Key Findings

Analysis of California Assembly Bill 32 Telehealth

Summary to the 2021–2022 California State Legislature, April 16, 2021

SUMMARY

The version of California Assembly Bill (AB) 32 analyzed by CHBRP would require coverage and reimbursement at parity with the equivalent in-person service for synchronous telehealth, including live video and telephone (audio-only) visits.

In 2022, of the 21.9 million Californians enrolled in state-regulated health insurance, all of them would have insurance subject to AB 32, plus the 2.7 million beneficiaries receiving Medi-Cal benefits through County Organized Health Systems (COHS) and the Fee-for-Service program (FFS).

Benefit Coverage: At baseline, 100% of enrollees with commercial or CalPERS health insurance that would be subject to AB 32 have coverage for live video telehealth services, and 80.4% of enrollees have coverage for telephone services. Similarly, 100% of Medi-Cal Managed Care beneficiaries have existing benefit coverage for live video services at baseline. However, 73.5% of beneficiaries in DMHC-regulated Medi-Cal Managed Care Plans have coverage for telephone services at baseline. Federally qualified health centers (FQHCs) and Rural Health Clinics (RHCs) are unable to provide live video services outside of the clinic's four walls and do not receive reimbursement for telephone at baseline. Postmandate, benefit coverage for telephone would increase to 100%, and FQHCs/RHCs would be able to obtain reimbursement for both live video and telephone visits provided to patients outside of the clinic's physical location. AB 32 is unlikely to exceed essential health benefits (EHBs).

Medical Effectiveness: CHBRP found that evidence regarding whether telehealth modalities and services result in equal or better outcomes than care delivered in person is mixed depending on the disease and condition, telehealth modality, and type of outcome studied: health outcomes, process of care, or use of other services. Because telehealth studies have only focused on a limited number of diseases and conditions, the findings may not be generalizable outside of the specific diseases and conditions studied.

Cost and Health Impacts[1]: The baseline presented in this analysis is a middle-ground estimate of 2022 in a hypothetical scenario in which AB 744 Telehealth has been fully implemented and the COVID-19 public health emergency regulations terminated, both of which laid the groundwork for telehealth adoption and use more broadly than in 2019 prior to the pandemic. In 2022, AB 32 would result in increases in utilization of live video and telephone visits for enrollees with commercial, CalPERS, and Medi-Cal Managed Care coverage. These changes in utilization would result in an additional $240,827,000 (0.18%) in annual expenditures. AB 32 would not result in offsets because of the reimbursement parity requirements between telehealth and in-person services, and because of the additional utilization of health care services.

CHBRP anticipates that AB 32 would bring coverage of telephone and live video services for ~4.85 million commercial/CalPERS and Medi-Cal enrollees (plus another 2.7 million Medi-Cal COHS and FFS enrollees) to parity with other state-regulated commercial carriers already providing coverage at baseline, thus increasing beneficiary access to and use of telehealth modalities. In turn, these beneficiaries would experience reduced delays in care (e.g., appointments, diagnoses, treatments) for conditions treated by primary care, behavioral health, orthopedic, rehabilitation, dermatology, and other specialty providers.

Because of the new coverage parity between Medi-Cal beneficiaries and commercial enrollees, CHBRP anticipates a reduction in disparities in access to health care and health outcomes for low-income people and people of color by providing equal access to all modalities of care, as well as reducing delays associated with in-person care for some conditions (appointments, diagnoses, treatment).

[1] Similar cost and health impacts could be expected for the following year, though possible changes in medical science and other aspects of health make stability of impacts less certain as time goes by.

CONTEXT

Telehealth services either replace (substitute) existing in-person visits or are new (additional/supplemental) visits that would not have taken place in the absence of telehealth coverage.

A significant share of Californians lack necessary connectivity and/or devices, other than telephone, that are required to engage in telehealth visits.[2] Consumer access to the Internet, telephone, or other electronic communication devices is necessary for communicating with health care providers for treatment and advice via telehealth.

