

California Health Benefits Review Program

Analysis of California Assembly Bill (AB) 2507 Telehealth: Access

A Report to the 2015–2016 California State Legislature

April 11, 2016



Key Findings:

Analysis of California Assembly Bill (AB) 2507 Telehealth Access

Summary to the 2015–2016 California State Legislature, April 2016



AT A GLANCE

Telehealth is broadly defined by the Health Resources and Services Administration as “the use of telecommunications and information technologies to share information, and provide clinical care, education, public health, and administrative services at a distance.” State law currently recognizes two forms of telehealth: live video and store-and-forward (capture of medical information and transfer to providers for later review).

Assembly Bill (AB) 2507 (introduced February 2016) would formally recognize telephone, e-mail, and synchronous text and chat conferencing as telehealth modalities. AB 2507 also requires reimbursement parity to equivalent in-person visits and allows for cost-sharing at least as favorable to the enrollee as equivalent in-person visits.

- **Enrollees covered.** CHBRP estimates that in 2017, all 25.2 million Californians with state-regulated coverage would be subject to AB 2507.
- **Impact on expenditures.** CHBRP estimates that in the first year postmandate, AB 2507 would increase overall health expenditures (premiums and out-of-pocket expenses) by between \$96.8 million (0.07% change) and \$402.6 million (0.28% change), depending on the rate of adoption of covered telehealth services.
 - CHBRP estimates premium increases may range from \$0.24 to \$1.33 PMPM for DMHC-regulated plans, depending on the rate of adoption. Or, from \$0.25 to \$1.09 for CDI-regulated policies, depending on the rate of adoption.
 - CHBRP assumes that out-of-pocket expenses would increase by between \$15.5 million (0.10%) and \$64.8 million (0.40%), depending on the adoption of telehealth services.
- **Essential health benefits.** AB 2507 would not appear to exceed EHBs. Services would be delivered in a different way (via telehealth), rather than be considered a new benefit.
- **Medical effectiveness.** Advances in technology are outpacing the publication of studies on these technologies, limiting the research literature on telehealth modalities. On the basis of the existing literature, CHBRP concludes:
 - **Live video:** There is a preponderance of evidence that care provided by live video is at least as effective as care provided in person for both physical and mental health conditions. In particular, there is clear and convincing evidence that live video is equivalent to in person care for both mental health services and dermatology.
 - **Store-and-forward:** There is a low preponderance of evidence that medical care provided by store-and-forward is at least as effective as medical care provided in person for both physical and mental health conditions.
 - **Telephone:** The studies of the effect of telephone consultations on subsequent utilization are inconsistent; therefore, the evidence that medical care provided by telephone compared to medical care provided in person is ambiguous.
 - **E-mail, and text or chat:** There is insufficient evidence to determine whether services provided by synchronous text and chat are as effective as medical care provided in person.
- **Benefit coverage.** Currently, CHBRP estimates that 78% of enrollees in state-regulated health insurance have telehealth coverage for phone, 76% have coverage for e-mail, and text or chat, whereas 91% have coverage for live video and store-and-forward.
- **Utilization.** Postmandate, CHBRP estimates that between 3.75% and 15% of all visits would be delivered via telehealth using a low adoption and high adoption scenario.

BILL SUMMARY

AB 2507 would further refine the state’s definition of telehealth to include live video, store-and-forward transfers, telephone, e-mail, and synchronous text or chat conferencing. The current definition includes synchronous interactions and store-and-forward interactions. Unlike previous telehealth bills, AB 2507 is not limited to a certain type of visit (e.g., evaluation and management). The bill would require reimbursement parity for telehealth visits as compared to equivalent visits in-person and allow for cost sharing at least as favorable to the enrollee as equivalent in-person visits. AB 2507 is not limited in scope to established patients, and may apply to any health care provider licensed by the Business and Professions Code. Patients must consent to receiving telehealth services via verbal, written, or digital consent. The proposed bill also adds new language indicating that the delivery of telehealth services should be “physician- or practitioner-guided and patient-preferred.” The bill indicates that a provider cannot require the use of telehealth if a patient prefers to receive treatment in person.

