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

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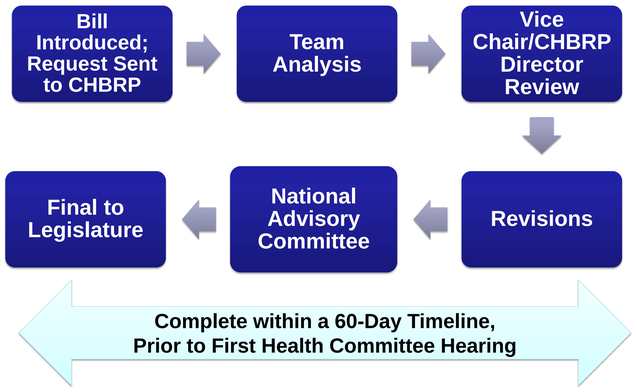
Research Objective

- 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.

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

- 25.2 million Californians with state-regulated health insurance in 2016.
- 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.

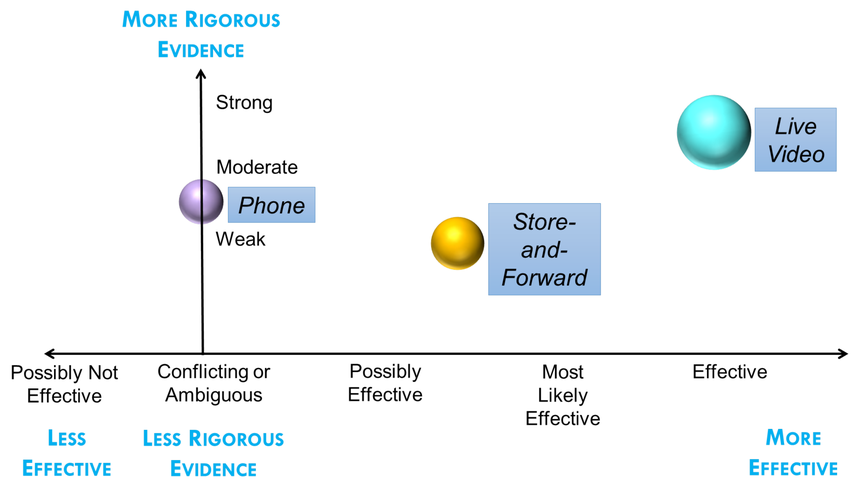
This work is funded by the California Health Benefits Review Program. To learn more, visit wwww.chbrp.org

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



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

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

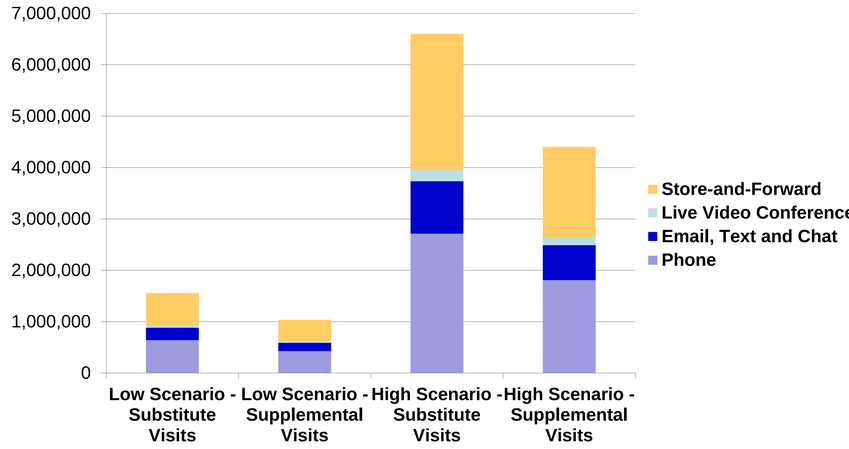


Figure 4. Estimated Health Care Expenditures in Millions Pre and Post AB 2507, for Low and High Scenarios

	Baseline (pre-AB 2507)	Postmandate (post-AB 2507)	Change (%)
Enrollee Out-of-Pocket Expenses			
Enrollee OOP Expenses (Low Scenario)	$16,248	$16,264	0.10%
Enrollee OOP Expenses (High Scenario)	$16,248	$16,313	0.40%
Total Expenditures			
Total Expenditures (Low Scenario)	$145,082	$145,179	0.07%
Total Expenditures (High Scenario)	$145,082	$145,484	0.28%

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.