Access to and utilization of telehealth was increasing due to changes in reimbursement policies by purchasers and payers before the COVID-19 pandemic, but it accelerated substantially during the pandemic. A California Health Care Foundation (CHCF) survey of health care providers (across clinical specialties) in September 2020 found that the number who reported using telehealth grew from 30% (pre-pandemic) to 79% during the pandemic, along with the proportion of telehealth appointments, which grew from 24% pre-pandemic to 51% during the pandemic. Telehealth use pre-pandemic was greatest among behavioral health providers, radiologists, pathologists, and emergency medicine physicians. Although telehealth use among all provider types jumped during the COVID-19 pandemic, the adoption of telehealth had been growing pre-pandemic; this upward trend appears to be holding even as telehealth use waned during the summer of 2020.

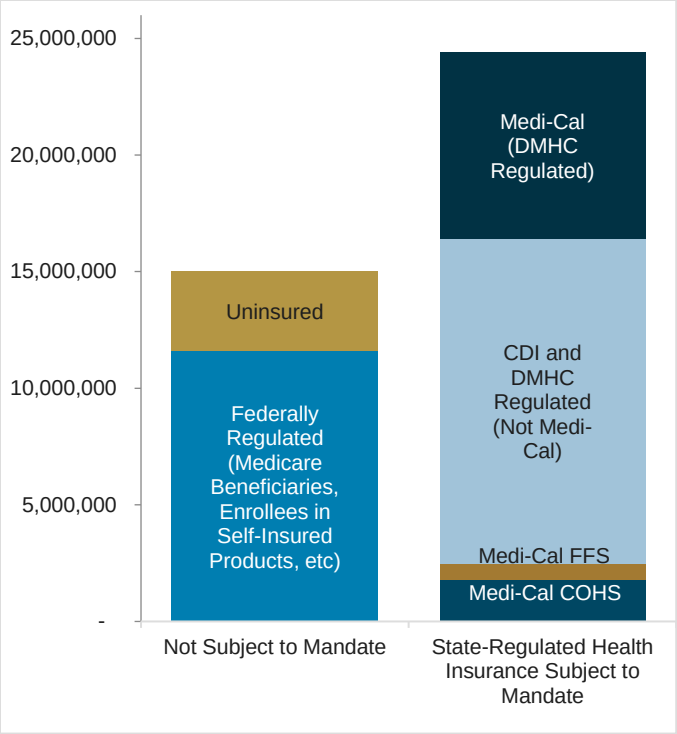
Disparities in use of some telehealth modalities persist due to existing connectivity barriers and differential insurance reimbursement policies for certain subpopulations (rural, Medi-Cal beneficiaries). Other reasons for disparities in use among patients include unaffordable devices (e.g., smartphones, computers), Internet and data plans, and a lack of digital literacy to operate devices and troubleshoot broadband difficulties.

BILL SUMMARY

AB 32 Telehealth would require coverage and reimbursement at parity with the equivalent in-person service for synchronous telehealth, including live video and telephone (audio-only) visits. This is accomplished through amendments to the Health and Safety Code, the Insurance Code, the Welfare and Institutions Code, and the indefinite extension of Department of Health Care Services (DHCS) public health emergency regulations. These changes also apply to federally qualified health centers (FQHCs) and Rural Health Clinics (RHCs), which were previously prohibited from providing and being reimbursed for synchronous telehealth unless the services were provided within the four walls of the clinic.

Figure A notes how many Californians have health insurance that would be subject to AB 32.

Figure A. Health Insurance in CA and AB 32



Source: California Health Benefits Review Program, 2021.

If enacted, AB 32 would apply to the health insurance of approximately 24.7 million enrollees (62.6% of all Californians). This represents 100% of the 21.9 million Californians who will have health insurance regulated by the state that may be subject to any state health benefit mandate law, which includes health insurance regulated by the California Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI), plus the 2.7 million beneficiaries receiving Medi-Cal benefits through County Organized Health Systems (COHS) and the Fee-for-Service program (FFS).

Existing Law

Existing law requires commercial and CalPERS plans and policies to cover and reimburse services appropriately delivered through telehealth on the same basis and to the same extent that the plan or policy is

[2] Refer to CHBRP's full report for full citations and references.

responsible for covering the same service delivered in-person (enacted through the passage of AB 744 in 2019 and implemented on January 1, 2021). "Equivalency" is typically determined based on the amount of time spent with the patient or reviewing records and providing consultation (such as during an eConsult). Some telehealth visits may not be equivalent to an in-person visit. For example, an e-mail exchange between a patient and provider may not rise to the same level as an in-person interaction.

