

ACCESS TO HEALTH CARE MADE EASIER

Promoting Best Practices in Ohio's Telehealth Policy

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EXECUTIVE SUMMARY

Telehealth has long held the potential to reduce costs and increase flexibility for patients and medical professionals because it allows patient and health care provider to interact remotely through a telephone or computer. The advantages of remote access to doctors and nurses have been well known for years, and telehealth has held particular promise for those in rural areas or those with limited mobility by alleviating the need for unnecessary and costly in-person visits. But those benefits and advantages had been hobbled by outdated rules and regulations. Those rules, however, have begun to change and as policymakers rethink telehealth's role in patient care they should amend regulations and adopt new policies that will foster innovation and ensure best practices in this burgeoning field.

Facing the COVID-19 crisis, the Trump and DeWine administrations helped prevent the pandemic from overwhelming national and state health care systems and hospitals by changing rules and restrictions regarding how private insurance, Medicare, and Medicaid cover telehealth services. As the public health crisis unfolded, demand for telehealth skyrocketed by more than 3,000 percent and, given patient satisfaction levels, experts expect demand to remain high¹ as more patients—and their caregivers—learn the cost-, convenience-, and quality-benefits of telehealth first-hand.² And there is now widespread agreement among patients, care providers, and lawmakers that telehealth offers patients safe, effective, and efficient options in health care, and the time has come to adjust the rules that govern it.³

Ohio's telehealth bill, House Bill 679, takes significant strides to make the necessary adjustments. For the most part, the bill advances best practices in telehealth policy.⁴ It does not mandate payment parity, which could undermine telehealth's ability to lower health care costs for patients and care providers. House Bill 679's cost-sharing provisions generally treat telehealth visits the same as in-

¹ Oleg Bestsenny, Greg Gilbert, Alex Harris and Jennifer Rost, **Telehealth: A quarter-trillion-dollar post-COVID-19 reality?** McKinsey and Company, May 29, 2020.

² **Literature Review: The Triple Aim and Home Telehealth for Patients with Chronic Diseases**, Center for Connected Health Policy, August 2013.

³ Lauren Clason, **Key GOP Senator endorses permanent telehealth provisions**, *Roll Call*, June 17, 2020; Chris Mill Rodrigo, **Bipartisan senators call for making telehealth expansion permanent post-coronavirus**, *The Hill*, June 15, 2020; Heather Landi, **Providers to Congress: Patients will lose access to care without permanent expansion of telehealth**, *FierceHealthCare.com*, June 18, 2020.

⁴ **House Bill 679**, legislature.ohio.gov.

person visits, but the bill mistakenly waives those provisions for certain provider-initiated visits. The legislation does not restrict telehealth services to certain professionals and instead wisely leaves decisions regarding the appropriate standard of care up to the medical licensing boards, which are better equipped to make those judgements.

State policymakers should encourage expanded telehealth use and innovation. Minor changes to House Bill 679 can improve upon a solid foundation that will help maximize telehealth's potential advantages and inform best practices as the public and the health care system adapts to this effective new tool.

INTRODUCTION

As the COVID-19 virus threatened to overwhelm the nation's hospitals in the spring of 2020, patients and health care providers turned to an available, but under-used method of accessing care: telehealth. Telehealth allows doctors to meet with patients, assess their ailments and concerns, and even screen for potential problems remotely, with patients never leaving their homes and doctors and nurses remaining in their offices. Telehealth offered a safe, efficient, and effective way for doctors to see more patients, without subjecting either the patients or doctors' offices to the risks of COVID-19 and other communicable diseases. Understandably, demand for telehealth surged.

Before the pandemic, however, doctors and patients had underutilized the potential benefits of telehealth, in part due to state and federal regulations. Regulators temporarily relaxed many of the restrictive rules that had prevented patients from accessing care remotely. The advantages of telehealth have since become obvious to patients, care providers, and regulators, and there is nothing to be gained by reinstating outdated rules and regulations. Policymakers should recognize telehealth's recent success and popularity—especially the benefits it offers to those living in rural areas—and make the temporary rule changes permanent at the state and federal levels.

Ohio's General Assembly has taken up House Bill 679, which improves upon existing law governing health care, telehealth, and health insurance in Ohio. The bill rightly avoids several pitfalls by treating cost-sharing arrangements for telehealth services as it does in-person visits, and by allowing telehealth to be provided by telephone and other devices without mandating virtual video services that may be unavailable in some areas. But House Bill 679 is not perfect and improvements can and should be made to ensure that innovation will continue and the full advantages of telehealth remain as widely available as possible well beyond the current pandemic.

