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Robert Wood Johnson
Foundation

Health Policy Brief

AUGUST 15, 2016

Telehealth Parity Laws. Ongoing reforms are expanding the landscape of telehealth in the US health care system, but challenges remain.

WHAT'S THE ISSUE?

Despite the fact that no other developed country even comes close to the United States in annual spending on health care, 20 percent of Americans still live in areas where shortages of physicians and health care specialists exist, and the United States still ranks the [lowest](#) overall among eleven industrialized countries on measures of health system efficiency, access to care, equity, and healthy lives. Many believe that the answer to issues of cost and access in the US health system lies in telehealth, which increases access to care, alleviates travel costs and burdens, and allows more convenient treatment and chronic condition monitoring.

With the implementation of the Affordable Care Act (ACA), the federal government announced the move toward encouraging and including telehealth services in health care coverage. The ACA, however, only implemented telehealth at the federal level through Medicare, in selected circumstances; the power to determine which, if any, telehealth services is covered by Medicaid still remains largely within the powers of individual states. Also, states can govern private payer telehealth reimbursement policies. This means that telehealth implementation varies from state to state in terms of what services providers will be reimbursed for delivering, as well as what sort of “parity,” defined as “equivalent

treatment of analogous services,” is expected between in-person health services reimbursements and telehealth reimbursements. This variation affects providers’ ability to implement telehealth options, thereby reducing the patients’ ability to use these services and become comfortable with the telehealth processes. Consequently, telehealth faces significant obstacles in becoming an accepted and used health care option for individuals, and states and the nation as a whole cannot fully realize the cost savings of telehealth.

WHAT'S THE BACKGROUND?

Telehealth is “the use of technology to deliver health care, health information or health education at a distance.” It increases contact between patients and health care providers, generally without requiring the physical contact of in-person physician visits. Within telehealth, there are three main types of services: store-and-forward (also known as asynchronous communication), real-time video (synchronous conversation), and remote patient monitoring.

Asynchronous communication or store-and-forward services are those that transmit medical data to a physician or practitioner for later review and do not require real-time communication between the sender and receiver of the information. Generally, store-and-forward services are good for diagnosis and treatment.

20%

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Synchronous communication is real-time communication using interactive audio and visual equipment, such as video conferences between a patient and specialist. These types of interactions resemble typical physician appointments without the travel. Remote patient monitoring allows a provider to continue to track health care data for a patient released to his or her home or a care facility, potentially reducing readmission rates. Effective treatment plans might require use of all three types of telehealth, as well as services that might not fall into these categories. Currently, though, the distinction among these types of services is important in understanding what private and public insurance policies cover.

Telehealth has the potential to resolve a number of issues in the US health care system. Most importantly, telehealth can improve access to health care in populations that are underserved, such as rural areas, as 20 percent of Americans live in rural areas, but only 9 percent of physicians practice in these areas. Telehealth allows patients to access care through real-time appointments and specialist consultations and to reduce the amount of time and resources rural patients spend to access some health care resources.

Additionally, some estimate that the combination of store-and-forward, real-time communication, and remote patient monitoring usage in emergency departments, prisons, nursing home facilities, and physician offices could save the United States [\\$4.28 billion](#) on health care spending per year. In particular, remote monitoring services allow patients to take greater control of and interest in their personal health, manage their health and chronic disease, and receive more monitoring and feedback from health care providers.

Chronic disease affects one million Americans, while accounting for about 75 percent of health care costs; studies have found that the use of technology in chronic disease care is associated with reductions in hospitalizations, shorter lengths-of-stay, reduced care costs, and better adherence to medication regimes. Many costs either [covered](#) or not covered by existing payment methods might not be consistent with coverage under telehealth-friendly paradigms. Telehealth is believed to have the potential to level inequity in care and access across socioeconomic and cultural levels and to improve the efficiency, coordination, and integration of health care systems. Finally, [some argue](#) that telehealth has the potential to create more patient-centered care while

reducing costs by “promoting and improving patient-centered services; patient-provider communications; patient self-management with provider feedback; health literacy; medication management; provider-provider consultants; and changes in health and lifestyle behavior.”

Although telehealth has a wide range of potential benefits, the delivery of health care via telecommunication technology presents health care providers and organizations with unique risks and challenges. Some of the main areas of [concern](#) include the following: fears of a breakdown in the relationship between health professional and patient (for example, inability to perform the whole consultation); problems with the quality of health information (for example, lack of access to a patient’s full medical record); and organizational complications (for example, problems with infrastructure planning and development). Moreover, the United States still faces considerable hurdles in implementation of telehealth, including variations in state coverage, lack of uniformity in parity laws, variations in physician licensure requirements, and unresolved questions around patient privacy and reimbursement. Malpractice liability concerns have also been exacerbated by the move toward more telehealth-based services. For example, liability policies generally specify that coverage is only available for a claim that occurs in a specific jurisdiction. A telehealth physician sued in a state other than the jurisdiction in which he or she is covered might find that no coverage is available to either defend the claim or pay indemnity if there is an adverse judgment. As long as these concerns persist, they threaten to impede implementation and development of telehealth services and reduce incentives for developing and using them to deliver care.