Telehealth coverage policies for Medi-Cal (Managed Care, COHS, and FFS) are determined through the Welfare and Institutions Code, as well as guidelines and All Plan Letters published by the Department of Health Care Services. However, Managed Care Plans are able to provide telehealth services to enrolled beneficiaries that exceed DHCS coverage policies. Medi-Cal Managed Care Plans could decide to cover telehealth if they believe it is helpful in managing their patients and controlling costs. However, because it is not a requirement, it is not explicitly included in the capitation rates set for each county and plan.

DHCS' telehealth coverage policy has been evolving over the last few years. DHCS released new guidance in 2019 that expanded the number of telehealth modalities and services for which Medi-Cal provides reimbursement. Medi-Cal reimburses for live video and does not limit it to certain specialties or services. Medi-Cal only reimburses for services provided via telephone using the "virtual check-in via telephone" code. Coverage and reimbursement of this code is not limited to certain specialties or services.

There are two public health emergency regulations that AB 32 would extend indefinitely: DHCS' COVID-19 Public Health Emergency Telehealth Policy and Welfare, and Institutions Code 14132.723. These regulations include provisions that require reimbursement for telehealth services to be equal to the equivalent in-person service and requires reimbursement for telephone (audio only) services.

FQHCs/RHCs

FQHCs, FQHC-lookalikes, and RHCs are subject to federal statute governing Medi-Cal reimbursement. They typically provide health care to low-income and underserved populations, and are entitled to cost-related prospective payments for the services delivered. FQHCs (including "lookalikes") and RHCs must meet certain requirements and provide certain services to obtain these specific designations. Because of this interaction, FQHCs and RHCs are subject to different rules than other Medi-Cal providers regarding telehealth. For example: all health care services must be provided within the clinic's "four walls"; and telephone services are not reimbursed.

In addition to providing primary care services to low-income people, FQHCs and RHCs provide dental, mental health, vision, and substance use disorder care, as well as "enabling services" (e.g., case management, enrollment assistance, interpretation, transportation, etc.). These clinics treat about 23% of all Medi-Cal beneficiaries in California. As a proportion of patients seen by FQHCs, Medi-Cal beneficiaries comprise 66% of patients seen at the more than 260 FQHCs in California.

IMPACTS

Benefit Coverage, Utilization, and Cost

Telehealth capacity among providers has improved during 2020 due to COVID-19. This improvement in capacity to deliver and bill for telephone and live video will enable providers to respond to new benefit coverage in 2022, regardless of the state of the pandemic or public health emergency. This increased capacity will allow FQHCs and RHCs in particular to respond differently to telehealth benefit coverage than they would have in the absence of the COVID-19 public health emergency.

The implementation of AB 744 on January 1, 2021, which required benefit coverage for synchronous telehealth services by commercial and CalPERS plans and policies, and the COVID-19 public health emergency will bolster the capacity of health care providers to deliver telehealth in 2022 whether AB 32 is enacted or not.

Telehealth will likely represent a larger proportion of health care services than in the past due to new capacity, patient convenience, patient reticence about obtaining in-person care due to the ongoing effects of the pandemic, and practice adoption.

The baseline presented in this analysis is a middle-ground estimate of 2022 in a hypothetical scenario in which AB 744 has been fully implemented and the COVID-19 public health emergency regulations terminated, both of which laid the groundwork for telehealth adoption and use more broadly than in 2019 prior to the pandemic.

Benefit Coverage

At baseline, 100% of enrollees with commercial or CalPERS health insurance that would be subject to AB 32 have coverage for live video telehealth services,

whereas 80.4% of enrollees have coverage for telephone services. Approximately 7% of enrollees in CalPERS HMOs do not have benefit coverage for telehealth delivered via telephone.

AB 32 would require commercial and CalPERS health plans and policies to provide new benefit coverage for telephone telehealth services for 19.6% of enrollees.