NEW DEMAND, NEW RULES REVEAL TELEHEALTH'S HIDDEN BENEFITS

The COVID-19 crisis has highlighted the shortcomings of an over-regulated health care system. Among those shortcomings have been state and federal telehealth regulations that prevent some patients from seeing their chosen health care providers. To help manage the pandemic, however, the Trump and DeWine administrations temporarily amended many of those rules to improve access to telehealth services under Medicare and Medicaid.⁵ The temporary changes relaxing those restrictions have revealed many of the previously hidden benefits of telehealth, and consumer demand for telehealth services has surged accordingly with more than nine million Medicare beneficiaries, for example, receiving at least one telehealth service between mid-March and mid-June 2020.⁶

Available telehealth services generally fall within three categories: synchronous, asynchronous, and remote patient monitoring (RPM).⁷ Prior to the COVID-19 pandemic, small-scale studies showed all three categories demonstrating high satisfaction rates among patients, with all three categories ripe for innovation and expanded use.⁸

Health care providers offer synchronous services in real time through secure video apps or by telephone.⁹ Studies have investigated the value and patient perceptions of synchronous services in psychiatry, sleep apnea, neurology, asthma, and

⁵ **Gov. DeWine signs executive order to allow easier telehealth access**, 10tv.com, April 15, 2020; and Seema Verma, **Early Impact Of CMS Expansion of Medicare Telehealth During COVID-19**, HealthAffairs.org, July 15, 2020.

⁶ Seema Verma, **Early Impact Of CMS Expansion of Medicare Telehealth During COVID-19**, HealthAffairs.org, July 15, 2020.

⁷ In this report, following other authors, the term telehealth will be used to refer to “the broad use of telecommunications for health-related services,” which includes services delivered via telemedicine. (Nicol Turner Lee, Jack Karsten and Jordan Roberts, **Removing regulatory barriers to telehealth before and after COVID-19**, The Brookings Institution and The John Locke Foundation, May 6, 2020) In other contexts, telemedicine refers to services specifically provided by physicians to patients while telehealth also includes interactions between physicians and other health professionals. Distinguishing between the two can be important in reforming specific state policies but, as discussed below, the focus here is on the benefits of permanently removing barriers and maximizing the value of new health care technology.

⁸ **Patient Satisfaction Research Catalogue**, Center for Connected Health Policy, August 2018.

⁹ Nicol Turner Lee, Jack Karsten and Jordan Roberts, **Removing regulatory barriers to telehealth before and after COVID-19**, The Brookings Institution and The John Locke Foundation, May 6, 2020.

pediatric obesity. A clear majority of patients (or their parents) receiving telehealth in these areas rated the service they received highly.¹⁰ For example, a 2014 survey of veterans in rural areas found that teleneurology saved them an average of \$48,000, and five hours and 325 miles of driving, with 95 percent of respondents saying they wished to continue receiving care this way.¹¹

Asynchronous, or store-and-forward, services allow patients who do not have urgent needs to send information to their health care provider for later evaluation.¹² As with synchronous video services, the majority of patients receiving asynchronous services have been satisfied with their care for a range of conditions, including dermatology, chronic conditions, ophthalmology, cosmetic surgery, and smoking cessation.¹³ A study of asynchronous ophthalmology found very high patient satisfaction ratings, 4.95 out of five, and that it cut the amount of time spent on visits by 25 percent for patients and 50 percent for providers, while also improving access to care.¹⁴

RPM uses digital technology, including wearable devices, to send patient health data to providers securely,¹⁵ which can be particularly useful for patients with chronic conditions and the elderly.¹⁶ Continuous glucose monitors, for example, can monitor patients without requiring time-consuming office visits to catch sudden blood sugar fluctuations.¹⁷

Telehealth services are particularly valuable to patients in rural areas that have suffered a rash of hospital closures in recent decades that may make accessing care more costly and difficult.¹⁸ In 2010, approximately 20 percent of Ohioans, or 2.5 million people, lived in rural areas,¹⁹ while less than 10 percent of physicians are

¹⁰ *Patient Satisfaction Research Catalogue*, Center for Connected Health Policy, August 2018.

¹¹ Larry E. Davis Julia Coleman, JoAnn Harnar and Molly K. King, “**Teleneurology: successful delivery of neurologic care to 354 patients living remotely in a rural state**,” *Telemedicine and e-Health*, Volume 20, Number 5 (May 2014) p. 473-477.

¹² “**What is Telehealth?**” *NEJM Catalyst Innovations in Care Delivery*, February 1, 2018.

¹³ *Patient Satisfaction Research Catalogue*, Center for Connected Health Policy, August 2018.

¹⁴ April Y Maa, Barbara Wojciechowski, Kelly J Hunt, et al., “**Early Experience with Technology-Based Eye Care Services (TECS): A Novel Ophthalmologic Telemedicine Initiative**,” *Ophthalmology*, Volume 124, Issue 4 (April 1, 2017) p. 539-546.

¹⁵ “**What is Telehealth?**” *NEJM Catalyst Innovations in Care Delivery*, February 1, 2018.

