

# Telehealth Payment Parity Literature Review

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## Executive Summary

This review attempts to provide information regarding whether a request for a policy or legislation requiring payment parity (same allowed reimbursement amounts for telehealth as in-person visit costs) should be considered. Research in this area is limited and there are differences according to the methodology for assessing total cost and types of visits. Key findings include:

- The costs of an ambulatory telehealth visit is on average around \$40 lower compared to an in-person visit.
- Most clinics are not completely shut down and have to bear the fixed costs and personnel salary even when telehealth is performed at home by physicians.
- 91.6% of patients had 'excellent' satisfaction with telemedicine urgent care visits.
- Access to vulnerable groups including old age and minorities has increased with audio telehealth services.
- 7 states in the country have established both service parity and payment parity for telehealth services. Utah has only service parity for telehealth.
- Some telehealth services like ambulatory care take up lower physician time than in-person services, but some specialty telehealth services like surgery take up higher physician time.
- Physician professional organizations prefer payment parity for telehealth services. Patients and payers prefer the same level of telehealth services that were available and provided during the pandemic.

## Introduction

Telehealth is the “use of technology to deliver healthcare, health information, or health education at a distance” (Yang, 2016). It is a potential solution to both disparities in healthcare access and high costs of healthcare in the US. With 20% of Americans living in rural areas, but only 9% of physicians practicing in those areas, telehealth provides a potential way for these underserved populations to more easily access healthcare providers (Yang, 2016). In 2018, national health expenditures in the US grew to \$3.6 trillion, the most per capita of any developed country (Karsten et al., 2020). Telehealth services offer a potentially less expensive service than in-person visits, as evidenced by studies on the Veterans Affairs healthcare system, an early adopter of telehealth (Russo et al., 2016, American Hospital Association).

1. Have there been any studies surrounding payment parity for telehealth? Any in support of, or against? What did they say, and what data do they have to substantiate their stance?

Payment parity initially raises an important question of parity of ‘value of care’ produced by telehealth services compared to in-person services. The services provided by telehealth visits generally may require less clinical effort compared to in-person care and also has the potential to be less valuable (less efficient) which may increase the number of visits (revisits) by the patient or the need to visit an in-person clinic. (Ellimoottil C, 2021). These lead to possible duplication of services and increased costs for the patients, especially for healthcare ailments that require more physician examination and those that could not be adequately treated by the telehealth visit. This raises an important question of the value of paying telehealth services on par with in-person services. However, evidence shows that a comparable level of clinical effort is

required for both in-person and telehealth care for services, especially for services that do not require physical clinical examinations.

The 2021 evaluation and management guidelines that clinicians use for coding patients states that it is not required to do a physical examination on a patient unless medically needed and they can choose their billing levels (Evaluation and Management Codes 2021). Also, there are arguments that the mode of delivery of care (telehealth vs in person) should not be used to decide whether the care is of low or high value (Ellimoottil C, 2021). Many clinical and professional medical associations are still deliberating about the clinical conditions that could be adequately managed in the same way both in clinic and in telehealth.

More clinical evidence about conditions that could be treated in the same way (clinic and telehealth) will provide more clarity for the health insurers and government policy makers to decide the reimbursement and parity levels. However a 2015 survey of physicians showed that 91% of whom were non-telehealth users and 80% of whom were telehealth users agreed with the statement "Patients are likely to see a higher quality of care when they see a physician in-person." (Klink et al., 2015).

The most important question is whether it costs less for the clinicians for the provision of telehealth compared to in-person care. There are 3 components of physician reimbursement that are set by the CMS namely the malpractice insurance, clinical effort, and practice expenses (Ellimoottil C, 2021). Malpractice insurance will not vary whether the care is delivered by telehealth or by in-person services and the clinical effort may not vary for most of the health conditions unless a physical examination may be required. The main area of expected difference in costs is the practice expenses which raises the question of different reimbursement rates and payment parity between these two modes of patient care delivery.

Most clinics have not been completely shut down but allow physicians to provide telehealth services from their homes and they have to bear the fixed costs of the clinics and also associated costs of utilities, clinic staff salaries (Ellimoottil C, 2021). However there may be

savings in the usage of related clinical items such as gloves, masks etc. But the costs of digital devices to provide telehealth and maintenance of those devices may offset the minor savings from the non-usage of clinical items like gloves.

Some studies showed that the time spent for seeing a patient of the same diagnosis was 70.89 minutes in urgent care, while it was only 9.38 minutes in virtual urgent care raising the question of physicians reducing the consultation time in telehealth care to increase the number of consultations (Khairat et al. 2021). But for specialties like surgery diagnosis of a patient through telehealth may require them more time than in-person clinic (Portney D et al (2020). Thus, some specialty physicians even need to be compensated more for telehealth services compared to in-person clinics.

