The Reforming States Group

EXECUTIVE SUMMARY

Telehealth Private Payer Laws: Impact and Issues

by the Center for Connected Health Policy

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Health systems across the country face increasing pressure to expand access to care, while improving the efficiency and quality of care in the face of limited resources. Consequently, state policymakers have shown a growing interest and receptivity to the use of telehealth technologies to help meet these demands. Telehealth is defined as the use of electronic technology to provide diagnostic and treatment services, enhanced communication and care coordination, patient monitoring, and education from a distance. This virtual communication can be between two health care providers or between the health consumer and the care provider using one of the following modalities: "real-time" live video; asynchronous or "store-and-forward" communication, which uses a secure e-mail platform and is not in real time; or through remote patient monitoring (RPM).

Telehealth care has existed for decades and, with the rapid advances in technology and electronic communications, its use has proven to be as effective in many situations as in-person care. While a substantial body of literature and evidence for telehealth exists, its ubiquitous use remains elusive. The passage of the Affordable Care Act (ACA) in 2010 and Medicaid expansion have resulted in millions of Americans having the ability to seek care, yet access to needed care remains a challenge for many due to the shortage of primary and specialty care services and facilities in much of the country. This factor, coupled with increased access to affordable high-speed broadband and wireless communications, has created a perfect storm that has motivated state policymakers to consider telehealth as a viable option to address the health care needs of their constituents.

Since 2010, there has been nearly triple the number of states that have enacted legislation related to telehealth care, and the most common legislation has been what is known as private payer laws. The state telehealth private payer laws range in scope and features, adding further complexity to the already convoluted telehealth policy environment where no two states are alike. Although these private payer telehealth laws are gaining momentum, to date there has not been a comprehensive analysis of these laws or the impact they may have on expanding the use and payment for telehealth services.

This report, commissioned by the Reforming States Group (RSG), grew out of the group's interest in the topic. Supported by the Milbank Memorial Fund since 1992, the RSG is a bipartisan group of state executive and legislative leaders who, with a small group of international colleagues, meet annually to share information, develop professional networks, and commission joint projects.

To further understand and assess the impact of these laws on telehealth utilization, the Center for Connected Health Policy (CCHP) conducted a five-month study (September 2016 to January 2017) that sought to accomplish the following:

- Assess and describe the impact of telehealth private payer laws on commercial payers.
- Describe the effects of telehealth private payer laws on utilization.
- Assess any influence these laws had on state Medicaid telehealth policies.
- Provide suggestions to improve private payer laws and their impact.

Further, this study seeks to achieve a better understanding of the following policy factors that greatly affect the effectiveness of private payer laws:

1. Inclusion/exclusion of language—Is the presence or lack of certain language or phrases a help or hindrance to the utilization of telehealth?
2. Parity in payment—Does the law require a payment amount for telehealth-delivered services to be equal to what is given for in-person services?
3. Modality—Are there any limitations on what type of telehealth modality can be used?
4. Location—Are there any limitations on where a telehealth service can take place?
5. Providers and specialties—Are there any limitations on the types of providers who may provide services via telehealth and/or the types of specialty it can be used for?

Private Payer Laws Assessment

To date, 31 states and the District of Columbia have enacted telehealth private payer laws. CCHP developed a relative scoring scale based on 14 key factors to determine the comprehensiveness of scope of each law. Minnesota was the only state that received a perfect score based on these criteria. All states included live video in their definition of telehealth, but store-and-forward and RPM appeared less frequently, thus it was questionable as to whether these were recognized as reimbursable costs. For the most part, telehealth private payer laws tended to not include limitations on where the patient was located at the time of service based upon geography and/or site or the type of provider and type of services that could be reimbursed, unlike the federal Medicare program that restricts each of these categories in some way. Notably, only three of the 32 jurisdictions included an explicit mandate for equal payment regardless of whether the service was delivered in person or via telehealth.

The absence of specific language regarding these factors in a telehealth private payer law can have the effect of providing private payers with greater discretion to set their own policies regarding each factor. It became clear that the absence of language regarding a certain factor could be just as important as the explicit inclusion of language.

Private Payer and Medicaid Interviews

Private Payers

To gain a deeper understanding of the impact on commercial health insurance payers, CCHP conducted in-depth interviews with payers in California, Mississippi, Montana, Oklahoma, Texas, and Virginia. CCHP selected these states because their private payer laws had been in effect more than three years. Another goal in the state selection process was to achieve a broad variety in geography and population.

Over four months, at least two plans operating in each state were interviewed via either phone or email. Some health plans declined to be interviewed. As a result, it is possible that the interview sample may be biased toward those willing to incorporate telehealth as a reimbursable benefit. To try to counteract this possibility, CCHP attempted to research online the recent telehealth policy of those health plans that declined to be interviewed to gather information that addressed the assessment questions. CCHP agreed to not identify the participants in these interviews to obtain the most open responses possible.

