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STATEMENT FOR THE HEARING RECORD

Senate Committee on Health, Education, Labor, and Pensions

Telehealth: Lessons from the COVID-19 Pandemic

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Introduction

The Pacific Business Group on Health (PBGH) is a non-profit organization dedicated to the vision of a healthcare system driven to deliver the best health outcomes, experience, and affordability for consumers and purchasers. Representing more than 40 large public and private employers and health care purchasers, our members provide health coverage to more than 15 million people and spend more than $100 billion on health care services every year.

Since telehealth's genesis in the 1990s, employers and private purchasers have been on the leading edge of providing telehealth services to their enrollees.[1] However, despite expansion in the availability of telehealth for various services, regulatory and legal barriers have hampered its growth.[2] The unprecedented temporary waiver of regulatory barriers in response to the COVID-19 epidemic provides policymakers and stakeholders a valuable opportunity to study the clinical and cost-effectiveness of telehealth. While some telehealth advocates see this experience as an opportunity to permanently eliminate any limitations on telehealth services and institute universal payment parity, **PBGH urges a thoughtful, nuanced approach to ensure that policy changes expand access to clinically appropriate and cost-effective care, while avoiding blanket mandates that will serve only to drive up costs across the system.**

COVID-19 Context

The COVID-19 pandemic has put unprecedented strain on our health care system and economy. With a majority of people in the country unable or unwilling to conduct in-person health care visits, many have turned to telehealth services as an alternative. Responding quickly to this dynamic, the Department of Health and Human Services swiftly waived a number of rules to

[1] https://www.liebertpub.com/doi/10.1089/tmj.2013.0256
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5389433/

provide greater access to telehealth, including changes to Health Insurance Portability and Accountability Act (HIPAA) privacy requirements and site-of-service rules, and temporarily instituted Medicare payment parity. Congress, for its part, has allocated funding under the Coronavirus Aid, Relief, and Economic Security (CARES) Act, and allowed high deductible health plans to cover telehealth services before a consumer meets their deductible.

While it is too soon for accurate findings regarding the impact of these changes, early indications appear to show that millions of patients are accessing telehealth for the very first time.[3] In the midst of a deadly pandemic, providing this flexibility has surely saved countless lives and prevented the worsening of chronic conditions.

Defining High Value Telehealth – Our Recommendations

While telehealth holds the promise of dramatically expanding access to cost-effective care, particularly for those with limited access to in-person care including immobile elderly patients, those in rural areas, and people without access to affordable transportation options, it comes with its own limitations. First, telehealth is clinically appropriate for many, but by no means all health care services. Second, particularly when provided by a freestanding telehealth service provider, the care is often uncoordinated with a patient's regular source of care, a problem that leads to unnecessary care, higher costs, and more medical errors. Finally, if deployed in a poorly designed fee-for-service environment, telehealth services all too often supplement, rather than substitute for in-person care, meaning higher utilization and higher costs.

A high-value telehealth system should avoid these pitfalls. Specifically, as policymakers consider the future of telehealth regulation and payment policy, they should stay focused on promoting a system that meets the following three principles:

1) **Clinical Appropriateness:** While some services, including certain evaluation and management services, may be appropriate for telehealth, services that for example, require a thorough physical examination or an intervention conducted by a clinician are likely not clinically appropriate and should not be reimbursed at the same level as an in-person service.
2) **Care Coordination:** While freestanding telehealth service providers may have a role in expanding access to care in certain circumstances, telehealth is best provided in the context of a patient's longitudinal care team (e.g., primary care physician or specialist managing a chronic condition). When freestanding telehealth providers are used, they should be required to closely coordinate care with the patient's care team. To ensure patients' longitudinal providers are capable of providing HIPAA compliant telehealth services, policymakers should extend privacy waivers adopted by HHS.
3) **Substitutive, not Supplemental:** With health care consuming nearly one-fifth of the nation's gross domestic product, it is vital that policymakers work to reduce costs. This includes implementing policies to eliminate unnecessary and duplicative procedures and tests.

[3] https://www.cnbc.com/2020/04/03/telehealth-visits-could-top-1-billion-in-2020-amid-the-coronavirus-crisis.html

We believe federal and state policymakers should consider these principles when designing telehealth payment for payments under their direct control – namely in Medicare and Medicaid. Regardless of how policymakers design telehealth payment for public payers, it is critical that they not impose strict payment requirements on private purchasers of telehealth services. **To wit, a blanket payment parity requirement on private payers would eliminate our ability to design a benefit package that ensures access to high value health care while holding costs down.**

Meeting these three principles in a fee-for-service environment will be particularly difficult, where there are few financial incentives to limit clinically inappropriate services, pay for care coordination, or stop unnecessary utilization. **We, instead, encourage policymakers to deploy a national telehealth policy focused on prospective, population-based payment models in which providers accountable for the total cost of care and health care outcomes.** Outside of such a system, we fear that a proliferation of telehealth will only exacerbate the underlying problems already bedeviling our broken health care delivery system.

Finally, as telehealth continues to become more widely available, **policymakers should continue to invest in independent research and evaluation on the effectiveness of telehealth on both improving outcomes and reducing costs.**

We appreciate the opportunity to provide comment on this critical and timely issue, and look forward to working together to promote high value telehealth services in the future. Please contact Shawn Gremminger, Director of Health Policy, at sgremminger@pbgh.org.