

Federal Telehealth Flexibilities in Private Health Insurance During the COVID-19 Public Health Emergency: In Brief

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The Coronavirus Disease 2019 (COVID-19) public health emergency (PHE), first declared by the Secretary of the Department of Health and Human Services (HHS) on January 31, 2020, was most recently renewed on January 11, 2023, and the Biden Administration has announced plans to end the emergency on May 11, 2023.¹ Prior to the COVID-19 PHE, there were no federal requirements that private health insurance plans offer telehealth coverage, nor were there prohibitions on such coverage. Certain other federal requirements presented difficulties for private health insurance plans that sought to quickly add telehealth coverage as part of their response to the COVID-19 PHE. The following sections describe the federal flexibilities created in response to such issues and when those flexibilities are to end.

Telehealth Coverage in Private Health Insurance

Generally, *telehealth* is the use of electronic information and telecommunication technologies to support remote clinical health care, patient and professional health-related education, public health, and other health care delivery functions. There is no federal definition of *telehealth* for the purposes of private health insurance coverage, but a stakeholder group, the Center for Connected Health Policy (CCHP), refers to telehealth as “a collection of means or methods, not a specific clinical service, to enhance care delivery and education.”² By this definition, telehealth is not a distinct clinical service but a mode of service delivery. In other words, generally, a private health insurance plan does not “cover telehealth” in addition to other covered benefits; rather, a plan may provide coverage for a particular benefit or service when provided in person or via telehealth. The types of telehealth modalities covered by a plan also may vary. For example, some plans may cover certain services when provided via audio technology only and other services when provided via live video technology.

Private health insurance plans may offer telehealth services in various ways. Some plans have providers in their network that offer services via telehealth only and others both in-person and via telehealth. Additionally, some health plans offer services through specialized telemedicine service providers, such as Teledoc, Doctor on Demand, or MDLIVE (not an acronym). Some plans may cover almost all of the offered benefits solely via telehealth, whereas others may provide coverage for only a few services via telehealth and may cover largely in-person services. Plans also may have some but not all health services available via telehealth.

Prior to the COVID-19 PHE, regulation of telehealth coverage (i.e., benefits/services provided via telehealth) in private health insurance generally occurred at the state level for those types of plans that states have the ability to regulate. Therefore, telehealth coverage varied greatly between plans due to differing state requirements. For additional information regarding telehealth at the state level, see “State Laws and Private Health Insurance Telehealth,” below.

¹ See Department of Health and Human Services (HHS), Administration for Strategic Preparedness and Readiness, “Declarations of a Public Health Emergency,” at <https://aspr.hhs.gov/legal/PHE/Pages/default.aspx>. The Biden Administration released a policy statement on January 30, 2023, indicating it intends to end the Coronavirus Disease 2019 (COVID-19) public health emergency (PHE) declaration on May 11, 2023. See Executive Office of the President, Office of Management and Budget, “Statement of Administration Policy: H.R. 382—A Bill to Terminate the Public Health Emergency Declared with Respect to COVID-19,” January 30, 2023, at <https://www.whitehouse.gov/wp-content/uploads/2023/01/SAP-H.R.-382-H.J.-Res.-7.pdf>.

² Center for Connected Health Policy, “A Framework for Defining Telehealth,” at https://cchp.nyc3.digitaloceanspaces.com/2021/04/Telehealth-Definintion-Framework-for-TRCs_0.pdf. This understanding is similar to other definitions for telehealth in public insurance programs. For example, in the Medicaid program, the Centers for Medicare & Medicaid Services (CMS) define *Medicaid telehealth* as “the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance.” See Medicaid.gov, “Telemedicine,” at <https://www.medicare.gov/medicaid/benefits/telemedicine/index.html>.

Federal Telehealth Flexibilities for Private Health Insurance Coverage Introduced During the COVID-19 Public Health Emergency

The COVID-19 pandemic accelerated interest in telehealth as a way to protect health care providers and to maintain or improve patients' access to care and safety. After the COVID-19 PHE declaration, the Centers for Medicare & Medicaid Services (CMS, an agency in HHS) and the Departments of HHS, Labor, and the Treasury (collectively referred to as *the Tri-agencies*) issued guidance creating some time-limited federal flexibilities for group and non-group health plans (for information on types of private health insurance plans, see the text box below).