¹⁶ *Patient Satisfaction Research Catalogue*, Center for Connected Health Policy, August 2018.

¹⁷ *Ibid.*

¹⁸ **172 Rural Hospital Closures: January 2005 – Present (130 since 2010)**, ShepCenter.UNC.edu, (Last visited August 12, 2020).

¹⁹ **Urban Percentage of the Population for States, Historical**, ICIP.IAState.edu (Last visited August 13, 2020); author’s calculation.

in rural areas and almost all medical specialists settle in urban areas.²⁰ More convenient access to care through telehealth means rural patients will be more likely to seek care when they need it, rather than forego care and allow health conditions to worsen.²¹ Telehealth can also connect rural patients to distant, specialized services, and avoid the exorbitant costs of transferring patients.²²

Given the potential savings and benefits that telehealth services can provide, it is not surprising that the COVID-19 pandemic spurred greater demand for such services. Economists have shown repeatedly that when it becomes easier and less expensive for patients to receive health care services, they are more likely to use them, and markets will adapt to meet their needs efficiently.²³ As Dr. David Stukus, an allergist and immunologist in Columbus, put it: “Think of it: You don’t have to miss work. You don’t have to find transportation or spend money on gas to drive Downtown to see us. . . . Wouldn’t it be great if you could live in Portsmouth and can hop on the phone and see an allergy specialist at Nationwide Children’s Hospital? I think patients will soon demand this option.”²⁴ Indeed, they have.

The Center for Medicaid and Medicaid Services (CMS) recently reported that after administrative rule changes made telehealth services more available, telehealth use among its beneficiaries increased 2,900 percent in just a few weeks, rising from 10,000 to 300,000 visits per week.²⁵ FAIR Health’s Monthly Telehealth Regional Tracker recorded a 4,347 percent increase in telehealth visits among private insurers compared to March 2019.²⁶ The Department of Veterans Affairs saw a similar uptick in demand with a 12,000 percent increase in video visits from home between March and July 2020, and nearly 140,000 telehealth visits in the first week of July alone. In May, Veterans Affairs reported more than two million video visits in one day for the first time and, from January to May of this year, its patient

²⁰ Roger A Rosenblatt and L Gary Hart, “**Physicians and rural America**,” *Western Journal of Medicine*, Volume 173, Number 5 (November 2000) p. 348-351.

²¹ Marc Harrison, “**A 5-Point Model for Value-Based Health Care**,” *Harvard Business Review*, October 23, 2019.

²² *Ibid.*, Marc Harrison, “**Telehealth is Improving Health Care in Rural Areas**,” *Harvard Business Review*, May 15, 2019.

²³ Oliver E. Williamson, “**The Economics of Organization; The Transaction Cost Approach**,” *American Journal of Sociology*, Volume 87, Number 3 (November 1981) p.548-577.

²⁴ Holly Zachariah and Jacob Myers, “**Rebuilding America: Telemedicine use prompted by COVID-19 here to stay, doctors and health care officials say**,” *The Columbus Dispatch*, May 28, 2020.

²⁵ The Editorial Board, “**The Doctor Will Zoom You Now**,” *The Wall Street Journal*, April 26, 2020.

²⁶ Bryan Walsh, “**Telemedicine leads on coronavirus innovations**,” *Axios*, June 3, 2020.

portal filled an additional 770,000 prescriptions compared to the same period in 2019.²⁷

Closer to home, Ohio’s health systems have experienced the same surge in telehealth visits since the pandemic’s on-set. OhioHealth reports that it had 7,500 video visits and 75,000 telephone appointments between March 2 and the end of May 2020. The Wexner Medical Center at The Ohio State University went from 134 visits and 39 telephone appointments in January and February of 2020 to more than 30,000 video visits and 35,710 phone calls over five weeks in March and April. Mount Carmel Health System went from fewer than 20 virtual visits over a similar period in 2019 to more than 19,500 visits in March and April. Nationwide Children’s Hospital had 45,000 telehealth visits between March and May, more than half of them using video.²⁸ Cleveland Clinic went from an average of 5,000 telehealth visits per month to 200,000 in April alone.²⁹ Given such overwhelming demand, there is little reason to expect the telehealth tide to recede. As Seema Verma, the CMS director observed regarding telehealth’s popularity and success, the “genie is out of the bottle . . . there is no going back” to outdated rules that limited access to this valuable health care tool.³⁰

Prior to the COVID-19 crisis, federal and state policies heavily restricted which telehealth services caregivers could provide, and which services Medicare and Medicaid would cover. Those policies relied on standards written well before telehealth came into its own.³¹ Under the old rules, for example, Medicare fee-for-service would cover telehealth services only for patients in rural areas experiencing a shortage of health care workers. And patients could not access telehealth from

²⁷ Kameron Matthews, assistant under secretary for health for community care, Testimony before the U.S. Senate Committee on Veterans’ Affairs, “**VA Telehealth During and Beyond Covid-19: Challenges and Opportunities in Rural America**,” July 29, 2020.