CONTEXT FOR BILL CONSIDERATION

Technology: According to a 2013 survey from the California Public Policy Institute, most Californians (86%) use the Internet at least occasionally, an increase of 21 percentage points since 2000. Sixty-nine percent of Californians have high-speed broadband access at home, but differences in access are apparent by income, education, race, ethnicity, and geographic location. Nearly 92% of Californians report having a cell phone, and 58% have a smart phone, with younger age groups (i.e., 18–34 years) more likely to use a smart phone. Smart phone usage also increases with higher education and income levels. Thirty-two percent of Californians use the Internet to contact a health insurance provider or medical professional (32%), whereas over half (55%) seek out medical information online.

Telehealth: As stated, in addition to the telehealth modalities currently recognized by state law (live video and store-and-forward), AB 2507 would also formally recognize telephone, e-mail, and synchronous text and chat conferencing as billable telehealth modalities. CHBRP analyzed the potential impact of AB 2507 related to these telehealth modalities:

- Live video (real-time interaction via video communications);
- Store-and-forward (capture and secure transmission of medical information, such as photo or x-rays, for review by a health care provider at a later time);
- Telephone; and
- E-mail, and synchronous text and chat

Medical Effectiveness

The evidence related to medical effectiveness of telehealth varies by modality. The scope of AB 2507 applies to virtually all diseases and conditions. The telehealth literature generally focuses on a limited number of conditions (e.g., dermatology, neurology, psychiatry/psychology) and may not be generalizable to other conditions. Furthermore, a major challenge in assessing medical effectiveness of telehealth is the speed of technological advancements in the field, which often outpaces the research literature about these technologies.

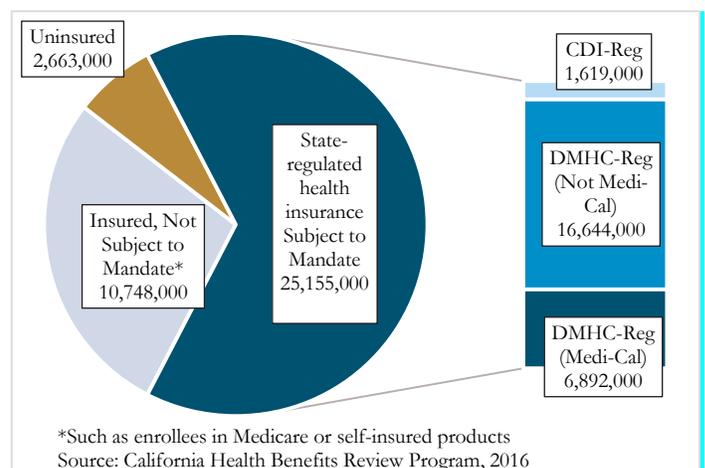
- **Live video:** There is clear and convincing evidence that these modalities are at least as effective as in-person care for both mental health services and dermatology. However, this evidence may not be generalizable to live video usage in other specialty areas.
- **Store-and-forward:** For the areas studied (e.g., in dermatology), there is a low preponderance of evidence that medical care provided by store-and-forward is at least as effective as medical care provided in person. The evidence suggests that store-and-forward technology reduces wait times for specialty outpatient care.
- **Telephone:** For the areas studied (e.g., mental health), the studies of the effect of telephone consultations on subsequent utilization are inconsistent. Therefore, the evidence that medical care provided by telephone compared to medical care provided in person is ambiguous. Furthermore, it is

unknown whether diagnoses made using these technologies are as accurate as diagnoses made during in-person visits.

- **E-mail, text and chat:** There is insufficient evidence to determine whether services provided by synchronous text and chat are as effective as medical care provided in person. CHBRP notes that the absence of evidence does not mean there is no effect; it means the effect is unknown.