At baseline, 100% of Medi-Cal Managed Care beneficiaries have existing benefit coverage for live video services. However, 73.5% of beneficiaries in DMHC-regulated Medi-Cal Managed Care Plans have coverage for synchronous telephone services. AB 32 would require Medi-Cal Managed Care Plans, COHS, and the Fee-for-Service program to provide new benefit coverage for synchronous telephone services for 26.5% of beneficiaries.

As mentioned previously, FQHCs and RHCs were unable to provide live video services outside of the clinic's four walls and did not receive reimbursement for telephone. If a Medi-Cal Managed Care beneficiary sought services from an FQHC or RHC, they would not be able to access those services via telehealth. Postmandate, FQHCs and RHCs would be able to provide and receive reimbursement for synchronous telehealth services provided outside of the clinic's physical location.

Utilization

Of the new telehealth visits provided postmandate, CHBRP estimates that supplemental services will represent 50% of additional telehealth services and 50% will replace in-person care due to the ongoing effects of the pandemic and reticence by patients to seek in-person care.

For commercial and CalPERS enrollees:

At baseline, use of telehealth will comprise 11% of all primary care visits and 8% of specialty visits among commercial and CalPERS enrollees. For behavioral health, telehealth represents 40% of use.

Due to new benefit coverage for telephonic services for 19.6% of enrollees, utilization will increase by 24% postmandate. This increase in telephone utilization results in a decrease in in-person visits for primary care and urgent care visits (−0.66%), behavioral health (−4.91%), and specialist visits (−0.45%). There were no utilization changes postmandate for live video due to AB 32 because 100% of commercial and CalPERS enrollees already had coverage for live video services.

Postmandate, use of telehealth will comprise 12% of all primary care visits and 8% of specialty visits among commercial and CalPERS enrollees. For behavioral health, telehealth represents 45% of use in the commercial market.

For beneficiaries of DMHC-regulated Medi-Cal Managed Care Plans:

At baseline, use of telehealth comprises 3% of all primary care visits, 3% of specialty visits, and 3% for behavioral health for Medi-Cal Managed Care beneficiaries. Approximately 3% of primary care and behavioral health visits were provided via telehealth for FQHC/RHCs.

Due to new benefit coverage for telephonic services for 26.5% of Medi-Cal Managed Care beneficiaries, telehealth utilization for non-FQHC and RHC practices and clinics is projected to change in the following ways:

- Primary care: telephonic telehealth services will increase postmandate by over 600%. Some new telephonic visits will replace live video visits, which results in a decrease of 11% in live video visits.
- Outpatient mental health and substance use disorder (MH/SUD): telephonic telehealth services will increase postmandate by almost 550% and live video services by over 140%.
- Outpatient specialist visits: telephonic telehealth services will increase postmandate by over 400%, with a decrease in live video visits of nearly 40%.
- In-person services will decrease by approximately 5% for primary care and MH/SUD and over 3% for outpatient specialist visits.

At baseline, in FQHCs and RHCs, there were no telephonic visits and a small number of live video visits (4.10 primary care and urgent care, and 1.39 MH/SUD per 1,000 enrollees). Due to the extension of COVID-19 public health emergency regulations that allow these clinics to more broadly provide telehealth services and receive reimbursement at parity:

- There will be increases in use of telephonic services for primary care and urgent care (postmandate 15.52 visits per 1,000 enrollees), and MH/SUD (postmandate 4.61 visits per 1,000 enrollees).

- Due to some new telephonic visits replacing live video visits, the use of live video visits will decrease to 1.09 live video primary care and urgent care visits, and to 1.01 live video outpatient MH/SUD visits.

- In-person services will decrease by almost 5% for primary care, MH/SUD, and outpatient specialist visits.

Postmandate, use of telehealth will comprise 12% of all primary care visits, 8% of specialty visits, and 12% for behavioral health for Medi-Cal Managed Care beneficiaries. Approximately 12% of primary care and behavioral health would be provided via telehealth for FQHC/RHCs postmandate.

Per-Unit Cost

There is no impact on per-unit cost for commercial or CalPERS enrollees because plans already reimburse at parity with in-person services. In the case of Medi-Cal Managed Care, the parity requirements of AB 32 would increase per-unit costs by between 5.42% and 780.67%. The primary driver of the change in average per-unit costs are the all-inclusive prospective payment service (PPS) rates that would be paid to FQHCs and RHCs for primary care, urgent care, and MH/SUD services due to the requirement to pay at parity with in-person visits for all Medi-Cal providers, including FQHCs and RHCs that are paid a cost-related PPS visit rate.

