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States' Actions to Expand Telemedicine Access During COVID-19 and Future Policy Considerations

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Abstract

- **Issue:** To encourage greater use of telemedicine during the COVID-19 pandemic, states took action to enhance private insurance coverage of telemedicine. As temporary orders and voluntary insurer efforts end, policymakers are considering how best to regulate telemedicine post-pandemic.
- **Goal:** To better understand the changing regulatory approach to telemedicine in response to COVID-19.
- **Methods:** A review of state actions to expand individual and group health insurance coverage of telemedicine between March 2020 and March 15, 2021, and a scan of statutes existing prior to March 2020 in all 50 states and the District of Columbia. Structured interviews with insurance regulators in 10 states that increased access to telemedicine during the pandemic.
- **Key Findings and Conclusion:** Twenty-two states changed laws or policies during the pandemic to require more robust insurance coverage of telemedicine. States focused on three key areas: requiring coverage of audio-only services, waiving cost sharing or requiring cost sharing no higher than identical in-person services, and requiring reimbursement parity between telemedicine and in-person services. Data on how longer-term expansion of telemedicine affects access, cost, and quality of care may help shape future policies.

Introduction

The COVID-19 pandemic created an urgent need for remote access to health care to reduce the risk of community spread and protect patients. Although telemedicine has long been used to deliver health care services, take-up has historically been limited.[1] A 2018 survey of physicians found just 18 percent had used telemedicine to deliver care, and less than 10 percent of U.S. residents had experience with telemedicine.[2] By one estimate, less than 1 percent of medical services and treatments were provided through telemedicine in January 2020.[3]

Before the pandemic, most states (35) required state-regulated individual and group health insurance to cover telemedicine visits. Half of states (25) required insurers to limit cost sharing, while just 15 required insurers to reimburse providers for a telemedicine visit on par with the reimbursement for an in-person visit. Only three states required coverage of audio-only telemedicine visits (Appendix A).

To encourage greater use of telemedicine among providers and patients during the pandemic, federal regulators temporarily relaxed restrictions for Medicare-paid visits in March 2020.[4] Guidance raised Medicare payment for telemedicine visits to the same level as in-person visits, waived or reduced cost sharing for patients, and allowed audio-only visits, among other changes.[5] Federal officials also encouraged states and insurers to provide similar flexibility under private insurance (such as by waiving certain federal privacy and security standards).[6]

States did just that, and some insurers voluntarily took steps to encourage greater use of telemedicine.[7] Since these changes, telemedicine use has greatly expanded from a tiny proportion of office visits pre-pandemic to a high of 16 percent of visits at large practices (more than 100 clinicians) by mid-April 2020.[8] Evidence suggests virtual visits for behavioral health increased substantially, in part to accommodate greater demand for such services during the crisis.[9]

We reviewed state actions — including new statutes, emergency orders, and subregulatory guidance — related to state-regulated individual and group health insurance coverage of telemedicine from the start of the pandemic in March 2020 to March 15, 2021. We also conducted a scan of statutes existing prior to March 2020 in all 50 states and the District of Columbia. In addition, we interviewed insurance regulators in 10 states that increased access to telemedicine during the pandemic.[10]

Findings

States Moved Quickly to Enhance Telemedicine Coverage

Twenty-two states changed laws or policies during the pandemic to require more robust insurance coverage of telemedicine. They used legislation, executive orders, and other agency actions, such as bulletins, notices, and executive orders from the department of insurance or a similar agency (Appendix B).

Most of these states pursued changes via administrative action. Use of executive authority allowed states to move relatively quickly during the crisis, though it has meant that the new telemedicine coverage requirements are temporary. For example, seven governors included specific telemedicine coverage requirements in executive orders, which are binding during the public health emergency but expire thereafter.

Some states used bulletins, notices, or executive orders from the department of insurance or a similar agency to enhance coverage. Administrative action also moved through various other vehicles (such as bulletins, notices, and executive orders from the department of insurance or similar agency) in states where sufficient statutory authority already existed or where an executive order created new authority without detailing specific requirements.

Eight states passed new legislation. Although the legislative process takes more time, it is necessary for permanent changes.[11]

States Chose Key Policy Changes to Expand Telemedicine Coverage

Five states that did not previously require coverage of telemedicine services changed their policies during the pandemic, bringing the total number of states that currently require coverage to 40 (Exhibit 1). In addition to securing this broad coverage obligation, states took other steps to enhance coverage and ensure access to health services while in-person care was limited during the pandemic. Telemedicine provides such access when medically appropriate.

Requiring coverage of audio-only visits. In a significant change from prior practice, 18 states for the first time required coverage of services provided over the phone (Exhibit 2). A recent study of primary care practices found that coverage of audio-only services "has proved to be invaluable."[12] Many patients have limited or no access to broadband internet or devices needed for audio-visual appointments.[13] Regulators said this change has been particularly important for older patients who may be unfamiliar with audio-visual technology and for patients with behavioral health conditions who find audio-only visits more comfortable.