WHAT’S THE LAW?

Telehealth in the United States is currently affected by laws and regulations at the federal and state levels. Currently, there is no uniform legal approach to telehealth, and this continues to be a major challenge in its provision. In particular, concerns about reimbursements, for both private insurers and public programs such as Medicaid, continue to limit the implementation and use of telehealth services. When certain telehealth services are not reimbursed or are reimbursed at lower levels than in-person services, the incentives to provide telehealth services decrease.

“Telehealth can improve access to health care in populations that are underserved, such as rural areas.”

16

At least sixteen states have some sort of reimbursement for remote patient monitoring.

At the federal level

The federal government provides some incentives through the ACA to develop telehealth services at the state level, including grants and reimbursement incentives. Additionally, the federal government largely leaves decisions about implementing or reimbursing for telehealth in Medicaid programs to the states. It does, however, play a role in shaping telehealth services for Medicare programs, and the limitations the government places on those programs provide a less-than-ideal example for states to follow.

Medicare will only reimburse for synchronous communications and does not cover any store-and-forward services or remote patient monitoring for chronic diseases, except in Alaska and Hawaii. Telehealth services that Medicare covers as substitutes for in-person visits include consultations, office visits, psychiatry services, and some physician fee schedule services. Many restrictions apply to this type of coverage. The patient must be present at an originating site for the visit or treatment and cannot be at home to receive services. Originating sites must be one of the following: the office of a physician or practitioner, a critical access hospital, a rural health clinic, a federally qualified health center, a hospital, a renal dialysis center, a skilled nursing facility, or a community mental health center.

Furthermore, only originating sites located in areas designated as a rural health profession shortage area, in counties that are not included in a metropolitan area, or in entities that approved by the secretary of health and human services are eligible for reimbursement of telehealth services. Additionally, the practitioners must have admitting privileges in the distant location where they provide services and hold a license recognized by the state where that location is. The Centers for Medicare and Medicaid recently introduced a new coverage model that would extend telehealth coverage to up to 80 percent of Medicare beneficiaries in metropolitan areas, but the current structure strictly limits the services provided for and reimbursed by Medicare.

At the state level

States have significant control over reimbursement schemes for telehealth services, both within their state Medicaid programs as well as through laws governing private insurers. While states have implemented telehealth coverage laws, of greater concern and contro-

versy are telehealth parity laws that require reimbursement by health plans for telehealth services at the same or equivalent rate as paid for in-person services. Without parity laws, health plans can pay for telehealth services at only a percentage of what they pay for in-person services. Many telehealth coverage laws passed by states fail to include parity language, meaning some states have provided for telehealth coverage but have not implemented the necessary cost reimbursements to incentivize health care professionals to provide telehealth services over in-person services. The next section of this brief looks at the state laws for reimbursement of Medicaid telehealth services, before turning to state parity laws for private insurers.

State Medicaid and telehealth

States retain significant control over what telehealth services are covered and will be reimbursed by Medicaid. Forty-nine states and the District of Columbia have some coverage for telehealth, and nearly all reimburse for live video telehealth. Under Medicaid, only nine states reimburse for store-and-forward services, while at least sixteen states have some sort of reimbursement for remote patient monitoring. Two additional states, Pennsylvania and South Dakota, reimburse for remote patient monitoring through their departments of aging, instead of Medicaid. Most states do not reimburse e-mail, phone, or fax communications in telehealth. Four states only allow reimbursement for telehealth from physicians, while nineteen states restrict provider types to a list of nine. Fifteen states and the District of Columbia do not restrict reimbursement based on provider types. While there are restrictions on provider types, the majority of states do not restrict Medicaid reimbursement for telehealth to rural locations, unlike current Medicare requirements.

Private insurers and state telehealth coverage

Thirty-two states and the District of Columbia have parity laws that cover private insurers and reimbursement to telehealth services. These laws require commercial health insurance companies to cover services provided through telehealth to the same extent as those services are covered in person. Many variations exist across the states, though, in how states and private insurers pay out these reimbursements and what they cover. The variations in these parity laws created large differences in telehealth coverage across the country.

“When states put restrictions on telehealth service reimbursement, they prevent telehealth from becoming more widespread and decrease its use.”

