

The Promise of Telehealth Beyond the Emergency



Arielle Kane

Director of Health Care, Progressive Policy Institute

Dean Clancy

Senior Health Policy Fellow, Americans for Prosperity

In the past few months, millions of Americans have experienced a first, tantalizing glimpse of the promise of telehealth.¹

The use of telehealth – the remote delivery of care and monitoring of patients’ health using digital telecommunications tools – has surged during the ongoing Covid-19 pandemic, as policymakers and insurers across the country have eased restrictions on these tools in order to slow the spread of the novel coronavirus, for which humans have no immunity. Digital encounters can help people avoid unnecessary in-person contacts and receive care at home instead of a potentially overwhelmed hospital or clinic.

As a result of numerous policy changes at the state and federal levels, the use of telehealth has grown faster in the past five months than in the preceding 25 years. During this time:

- Nationally, nearly one in two consumers have used telehealth to replace a cancelled in-person appointment.²
- More than 11.3 million Medicare enrollees have accessed care from the comfort and safety of their own homes, up from nearly zero the year before.³
- American veterans have availed themselves of 1.1 million telehealth visits through the Veterans Administration.⁴

Most of the current telehealth expansions are temporary and will expire with the end of the current public health emergency declaration.⁵ A key question arises: **Should the reforms be made permanent?**

Although our two organizations differ on many health policy issues, on this question we agree. The current, temporary telehealth reforms are good for patients and should be made permanent.

In this paper, we will explain why we think telehealth is valuable and give a high-level overview of the recent policy changes. We’ll also explain why the adoption of telehealth has been slow until now and identify reforms we believe should be made permanent. Finally, we’ll recommend additional policy changes that could help further promote the promise of telehealth. Our hope is that our writing this paper together will persuade state and federal policymakers to make that promise a reality for patients.

SECTION 01

Why is telehealth valuable?

Telehealth can save time, money, and most importantly lives. Studies show that digitally delivered care typically costs only about half of the cost of services provided in doctors’ offices and urgent care clinics⁶ and can dramatically reduce unnecessary emergency room trips for patients with chronic conditions.⁷

On a more personal level, the promise of telehealth takes many forms. To access health care conveniently from the comfort of home, for example, or to have one's vital signs monitored remotely in real time, to check in with a doctor or nurse with a question without having to take time off work, or to send a photo or email to your doctor for review and go on about your business – these are just some of the ways in which modern telecommunications tools can make life better for people.

Real-time forms of care, such as two-way video, can obviously help slow a contagion by reducing personal contact. But asynchronous forms of care, such as recorded video and so-called store-and-forward systems, can also be very helpful, especially when a matter is non-urgent. For example, in ophthalmology, people may have a question about a prescription lens renewal. Or in dermatology, they might want to have a rash or mole examined at the provider's convenience.

The real question is not whether telehealth is valuable, but why it isn't already a standard feature of modern medicine.

SECTION 02

Why has telehealth adoption been slow until now?

Until this year, America has been slow to adopt telehealth. Although private payers have been quicker than public payers to cover telehealth services, overall adoption has been modest. Why? Primarily because of barriers erected by various stakeholders, often in the name of assuring quality and safety for patients. This has been done despite a growing body of evidence that telehealth improves clinical outcomes.⁸

For example, the substitution of digital tools for in-person care has long faced skepticism from private insurers and Medicare, as well as some state regulators, who fear widespread adoption will lead to overutilization and fraud. Some physician groups, too, have feared it could disrupt existing practice patterns and have a negative effect on their members' incomes.

At the same time, state professional licensure laws have limited the provision of remote care by health professionals licensed out-of-state.

Admittedly, until this year patients do not seem to have been clamoring for access to telehealth. But with the pandemic, that appears to be changing. While an April 2020 survey found that just 32 percent of Americans had ever used a telehealth service, by May that number had risen to 44 percent, with 80 percent of Americans agreeing with the statement that Covid-19 had made telehealth “an indispensable part” of the healthcare system.⁹ Sixty-five percent said they believe they will use telehealth services after the pandemic is over.¹⁰

SECTION 03

What policy changes have been made in recent months?

