

# Key Findings:

## Analysis of California Assembly Bill 744 Telehealth

Summary to the 2019–2020 California State Legislature, April 16, 2019



### AT A GLANCE

The version of California Assembly Bill 744 analyzed by CHBRP would require reimbursement parity between telehealth services and the equivalent in-person visit.

1. CHBRP estimates that, in 2020, all 24.5 million Californians enrolled in state-regulated health insurance would have insurance subject to AB 744.
2. **Benefit coverage.** More than half (51% to 80%) of enrollees currently have coverage for telehealth paid at parity with equivalent in-person services. AB 744 would not exceed essential health benefits (EHBs).
3. **Utilization.** Of the 20% to 49% of enrollees receiving new coverage for various services reimbursed at parity under AB 744, CHBRP estimates a marginal increase in use among commercial and CalPERS enrollees ranging from a low of 3/1,000 emergency department visits, diagnostic services and other services to a high of 12.1/1,000 primary care and urgent care visits. Among Medi-Cal Managed Care enrollees, utilization would increase by 2.2/1,000 outpatient mental health and substance use disorder visits and a high of 51.6/1,000 primary care and urgent care visits.
4. **Expenditures.** In 2020, total net annual expenditures would increase by \$278,298,000, or 0.17%.
  - a. Although some services are currently paid at parity, for services *not* paid at parity, commercial insurers and CalPERS would need to pay at rates that are 42% to 137% higher to be equivalent to the corresponding in-person visits.
  - b. Medi-Cal Managed Care plans would need to pay at rates that are 15% to 30% higher to be equivalent to the corresponding in-person visits.

### AT A GLANCE, Cont.

5. **Medical effectiveness.** Evidence of effectiveness is mixed for services delivered via telehealth. Among the telehealth modalities and services reviewed, there is evidence that most modalities and services improve health outcomes. Evidence regarding effects on process of care, access, and utilization is insufficient or inconclusive for most modalities and services.
6. **Public health.** The public health impact of AB 744 is unknown, although CHBRP anticipates that some newly covered patients will be able to obtain more timely specialty or primary care, especially for those in rural regions. These patients will also experience reduced travel time and associated costs.
7. **Long-term impacts.** CHBRP assumes that technology improvements, the 2019 Centers for Medicare & Medicaid (CMS) reimbursement policy, and continued adoption of value-based, bundled care reimbursement models will likely increase use of e-mail, videoconferencing, and other telehealth services between patients and providers.

### CONTEXT

Telehealth is defined by AB 744 as “the mode of delivering healthcare services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care.”<sup>1</sup>

CHBRP focuses on the most common types of telehealth modalities:

- **Live video** — uses two-way, interactive video to connect users. Occurs provider-to-provider at a distant site or between a patient and a provider;

<sup>1</sup> Refer to CHBRP’s full report for full citations and references.

- **Store and forward** — provider captures medical information (e.g., photo, recording) and transmits information to a remote provider for later review;
- **E-mail and synchronous text and chat conferencing** — health system portals provide email, chat or text options for patients to contact providers; and
- **Telephone** — landline, cell phone.

Telehealth modalities may be used to facilitate patient-to-provider or provider-to-provider communication. These modalities are also used to support eConsults (provider-to-provider) and remote patient monitoring (passive patient-provider interaction) services. Additional definitions of telehealth modalities are included in Table 2 of the full report.

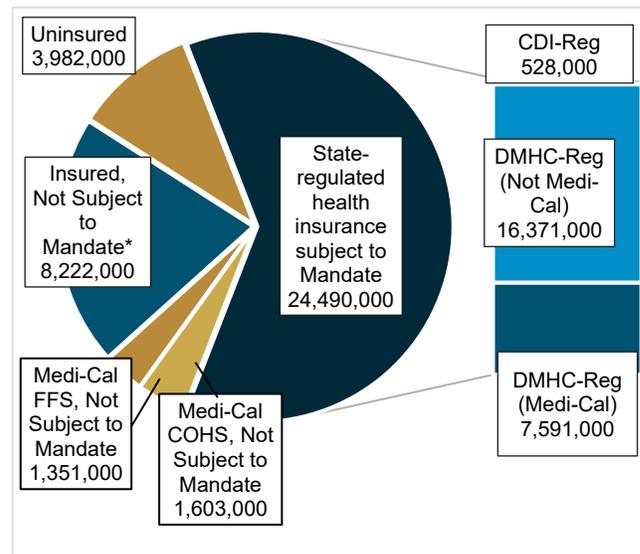
## BILL SUMMARY

AB 744 would:

- Require health plans and policies to reimburse telehealth services on the same basis and to the same extent the plans and policies reimburse for the same service through in person diagnosis, consultation, or treatment.
- Allow plans and policies to apply cost-sharing to telehealth services, not to exceed cost-sharing for the equivalent in-person service.
- Prohibit plans and policies from limiting telehealth services to only those provided by third-party providers and from denying coverage for a service solely because it is provided via telehealth.

