AB 744 and Other 2019 Bills Seek to Increase and Improve Telehealth Delivery in California

Avoid driving, get help instantly. That's the premise of telehealth. Telehealth, under California law, is defined as "the mode of delivering health care 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."[1] One study has shown that the use of telehealth, in California, has been found to save a patient 278 miles in driving, 4 hours in time, and $156 in direct travel costs per consultation.[2] As such, telehealth has been used as an innovative strategy to increase access to health care for rural and underserved populations.[3]

Agreeing with the benefits of telehealth, the California Legislature has statutorily recognized, on multiple occasions, that "the practice of telehealth [is] a legitimate mean[] by which an individual may receive health care services from a health care provider without in-person contact with the provider."[4] However, telehealth in California cannot reach its full potential due to barriers like inadequate payment for telehealth providers.[5] Because providers are not well reimbursed or may not be reimbursed at all for telehealth services, providers are less inclined to move away from in person services.[6] A 2018 report by the U.S. Departments of Health and Human Services, Treasury, and Labor recommended that states enact laws to remove prohibitions on reimbursements for telehealth services.[7] This legislative session, California's AB 744 seeks to do just that by establishing reimbursement parity for telehealth services. Additionally, other bills have been introduced to increase and incentivize access to telehealth services as well as understand the utilization of telehealth services.

Expanding Telehealth Coverage and Reimbursement

To increase access to telehealth, the Legislature proposed four bills that would increase reimbursement and expand coverage for telehealth services: AB 744, AB 1494, and AB 1676.

AB 744 would require health plans and health insurers to reimburse and cover the cost of a telehealth service "on the same basis and to the same extent" as an in-person service. This means that the deductible, copayment, or coinsurance requirement for a healthcare service delivered via telehealth cannot exceed the cost-sharing of a service delivered in-person. Additionally, an annual or lifetime dollar maximum must apply in the aggregate to all items and services covered, preventing a separate maximum for telehealth services. If passed, AB 744 would resolve a significant barrier to telehealth implementation by delivering parity for telehealth reimbursements.[8] Additionally, AB 744 prohibits two types of coverage exclusions. First, the bill would prohibit a health plan or insurer from excluding "coverage for a healthcare service solely because the service is delivered through telehealth services." Second, the bill would prohibit coverage from being limited to services delivered by select third-party corporate telehealth providers. This should allow more telehealth innovation to happen.

The next three bills increase the use of telehealth as an acceptable care delivery model. AB 1494 would make telehealth services reimbursable for Medi-Cal beneficiaries when it satisfies two conditions: (1) when the telehealth service is provided by an enrolled community clinic or an enrolled fee-for-service Medi-Cal provider, clinic, or facility and (2) when the service is provided during or immediately following a state of emergency. The Legislative Counsel noted that this bill would mean that "neither face-to-face contact nor a patient's physical presence on the premises of an enrolled community clinic is required for services provided by the clinic to a Medi-Cal beneficiary during or immediately following a state of emergency." The bill also would require a stakeholder process to figure out reimbursement of telehealth services, including submission of claims.

AB 1676 would speed up mental health treatment for children and pregnant and postpartum people. This bill would require health care service plans and health insurers to establish a telehealth consultation program that would provide access to providers like pediatricians, obstetricians, primary care providers, and psychiatrists.

However, specialized health care service plans are exempted from this bill, except those that offer professional mental health services. Similarly, AB 798 creates a pilot telehealth consultation program for women suffering from maternal mental health disorders, including postpartum depression and anxiety disorders. The goal of the program is to increase the capacity of health care providers that serve pregnant and postpartum women for up to one year after delivery. To accomplish this, the pilot program, among other things, would link women with individual services in their communities and provide access to perinatal psychiatric consultations. These two bills also include provisions that would help lawmakers and policymakers better understand how telehealth is utilized. Those provisions are discussed below.

Understanding Telehealth Utilization and Impact

In addition to increasing telehealth coverage and reimbursement, four bills introduced this session also include language that will help health policy makers better understand the effects of telehealth and how telehealth is utilized: AB 798, AB 1642, AB 1676, and SB 612.

