research Professor and Co-Director of the Center on Health Insurance Reforms at Georgetown University's McCourt School of Public Policy noted during her testimony before the Subcommittee on Health, Employment, Labor, and Pensions on April 26, 2023:

> Numerous market studies have found that many unscrupulous insurers and brokers deceptively market excepted benefit products such as fixed indemnity insurance as substitutes for comprehensive insurance, when in fact they are anything but. Too often, consumers believe they are purchasing health insurance coverage that will provide financial protection if they get sick or injured, only to find out that the plan does not cover even a small fraction of their costs.[19]

Similarly, a 2020 analysis by the Brookings Institution identified numerous cases in which excepted benefits have been designed to mimic traditional health benefits and are marketed to workers, often paired with a group health plan that offers very little coverage of basic care and does not meet minimum standards under the ACA.[20] These arrangements may violate the employer shared responsibility requirement, prompting Committee Democrats to encourage the U.S. Department of Labor to increase its oversight activities in this area.[21]

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[17] *See, e.g.,* Manouchehr Saljoughian, *The Benefits and Limitations of Telehealth*, 46 U.S. Pharmacist 8 (2021) ("Telemedicine visits are not a complete substitute for in-person visits; nor they are feasible for all patients or clinical situations. For example, technology does not always work smoothly, and technical difficulties may interfere with delivery of care.").

[18] Christen Linke Young and Kathleen Hannick, *Fixed Indemnity Health Coverage Is a Problematic Form of "Junk Insurance,"* Brookings Inst. (Aug. 4, 2020), https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/08/04/fixed-indemnity-health-coverage-is-a-problematic-form-of-junk-insurance/.

[19] *Reducing Health Care Costs for Working Americans and Their Families: Hearing Before the Subcomm. on Health, Empl., Lab., & Pensions of the H. Comm. on Educ. & the Workforce*, 118th Cong. 10 (2023) (testimony of Sabrina Corlette, Research Professor and Co-Director, Center on Health Insurance Reforms at the Georgetown University McCourt School of Public Policy).

[20] Young and Hannick, *supra* note 18.

[21] *Scott, Wilson to DOL: Protect Workers' Access to Comprehensive Health Benefits*, H. Comm. on Educ. & Labor, U.S. House of Representatives (Oct. 7, 2020), https://democrats-edworkforce.house.gov/media/press-releases/scott-wilson-to-dol-protect-workers-access-to-comprehensive-health-benefits.

Broadening excepted benefits under H.R. 824 would present similar risks for consumers. Although the ANS would require employers to provide a notice to consumers warning them that the coverage is limited, similar notices[22] exist in the individual excepted benefits market, yet experts continue to observe misleading marketing and consumer confusion.[23] Moreover, the notice does not require consumers be informed that coverage through the ACA Marketplaces is available, which would likely be a more appropriate option for individuals whose employer offers a plan that does not provide coverage that meets standards for affordability and comprehensiveness.

DEMOCRATIC AMENDMENT OFFERED DURING MARKUP OF H.R. 824

Committee Democrats put forward one amendment to improve the bill. Offered by Rep. Mark DeSaulnier (D–CA–10), this amendment would have ensured that the legislation would not reduce the quality of care received by patients by preventing the legislation from taking effect unless the U.S. Secretary of Labor certifies that it will not limit access to in-person care or reduce care coordination. Committee Republicans rejected this amendment.

Amendment	Offered By	Description	Action Taken
#2	Mr. DeSaulnier	To provide that bill will not take effect unless the Secretary of Labor certifies that it will not undermine coordination of care or reduce access to in-person care.	Defeated

CONCLUSION

Committee Democrats agree that telehealth—as part of a comprehensive benefit package that is subject to strong guardrails that protect consumers—can be a useful method of delivering care to patients. However, H.R. 824 fails to meet necessary standards to ensure that the bill furthers the appropriate use of telehealth. Instead, it would create harmful loopholes in consumer protection laws, expose individuals to potential misleading marketing and less comprehensive coverage, and further fragment the delivery of care.

For the reasons stated above, Committee Democrats opposed H.R. 824 when the Committee on Education and the Workforce considered it on June 13, 2023. We urge the House of Representatives to do the same.

ROBERT C. "BOBBY" SCOTT,
Ranking Member.
JOE COURTNEY.
GREGORIO KILILI CAMACHO SABLAN.
SUZANNE BONAMICI.
MARK TAKANO.
MARK DESAULNIER.
JAHANA HAYES.

[22] 45 C.F.R. § 148.220.
[23] Dania Palanker and Kevin Lucia, *Limited Plans with Minimal Coverage Are Being Sold as Primary Coverage, Leaving Consumers at Risk*, Commonwealth Fund (Sept. 10 2021), https://www.commonwealthfund.org/blog/2021/limited-plans-minimal-coverage-are-being-sold-primary-coverage-leaving-consumers-risk.

HALEY M. STEVENS.
JAMAAL BOWMAN.

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