How the United States Can Use Telehealth Expansion to Achieve Market Savings

The COVID-19 pandemic necessitated the rapid expansion of telehealth services. This has led the federal government and many states to expand insurance coverage for telehealth services through emergency waivers of certain requirements. Implemented ideally, widespread telehealth use could lower the overall cost of health care in commercial markets by lowering per-patient and per-visit costs for specialty and primary care providers, while increasing patient satisfaction and quality of care. However, if done poorly, telehealth expansion could increase healthcare costs by providing easy access to care that is unlikely to improve health outcomes. Thus, to achieve the potential cost and quality benefits of commercial telehealth use beyond the pandemic, federal and state laws should aim to effectively harness the growth of telehealth in targeted areas to achieve the highest value services and market savings.

The current absence of federal standards in regulating the use and cost of telehealth in private markets calls on state governments to develop their own frameworks governing this area of law and insurers to develop cost-effective solutions regarding telehealth payment. To ensure that commercial health insurance markets maximize the cost-related benefits of telehealth adoption, state legislators should implement regulations that incentivize telemedicine for the right kinds of care and payment-delivery models. This brief discusses the pros and cons of telehealth use in Part I by highlighting some of the areas in which telehealth is most and least effective in supporting high value care. In Part II, it proposes three ways in which legislators can safeguard the benefits of commercially available telehealth services while using it to lower, instead of raise, costs.

I. Advantages and Disadvantages of Telehealth

The term telehealth broadly encompasses "the use of electronic information and telecommunication technologies to support and promote" clinical care, health-related education, public health, and health administration.[1] Telemedicine is a subset of telehealth and more specifically refers to the practice of medicine between a patient in one location and at least one health care provider.[2] This brief generally focuses on the broader category of telehealth but uses the term telemedicine to refer precisely to the provision of care.

A. Advantages and Effective Uses of Telehealth

Telehealth provides several obvious benefits, such as time and cost savings for patients and providers associated with travel, childcare, and other opportunity costs. Moreover, in at least five scenarios, telehealth appears to successfully lower costs without compromising quality. First, telehealth is most beneficial for patients without complex underlying health issues for uncomplicated routine care, such as mental health services and remote patient monitoring (RPM).[3] Neurology experts have found telemedicine more effective than traditional forms of care in managing chronic neurological diseases, in part due to the effectiveness and convenience of RPM from a patient's home.[4] Second, telehealth can provide a practical solution for rural areas that might otherwise lack access to providers. Third, telemedicine use can achieve significant savings by preventing potential emergency care. For instance, when nursing homes substituted telemedicine for on-call physicians in off hours, it decreased costs by preventing emergency hospitalizations for older residents.[5] Fourth, eConsults between providers enable a primary care physician (PCP) to coordinate care with a specialty care physician so the patient can readily access care from an expert in a specialized healthcare field.[6]

B. Disadvantages and Considerations of Telehealth

On the other hand, increasing telehealth use for other applications could be problematic. Principally, the most elderly and medically vulnerable populations are not always the best candidates for replacing all in-person medical services with telemedicine, depending on their conditions. Patients with ongoing, complex health issues could suffer from replacing their visits entirely with telemedicine because virtual visits could prevent physicians from detecting essential changes or

complications that patients may not be able to notice themselves or express clearly via telehealth. Some providers worry that for certain patients and conditions, they could not evaluate the health of these patients as thoroughly in a virtual setting as they otherwise could, because providing care through a screen could prevent them from detecting nuances that would be more evident in person.[7]

Also, increases in telehealth for all services and patients could raise the overall price of health care if abused or poorly executed. Particularly, it could adversely impact healthcare costs if used in non-high-value circumstances. To maximize potential savings in commercial markets, users must replace some portion of in-person care with telehealth services instead of using it to supplement traditional visits. That is, to reduce overall healthcare costs requires the number of in-person visits to decrease at a similar or higher rate than the increase in telehealth visits. Otherwise, more frequent use of services due to telemedicine's accessibility could raise overall costs if it were to increase the total number of medical visits. The total number of visits will increase if most telehealth visits are either: a) likely to result in duplicative care, or b) sought for the types of services that do not typically require medical care, such as the common cold. For example, in California, the increased utilization involved in treating acute respiratory infections via telemedicine caused it to be more expensive than treating the infections in-person, despite lower spending per episode of care.[8]

Finally, telehealth services must cost less per episode than their in-person counterparts to achieve overall cost savings. As with any medical technology, providers or health systems will use telehealth if it increases their operating profit margins. However, although reimbursement parity may encourage healthcare providers to increase adoption of telehealth during a pandemic, as it did during the COVID-19 emergency, it cannot remain a long-term policy solution. Telehealth reimbursement parity could increase overall healthcare spending unless significant declines in the number of visits accompany the practice.