Types of Private Health Insurance Plans

Federal requirements (and flexibilities) may apply to some or all types of private health insurance plans.

Broadly, private health insurance includes group plans of several types and non-group plans. Group plans largely refer to health benefits provided to employees (and their dependents) by employers that sponsor such benefits. Employers and other group health plan sponsors may purchase coverage from a state-licensed insurer and offer it to their group (i.e., they may *fully insure*). Alternatively, sponsors may finance coverage themselves (i.e., they may *self-insure*). Fully insured plans may be purchased in the large- or small-group markets. For purposes of private health insurance regulation, a *small group* is typically defined as a group of up to 50 individuals (e.g., employees) and a *large group* is typically defined as one with 51 or more individuals.

Consumers purchase non-group plans directly from an insurer. In general, non-group plans are fully insured. The non-group market (also called the *individual market*) and the small-group market include plans sold on and off the health insurance exchanges—the individual exchanges and the Small Business Health Options Program (SHOP) exchanges, respectively. Private health insurance regulations apply differently to different types of private health insurance plans.

Note: For more information on private health insurance plans, see CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*.

The Tri-agencies' guidance generally encouraged all private health insurance plans in each agency's jurisdiction to promote the use of telehealth services.³ The guidance suggested specific steps plans could take to do so, including by (1) notifying consumers of the availability of telehealth and other remote care services; (2) ensuring telehealth access to a robust suite of such services, including mental health and substance use disorder services; and (3) covering telehealth and other remote care services without cost-sharing or medical-management requirements.⁴ This and/or subsequent agency guidance also provided certain specific flexibilities to facilitate telehealth coverage. In addition, Congress passed legislation enacting time-limited flexibilities or changes to telehealth coverage requirements.

³ CMS, "FAQs on Availability and Usage of Telehealth Services Through Private Health Insurance Coverage in Response to Coronavirus Disease 2019 (COVID-19)," March 24, 2020, at <https://www.cms.gov/files/document/faqs-telehealth-covid-19.pdf> (hereinafter CMS FAQ, March 2020); Departments of Labor (DOL), HHS, and the Treasury, "FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation, Part 42," April 11, 2020, at <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-42.pdf#page=10> (hereinafter Tri-agency FAQ 42, April 2020).

⁴ CMS also issued a letter to nonfederal governmental plans encouraging them to cover telehealth services. See Letter from Samara Lorenz, Director of Oversight Group, Center for Consumer Information and Insurance Oversight, CMS, to Sponsors of non-Federal governmental plans, June 5, 2020, at <https://www.cms.gov/files/document/COVID-19-Letter-to-Non-Federal-Governmental-Plans.pdf> (hereinafter CMS, Nonfederal Plans Letter, June 2020). For more information on these types of plans, please see CRS In Focus IF11359, *Applicability of Federal Requirements to Selected Health Coverage Arrangements: An Overview*.

The following sections describe each telehealth flexibility introduced during the COVID-19 PHE. See **Table 1** for a summary of each flexibility and its applicability to different types of plans.

Allowing Midyear Plan Design Changes to Increase Telehealth Coverage

Both CMS, for the plans it regulates, and the Tri-agencies, for the plans they regulate, issued guidance to permit midyear plan design changes to increase telehealth coverage in fully insured health plans, both group and non-group, and in self-insured health plans. Generally, once a health insurance product is approved for sale,⁵ which happens prior to the open enrollment period,⁶ insurers offering individual and group insurance plans are not allowed to modify benefits or cost sharing associated with the approved product per federal requirements. In March 2020, CMS released guidance stating that it would not take enforcement action against insurers that made midyear changes to products to provide greater coverage for telehealth services or to reduce or eliminate cost-sharing requirements for telehealth (even if such changes were not related to COVID-19).⁷ CMS stated that such changes must be consistent with state law and encouraged state regulators to take similar actions.

Similarly, the Tri-agencies issued guidance in April 2020 allowing insurers offering non-group and group plans, including self-insured group health plans, to add telehealth and other remote health services midyear without providing the required 60-day advance notice.⁸ The Tri-agencies stipulated that group health plans may not limit or eliminate other benefits or increase cost sharing to offset the costs of those services and must provide notice of changes to enrollees as soon as reasonably practicable.

