A Rapid Analysis of a California Telehealth Bill: Academic Rigor on the Legislature's Timeline

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Research Objective
- Assess the 2016 California Assembly Bill (AB) 2507 which proposed recognizing additional telehealth modalities and expanding reimbursement for telehealth services.
- Describe the California Health Benefits Review Program (CHBRP) legislative analysis process. CHBRP provides independent, evidence-based analyses to the CA legislature regarding projected impacts of health insurance legislation within 60 days.
- Evaluate existing evidence related to the medical effectiveness of telehealth services. Estimate the cost and utilization impacts of the bill. Describe potential public health impacts.

Definition of telehealth:
- Reimbursement parity:

CHBRP performed a literature review to determine the medical effectiveness of telehealth and synchronous text or chat messaging.

Figure 1. CHBRP Bill Analysis 60-Day Timeline

Bill Summary
AB 2507 would have made the following changes in CA:
- Definition of telehealth: Refine CA’s telehealth definition to include e-mail and synchronous text or chat messaging.
- Reimbursement parity: Require reimbursement parity for telehealth visits compared to equivalent in-person visits.

Populations Studied and Study Design
- CHBRP performed a literature review to determine the medical effectiveness of telehealth modalities, surveyed California health insurance plans, and analyzed the MarketScan claims database of Truven Health Analytics.
- CHBRP projected the marginal impacts of the bill in the first year, were it to pass into law.

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Principal Findings – Medical Effectiveness
Evidence of effectiveness varied by telehealth modality and specialty.
- **Live Video**: Preponderance of evidence that live video is at least as effective as in-person care. Clear and convincing evidence that it is equivalent to in-person care in mental health and dermatology outcomes.
- **Store and Forward**: Low preponderance of evidence that store-and-forward is at least as effective as in-person care for conditions studied.
- **Phone**: Ambiguous evidence.
- **Email, Text and Chat Messaging**: Insufficient evidence.

Figure 2. Medical Effectiveness of Different Telehealth Modalities

Principal Findings – Benefit Coverage, Utilization and Cost
- At baseline, there were differing levels of coverage for telehealth:
  - **Phone**: 78% of enrollees had coverage;
  - **Email, Text, Chat**: 76% had coverage;
  - **Live Video, Store-and-Forward**: 91% had coverage.
- Two scenarios were considered for utilization:
  - **Low Scenario**: 3.75% of all visits delivered via telehealth;
  - **High Scenario**: 15% of all visits delivered via telehealth.
- Some telehealth services would replace in-person visits (substitute) while other telehealth services would occur in addition to in-person visits (supplemental).
- **AB 2507 would increase total health expenditures (premiums and out-of-pocket expenses)** by between:
  - **Low Scenario**: 0.07% ($96.8 million);
  - **High Scenario**: 0.28% ($402.6 million).

Figure 3. Additional Telehealth Visits in 1st Year - Low and High Scenarios

Note: Size of bubble indicates amount of evidence for each telehealth modality.

Principal Findings – Public Health
- Patient experience may improve through increased access to care, convenience.
- Travel time and travel costs may decrease for some urban and rural enrollees.
- Some enrollees with transportation challenges may have better outcomes.
- However, AB 2507 could exacerbate access to care disparities for some enrollees with certain socioeconomic characteristics (e.g., age, language, income, tech savviness, etc.) that may impede the use of telehealth modalities.

Conclusions
- Ultimately, AB 2507 did not pass and did not become law in CA.
- Existing telehealth evidence is not keeping pace with innovations in the field.
- CHBRP’s model can be replicated in other states to enhance evidence-based policy decision making.
- Telehealth bills are a continuing trend. According to the Center for Connected Health Policy, 150+ state telehealth bills were introduced in 2016 with 48 becoming law. In 2017, 200+ state telehealth bills were introduced in 44 states.