

Key Findings:

Analysis of California Senate Bill SB 289 Telephonic and Electronic Patient Management

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



AT A GLANCE

Senate Bill SB 289 (introduced February 2015) would require health insurance carriers to cover and reimburse physicians and nonphysicians for patient-initiated evaluation and management (E/M) services for telephone, e-mail, live videoconference, and store-and-forward. Only services provided to established patients would be eligible

- **Impact on benefit coverage.** CHBRP estimates that in 2015, 11.7 million enrollees have coverage for telephone and e-mail and 19.2 million have coverage for other telehealth modalities covered by SB 289. Postmandate, all 24.6 million California enrollees with state-regulated coverage would have benefit coverage for these modalities.
- **Impact on utilization.** CHBRP estimates the share of telehealth visits to in-person visits could range from 7.4% to 29.2%. In person visits could decrease by 0.9% to 15.0% depending on patient/provider take-up of all telehealth modalities.
- **EHBs.** SB 289 does not appear to add services health insurers must cover, but affects the setting in which already-covered services are provided. Therefore, SB 289 does not appear to exceed EHBs.
- **Medical effectiveness.**
 - There is insufficient evidence to determine whether E/M services provided via telephone or e-mail are as effective as medical care provided in-person.
 - The evidence suggests that medical care provided by live videoconferencing and store-and-forward is at least as effective as medical care provided in person for those diseases and conditions studied.
- **Public health.** If enacted, patient experience would improve as physicians increase e-mail and telephone responses to patient inquiries, increased convenience, and reduce or eliminate travel times to in-person visits.
- **Long-term impacts.** Technology will continue to drive changes in telehealth. Electronic health records, online patient portals, and increased use of smart phones will increase demand for these types of services. Insurers and physicians could respond by expanding their capacity to deliver those services in a secure manner.

BILL SUMMARY

SB 289 would require state-regulated health insurance, after January 1, 2016, to cover and reimburse physicians for telephonic and electronic E/M services for established patients. If passed, SB 289 would require carriers to pay for those services provided via telephone and e-mail, live videoconferencing, and “store-and-forward,” a method by which patients capture medical information and transmit that information to physicians to evaluate at a later time.

Based on SB 289’s language, CHBRP limits analysis of services delivered via telephone and e-mail to cases where an established patient initiates contact with the health care provider.

Finally, SB 289 specifies that reimbursements must be equivalent in “complexity and time expenditure.” CHBRP uses the American Medical Association’s Current Procedural Terminology (CPT) coding descriptions for the required amount of time spent on encounters and the complexity of a patient’s illness.

CONTEXT FOR BILL CONSIDERATION

What is telehealth? California law currently includes two methods of electronic communication in its definition of telehealth: live videoconferencing and store-and-forward. Although current law recognizes these two modalities as telehealth, it does not require or set standards for reimbursement. SB 289 would require reimbursement for these modalities, and would also require coverage and reimbursement for telephone and e-mail. Therefore, CHBRP analyzed the impact of SB 289 for four modalities: telephone, e-mail, live videoconferencing, and store-and-forward.

Patient interest in technology for medical transactions: A December 2014 survey of patients in the U.S. found that 64% of patients were interested in using online video. Interest in live videoconferencing with providers peaked among younger adults (74% of respondents ages 18 to

34) and declined gradually to 65% among respondents ages 55 to 64, before significantly decreasing among adults 65 and older. The survey found that 60% of respondents would rather use live videoconferencing to obtain a refill for their prescription drug rather than visit their doctor's office (American Well, 2015).

CHBRP KEY FINDINGS: INCREMENTAL IMPACT OF SB 289

Medical Effectiveness

Telephone and e-mail: There is insufficient evidence to determine whether services provided via telephone or e-mail are as effective as medical care provided in person. Further, it is unknown whether diagnoses made using these technologies are as accurate as diagnoses made during in-person visits. Studies on the effect of telephone consultations or e-mail communication on subsequent utilization are inconsistent. CHBRP notes that the absence of evidence does not mean there is no effect; it means the effect is unknown.

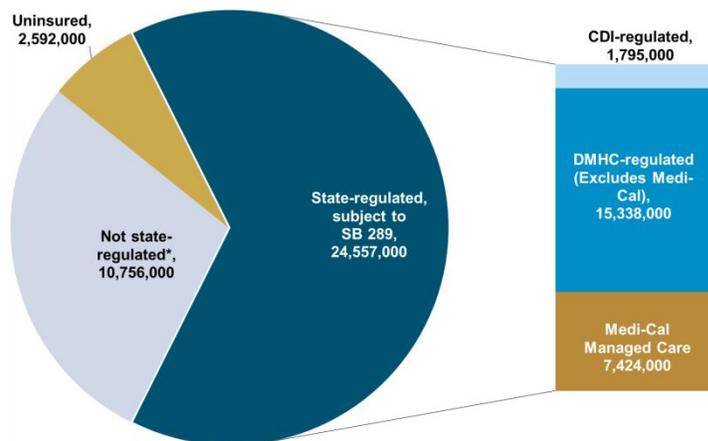
Live videoconferencing and store-and-forward: For the diseases and conditions studied, there is a preponderance of evidence that medical care provided by live videoconferencing or store-and-forward is at least as effective as medical care provided in person for both physical and mental health conditions. In particular, there is clear and convincing evidence that live videoconferencing is equivalent to in-person care in psychiatric health outcomes. The evidence also suggests that store-and-forward technology reduces wait times for specialty outpatient care.