As a result, to ensure telehealth remains cost-effective, insurers and providers must consider the situations in which telehealth will likely increase care utilization and overall costs. Legislators could even propose laws to restrict insurers from covering telehealth for the types of services that are most likely to adversely affect healthcare

cost or quality. However, since medical professionals and insurers are typically best suited to make the types of health and financial decisions, any laws of this sort should be done with caution and drafted in consultation with medical professionals and research in the appropriate fields.

II. Policy Recommendations to Encourage Best Uses of Telehealth

Based on the considerations discussed in Part I, this brief provides three proposals for legislators to effectively regulate telehealth use in commercial markets and achieve optimal cost savings from telehealth services. First, legislators should lift restrictions on telehealth coverage and reimbursement based on factors such as the patient's geographic location. Second, legislators should prohibit commercial payers from imposing similar coverage and reimbursement restrictions based on arbitrary factors. Third, legislators should incentivize alternative payment models (APMs) to deter the use of telehealth when it would not constitute high-value care to achieve optimal cost savings from telehealth services.

A. Waive Restrictions on Payment, Coverage, and Reimbursement Based Upon Certain Specific Criteria

Legislators should begin by removing several common provisions that restrict the use of telehealth to fewer applications without evidence that the limits relate to increased value or quality of care. Laws that restrict patient locations, types of technology, scope of services, and types of providers permitted for telehealth services should be permanently waived to fully achieve the potential savings from telehealth.

During the coronavirus pandemic, state and federal waivers of these requirements helped providers temporarily increase telemedicine to provide necessary services while preventing the spread of COVID-19. Specifically, the Centers for Medicare and Medicaid Services (CMS) implemented several temporary waivers on telehealth conditions on the federal level to expand telehealth use during the COVID-19 crisis (see discussion of federal telehealth waivers on the Source Blog).[9] Previous law permitted Medicare to reimburse beneficiaries for limited telehealth services only if

the recipient lived in a designated rural area and received the services at a medical facility.[10] The waivers enabled Medicare to reimburse beneficiaries for telehealth services received at any location, including their homes.[11] In addition, CMS expanded the types of practitioners allowed to practice telemedicine, added 135 telehealth services to those eligible for reimbursement, and waived the audio-video technology requirement.[12] Additionally, thirty states expanded insurance coverage, reimbursement, or cost-sharing requirements for telehealth services during the COVID-19 emergency (see The Source's COVID-19 Crisis page for detailed coverage).

Unsurprisingly, once state governments, Medicare, and insurers made telehealth services as profitable as in-person care was pre-pandemic, providers dramatically increased their use of telemedicine.[13] To continue this trend and achieve less costly care, federal and state governments should permanently lift many of the regulations that were waived during the pandemic so providers may choose which services and patients are best suited for telehealth.[14]

Many healthcare industry groups and physicians agree that the federal government should permanently waive limitations on the locations in which patients may receive telehealth services.[15] Restrictions that require patients to be at a health facility prevent patients from saving the time and costs associated with transportation. Therefore, this restriction undermines the convenience and other benefits of telehealth to patients and its potential cost savings. Other restrictions that limit the types of HIPAA-compliant technologies, the scope of services, and the types of providers licensed to practice telemedicine should also be permanently removed, as such requirements could limit medically necessary choices and high-value care. Additionally, some states require a previously established provider-patient relationship before a telemedicine visit. While delivering care via telemedicine sometimes necessitates a previously established relationship, depending on the circumstances, a blanket restriction severely impedes a patient's ability to choose a high value provider for telehealth services. Thus, the state should waive this restriction by allowing providers, rather than payers, to determine when to require a previously established provider-patient relationship.

B. Encourage More Effective Benefit Designs and Prohibit Restrictions on

Telehealth Payment, Coverage, and Reimbursement

Even absent federal or state statutory restrictions on telehealth services, insurance benefit designs may still limit reimbursement or coverage of telehealth claims. Insurers sometimes withhold reimbursement or limit coverage based on the type of service provided, technology used, lack of a previously established provider-patient relationship, and other factors. Hence, legislators must not only remove these restrictions from state laws, but also encourage better insurance benefit design that would block commercial payers from imposing restrictions that limits high value telehealth care.