A study conducted in North Carolina from January to December 2018 showed that the amount billed to the patient for virtual urgent care was three times lower than in-person urgent care (\$49 vs \$142.657). Travel costs estimation showed that the travel costs were only \$0.69 on average showing that the cost of travel was only minor. Both patients and physicians saved time using the virtual care with an average turnaround time of 55 minutes for in-person care vs 9.5 minutes for virtual care and the patients also saved an average travel time of 13 minutes per visit. Patient satisfaction with the virtual visits were also very good with 91.96% rated their experience as excellent. Only the voluntary reviews were analyzed so care should be maintained in interpreting the patient satisfaction (Khairat et al. 2021). Lower costs between virtual and in-person care were in part associated with driving time, travel reimbursements, work time lost, and travel distance. Virtual care was particularly more beneficial for people travelling from rural areas. The main limitation here is that the costs in this study were estimated based on the amount billed to the patient rather than the actual costs of care. Also, the care time for the in-person visit consisted of the total time the patient was in the healthcare facility including the checking in, waiting, time with the nurses, time with the physicians and check out time. The 'service time' of only the time spent with the physicians in the in-person care is not available and

this may bias the actual comparison with the virtual visit which only consists of the 'service time' with the physicians.

The potential savings associated with telehealth are more apparent in specific situations. For example, a study of over 5,000 telehealth visits among Veterans Affairs (VA) patients in rural Vermont found that the average patient saved 145 miles of travel distance per visit by using telehealth instead of visiting the nearest VA clinic. This led to an estimated savings of over \$160,000 for the VA, which reimburses patients for travel costs (Russo et al., 2016). The Veterans Health Administration was one of the earliest adopters of telehealth in the 1990s. It was estimated that in 2012, a year in which their telehealth program served more than 150,000 users, the cost to deploy telehealth was \$1,600 per patient per year, whereas traditional home-based care cost \$13,000 per patient per year, and that number was \$77,000 for nursing home care (American Hospital Association).

A study published in the Journal of American Medical Association showed that in the covid related groups, patients with greater than one telehealth contact per month with the provider experienced \$32.60 lower cost of care compared to in-person visits. Also, in the non-covid group, patients with more than one telehealth contact per month have a \$6.24 lower cost of care compared to in-person visits.

A study by Yamamoto 2014 showed that telehealth saves payers roughly \$45 per visit even if the visits are reimbursed at the same rate as a physician's office visit. However it is unclear if these costs are for providers that only do telehealth out of their homes or if they include providers who do telehealth from an office and have office related overhead costs (Yamamoto, 2014).

A study looking at acute respiratory infection visits in the CalPERS Blue Shield of California health plan found relatively similar per-visit cost numbers, with an estimate that, when accounting claims from the initial visit, follow-up visits, pharmacy, imaging, and testing, telehealth visits cost an average of \$79 per visit, while visits to the physician's office were \$146

per visit, and visits to the emergency room were \$1,734 per visit (Ashwood et al., 2017). Emergency room visits constitute the most expensive care option for any health condition. Provision of on demand virtual telemedicine visits have shown to reduce unwanted emergency room visits and unwanted higher cost of care associated with emergency room usage (Nord G et al. 2019). Specific telehealth services that are available at adequate time to the patients that prevent emergency room visits highlight the cost effectiveness of telehealth services.

A 2014 study by Yamamoto found that the average cost per visit decreased from \$136 - \$176 (commercial insurance) for in person care down to \$40 - \$50 for telehealth visits, however these costs were based on insurance reimbursement rates rather than analysis of true costs (Yamamoto, 2014). Also, the study did not estimate the overhead costs of providing healthcare in a telehealth vs in person clinic setting and this makes it difficult to conclude whether the telehealth physicians/clinics had to bear the uncompensated costs that were not paid by the insurers. Although there are arguments that telehealth saves time, travel distance and associated costs for patients compared to regular in person care, but some clinics actually require physicians to provide telehealth services in their regular offices which makes the physicians and clinics have the same service provision and overhead costs but with lower reimbursement rates from health insurers.

Access to healthcare is an important problem faced. Medicare is also deciding to reduce payment rates for audio-only telehealth consultations. Patients who were older, belonging to minority groups, and in rural areas were preferring audio telehealth services because of the lack of technology for video services and also lack of access to a inperson clinic. Cutting reimbursement rates for audio-telehealth services may make physicians utilize their time for higher reimbursed in-person services and reduce audio-telehealth time, thus reducing healthcare access to vulnerable groups (Ellimoottil C, 2021). Having telehealth payment parity for audio telehealth services may increase physician time for audio telehealth services and

inturn increasing access. However, a study done during the Covid pandemic showed that the use of telehealth services was lower in the areas with higher populations of disadvantaged people because of lower rates of telehealth adoption in the most disadvantaged areas (Weiner JP et al (2021)).