Both CMS and the Tri-agencies indicated they would continue to take enforcement action against plans that limit or eliminate other benefits, or increase cost sharing, to offset the costs of increased telehealth benefits. Both of these nonenforcement policies regarding midyear plan design changes to increase telehealth coverage are to end when the PHE declaration expires.⁹ This flexibility has been in effect during the entire PHE, but it may have been more salient when the

⁵ A health insurance product is a particular set of benefits and cost sharing offered by an insurer.

⁶ An open enrollment period is a timeframe in which an eligible person may enroll in health plan coverage (eligible individuals may also enroll at other times if they have a qualifying life event, for example). Many plans offer an open enrollment period annually, though the timeframe may differ depending on the source of the coverage (for example, different employers may have different open enrollment periods).

⁷ See question 2 in CMS FAQ, March 2020.

⁸ See question 14 in Tri-agency FAQ 42, April 2020. In later guidance, the Tri-agencies provided information to plans on meeting the advance notice requirements at the end of the PHE. See question 13 in HHS, DOL, Treasury, “FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 43, June 23, 2020, p. 11 (hereinafter Tri-agency FAQ 43, June 2020).

⁹ The Tri-agency guidance also specified that grandfathered health plans would not lose their grandfathered status if, during the COVID-19 PHE, they provided greater coverage for telehealth services or reduce or eliminate cost-sharing requirements for telehealth. The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) provided that group health plans and health insurance coverage in which at least one individual was enrolled as of enactment of the ACA (March 23, 2010) could be *grandfathered*. For as long as a plan maintains its grandfathered status, it is exempt from specified federal health insurance requirements established under the ACA. See question 15 in Tri-agency FAQ 43, June 2020. Also, to the extent that state and local laws prohibit midyear changes for nonfederal governmental plans, CMS encouraged states and local authorities not to take any enforcement actions against nonfederal governmental plans that make midyear changes to provide greater coverage for telehealth services or to reduce or eliminate cost-sharing requirements for telehealth. See CMS, Nonfederal Plans Letter, June 2020. For more information on these types of plans, please see CRS In Focus IF11359, *Applicability of Federal Requirements to Selected Health Coverage Arrangements: An Overview*.

guidance was issued in 2020 than in subsequent years, as health plans could have sought approval for plan design changes relating to telehealth prior to open enrollment in those years.

Allowing Certain Employers to Offer Coverage Only for Services Provided via Telehealth and Other Remote Care Services

Generally, health plans that provide medical care, including through telehealth, and otherwise meet the definition of a group health plan must meet federal requirements that are applicable to such plans. However, Tri-agency guidance provided temporary relief from specified federal requirements for certain telehealth-only group health plans, permitting a large employer to offer coverage only for telehealth and other remote care services to employees who are not eligible for any other group health plans offered by the employer.¹⁰ Such a plan might cover only a certain number of virtual primary care visits, for example. The guidance specifies which requirements would still apply to such plans. This flexibility is permitted for the duration of any plan year beginning before the end of the COVID-19 PHE.

Allowing Telehealth Coverage Pre-deductible for Catastrophic Plans

CMS also permitted an additional flexibility for *catastrophic plans*. Catastrophic plans are offered on the non-group (or individual) market and are available to individuals under the age of 30 and those who are over 30 but meet certain criteria. Although catastrophic plans cover a set of *essential health benefits*, as do other non-group plans, catastrophic plans generally may only provide pre-deductible coverage of at least three primary care visits and certain preventive services.¹¹

CMS allowed insurers to modify their catastrophic plans to provide pre-deductible coverage for telehealth services, as well, and still meet the requirements to be a catastrophic plan.¹² Pre-deductible coverage for telehealth services allows an enrollee's health plan to cover some of the costs associated with services provided via telehealth before the enrollee pays the full amount of the deductible. This non-enforcement policy is to end when the PHE declaration expires.