In July 2020, for example, Colorado passed a law that eliminated several of the coverage hurdles discussed above to improve telehealth coverage under commercial plans in three major ways.[16] First, the legislation prohibits health insurance carriers from limiting the technologies that providers may use to deliver telemedicine, other than to require HIPAA-compliant technologies.[17] Second, the law prohibits carriers from requiring a covered patient to have a previously established relationship with the provider from whom they seek medically necessary telemedicine services.[18] As discussed above, this rightfully shifts the decision from legislators to providers and patients to determine when telemedicine is appropriate. Third, the law precludes carriers from conditioning a provider's reimbursement for telehealth services on any "additional certification, location, or training requirements."[19] By clearly defining telehealth within the statute to include HIPAA-compliance and permissible types of services, the Colorado law prevents commercial health insurance carriers from limiting providers' and covered persons' abilities to use telehealth. This type of law constitutes a win for providers because it allows them to determine which types of covered patients and services will benefit most from telehealth without apprehensions that an insurer will withhold or limit payment.

States should enact laws like Colorado's, as discussed above.[20] In addition, states could explicitly regulate who decides when care is appropriately delivered via telehealth. Specifically, statutes could establish that providers, and not insurers, may choose when medically necessary care shall be adequately provided via telehealth and when it shall require a previously established relationship with the

patient. Otherwise, insurers may restrict coverage, reimbursement, and payment when they deem services inappropriate for telehealth delivery. Preventing insurers from engaging in this practice ensures that medical practitioners will consider relevant circumstances and expand telehealth where it is most beneficial.

Finally, to further encourage payers to effectuate high-value benefit design that could best utilize telehealth, state legislators should also promote price transparency efforts. For example, state mandated all-payer claims databases would collect health insurance claims and health services cost data from a variety of payers, which would help payers implement and improve benefit designs. Additionally, state laws could further encourage high-value benefit design via tiered and narrow networks and co-payment structures that incentivize the most cost-effective uses of telehealth. These policy options provide viable short-term solutions for insurers and providers to improve structural issues in insurance network designs.

C. Incentivize Alternative Payment Models Rather than Fee-for-Service

While price transparency and effective benefit designs can begin to incentivize high-value care, a more permanent cost-saving solution requires system-wide reform. Alternative provider payment models (APMs) could be powerful methods to incentivize patients and providers to widely adopt telehealth for appropriate purposes and deter them from uses that do not decrease costs. Whereas insurers in the traditional fee-for-service payment model reimburse providers for each service they render to a patient, APMs incentivize high-value care and could achieve more savings. Potential APMs include pay-for-performance, full or partial capitation, bundled payment, and a fully integrated system with insurance.

1. *Why are alternative payment models preferable over fee-for-service payment?*

Pay-for-performance, also called value-based payment, bases provider payment on patient health outcomes and may be implemented in conjunction with a fee-for-service model.[21] Adopting a pay-for-performance model would encourage providers to use telehealth where it has the potential to maintain or improve patient health outcomes while discouraging telehealth use where it could increase costs or

hurt health quality outcomes.

Full or partial capitation would also encourage cost-efficacy while maintaining accountability for high quality care. Under a capitation model, a provider receives in advance a fixed amount per patient per unit of time.[22] For example, participating accountable care organizations (ACOs) with upfront, fixed payments in Medicare's Advance Payment ACO Model practically engage in a full capitation model.[23] Population-based payment (PBP), a similar model, gives providers a risk-adjusted monthly payment to cover necessary services for each person in a set population, incentivizing providers to maintain the population's health.[24] Harvard Business Review considers PBP the "only payment system that fully aligns providers' financial incentives with the goal of eliminating all major" waste categories.[25] This refers to the unnecessary or "wasted" use of resources that occurs when patients receive inefficient or overlapping care because providers fail to properly coordinate care. Moreover, a PBP system takes away from insurers the management of the amount, type, and cost of health care and places it with medical providers. Then, it shares the savings with provider groups. Under partial capitation, providers receive a fixed payment amount for some specified services or items that patients may seek within a time period, plus fee-for-service reimbursement for not-specified services.[26]

Bundled payment models, or episode-based payment models, include ACOs and offer a structure between fee-for-service reimbursement and capitation. In a bundled payment model, health care providers are reimbursed based on the expected costs for clinically defined episodes of care.[27] This incentivizes providers to limit costs, prevent avoidable complications, and collaborate with other providers, including specialists.[28] One bundled payment combines all services involved in an episode of care, such as a major surgery. Since one price tag covers an episode of care, the price is holistic and transparent, therefore more meaningful to patients. One drawback to this type of payment is the difficulty in defining an episode of care for patients with complex and intertwined health issues.[29] On the other hand, these are the types of patients that may not be well suited for certain telehealth services in the first place. Thus, one solution may be for insurers to use different payment models for reimbursing different providers, i.e. implementing APMs to reimburse providers who work on certain types of procedures and services.