Caveats: A major methodological limitation of the literature is simply the pace of technological change. Technology developments and use advance at a faster rate than the research literature. By the time a research study is published, the technology under study is outdated, making it difficult to draw conclusions about the medical effectiveness of current technologies. Another important limitation of the studies is the inability to disaggregate the mandated services from other interventions, such as an integrated web portal that includes emails as well as information about self-care, access to test results, and ability to refill prescriptions.

Benefit Coverage, Utilization, and Cost

SB 289 affects the health coverage of 24.6 million enrollees with state-regulated health insurance (**Figure 1**).

Figure 1. SB 289 Interaction with California Enrollees



*Not state regulated = Federally regulated health insurance, such as Medicare, veterans, or self-insured plans and thus not subject to SB 289.

Source: California Health Benefit Review Program, 2015

Benefit coverage: Currently, 48% of enrollees have benefit coverage for telephone and e-mail and 78% of enrollees have benefit coverage for live videoconference or store-and-forward. Postmandate, 100% of enrollees with state-regulated health insurance would have benefit coverage for all four telehealth modalities.

Kaiser Permanente: CHBRP relied on data from Kaiser Permanente Northern California to estimate changes in the number of E/M visits between physicians and patients. Kaiser's experience is the only well-documented examination of the utilization of telephone and e-mail visits between physicians and patients, pre- and post-implementation of a strategy that included telephone, secure e-mail, and live videoconferencing visits (Pearl, 2014).

Data limitations: Although Kaiser's rate of telephone and e-mail use serves as a good benchmark, it may underestimate the impact of SB 289 on the adoption of all four modalities statewide.

- Kaiser does not impose cost sharing for its e-mail or telephone use. CHBRP assumes lower patient cost sharing for telehealth services, proportional to the price of the service, would occur, which

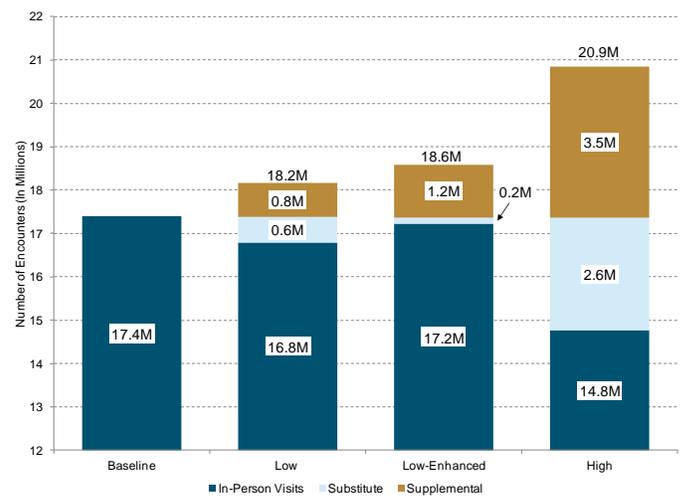
could either dampen enrollees' use of any of the four telehealth modalities, or prompt physicians to encourage enrollees to interact via a certain telehealth modality if they prove to be effective or cost efficient. Therefore, Kaiser's rate of telephone and e-mail use may not generalize to nonsalaried providers outside of an integrated HMO setting.

- Kaiser is a closed and integrated health system, equivalent to a staff-model HMO, where similar physicians' salaries should not vary whether they are providing services in person or via e-mail, telephone, or live videoconferencing. Such a system may realize savings efficiencies from the use of telephone and e-mail, whereas the impact of SB 289 on noncapitated (fee-for-service) health insurance may be more limited because the networks of providers may or may not be well-integrated enough to realize savings.

Utilization and cost estimates: CHBRP modeled multiple scenarios to provide policymakers with a range of estimates of the potential impact of SB 289 on both utilization and cost. Three scenarios presented in Figure 2 represent a range of estimates, based on how quickly physicians adopt to include telephone, e-mail, live videoconferencing, and store-and-forward into their workflow and practice. The scenarios assume a blended average of \$14 cost sharing for most telephonic or electronic visits. CHBRP estimates utilization increase for both capitated and noncapitated health insurance. CHBRP recognizes that capitation rates for specific medical groups might not increase immediately to reflect any anticipated increase in the total cost to provide health services. However, to the extent CHBRP assumed an increase in the utilization of the four modalities of telehealth services, and, in particular, supplemental telehealth services, 2016 cost and premium estimates in this report assumed that capitated rates set or negotiated by insurers with providers will reflect the use of benefits, including those that may occur via telehealth.