Federal actions: In non-emergency times, Medicare's ability to expand coverage to telehealth is quite limited. Services may only originate from inside an officially designated rural health professional shortage area, and from a statutorily allowed setting, which with very limited exceptions does not include the patient's home. There are rules limiting what types of providers may deliver telehealth services, and requiring that telehealth be delivered by a real-time, two-way, audio-video connection. Other technologies, such as audio-only telephone calls and secure private emails, are not covered. Neither are asynchronous (store-and-forward) tools or remote monitoring of patients' vital signs. On top of all this, the patient must have a prior existing relationship with the provider before he or she can use telehealth with that provider.¹¹

In late January of this year, after the federal Department of Health and Human Services officially declared the spread of Covid-19 to be a public health emergency and Congress provided authority to waive statutory restrictions on telehealth

during the pandemic, the Centers for Medicare and Medicaid Services (CMS) used those emergency powers to dramatically expand the telehealth services covered by Medicare and the digital platforms that may be used to provide care via telehealth. The agency also increased the amounts paid for telehealth visits and allowed providers to bill for services provided across state lines. Medicare officials also doubled the list of telehealth-provided services that Medicare will cover, including therapy services, emergency department visits, initial nursing facility and discharge visits, and home visits outside of rural shortage areas.¹²

Under the CARES Act, Congress liberalized the statute governing health savings accounts (HSAs) to allow patients to receive first-dollar coverage of telehealth services (meaning without having to first meet a deductible) through the end of 2021.¹³

State actions: Prior to the pandemic, almost all state Medicaid programs covered some telehealth services provided via live video; otherwise, state laws on telehealth varied dramatically. When the pandemic struck, all states eased at least some restrictions on telehealth, and 48 of them temporarily reduced some or all of their licensing requirements for out-of-state health care providers, making it easier for providers to treat patients across state lines. A couple of noteworthy examples: 1) Maryland expanded the state's definition of telehealth to include audio-only and store-and-forward technology – affecting all payers in the state, not just the Medicaid program. 2) New Hampshire permanently expanded telehealth benefits to all of its Medicaid recipients, not just underserved communities as had been allowed previously, and removed location limits on providers.

Private payer actions: Many private insurers increased their coverage and reimbursement rates for telehealth services. Humana, for example, is waiving all copays for tele-primary care and tele-behavioral health visits for its Medicare Advantage members. Furthermore, many private health plans are voluntarily mirroring the government's policies, or even going beyond them. Some states (California, for example) are pressuring private insurers to expand telehealth coverage, while others require them to do so.

Provider actions: Doctors and hospitals that have not previously offered telehealth services have been scrambling to adapt, both to make up for lost revenue as elective procedures have been put on hold and to safely maintain patient care. And some providers are restructuring their business models to make telehealth a permanent option for patients who pay out-of-pocket rather than through insurance.

SECTION 04

Which policy changes should remain in place?

As we've said, most of the recent policy changes are temporary. In light of the experience of the past few months, and the benefit to patients, it would be exceedingly odd to go back to the pre-Covid status quo. Happily, a consensus seems to be forming in favor of making those gains permanent. The Medicare agency has recently announced that it will make its newly added telehealth codes permanent, something it has the power to do under existing law, separate and apart from its temporary emergency powers.¹⁴ And numerous citizen organizations are urging congressional leaders to make other temporary Medicare telehealth changes permanent, as are a growing number of lawmakers – including a bipartisan group of 29 U.S. senators.¹⁵ Meanwhile, numerous lawmakers have introduced legislation, including the bipartisan CONNECT for Health Act, which would grant CMS standing authority to make a number of positive changes on a permanent basis.¹⁶

Here are the specific policies that we recommend Congress make permanent.

- **Continue allowing patients to use telehealth outside of rural areas and at home.**
- **Continue allowing providers to deliver care to both established and new patients.**
- **Continue allowing licensed providers to practice across state lines.** Because states typically require that providers

must be licensed in the state where the patient is located, current law would require providers keep multiple active licenses in order to serve patients residing in other states. Though CMS has temporarily lifted these licensing rules for Medicare patients, after the Covid crisis passes federal legislation should empower providers to use their own location as the nexus in which care takes place for the purposes of payment – making treating patients across state lines more accessible.

- **Continue allowing health care providers to use store-and-forward technologies where medically appropriate.**
- **Do not impose payment parity for telehealth services versus those provided in person.** To encourage telehealth adoption and to ease the financial strain of the pandemic, Medicare is currently reimbursing health care providers for telehealth services as if provided in-person. This makes sense during a public health crisis where the goal is to encourage telehealth use, but at other time there's little reason to peg remote rates to in-person rates. Part of the promise of telehealth is that it can reduce costs. For example, when care is provided remotely, providers don't have to clean exam rooms, waiting rooms, and other spaces. Reimbursement should reflect these savings.

SECTION 05

Additional policies that would increase access:

We also recommend the following reforms that go beyond what Medicare has done to-date.