Lastly, a full integration plus insurance payment model involves one hybrid payer-provider. Kaiser Permanente operates a prime example of this model, in which a single entity serves as the insurer and care provider. It is believed that "when care and coverage are connected, it's easier to get high-quality care."[30] Since patients rely on one institution to both fund and deliver care, Kaiser has strong financial incentives to provide high-value care. As a result, the organization under this payment delivery model has inherent incentives to use telehealth only where it is cost-effective. Thus, it serves both goals of increasing telehealth use and decreasing overall healthcare costs.

2. *How should legislators promote effective payment models for telehealth use?*

To encourage payment models that will ensure telehealth's cost-effectiveness, legislators could repeal or create exceptions for state laws that directly or indirectly prohibit insurers from using certain types of APMs. While few laws, if any, directly prohibit the use of APMs, states sometimes create other "legal barriers" to APMs, such as California's Physician Ownership and Referral Act (PORA).[31] Self-referral and anti-kickback laws that state governments often implement to control healthcare costs or prevent fraud could also restrict commercial ACOs.[32] While ACOs can provide coordinated, high-quality care and save costs by avoiding unnecessary care,[33] their collaborative, centralized structure can fall within laws that prohibit "self-referrals."[34] Thus, to allow insurers and providers to experiment with APMs, states could create exceptions to these laws to permit ACOs that are not fraudulent or anti-competitive. Successfully promoting the general use of alternative payment models would necessarily promote the use of telehealth when, and only when, it constitutes high-value care.

This legislative session, California considered a law targeted at promoting APMs.[35] Expressly, the California Health Care Quality and Affordability Act ("Act") would "facilitate increased adoption of value-based payment models focused on improving affordability, quality, service, equity, and efficiency," and simultaneously invest more in primary care.[36] The Act recognized that value-based payment models align better with the legislature's goal to promote health care affordability, efficiency, and quality than fee-for-service payment. This type of law would create a foundation for alternative payment model reform. States could enact

similar laws and strengthen them by requiring the authorized entity to carry out its duties during a specific time frame, suggesting the type of experts to involve, and enumerating specific regulations to implement the law.

Finally, state legislators could go further and create targeted financial incentives for payment models that will support high-value and cost-effective uses of telehealth. For example, they could avail tax cuts to insurers or providers who both (1) adopt APMs, and (2) provide certain protections for telehealth prices on patient and provider levels. The shared savings program mandated by Title XVIII of the Social Security Act provides an example of a law that creates financial incentive for implementing an APM.[37]

III. Conclusion

As Congress noted in the CONNECT for Health Act of 2019, which garnered support from thirty senators,[38] "[r]esearch has found that telehealth services can expand access to care, improve [quality], and reduce spending, and that patients receiving telehealth services are happy with their experiences."[39] Certainly, telehealth expansion has risen this year and can be beneficial in the long run. To maximize the benefits of telehealth, states should eliminate restrictions on patient location, HIPAA-compliant technologies, providers, and services eligible for telehealth. However, legislators must consider that increased telehealth use risks potential increases in health insurance costs. To prevent this, legislators should take the control over telehealth growth away from insurers and entrust providers to determine when telehealth use is appropriate. Additionally, state policymakers should consider creative ways to incentivize insurers to adopt alternative payment systems. This overarching solution would prevent telehealth overuse that fee-for-service models sometimes encourage and would maximize potential savings in commercial markets. In summary, by balancing the pros and cons of telehealth use, states can establish regulatory structures that ensure payers and providers implement telehealth where it will manage care effectively, maximize quality health outcomes, and promote cost efficiency.

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[1] *Telehealth and Telemedicine: A Research Anthology of Law and Policy Resources*, Centers for Disease Control and Prevention (last accessed Aug. 5, 2020, 4:43 PM), https://www.cdc.gov/phlp/publications/topic/anthologies/anthologies-telehealth.html.

[2] *Id.*

[3] Suzanne Delbanco & Emma Wager, *Will Telehealth Continue Post-COVID?*, HUm. Rsch. Exec. (July 14, 2020).