AB 1676, in addition to increasing via telehealth mental health services for children and pregnant and postpartum people, would require health plans and insurers to keep track of the utilization of its telehealth consultation program and the availability of psychiatrists to ensure improvement of the program. Similarly, AB 798 would require a legislative report that documents the impact of the pilot consultation program on the number of women who are screened, assessed, and treated for maternal mental health disorders.

Additionally, AB 1642 would mandate that federally required review of Medi-Cal managed care plans include information about how each plan uses clinically appropriate telecommunications technology, like telehealth and e-visits, to satisfy network adequacy standards. On the other hand, SB 612 would require a health insurer, a health care service plan, including a Medi-Cal managed care plan, or a medical group, to report to the Office of Statewide Health Planning and Development (OSHPD) its participation in collaboratives and activities including telehealth services that are accessible to families, diverse communities, and

underserved populations.

Conclusion

Telehealth has been found to improve health outcomes, reduce healthcare costs, and increase access to healthcare.[9] In addition to increasing access, telehealth has been cited to increase competition by increasing the supply of healthcare providers and extending a provider's reach.[10] By mandating certain telehealth services and achieving parity for telehealth services, these bills, if passed, will make telehealth a more widely accepted delivery model. Additionally, these bills will also enable policy makers to better understand how telehealth is utilized today and how to improve telehealth programs. All in all, these bills will alleviate the lack of healthcare access and may even decrease healthcare costs. Stay tuned to see how these bills fare!

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[1] Cal. Bus. & Prof. Code § 2290.5(6).

[2] Navjit W. Dullet, et. al., *Impact of a University-Based Outpatient Telemedicine Program on Time Savings, Travel Costs, and Environmental Pollutants*, 20 Value in Health 542 (Apr. 2017), https://www.valueinhealthjournal.com/article/S1098-3015(17)30083-9/fulltext

[3] *See* Barbara Johnston & Neil A. Solomon, Telemedicine in California: Progress, Challenges, and Opportunities 5, 7 (July 2008) (prepared for the California HealthCare Foundation).

[4] *See* Cal. Health & Safety Code § 1374.13; Cal. Ins. Code § 10123.85; Cal. Welf. & Inst. Code § 14594; Cal. Welf. & Inst. Code § 14132.72.

[5] California Telemedicine and eHealth Center, Optimizing Telehealth in California: An Agenda for Today and Tomorrow 1 (Jan. 2009) (hereinafter Cal. Telemedicine). *See also* Jessica Kim Cohen, *5 challenges hindering telehealth market growth*,

Becker's Hospital Review (Nov. 13, 2018) (noting lack of reimbursement for telehealth services is one of the five challenges hindering telehealth growth).

[6] *See* United States Government Accountability Office, Telehealth and Remote Patient Monitoring Use in Medicare and Selected Federal Programs (GAO-17-365) at 26 (Apr. 2017) (stating that payers "confirmed that cost increases and inadequate payment, as well as infrastructure requirements, are barriers to the use of these technologies"). *See also* Susan D. Hall, Reimbursement persists as obstacle to telehealth adoption, FierceHealthcare (Aug. 16, 2016).

[7] U.S. Department of Health and Human Services, U.S. Department of the Treasury, & U.S. Department of Labor, Reforming America's Healthcare System Through Choice and Competition 42 (Dec. 2018) (hereinafter U.S. Departments).

[8] *See* Y. Tony Yang, *Telehealth Parity Laws*, Health Affairs (Aug. 15, 2016) (noting that "[w]ithout parity, there are limited incentives for the development of telehealth or for providers to move toward telehealth services. If there are no incentives to use telehealth, then providers will continue to focus on in-person care, which will keep health care costs high, continue to create access issues, and possibly provide lesser standards of care for chronic disease patients who benefit from remote monitoring").

[9] Cal. Telemedicine, *supra* note 5, at 2.

[10] U.S. Departments, *supra* note 7, at 40. *See also* Cal. Telemedicine, *supra* note 5, at 3. *See also* Keith L. Martin, *Telehealth as a competitive edge, not a competitor's advantage*, 95 Medical Economics (Apr. 2018) (pointing out that "[p]roviding telehealth access . . . makes a smaller practice more competitive").