Allowing Telehealth Coverage Pre-deductible for Health Savings Account-Qualified High Deductible Health Plans

A health savings account (HSA) is a tax-advantaged account that individuals can use to pay for unreimbursed medical expenses (e.g., deductibles, co-payments, coinsurance, services not covered by insurance). Individuals are eligible to establish and contribute to an HSA if they have coverage under an HSA-qualified high deductible health plan (HDHP), do not have disqualifying coverage, and cannot be claimed as a dependent on another person's tax return. To be considered an HSA-qualified HDHP, a health plan must meet several criteria: (1) it must have a deductible above a certain minimum level, (2) it must limit out-of-pocket expenditures for covered benefits to no more than a certain maximum level, and (3) it can cover only certain preventive services and (for limited time periods) telehealth services before the deductible is met.

¹⁰ See question 14 in Tri-agency FAQ 43, June 2020.

¹¹ A *deductible* is the amount an enrollee is required to pay for health care services or products before the enrollee's insurance plan begins to provide coverage. For more information on the essential health benefits, see CRS Report R44163, *The Patient Protection and Affordable Care Act's Essential Health Benefits (EHB)*.

¹² See question 3 in CMS FAQ, March 2020.

Section 3701 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act; P.L. 116-136) allowed pre-deductible coverage of telehealth by HSA-qualified HDHPs for services that began on or after January 1, 2020, and for plan years that began on or before December 31, 2021.¹³ This provision was extended in subsequent legislation; most recently, Section 4151 of the Consolidated Appropriations Act, 2023 (P.L. 117-328), allowed the policy to continue for plan years beginning after December 31, 2022, and before January 1, 2025.¹⁴

Providing That COVID-19 Testing Coverage Requirements Apply with Regard to Telehealth Visits

The Families First Coronavirus Response Act (FFCRA; P.L. 116-127), as amended by the CARES Act, required most plans to cover COVID-19 testing, test administration, and related items and services, as defined by the acts. Section 6001(a)(2) of FFCRA required plans and issuers to provide coverage of these items and services furnished to an individual in various ways as specified (including telehealth visits) without consumer cost sharing. This testing coverage requirement, including as related to telehealth, applies only during the COVID-19 PHE.¹⁵

Table 1. Summary of Federal Telehealth Flexibilities and Applicability to Plan Types

Flexibility	Individual (Non-group)	Small Group	Large Group	Self-Insured	Expiration	Source(s)
Allowing midyear plan design changes to increase telehealth coverage ^a	Yes, to the extent consistent with state law	Yes, to the extent consistent with state law	Yes, to the extent consistent with state law	Yes	Until COVID-19 PHE ends	CMS FAQ, March 2020; Tri-agency FAQ 42, April 2020
Allowing certain employers to offer coverage only for services provided via telehealth and other remote care services	NA	NA	Yes	Yes, for large employers ^b	Until end of the plan year during which the COVID-19 PHE ends	Tri-agency FAQ 43, June 2020

¹³ Internal Revenue Service, *Internal Revenue Bulletin: 2020-22*, May 26, 2020, at https://www.irs.gov/irb/2020-22_IRB#NOT-2020-29. The Coronavirus Aid, Relief, and Economic Security Act (CARES Act; P.L. 116-136) also included a provision allowing individuals to enroll in a plan covering only telehealth and other remote care services, and such a plan would not be considered disqualifying coverage for the purposes of health savings account eligibility for plan years beginning on or before December 31, 2021. The Consolidated Appropriations Act, 2022 (P.L. 117-103), allowed this policy to continue for months after March 31, 2022, and before January 1, 2023. The Consolidated Appropriations Act, 2023 (P.L. 117-328), allowed this policy to continue for plan years beginning after December 31, 2022, and before January 1, 2025. For additional information, see CRS Report R45277, *Health Savings Accounts (HSAs)*.

¹⁴ Section 307 of the Consolidated Appropriations Act, 2022 (P.L. 117-103), allowed the policy to continue for months after March 31, 2022, and before January 1, 2023.

¹⁵ For more information on this requirement, see CRS Report R46481, *COVID-19 Testing: Frequently Asked Questions*.