Benefit Coverage, Utilization, and Cost

Figure 1. Health Insurance in CA and AB 2507



AB 2507 would apply to all state-regulated insurance (as shown in Figure 1), including DMHC–Medi-Cal managed care.

CHBRP estimates postmandate usage of telehealth services with a low and high adoption scenario, ranging from 3.75% of total visits delivered via telehealth postmandate to 15% of total visits delivered via telehealth postmandate.

CHBRP estimates that in the first year postmandate, AB 2507 would increase overall health expenditures (premiums and out-of-pocket expenses) by between \$96.8 million (0.07% change) and \$402.6 million (0.28% change).

CHBRP estimates premium increases to range from \$0.24 to \$1.33 per member per month (PMPM) for DMHC-regulated plans, depending on the rate of adoption. Increases range from \$0.25 to \$1.09 PMPM for CDI-regulated policies, depending on the rate of adoption.

CHBRP assumes that out-of-pocket expenses would increase by between \$15.5 million (0.10%) and \$64.8 million (0.40%), depending on the adoption of telehealth services.

Public Health

CHBRP estimates that, postmandate, patient experience would improve as providers increase their e-mail and telephone responses to patient-initiated inquiries. The improvement is partly attributable to increased access to (specialty or primary) care, as well as improved convenience for patients, such as reduced wait times for some visits.

For mental health and dermatology, evidence indicates that outcomes for live videoconferencing and store-and-forward were equivalent to in-person care; however these results may not be generalizable to other conditions. CHBRP estimates that utilization would increase from approximately 86,000 to 364,000 live videoconferencing encounters and from approximately 1 million to 4.4 million store-and-forward encounters. For those newly covered enrollees seeking mental health and dermatologic care via telehealth, CHBRP estimates that positive outcomes could occur for some with these conditions; however, the public health impact for other conditions is unknown.

In the case of AB 2507, key social determinants of health that may be affected by the mandate include transportation, rural living, and socioeconomic characteristics (age, race/ethnicity, income, language).

CHBRP estimates that, postmandate, travel costs and travel time would likely decrease for some urban and rural enrollees using newly-covered, patient-initiated telehealth services. As a result, some enrollees with transportation challenges may have better outcomes because they would no longer delay or avoid in-person visits by favoring telephonic or electronic communications with physicians; however, CHBRP is unable to quantify the exact impact due to a lack of data.

It is unknown whether AB 2507 would reduce disparities in access to care by ameliorating the effects of certain social determinants of health (transportation and geography). As noted, barriers to care could be reduced for some; however, AB 2507 also could exacerbate disparities in access to care for some enrollees with certain socioeconomic characteristics (e.g., age, language, income, etc.) that impede the use of telehealth modalities.

Likewise, it is unknown whether patient-initiated telehealth services would result in harms to patients. Note that an unknown finding could result in a positive, negative, or no impact.

Long-Term Impacts

CHBRP assumes that technology will continue to drive changes in telehealth. This includes increased penetration of electronic health records (EHR), associated patient portals and office management systems; increased use of mobile and remote communication devices (such as cellular telephones and or medical devices) and their applications; increased broadband coverage, which not only allows better Internet coverage, but also easier and more rapid transfer of large data files; and increased demand for these types of services from consumers, insurers, and providers. CHBRP projects that this trend, along with changes in reimbursement, would likely increase use of telephone, e-mail, and other telehealth services between patients and providers; however, the impact of telehealth on health outcomes requires further study.

The additional costs of reimbursing live video, store-and-forward transfers, telephone, e-mail, and synchronous text or chat conferencing are likely to increase with health care inflation and increased use of services. Although preliminary studies on telehealth show promise in specific populations, such as senior patients in assisted living centers, to date there are no widespread, peer-reviewed studies that indicate telehealth will reduce emergency department visits or inpatient stays directly. Given that certain telehealth visits may result in follow-up care or repeat visits for someone with acute health needs, it is also unclear whether or not telehealth might increase certain types of in-person visits at the same time.