Figure A notes how many Californians have health insurance that would be subject to AB 744.

**Figure A.** Health Insurance in CA and AB 744



Source: California Health Benefits Review Program, 2019.

Notes: \*Medicare beneficiaries, enrollees in self-insured products, etc.

## IMPACTS

### Benefit Coverage, Utilization, and Cost

#### Benefit Coverage

The baseline coverage and payment parity across all modalities for telehealth services varied by type of health care service, with the fewest enrollees (50.9%) having coverage for radiology and lab/pathology services delivered via telehealth and a high of 80.3% of enrollees having coverage for outpatient mental health and substance use disorder services via telehealth. Overall, the majority of enrollees have coverage through health plans and insurers that pay providers for telehealth services at parity with equivalent in-person services.

Some telehealth services may be delivered through third-party vendors (e.g., Teladoc). Approximately 10% of commercial insurance enrollees and 17% of Medi-Cal enrollees have access to these third-party services. CHBRP assumes that postmandate, this type of encounter will remain ineligible for reimbursement because the encounter may be with a nonbillable provider (e.g., because nonbillable providers tend to deliver these types of services or billable providers of a national vendor may not be licensed by California's Business and Professions code).

## Utilization

CHBRP estimates that, postmandate, telehealth visits would represent 5.7% of all visits for those newly covered enrollees due to the added coverage and reimbursement parity required by AB 744; this would match the utilization rate of those enrollees already covered at baseline. The increases are attributable to areas where telehealth would likely substitute for in-person services (i.e., teleradiology, telestroke, teleICU, and lab/pathology) and/or supplement existing in-person services (i.e. office visits, telepsychiatry). About 29% of the marginal increase in telehealth utilization is attributable to substitution and 71% is attributable to supplemental visits (visits previously provided, but not reimbursed, or not previously provided).

Of the 20% to 49% of enrollees receiving new coverage for various services reimbursed at parity under AB 744, CHBRP estimates a marginal increase in use among commercial and CalPERS enrollees ranging from a low of 3/1,000 emergency department visits, diagnostic services and other services to a high of 12.1/1,000 primary care and urgent care visits. Among Medi-Cal Managed Care enrollees, utilization would increase between 2.2/1,000 for outpatient mental health and substance use disorder visits and a high of 51.6/1,000 primary care and urgent care visits.

The increase in telehealth services postmandate is accompanied by a slight decrease in the use of in-person services. Estimated increases are larger in the Medi-Cal managed care enrollee population due to a lack of current coverage across all modalities at parity, along with the lack of cost-sharing requirements in Medi-Cal.

## Per-Unit Cost

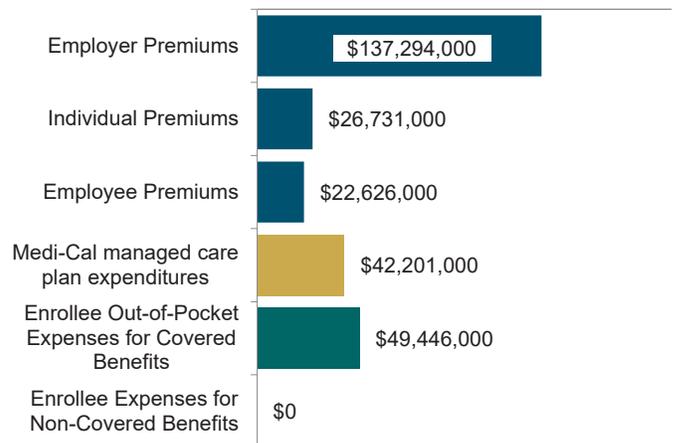
Telehealth services not currently paid at parity with equivalent in-person services include office visits for primary and urgent care, dermatology, other specialists, and outpatient mental health and substance use disorder. To reach parity, commercial insurers and CalPERS would need to pay rates that are 23% to 120% higher to be equivalent to in-person visits for the same services. Medi-Cal Managed Care plans would need to pay at rates that are 15% to 30% higher to be equivalent to the corresponding in-person visits.