[4] Bastiaan R. Bloem, *The Coronavirus Disease 2019 Crisis as Catalyst for Telemedicine for Chronic Neurological Disorders*, JAMA Neurology, Apr. 2020, at 927-28.

[5] David C. Garbowski & A. James O'Malley, *Use of Telemedicine Can Reduce Hospitalizations of Nursing Homes Residents and Generate Savings for Medicare*, 33:2 Health Affs. 244, 244-48 (2014).

[6] Delbanco, *supra* note 3.

[7] David Blumenthal, *Where Telemedicine Falls Short*, Harv. Bus. Rev.: Tech., May-June 2020.

[8] Scott Ashwood et al., *Direct-to-Consumer Telehealth May Increase Access to Care But Does Not Decrease Spending*, 36:3 Health Affs. 485, 489 (2017).

[9] Megan Pham, *Federal Telehealth Waivers Provide Flexibility During the COVID-19 Crisis to Expand Coverage and Access to Healthcare*, The Source on Healthcare Price and Competition (June 30, 2020).

[10] Seema Verma, *Early Impact of CMS Expansion of Medicare Telehealth During COVID-19*, Health Affs. Blog (July 15, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200715.454789. CMS likely required this initially to prevent beneficiaries from overusing telemedicine and to ensure a staff member at the health facility could obtain any clinical information or

measurements that the telehealth provider desired from the patient.

[11] *Id.*

[12] *Id.*

[13] Ateev Mehrota et al., *Telemedicine: What Should the Post-Pandemic Regulatory and Payment Landscape Look Like?*, Commonwealth Fund (Aug. 2020).

[14] *Id.*

[15] Heather Landi, *More Than 300 Organizations, Physician Groups Push Congress to Take Action on Telehealth Policies*, Fierce Healthcare, June 2020.

[16] Tripp Baltz, *Telehealth Barriers Smoothed Under New Colorado Law*, Bloomberg L (July 6, 2020, 12:49 PM).

[17] Reimbursement for Telehealth Services, 2020 Colo. Sess. Laws 1138. *See also* S.B. 212, 72nd Gen. Assemb., 2nd Reg. Sess. (Co. 2020).

[18] *Id.*

[19] *Id.*

[20] *Id.*

[21] *Definitions of Payment Model Terms*, Catalyst for Payment Reform: National Compendium on Payment Reform (2016).

[22] *Glossary*, The Source on Healthcare Price and Competition (last accessed Sept. 29, 2020, 7:45 PM).

[23] *Advance Payment ACO Model*, Ctrs. for Medicare and Medicaid Servs.: Innovation Center (last updated on June 15, 2020).

[24] Rachael Matulis, *It's Not Just Risk: Why the Shift to Value-Based Payment Is Also About Provider Flexibility*, Ctrs. for Health Care Strategies, Inc. (Mar. 21, 2019).

[25] Brent C. James & Gregory P. Poulson, *The Case for Capitation*, Harv. Bus. Rev.: Econ. Soc'y, July-Aug. 2016.

[26] Definitions of Payment Model Terms, *supra* note 21.

[27] Glossary, *supra* note 22.

[28] David Blumenthal & David Squires, *The Promise and Pitfalls of Bundled Payments*, Commonwealth Fund (Sept. 7, 2016).

[29] *Id.*

[30] *Your Care Experience*, Kaiser Permanente (last accessed Sept. 19, 2020, 4:00 PM).

[31] Ann Hollingshead, *State Actions to Promote and Restrain Commercial Accountable Care Organizations*, Sch. of Pub. Health, U.C. Berkeley: Nicholas C. Petris Ctr. on Health Care Mkts. and Consumer Welfare, Oct. 2015, at 7, 27.

[32] *Id.* at 7.

[33] Glossary, *supra* note 22.

[34] *Id.* at Executive Summary.

[35] A.B. 2817 Legis., Reg. Sess. (Cal. 2019-20).

[36] *Id.* § 152002(d). The Act would have established the Office of Health Care Quality and Affordability Board ("Board") and permitted it to "adopt model standards for establishing value-based payments" for contracts between payers and providers, *id.* § 152011(a)-(b). The Act additionally provided how the Board would regulate model standards and required the Board to consult state departments, third-party value-based payment reform organizations, and other healthcare financing and quality experts, *id.*

[37] 42 U.S.C. § 1395b-4 (1998).

[38] Jacquie Lee, *Telehealth's Post-Virus Power in Doubt as Virtual Visits Decline*,

Bloomberg L (Aug. 13, 2020, 7:56 AM).

[39] S. 2741, 116th Cong. (2019).