Flexibility	Individual (Non-group)	Small Group	Large Group	Self-Insured	Expiration	Source(s)
Allowing telehealth coverage pre-deductible for catastrophic plans	Already permitted for most PHI plans prior to PHE, extended to catastrophic plans	Already permitted for most PHI plans prior to PHE	Already permitted for most PHI plans prior to PHE	Already permitted for most PHI plans prior to PHE	Permitted for catastrophic plans until the COVID-19 PHE ends	CMS FAQ, March 2020
Allowing telehealth coverage pre-deductible for HSA-qualified HDHPs	Already permitted for most PHI plans prior to PHE, extended to HSA-qualified HDHP plans	Already permitted for most PHI plans prior to PHE, extended to HSA-qualified HDHP plans during PHE	Already permitted for most PHI plans prior to PHE, extended to HSA-HDHP plans during PHE	Already permitted for most PHI plans prior to PHE, extended to HSA-qualified HDHP plans during PHE	Permitted for HSA-HDHP plans for plan years beginning before January 1, 2025	CARES Act; CAA 2022; CAA 2023
Providing that COVID-19 testing coverage requirements apply with regard to telehealth visits	Yes	Yes	Yes	Yes	Until COVID-19 PHE ends	FFCRA; CARES Act

Sources: Congressional Research Service analysis of Centers for Medicare & Medicaid Services (CMS), “FAQs on Availability and Usage of Telehealth Services Through Private Health Insurance Coverage in Response to Coronavirus Disease 2019 (COVID-19),” March 24, 2020, at <https://www.cms.gov/files/document/faqs-telehealth-covid-19.pdf> (referred to as CMS FAQ, March 2020); Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury, “FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation, Part 42,” April 11, 2020, at <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-42.pdf> (referred to as Tri-agency FAQ 42, April 2020); HHS, DOL, and Treasury, “FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation, Part 43,” June 23, 2020, at <https://www.cms.gov/files/document/FFCRA-Part-43-FAQs.pdf> (referred to as Tri-agency FAQ 43, June 2020); Coronavirus Aid, Relief, and Economic Security Act (CARES Act; P.L. 116-136); Consolidated Appropriations Act, 2022 (CAA 2002; P.L. 117-103); Consolidated Appropriations Act, 2023 (CAA 2023; P.L. 117-328); Families First Coronavirus Response Act (FFCRA; P.L. 116-127).

Notes: HDHP = high deductible health plan; HSA = health savings account; NA = not applicable; PHE = public health emergency; PHI = private health insurance.

- a. The Tri-agency guidance specified that grandfathered health plans would not lose their grandfathered status if, during the COVID-19 PHE, they provided greater coverage for telehealth services or reduce or eliminate cost-sharing requirements for telehealth. See question 15 in Tri-agency FAQ 43, June 2020. The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) provided that group health plans and health insurance coverage in which at least one individual was enrolled as of enactment of the ACA (March 23, 2010) could be grandfathered. For as long as a plan maintains its grandfathered status, it is exempt from specified federal health insurance requirements established under the ACA. For more information on these types of plans, please see CRS In Focus IFI 1359, *Applicability of Federal Requirements to Selected Health Coverage Arrangements: An Overview*.

- b. A *small group* is typically defined as a group of up to 50 individuals (e.g., employees), and a *large group* is typically defined as one with 51 or more individuals.

State Laws and Private Health Insurance Telehealth Coverage

Regulation of private health insurance coverage of telehealth at the state level existed prior to the COVID-19 PHE and continued during the PHE. Two of the main types of laws at the state level addressing telehealth coverage in private health insurance are as follows:¹⁶

- Coverage parity laws, which are requirements on health plans to provide telehealth coverage on the same terms as in-person services, including having the same cost-sharing requirements and the same medical management (e.g., prior authorization) requirements
- Payment parity laws, which are requirements on health plans to pay providers at the same rate whether a service was provided in person or via telehealth

States have taken various approaches to health plans during the COVID-19 PHE. Some states that did not have parity laws in place prior to the PHE issued orders to require coverage or payment parity (or both). For example, Alaska requires telehealth coverage, including requiring that non-network telehealth services are covered if there is coverage for non-network in-person services. Arizona requires that cost sharing for telehealth be lower than cost sharing for in-person services to encourage use of telehealth during the PHE.¹⁷ Some states have made these changes to telehealth coverage permanent; others have modified or ended these policies. The CCHP developed and continually updates a survey of state laws/regulations generally and during the COVID-19 PHE.¹⁸