The other argument is that telehealth seems to have the potential for overuse and moral hazard by patients, especially those who are covered by lower deductible plans because of ease and faster access to physicians and lesser opportunity cost of having to forgo work for visiting the in-person clinic. This may lead to higher unnecessary utilization and associated higher costs to the insurer. However, evidence from the Blue Cross and Blue Shield health insurance data has shown that telehealth services increased around 20 times during the pandemic but the overall ambulatory care visits did not increase. This shows that telehealth served as a substitute for in-person care (Ellimoottil C, 2021). While the concerns of overuse or fraud may be true in some instances, they could be prevented by proper billing and coding of the same services on par with in-person services. Revisits rates for telehealth users also seem to be less. Teladoc supports the idea that telehealth visits require low levels of follow-up, finding that only 6% of telehealth visits required follow-up, compared to 13% of office visits, and 20% of emergency department visits (Uscher-Pines & Mehrotra, 2014). Another 2014 study also showed that 83% of telehealth visits resolved a patient's problems without a follow-up or referral (Yamamoto, 2014).

Payment parity for telehealth services (audio and video telehealth) will improve access geographically for those in underserved areas, for vulnerable groups specifically elderly people and minorities (Shah SJ 2018, Khairat S 2019, Schwamm LH 2004), provide the same quality of care and management for most medical needs, and also have the potential to reduce indirect costs to the patients. More evidence on patient outcomes among those treated by virtual vs in-person services may also be needed to decide the payment rates.

## 2. Nationally, has there been any legislation surrounding payment parity for telehealth?

Nationally there is coverage parity for telehealth since 43 states and District of Columbia mandate the commercial health insurance providers to cover telehealth services. Although coverage parity is achieved in most of the states, payment parity is not present. Only a few states like Alabama, Idaho, Louisiana, North Carolina, South Carolina, Wisconsin, and Wyoming have established both service parity and payment parity for telehealth services. All other states, including Utah, have only service parity (Ellimoottil C, 2021).

The Centers for Medicare and Medicaid Services (CMS) established payment parity for telehealth services in par with clinic services during the Covid-pandemic using its waiver. Both in-person, video and audio physician visits were reimbursed at the same rates. However, the CMS has already announced that audio telehealth services will not be covered for management visits and also that telehealth will be paid at a lower rate compared to the rates during the pandemic (Congress Report: Medicare Payment Policy, Medicare Physician Fee Schedule 2021). As opposed to Medicare, laws regulating how private payers cover telehealth services vary by state. 13 states have no private payer telehealth parity laws, 7 states offer partial coverage on only certain services, 19 states offer full telehealth coverage parity, and 11 states mandate both full coverage and payment parity, requiring telehealth services to be reimbursed at the same rate as in-person visits (Karsten et al., 2020).

## 3. Is there anything out there that discusses the stances of insurance companies, healthcare providers, patients and other stakeholders?

A review of the views of 24 organizations including providers, payers, patient advocates, and health IT organizations found that many of them believe that the lowered restrictions on telehealth use that the federal government enacted during the pandemic should be continued even after the state of emergency ends. These include the expanded list of covered services,



allowing patients to use telehealth from their homes in any geographic location, and allowing providers to cross state lines when providing telehealth services. As for payment parity, the American Hospital Association, the Federation of American Hospitals, the American Association of Nurse Practitioners, the American Medical Group Association, the American Association of Retired Persons (AARP), and the American Medical Association all shared the perspective that Medicare should “continue to pay the same rate per service whether using telehealth or visiting in person.” Additionally, multiple rural health patient and provider organizations shared the viewpoint that the federal government should “change telehealth payment policy for rural health clinics and federally qualified health centers to achieve parity with in-person visits and better fit their unique reimbursement systems” (Felt-Lisk, 2020).

Many providers see payment parity as a way to increase telehealth availability, with reimbursement being one of the biggest barriers to providers adopting telehealth services. In a study examining over 7 million private payer outpatient claims between 2010 and 2015, the investigators found that telehealth visits are 30% more likely to occur in states with at least some kind of coverage or payment parity laws compared to states with no telehealth parity laws during that time. The authors suggest that this is due to lack of reimbursement being a significant barrier to telehealth entry for many healthcare providers (Harvey et al., 2019).

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