While many states mandate reimbursement, not all require reimbursement to be equivalent to or at the same rate as in-person services. Colorado, Missouri, and Virginia require payment on the same basis as in-person services, which allows them to take into consideration the cost differences of telehealth versus in-person services. Twenty-three states and the District of Columbia have full parity, meaning coverage and reimbursement is comparable from in-person to telehealth services. Arizona is the only state that limits parity to geographic regions and specific services. Michigan, Oregon, and Vermont only authorize reimbursement for telehealth that uses interactive, audio-visual systems, and Arkansas places “arbitrary limits” on patient locations and provider types, as well as requiring an in-person visit to establish a patient-provider relationship. Nevada is the only state to extend parity to workers’ compensation programs.

WHAT’S THE DEBATE?

Proponents of telehealth and parity in reimbursement laud the potential cost savings over in-person care. Telehealth could achieve such substantial savings for a number of reasons, including the potential reduction of chronic condition–associated readmissions through mobile health monitoring technologies and a decrease in unnecessary use of emergency appointments through remote visits with nurses instead.

Likewise, consumer demand for telehealth services is on the rise, with more and more patients looking to mobile applications, online services, and health tracking devices to monitor blood pressure and heart rate continuously. Additionally, many consumers see the positive benefits of telehealth: access to care, efficiency in services, saved time and energy, less stress and anxiety, and even improved well-being for family caregivers.

Opponents of telehealth, however, argue that telehealth services are not equivalent to in-person services and therefore should not receive parity to in-person services in reimbursements.

- First, opponents suggest that new technology should be approached with caution, as it sometimes proves unreliable and might lead to improper diagnosis and treatment, absent the physical examination. For example, the American Optometric Association opposed online eye exams (and parity in their reim-

bursement) and called such methods “sub-standard model[s] of care.”

- Second, many express concerns about the overall quality of care that can be provided using telehealth and worry that instead of correcting issues of access, telehealth might actually create greater inequity in the quality of care available in rural areas.

- Third, there are also concerns that many telehealth appointments might be one-time engagements, which creates problems when the health data from that appointment might not be added to a patient’s primary care physician. This creates gaps in records, which ultimately could have major effects on diagnosis and treatment at later times. Some telehealth services might place the burden of communicating telehealth appointments and results on the patient.

- Fourth, many are concerned about patient privacy, an area of growing concern in traditional services. The move toward telehealth programs means moving toward more digitalization of medical records, which then could leave records vulnerable to hacking and infiltration.

- Fifth, some argue that telehealth simply should not be reimbursed the same amount as in-person care precisely because of the cost savings associated with it. If telehealth services save money and are more efficient, the opponents argue, reimbursement for services should mirror those savings. Because of the high risks, possible lower quality of care, and cost savings of telehealth, many physicians believe that telemedicine should not be reimbursed on the same levels as in-person care.

In response, many point to the need to develop and support telehealth services to improve the quality of care provided and create incentives for patients and doctors to use telehealth. By reimbursing at the same rates as in-person services, states support the growth and development of telehealth, while encouraging more and more physicians to use it as a method of care. A 2014 [study](#) dispelled concerns that the convenience and accessibility of telemedicine will lead to overuse and increased total costs. Additionally, while privacy remains a concern for all of health care, many believe that the risks associated with telehealth are no greater than those posed by the move toward digital records in general. Furthermore, if reimbursements for telehealth do not align with in-person services, the cost savings projected

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Health Policy Briefs are produced under
a partnership of *Health Affairs* and the
Robert Wood Johnson Foundation.

Cite as: "Health Policy Brief:
Telehealth Parity Laws,"
Health Affairs, August 15, 2016.

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for telehealth will never be realized because providers will stay with in-person services to recoup their costs.

WHAT'S NEXT?

With telehealth technologies, providers can deliver high-quality care at a lower cost, a critical imperative in the accelerating era of value-based payment. On balance, the benefits of telehealth are substantial, assuming that more efforts will reduce or address the risks and challenges.

Congress is now considering a nationwide telehealth parity act. The [Medicare Telehealth Parity Act](#) is intended to modernize the way Medicare reimburses telehealth services and to expand coverage for Medicare beneficiaries. The act would expand the number of qualifying geographic locations and expand coverage of telehealth services, although its likelihood of enactment is unclear.

To reap the benefits of telehealth services, states are likely to move toward full parity laws for telehealth services. Without parity, there are limited incentives for the development of telehealth or for providers to move toward telehealth services. If there are no in-

centives 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.

In addition, states are likely to gradually remove restrictions from their parity laws that limit providers, locations, and services, and focus on integrating telehealth into regular health care coverage. It is possible that reimbursement will eventually cover store-and-forward services and remote monitoring, while leaving open the likelihood of covering services that fall outside of these categories, such as mobile applications and devices.

As the United States moves from uncoordinated, volume-based delivery of health services to an integrated, patient-centric, value-based model, health care delivery will increasingly focus on achieving higher-quality care, improved care access, and lower costs. In enabling health care organizations to provide high-quality, "anytime, anywhere" care to patients and operate more cost effectively, telehealth programs and play an important role in achieving these goals. ■

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