Considerations for Telehealth After the COVID-19 PHE

As listed in **Table 1**, between federal guidance and legislation, telehealth flexibilities for private health insurance during the COVID-19 PHE have included the following for certain types of plans, as specified:

- Allowing midyear plan design changes to increase telehealth coverage
- Allowing certain employers to offer coverage only for services provided via telehealth and other remote care services
- Allowing telehealth coverage pre-deductible for catastrophic plans
- Allowing telehealth coverage pre-deductible for HSA-qualified HDHPs

¹⁶ Health plans offered by state-licensed insurers are subject to state health insurance requirements. Because self-insured group plans are financed directly by the plan sponsor, such plans generally are not subject to such requirements.

¹⁷ State of Alaska, Department of Commerce, Community, and Economic Development, letter from Lori Wing-Heier, director of the Division of Insurance, to all health insurers in the state of Alaska and other interested parties, Bulletin 20-18, October 2, 2020, at https://www.commerce.alaska.gov/web/Portals/11/Pub/INS_B20-18.pdf; State of Arizona, Executive Order 2020-07, “Proactive Measures to Protect Against COVID-19,” March 11, 2020, at https://azgovernor.gov/sites/default/files/eo_2020-07.pdf. Emergencies declared by a state governor or other state organizations also may affect state laws.

¹⁸ For example, CCHP, “Private Payer Laws,” at <https://www.cchpca.org/topic/private-payer-covid-19/>. Others are available at <https://www.cchpca.org/policy-trends/>. Some of the state laws/regulations highlighted in the survey are broader than just private health insurance and cover telehealth policies with respect to other coverage types, such as Medicaid.

- Providing that COVID-19 testing coverage requirements apply with regard to telehealth visits

As noted in **Table 1**, some of the policies are to end with the end of the COVID-19 PHE. Others are to continue until the end of the applicable plan year or longer, in the case of telehealth coverage pre-deductible for HSA-HDHPs.

As the COVID-19 PHE winds down, telehealth is likely to remain an important part of private health insurance coverage.¹⁹ Many employers offer telehealth benefits to employees. According to a 2022 survey, 87% of employers with 50-199 employees (considered small employers for the purposes of this survey) offer telehealth benefits and 96% of employers with 200 or more employees (considered large employers in this survey) offer telehealth benefits.²⁰ Of surveyed employers with 50 or more employees, about one-third (34%) expect telehealth use will increase over the next year, whereas only 14% indicated it was likely to decrease.²¹ Telehealth for behavioral health services was particularly emphasized; data indicate that 67% of small employers and 86% of large employers noted that telehealth would be “very important” or “important” to providing behavioral health services in the future.²²

Congress may wish to monitor telehealth moving forward to determine if any of the flexibilities offered for private health insurance plans during the COVID-19 PHE should be made permanent. For example, legislation was introduced, but not enacted, in the 117th Congress that would have added telehealth as an excepted benefit, allowing telehealth-only plans.²³ Although such plans may be useful in providing coverage, there may be questions as to the use and robustness of such plans that Congress could choose to consider.

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¹⁹ See <https://www.whitehouse.gov/wp-content/uploads/2023/01/SAP-H.R.-382-H.J.-Res.-7.pdf>.

²⁰ Gary Claxton et al., *Employer Health Benefits 2022 Annual Survey*, Kaiser Family Foundation, October 27, 2022, pp. 191-195, at <https://www.kff.org/health-costs/report/2022-employer-health-benefits-survey/>. The number of small employers offering telehealth benefits decreased from 94% in 2021 to 87% in 2022.

²¹ Ibid, see figure 13.8, p. 195. In addition, 42% of employers expect telehealth use to stay about the same and 10% said they did not know.

²² Ibid, see figure 13.7, p. 194. Of the surveyed small employers, 36% indicated telehealth would be “very important” for providing behavioral health services and 31% said it would be “important.” For large employers, 55% indicated telehealth would be “very important” and 31% said it would “important.”

²³ For example, H.R. 7353, the Telehealth Benefit Expansion for Workers Act of 2022.

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