This enhancement has not been without some challenges. Regulators observed that some providers have begun to charge for short, three- to four-minute phone calls (for example, to answer a brief question or convey test results) that previously would not have required an in-person visit and thus would not have been billed. Regulators noted that these short calls can leave patients with unexpected cost sharing (sometimes the full cost of the visit if they have not met their deductible). Several regulators mentioned insurers have authority to determine when a call qualifies as a billable visit.[14]

Making telemedicine services more affordable to patients by reducing or eliminating cost sharing. Four states eliminated cost sharing for services provided by telemedicine, and three states added a requirement that cost sharing for telemedicine services not exceed charges for identical services provided in person (Exhibit 3). (Some other states prohibit cost sharing only for services related to COVID-19.)[15]

Requiring insurers to lower or eliminate cost sharing for all telemedicine was essential to encourage patients to access care remotely, regulators said. Some insurers in the 10 study states (including in Colorado, Massachusetts, and New Hampshire) voluntarily eliminated cost sharing on all telemedicine visits. However, some providers questioned when insurers would end these voluntary efforts and reinstate cost sharing. According to regulators, some insurers already have.

Expanding access to telemedicine by increasing provider reimbursement. Ten states added a requirement that insurers pay providers the same for telemedicine and in-person visits (Exhibit 4).

Requiring reimbursement parity faced little pushback during the pandemic. In Oregon, regulators lacked authority to require reimbursement parity but were able to reach temporary, voluntary agreements with insurers to increase telemedicine reimbursement rates.[16] A regulator in another state said that some insurers are planning to continue reimbursement parity once the temporary requirement expires.

It is also important to determine what parity in provider reimbursement means. One regulator noted that under Medicare, reimbursement levels for a given service account for "practice expense," meaning the cost to the practice of providing the service.[17] The regulator noted that while the work may be the same for telemedicine compared with an in-person visit, it is "an open question" whether the overhead expense to the medical practice is the same. In another state, insurers also have expressed concern about reimbursement parity if there are lower operating costs associated with telemedicine services compared with in-person services. A few regulators mentioned that insurers wanted to maintain the ability to pay lower rates for their limited networks of telemedicine-only providers.[18]

Insurers Were Quick to Support Changes Needed to Expand Access During the Pandemic

Regulators almost universally described insurers as cooperative and "on board" with state efforts to temporarily increase coverage requirements and relax restrictions on telemedicine use. However, regulators said requiring longer-term adoption of reimbursement parity would likely be contentious. Regulators also pointed out that health care utilization and, in turn, insurers' costs have been lower during the pandemic and that telemedicine could reduce the risk of untreated health care needs.

Policymakers Will Have to Monitor Use to Understand How Best to Regulate Post-Pandemic

States need data to inform debates on how best to regulate telemedicine after the pandemic. To monitor implementation of the temporary requirements, regulators have tapped existing work groups of patients or providers, including many in behavioral health and primary care.

One regulator held regular conference calls with providers that helped inform further guidance on how to interpret the requirements. Oregon and Massachusetts held listening sessions with providers, insurers, and consumers to get feedback on the state's regulatory approach.[19] Through this monitoring, regulators learned that the changes succeeded in expanding use of telemedicine. For behavioral health, a few noted the particular benefits of telemedicine, which appeared to produce more visits overall and fewer missed appointments.

But policymakers will need more formal mechanisms to collect data to guide policy decisions on whether and how to adopt changes on a permanent basis. For example, Oregon obtained data from its insurers that documented a 3,000 percent increase in telemedicine claims compared with the prior year.[20] Regulators also could use complaint data to identify issues that emerge for consumers, particularly as temporary requirements and insurers' voluntary efforts end. Some regulators reported plans to use claims data, obtained directly from insurers or from an all-payer claims database (APCD), to understand the impact of telemedicine on utilization and cost.

Policymakers also will need to understand the role of dedicated telemedicine networks. Some insurers are steering patients to their dedicated telemedicine networks through lower cost sharing than would apply for a virtual visit with their regular, in-network provider. Although these telemedicine networks may be less costly for patients and for insurers that have negotiated lower reimbursement rates, they may affect care coordination across providers, regulators said. Studies suggest fragmented care can result in poorer quality care and greater health care costs.[21]

Future Policy Considerations

Telemedicine quickly expanded during the pandemic, and although providers are not expected to maintain the same volume of telemedicine services after the pandemic, they are also not likely to return to pre-pandemic levels.[22]

Use of telemedicine during the pandemic has revealed numerous benefits. Providers and patients value the option to have care delivered virtually. Telemedicine has been particularly helpful for behavioral health, which is notable given the projected long-term mental health impacts of the pandemic.[23] And it has been an important tool to expand access to care in rural areas.[24] If there is a future public health emergency or another crisis that limits access to health care providers and facilities, we now know telemedicine can provide seamless access to many medical services.

But the benefits of expanded telemedicine have not been equitable to all patients. Research shows telemedicine use is lower in communities with higher rates of poverty and among patients with limited English proficiency, potentially undermining goals of expanding access to underserved communities and exacerbating health inequities.[25]

As temporary, pandemic-related requirements eventually expire, policymakers may need to address insurance coverage of telemedicine services over the long term. A permanent coverage requirement for audio-only services may reduce long-standing access issues in some communities and for some patients. Yet it also may raise questions about medical appropriateness for some services. So far this year, at least 30 states have weighed legislation that would revise telemedicine coverage standards, such as by increasing provider reimbursement or requiring coverage of audio-only services. Meanwhile, understanding the coverage landscape will help providers continue to invest in telemedicine technologies.

Conclusion

If telemedicine proves to be a less costly way to deliver care, payers and consumers may benefit from expanding coverage of telemedicine after the pandemic. However, whether telemedicine reduces overall health care costs depends on how services are reimbursed and if virtual visits reduce other services or simply add to utilization.[26] Having access to data can help stakeholders understand how longer-term expansion of telemedicine affects access, cost, and quality of care.