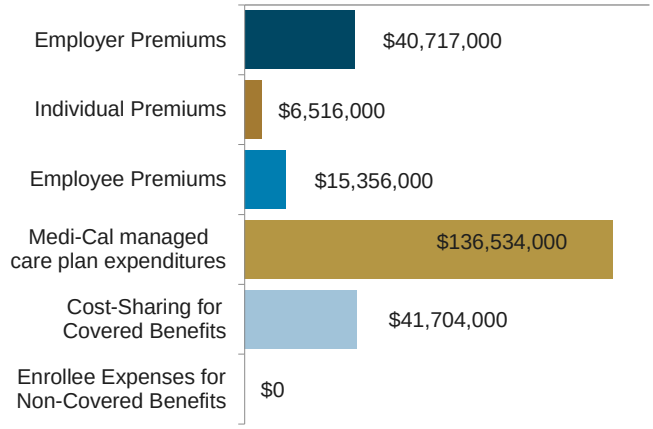
Expenditures

AB 32 would increase total net annual expenditures by $240,827,000, or 0.18%, for enrollees with DMHC-regulated plans, CDI-regulated policies, and DMHC-regulated Medi-Cal Managed Care Plans. This is due to an increase in total health insurance premiums paid by DMHC-regulated large-group plans ($0.29 per member per month [PMPM]), small-group plans ($0.77 PMPM), individual market plans ($0.20 PMPM), CalPERS HMOs ($0.13 PMPM), Medi-Cal Managed Care Plans for age under 65 years ($1.42 PMPM), Medi-Cal Managed Care for ages 65 and over ($1.41 PMPM), CDI-regulated large-group ($1.32 PMPM), and CDI-regulated individual market ($0.95 PMPM) policies. The largest increases in expenditures were in Medi-Cal Managed Care for age under 65 (0.63%), Medi-Cal Managed Care for age 65+ (0.30%), and CDI-regulated large group (0.26%).

CHBRP does not project any cost offsets or savings in expenditures that would result because of the enactment of provisions in AB 32. Because AB 32 requires payment for telehealth to be at parity with in-person care and because 50% of the increased telehealth use supplements in-person visits, no cost offsets or savings are anticipated. In addition, it is unlikely the actual cost of staff, technology, and resources used to deliver services via telehealth are less expensive than in-person care.

Overall, the increase in commercial and CalPERS expenditures are driven entirely by new benefit coverage because payment parity is already required for telehealth services. However, of the 0.57% increase in Medi-Cal Managed Care expenditures, almost all of the expenditure changes are due to parity requirements (0.56%) rather than benefit coverage changes (0.01%).

Figure B. Expenditure Impacts of AB 32



Source: California Health Benefits Review Program, 2021.

Medi-Cal

In addition to the estimated $136,534,000 increase in premiums for the 8.05 million Medi-Cal beneficiaries enrolled in DMHC-regulated Medi-Cal Managed Care plans, a proportional increase of $42.62 million is estimated to occur for the beneficiaries enrolled in COHS managed care and the Fee-for-Service program. CHBRP assumes the two populations to be relatively similar and to have relatively similar benefit coverage. Of the $136,534,000 increase in Medi-Cal Managed Care expenditures, $134,005,000 would be due to parity requirements and $2,529,000 would be due to new coverage of telehealth services. Additionally, of the $136,534,000 increase in expenditures, $24,450,000 (0.10%) would be due to the increase in coverage and parity requirements for telehealth services provided by FQHCs/RHCs.

CalPERS

Premium expenditures for CalPERS HMO employer plans are expected to increase by $1,154,000 (0.02%) due to AB 32. Per member per month total expenditures would increase by $0.21.

Number of Uninsured in California

Because the change in average premiums does not exceed 1% for any market segment, CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of AB 32.