Utilization impact: An assumption driving the push for telehealth is that it would increase access by improving efficiencies, and increase capacity to accommodate enrollees newly covered by the Affordable Care Act and rural populations. CHBRP estimates that SB 289 would result in an overall increase of between 4.5% and 21.1% patient-provider encounters, which includes both in-person and telephonic or electronic visits.

Figure 2. Impact of SB 289 on Utilization/Patient Encounters



CHBRP estimates that between 7.5% and 29.2% of all E/M visits would occur using telephone, e-mail, live videoconferencing, or store-and-forward.

“Substitute” vs. “supplemental” visits: Of the visits that would occur telephonically or electronically, CHBRP assumes 40% would be “substitute” visits — replacing existing in-person visits; and 60% would be visits that are “supplemental,” or in other words, visits that would not have been provided if not for the use of telehealth, visits that were previously unreimbursed because physicians could not bill for them, new time slots made because of the increased efficiency of telephonic or electronic visits over in-person visits, or an extension of a physicians' work hours.

Public health

Health outcomes: CHBRP estimates that use of all four modes of telehealth would increase in the first year postmandate; however, CHBRP is unable to quantify the effect of SB 289 on health outcomes.

Telephone and e-mail: CHBRP found insufficient evidence to determine whether services provided via *telephone* or *e-mail* are as effective as in-person visits, with the exception of email communication for glycemic control among diabetic patients. Therefore, although telephone encounters would increase by approximately 821,000 to 3,665,000 and email communication would increase by approximately 274,000 to 1,214,000 encounters, the public health impact of SB 289 is unknown. Note that the

absence of evidence is not “evidence of no effect.” It is possible that an impact — positive or negative — could result, but current evidence is insufficient to inform an estimate.

Live videoconferencing and store-and-forward: For mental health and dermatology, evidence indicates that outcomes for live videoconferencing and store-and-forward are equivalent to in-person care, and CHBRP estimates that utilization would increase by approximately 68,000 to 304,000 live videoconferencing encounters and by approximately 205,000 to 911,000 store-and-forward encounters. Therefore, CHBRP estimates that positive mental health and dermatologic outcomes could occur for some newly covered enrollees with these conditions.

Patient experience: CHBRP anticipates that increasing use of telehealth technologies would improve enrollees’ overall experience because:

- They would have more methods by which to communicate with their physicians;
- Distance and time travelling to and from in-person visits would be reduced, along with related costs. As a result, some enrollees may have better health outcomes because eliminating travel barriers would reduce the number of delayed or foregone in-person visits; and
- Time off work would also be reduced, leading to higher overall productivity.

Financial burden: CHBRP estimates that SB 289 would modify coverage and, depending on postmandate utilization rates, could increase enrollees’ net financial burden for additional telehealth services by over \$7.5 million to \$33.1 million because enrollees would now be subject to copayments on telephone, e-mail, live videoconferencing, and store-and-forward visits (equivalent to the copayment for in-person visits). The financial burden results from visits that (1) were previously occurring but not reimbursable, or (2) constitute visits that would not have occurred without SB 289, due to distance, inconvenience, or time.

Potential harms: Although the limited literature available cited potential concerns around fragmented care, misdiagnosis, or lack of adherence to security protocols, among other issues, it was considered weak in depth and breadth. That said, CHBRP found insufficient evidence to

determine whether services provided telephonically or electronically would harm patients.

Gender and racial disparities: Although there appear to be differences in interest and use of e-mail by sociodemographic characteristics, CHBRP is unable to estimate the impact of SB 289 on health disparities due to lack of evidence.

Long-term Impacts

CHBRP is unable to estimate the long-term impact of SB 289 on overall health outcomes and disparities due to the breadth of conditions telehealth may be used for and the unknown impact of future technology development. To the extent that advances in telehealth technology improve access and provider capacity, CHBRP projects some improvements in patient evaluation and management, especially for enrollees with transportation barriers or chronic health conditions. Because telehealth services can be reimbursed at a lower rate than equivalent in-person services, it is unlikely that physicians operating in a fee-for-service environment would seek to substitute telehealth visits for in-person visits. However, if there is opportunity for providers to deliver supplemental (i.e. new) telehealth services due to technology, excess capacity, changes in reimbursement, or other supports and incentives, there could be a larger expansion in use of telehealth services over time.

Essential Health Benefits and the Affordable Care Act

SB 289 would require reimbursement for services already included in the current required EHB benchmark, but provided in a different setting. Therefore, SB 289 does not appear to exceed or alter EHBs, and therefore appears not to trigger the ACA requirement that the state defray the cost of additional benefit coverage for enrollees in qualified health plans (QHPs) in Covered California.