## Expenditures

AB 744 would increase total net annual expenditures by \$278,298,000 or 0.17% for enrollees with DMHC-regulated plans and CDI-regulated policies. This increase is primarily driven by increases of \$132,415,000 (0.15%) in spending by private group employers, \$22,526,000 (0.24%) in spending by enrollees with individually purchased Covered California policies and \$42,201,000 (0.15%) in spending by Medi-Cal managed care plans.

This increase in total net annual expenditures is due to a \$228,853,000 change in total premiums (0.16% increase in total health insurance premiums paid by employers, Medi-Cal, and enrollees for newly covered benefits), adjusted by an \$49,446,000 (0.34%) increase in enrollee expenses for covered benefits.

**Figure B.** Expenditure Impacts of AB 744



Source: California Health Benefits Review Program, 2019.

## Medi-Cal

Total expenditures would increase by \$42,201,000 (0.15%) for Medi-Cal Managed Care Plans.

## CalPERS

Total expenditures would increase by \$4,879,000 (0.16%) for CalPERS HMO.

## Number of Uninsured in California

Because the change in average premiums does not exceed 1% for any market segment, CHBRP would expect

no measurable change in the number of uninsured persons due to the enactment of AB 744.

## Medical Effectiveness

Most studies pertinent to AB 744 examine the use of telehealth as a substitute for in-person care. In these cases, the relevant studies evaluated whether care provided via these technologies is at least as effective as in-person care and whether use of these technologies improves access to care and outcomes.

Evidence regarding the effectiveness of telehealth modalities and services is mixed depending on the type of outcome studied: access and utilization, process of care, or health outcomes.

### Access and Utilization:

- There is clear and convincing evidence that remote patient monitoring is effective.
- Preponderance of evidence that store and forward and eConsult are effective.
- Preponderance of evidence that live video does not reduce use of in-person health care services.
- Inconclusive evidence that e-mail, synchronous text and chat conferencing, telephone, and telerehabilitation are effective.
- Insufficient evidence that telestroke is effective.

### Process of Care:

- Clear and convincing evidence that live video is effective.
- Preponderance of evidence that telestroke is effective.
- Limited evidence that e-mail, synchronous text and chat conferencing, and telephone are effective.
- Inconclusive evidence that store and forward is effective.
- Insufficient evidence that telerehabilitation, eConsult, and remote patient monitoring are effective.

### Health Outcomes:

- Clear and convincing evidence that live video and remote patient monitoring are effective.
- Preponderance of evidence that telephone, telestroke, and telerehabilitation are effective.
- Limited evidence that store and forward and e-mail, synchronous text and chat conferencing are effective.
- And insufficient evidence that eConsult is effective.

## Public Health

Patient access to care could improve through provider use of live video, store and forward, eConsults, and remote patient monitoring; however, there is limited or insufficient evidence of other modalities (e-mail, chat, texting, telephone) improving access to care. Therefore, the public health impact of AB 744 is unknown, although CHBRP anticipates that at least some patients would be able to obtain more timely specialty or primary care. Those patients would also experience reduced travel time and associated costs.

CHBRP is unable to assess changes in public health outcomes due to vast differences in study quality and findings of effectiveness across health conditions and telehealth modalities. For areas where stronger evidence exists, such as live videoconferencing, telephone, and remote patient monitoring, and for certain specialty areas (e.g., mental health, dermatologic or diabetes care) enrollees could see equivalent or improved health outcomes as compared with in-person care.

## Long-Term Impacts

In Year 2 of implementation, AB 744 is expected to result in additional use of telehealth services such that telehealth represents 6.54% of all visits. This is due to a 21% increase above the 2020 estimated share of all outpatient visits that are telehealth visits (5.7%). If telehealth use continues to expand in subsequent years, it is likely that increased spending on telehealth will occur. One reason is that CHBRP projects that the majority of growth will occur in new (i.e., supplemental) telehealth services.

CHBRP assumes that technology will continue to drive adoption and integration of telehealth. CHBRP projects

that this trend, along with changes in CMS reimbursement policy in 2019, and continued adoption of value-based, bundled care reimbursement models will likely increase use of e-mail, videoconferencing, and other telehealth services between patients and providers. However, estimated cost-offsets from substitution and supplemental telehealth visits and in-person visits are unknown.

## **Essential Health Benefits and the Affordable Care Act**

AB 744 would not require coverage of a new state benefit mandate and appears not to exceed the definition of EHBs in California.