Medical Effectiveness

Most studies pertinent to this analysis examine the use of telehealth modalities as a substitute for in-person care. In these cases, the relevant studies evaluated whether care provided via these technologies resulted in equal or better outcomes and processes of care than care delivered in person, and whether use of these technologies improved access to care. Some studies assessed the effects of telehealth as a supplement to in-person care; these studies evaluated whether adding these technologies improves processes of care and health outcomes relative to receiving in-person care alone.

To examine whether services delivered via telehealth are of the same quality as in-person services, CHBRP examined three sets of outcomes: (1) health outcomes, including both physiological measures and patient-reported outcomes; (2) process of care outcomes, including treatment adherence and accuracy of diagnoses and treatment plans; and (3) access to care and utilization outcomes, such as wait time for specialty care, or number of outpatient visits, emergency department visits, and hospitalizations.

CHBRP found that evidence regarding whether telehealth modalities and services result in equal or better outcomes than care delivered in person is mixed, depending on the disease and condition, telehealth modality, and type of outcome studied: health outcomes, process of care, or use of other services. Because telehealth studies have only focused on a limited number of diseases and conditions, the findings may not be generalizable outside of the specific diseases and conditions studied.

For Live Video:

There is *preponderance of evidence*[3] that care delivered by live video is at least as effective as in-person care for **health outcomes** for several conditions and health care settings, including infectious disease, obesity, diabetes, and abortion.

There is *clear and convincing*[4] evidence that mental health services for attention deficit/hyperactivity disorder (ADHD) depression, and posttraumatic stress disorder (PTSD) delivered by live video are at least as effective as in-person care for **processes of care** and **health outcomes**.

There is *clear and convincing* evidence that dermatology diagnoses made via live video are as accurate as diagnoses made during in-person visits. There is a *preponderance of evidence* that scores on neurocognitive tests administered via live video are similar to scores obtained when tests are administered in person. Studies have also found diagnostic concordance between live video and in-person examination for shoulder disorders, otolaryngology, and fetal alcohol syndrome.

There is a *limited evidence* that care delivered by live video is at least as effective as in-person care for **access to care and utilization**.

For Telephone:

For the diseases and conditions studied, the *preponderance of evidence* from studies of the effect of telephone consultations suggests that telephone consultations were at least as effective as in-person consultations on **health outcomes**.

For the diseases and conditions studied, findings from studies of the effect of telephone consultations on **processes of care** and **access to care and utilization** are inconsistent; therefore, the evidence that medical care provided by telephone compared to medical care provided in person is *inconclusive*[5].

Comparing Live Video to Telephone:

There is *preponderance of evidence* that behavioral health services delivered by live video are comparable to services delivered by telephone consultation on **health outcomes**.

CHBRP found no studies that compared live video to telephone consultation on outcomes for processes of care and access to care and utilization of health

[3] *Preponderance of evidence* indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective.

[4] *Clear and convincing* evidence indicates that there are multiple studies of a treatment and that the large majority of studies are of high quality and consistently find that the treatment is either effective or not effective.

[5] *Inconclusive evidence* indicates that although some studies included in the medical effectiveness review find that a treatment is effective, a similar number of studies of equal quality suggest the treatment is not effective.

services. CHBRP notes that absence of evidence is not evidence of no effect.

Table A. Summary of Evidence of Medical Effectiveness of Synchronous Telehealth Compared to In-Person Care

	Health Outcomes	Processes of Care	Access and Utilization
Live video	Preponderance of evidence – effective	Clear and convincing evidence – effective	Limited evidence – effective
Telephone	Preponderance of evidence – effective	Inconclusive evidence	Inconclusive evidence

Source: California Health Benefits Review Program, 2021.

Public Health

Telehealth can supplant or substitute in-person visits for many diseases and heath conditions. The broad nature of telehealth modalities and the multiple metrics (e.g., access, process, outcomes, etc.) across modalities and countless conditions precludes quantitative estimates of changes in public health outcomes attributable to AB 32. However, based on evidence presented in this report:

- CHBRP anticipates that AB 32 would increase access to and use of telehealth modalities for ~4.85 million commercial/CalPERS and Medi-Cal enrollees (plus an additional 2.7 million enrollees in Medi-Cal COHS and FFS), thus bringing their coverage into parity with other state-regulated commercial carriers already providing coverage at baseline. In turn, these enrollees would experience reduced delays in care (e.g., appointments, diagnoses, treatments) for conditions treated by primary care, behavioral health, orthopedic, rehabilitation, dermatology, and other specialty providers.