- **States, too, should allow health care providers to practice across state lines.** Medical protectionism makes no sense in a digital age. Because professional licensure is primarily a state responsibility, states should remove licensing barriers that prevent out-of-state doctors and nurses from delivering care to in-state residents. States can do this unilaterally by automatically recognizing out-of-state licenses or by entering into multistate compacts, the members of which agree to recognize each other's licenses.
- **Expand broadband access.** Except for audio-only (telephone) visits, telehealth requires fast and reliable broadband internet access. Though Congress and the Federal Communications Commission (FCC) have funded such access through the Covid-19 Telehealth Program and the Rural Digital Opportunity Fund, broadband connectivity still lags in some parts of the country. Structural changes, like reducing the bureaucratic and regulatory obstacles to getting more providers involved, will help more people realize the potential of telehealth.
- **Study the outcomes.** The Department of Health and Human Services (HHS) should use the change in health care delivery as an opportunity to analyze the effectiveness of telehealth. It is important to study the effects of recent changes on utilization, access, and costs to inform future policy making. However, Congress should not allow the appropriate desire for further study to stand in the way of quickly implementing reforms that expand patients' access to telehealth services.
- **Remove barriers to affordable care.** The ultimate goal of all health reform efforts should be to ensure that everyone has access to the high-quality health care they need, when they need it, at a price they can afford. Telehealth can help with that, to be sure, but policy makers should also adopt sensible reforms that reduce costs and expand access to affordable care and coverage for everyone.

Conclusion

Widespread adoption of telehealth services during the Covid-19 pandemic has given millions of Americans their first real taste of the promise of telehealth. To be sure, there will always be a role for in-person care. And telehealth is not a panacea for the widely acknowledged failings of the U.S. health care system. But it is a very powerful tool, one that holds great promise to make life better for patients and especially for those who are elderly or infirm or who simply find in-person visits a challenge. But for that promise to become a reality, payers and policymakers must act. They must break down the regulatory and legal barriers that stand in the way of affordable, widespread access to telehealth. This is not a left-right issue. Our organizations stand together, ready to help America realize the promise of telehealth beyond the emergency.

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1. In this paper, we use the term “telehealth” to refer to the use of telecommunications and information technology (including audio-visual, audio-only, store-and-forward, and remote patient monitoring, asynchronous as well as synchronous) to provide access, across distance, to the following kinds of physical and mental health care services: assessment, diagnosis, treatment, intervention, consultation, supervision, and provision of information.
 2. [McKinsey & Co., “Telehealth: A quarter-trillion-dollar post-COVID-19 reality?” mckinsey.com, May 29, 2020.](#)
 3. [Rebecca Pifer, “Medicare members using telehealth grew 120 times in early weeks of COVID-19,” healthcarediver.com, May 27, 2020.](#)
 4. [Nicole Ogrysko, “How VA drastically expanded telehealth during the pandemic,” federalnewsnetwork.com, June 24, 2020.](#)
 5. The national Covid-19 public health emergency was declared on January 31, 2020. As of this writing, in August 2020, the exact end-date remains to be decided by the administration.
 6. [Teri Oelrich & Bryan Langlands, “The coronavirus pandemic has boosted telehealth,” forbes.com, June 8, 2020.](#)
 7. [Eric Wicklund, “Hospital’s Telehealth Program Reduces ER Visits,” mHealthIntelligence.com, January 25, 2019.](#)
 8. [Agency for Healthcare Research and Quality, “The evidence base for telehealth: reassurance in the face of rapid expansion during the COVID-19 pandemic,” May 14, 2020. See also American Hospital Association Issue Brief: “Telehealth: Helping hospitals deliver cost-effective care,” 2016.](#)
 9. [Harris Poll Research, “Telehealth: the coming ‘new normal’ for healthcare, part 2,” theharrispoll.com, June 2020.](#)
 10. [Change Healthcare - Harris Poll Research, “Half of consumers avoid seeking care because it’s too hard,” businesswire.com, July 13, 2020.](#)
 11. Medicare’s statutory payment policies for, and limitations on, telehealth are found at [42 U.S.C. 1395m\(m\)](#). The limitations apply within the traditional, fee-for-service part of Medicare, but not in the optional Medicare Advantage program, in which competing health plans may set their own telehealth coverage and payment policies.
 12. [Seema Verma, “Early impact of CMS expansion of Medicare telehealth during COVID-19,” Health Affairs, July 15, 2020.](#) For more information, see [telehealth.hhs.gov](#) and the [Center for Connected Health Policy](#).
 13. CARES Act, Public Law No. 116-136, enacted March 27, 2020.
 14. [Dan Diamond, et al., “Trump signs order aimed at boosting rural health care, telehealth,” Politico, August 3, 2020.](#)
 15. [https://www.schatz.senate.gov/imo/media/doc/Letter to leadership CONNECT for Health Act 06.12.20.pdf](https://www.schatz.senate.gov/imo/media/doc/Letter%20to%20leadership%20CONNECT%20for%20Health%20Act%2006.12.20.pdf)
 16. The proposed CONNECT for Health Act (116th Congress) is also known as [S.2741](#), introduced by Senator Brian Schatz, D-Hawaii, and [H.R.4932](#), introduced by Representative Mike Thompson, D-California.