From the interviews, CCHP found that all payers had limited telehealth reimbursement policies in some way. While none of the payers interviewed had imposed location or site limitations (in fact some encouraged policies that allowed the home or workplace to be an eligible site to receive services), they did impose limits in other areas, such as types of services reimbursed and the modality used. Live video was the modality reimbursed by all interviewees, with only a few offering some type of store-and-forward reimbursement. When asked if they would explore adding other modalities, several mentioned they were considering such an expansion.

When questioned as to why they were limiting telehealth services, the responses centered on the belief that telehealth was not appropriate for delivering all services. Certain services would not be suitable for delivery by technology only, which was why consultation codes were the most commonly reimbursed services for telehealth. Most interviewees said they were taking a slow, methodical approach in considering more expansive policies to ensure the services provided via telehealth would be as good as in-person delivered services.

The private payer interviews also uncovered the impact of other factors that affect the utilization of telehealth, such as licensing board guidelines on telehealth use and lack of appropriate billing codes. Additionally, the interviews found that many private payers were contracting with a third party to provide telehealth services to their enrollees rather than rely solely on their network providers.

Of interest, those interviewed generally agreed that utilization was lower than they had anticipated. When asked about the cause, several interviewees mentioned reluctance by network providers to utilize the technology for a variety of reasons and lack of consumer demand. Consumers were either unaware that a telehealth option existed or, if they were, there was a perceived preference to see a provider in person. However, after using the technology, both providers and patients appeared to be satisfied with the service.

Medicaid

CCHP also conducted interviews with representatives of Medicaid programs in each of the six sample states to see if the private payer laws affected their programs in any way. Unless there was some specific factor in the private payer law that was directed at the Medicaid program, no significant impact was reported. Most of the Medicaid programs studied were already reimbursing for some form of telehealth before their state telehealth private payer law was enacted.

The Medicaid programs usually had some parameters or limitations. Unlike private payers, Medicaid programs tend to explicitly limit the type of facility in which a telehealth service can take place, typically a health facility, and set parameters regarding who can be reimbursed and for what services.

Several Medicaid programs also cited low utilization rates and identified similar reasons as the private payers, such as provider reluctance to offer telehealth-delivered services, burdensome licensing board guidelines or regulations, and the lack of awareness among consumers that telehealth services were available.

Findings

Despite the passage of telehealth private payer laws, expansion of the use of telehealth to deliver care has not moved as rapidly or expansively as state policymakers may have envisioned. This could be due to the ambiguous way most of these laws are written, often omitting critical language that could encourage providers to utilize and be reimbursed for telehealth care. This lack of clarity in the language of the private payer laws provides discretion to the private payer to establish its own disparate policies that may or may not be restrictive, making it challenging for providers and patients to understand and navigate. Lack of distinction or clarity regarding the type of modality of telehealth to be covered is another factor that contributes to the slow uptake of telehealth care.

Other factors beyond the reach of a private payer law that have affected the further expansion of telehealth services that were identified in this study include limitations created by licensing boards, burdensome regulations governing telehealth payments, and lack of appropriate billing codes for specific forms of telehealth care resulting in lower or no payment.

And, while there is a growing awareness of "direct-to-consumer" type telehealth services, the health care consumer is generally unaware of what telehealth-delivered services are covered and available under their own plans, pointing to a need for greater education for both providers and payers.

Policymakers and advocates may want to:

- Consider explicit language that details the exact intent of policymakers such as ensuring all modalities are to be reimbursed by private payers.
- Ensure that payment parity language is included if the intent of policymakers is to have telehealth reimbursed at the same rate as in-person services.
- Consider inclusion of an education component for providers and consumers.
- Consider a robust, comprehensive telehealth policy within the state Medicaid program.
- Work with state licensing boards to create telehealth policies that allow licensees the flexibility to utilize technologies in delivering care, but still take into consideration the safety of the patient.

Conclusion

Telehealth-delivered care continues to have great promise to contribute to the Triple Aim of better health outcomes, improved patient and provider experiences, and increased efficient use of resources to lower costs. But numerous state policy obstacles inhibit health systems and payers from achieving the full potential of these technologies. This study makes clear there is broad misconception that because private payer laws are in place in many states around the country, telehealth is achieving its promise of parity of benefits and payment with in-person care. The reality is that lack of clarity and clauses that impede the expansion of telehealth-delivered services weaken many of these laws. More careful crafting of the language for these laws and a more comprehensive implementation plan that includes the voice of payers, providers, and consumers will be needed to achieve greater adoption of telehealth-delivered care in the future. Further analysis should be considered to assess the impact of specific payment parity laws in the three states identified (Delaware, Hawaii, and Minnesota) after they have been in place for at least three years.