- CHBRP anticipates AB 32 would bring live video and telephone-based care from FQHCs and RHCs into parity with Medi-Cal and commercial plans and policies, thus mitigating income disparities in care.

- CHBRP also anticipates that, as compared with in-person visits, AB 32 would produce equivalent (or in some cases, better) health outcomes for newly covered enrollees across some, but not all, diseases and conditions.

Disparities by income, race and ethnicity: People of color comprise the majority of Medi-Cal beneficiaries, who, by definition, are low-income. As a group, their telehealth coverage is unequal with much of the commercial market at baseline. CHBRP projects that, postmandate, AB 32 would bring telephone and live video telehealth coverage and reimbursement for Medi-Cal beneficiaries into parity with that of commercial plans and policies. This would decrease income disparities in access to health care and health outcomes by reducing delays in in-person care for some conditions (appointments, diagnoses, treatment), as well as providing equal access to all modalities of care.

CHBRP also projects that AB 32 would decrease overall racial and ethnic disparities that are present due to the different baseline coverage between commercial plans and policies and Medi-Cal, which is predominantly comprised of people of color. This would decrease disparities in access to health care and health outcomes by reducing delays in in-person care for some conditions (appointments, diagnoses, treatment), as well as providing equal access to all modalities of care. CHBRP is unable to quantify the reduction in racial and ethnic disparities.

It is unknown whether racial or ethnic disparities in access to or use of telehealth exist among the commercially-insured population; therefore CHBRP is unable to estimate an impact for this population.

These changes would be attributable to two mechanisms in AB 32: 1) new coverage for telephone (audio only) that brings Medi-Cal beneficiaries' coverage into parity with commercial plans and policies; and 2) permanent eligibility for FQHCs and RHCs to bill Medi-Cal for telephone and live video visits with Medi-Cal patients.

Disparities of transportation and geography: AB 32 would increase access to health care by reducing transportation barriers to in-person care by covering telephone (audio only) visits. AB 32 would also increase health care options and reduce travel costs and travel time for those enrollees who use the newly covered telephonic visits or reimbursable live video visits with FQHC/RHC providers. These enrollees and Medi-Cal beneficiaries may have equivalent or better outcomes (compared with in-person care) because they would no longer delay or avoid in-person visits because of travel difficulties.

For those rural (and some urban) enrollees and Medi-Cal beneficiaries who have no broadband connectivity (due to lack of infrastructure in remote areas or cost of service or devices), a landline telephone would remain a viable telehealth modality, resulting in equivalent or better outcomes (compared with in-person care).

Disparities in technology use: CHBRP anticipates AB 32 would decrease disparities in care associated with technology barriers for many Californians who are low-income (Medi-Cal), live in broadband deserts, or lack digital literacy by permitting access to reimbursable telephone and live video visits.

Long-Term Impacts

Although CHBRP estimates that telephonic telehealth services will increase in 2022 and 2023 due to new benefit coverage under AB 32 and the ongoing effects of the COVID-19 pandemic (as a barrier to in-person services), in the long term, CHBRP anticipates that technology capacity improvements could support additional use of live video. However, use of telephone for telehealth is likely to continue, especially for patients with technology limitations (e.g., Internet bandwidth, lack of smartphone or computer).

Under AB 32, Medi-Cal beneficiaries, especially those who access care through FQHCs/RHCs, would experience comparable coverage for telehealth care with their commercially-insured counterparts, which would allow them access to the same telehealth choices. In the long term, CHBRP projects that this new parity could narrow racial/ethnic, income, and geographic disparities in access to care and health outcomes. CHBRP projects AB 32 would increase enrollee access to health care in the long-term, especially for those who would use audio-only services; it would also provide more data to inform future research about the appropriateness of telehealth care as compared with in-person visits and other telehealth modalities.

Essential Health Benefits and the Affordable Care Act

AB 32 requires coverage of modes of delivery for health care services, but does not require coverage of specific tests, treatments, or services. Because AB 32 would not require coverage for a new state benefit mandate and therefore appears not to exceed the definition of EHBs in California.