²⁸ Holly Zachariah and Jacob Myers, **Rebuilding America: Telemedicine use prompted by COVID-19 here to stay, doctors and health care officials say**, *The Columbus Dispatch*, May 28, 2020.

²⁹ Tom Murphy, **Telemedicine shines during pandemic but will glow fade?** Associated Press, August 10, 2020.

³⁰ Laura Dyrda, **‘The genie’s out of the bottle on this one’: Seema Verma hints at the future of telehealth for CMS**, *BeckerHospitalReview.com*, April 28, 2020.

³¹ U.S. Department of Health and Human Services, U.S. Department of the Treasury, and U.S. Department of Labor, **Reforming America’s Healthcare System Through Choice and Competition**, December 3, 2018; Ohio Department of Medicaid, **Telemedicine Billing Guidance**, December, 2016; and Nicol Turner Lee, Jack Karsten and Jordan Roberts, **Removing regulatory barriers to telehealth before and after COVID-19**, The Brookings Institution and The John Locke Foundation, May 6, 2020.

home, only at certain types of health care facilities.³² Such rules did little to serve patients, and severely limited patient access to the potential benefits and efficiency of telehealth.

In the spring of 2020, however, CMS temporarily expanded Medicaid coverage to include 135 services provided via telehealth.³³ In April, CMS also announced that it would continue to add services to be covered by Medicare on a sub-regulatory basis based on requests from providers who are learning how best to use telehealth.³⁴ The new rules relaxed former restrictions on the originating site (the patient's location) and the distant site (the provider's location) that limited where services may occur.³⁵ Under the new rules, rural providers and patients may now interact with each other from their own homes³⁶—a temporary flexibility that health care experts agree should be permanent.³⁷

Indeed, the Trump Administration has already taken steps to make several of the emergency rule changes to Medicare's telehealth coverage permanent.³⁸ An executive order requires the Department of Health and Human Services, which oversees Medicare, to propose rules that would extend coverage of at least some telehealth services permanently.³⁹ Specifically, it requires nine telehealth services to be permanently reimbursable through Medicare and that 13 others be covered at least until the end of the calendar year in which the federal government declares

³² U.S. Department of Health and Human Services, U.S. Department of the Treasury, and U.S. Department of Labor, *Reforming America's Healthcare System Through Choice and Competition*, December 3, 2018.

³³ **List of Telehealth Services**, CMS.gov (Last visited June 5, 2020).

³⁴ **Trump Administration Issues Second Round of Sweeping Changes to Support U.S. Healthcare System During COVID-19 Pandemic**, Centers for Medicare and Medicaid Services press release, April 30, 2020.

³⁵ **Medicare Telemedicine Health Care Provider Fact Sheet**, Centers for Medicare and Medicaid Services press release, March 17, 2020.

³⁶ *Ibid.*; Jackie Drees, **7 things rural health clinics need to know about Medicare telehealth reimbursement**, BeckersHospitalReview.com, April 22, 2020.

³⁷ Andrea Willis, senior vice-president and chief medical officer, BlueCross BlueShield of Tennessee, Testimony before the U.S. Senate Committee on Health, Education, Labor and Pensions, **"Telehealth: Lessons from the COVID-19 Pandemic,"** June 17, 2020.

³⁸ **Trump Administration Proposes to Expand Telehealth Benefits Permanently for Medicare Beneficiaries Beyond the COVID-19 Public Health Emergency and Advances Access to Care in Rural Areas**, Centers for Medicare and Medicaid Services press release, August 3, 2020.

³⁹ **Trump Administration Announces New Actions to Improve Access to Healthcare across America**, U.S. Department of Health and Human Services press release, August 3, 2020; **Executive Order 13941 of August 3, 2020, Improving Rural Health and Telehealth Access**, *Federal Register*, Volume 85, Number 152 (August 6, 2020) p. 47881-47883.

the COVID-19 emergency over.⁴⁰ CMS will also be seeking public input regarding any other services Medicare ought to cover permanently.

The president's executive order also calls on CMS, Health and Human Services, the Federal Communications Commission, and the United States Department of Agriculture to take steps to improve the performance of Medicare for beneficiaries in rural areas.⁴¹ Twenty percent of Medicare patients, nearly 11 million people nationwide, live in rural areas.⁴² Specifically, the executive order requests that the agencies improve payment models, focus on preventing disease, leverage technology, increase access to care, and promote access to telehealth via broadband.⁴³

On the state level, many states (but not Ohio) have parity laws related to how private health insurance policies cover telehealth services and visits.⁴⁴ Partial telehealth-parity laws require private insurance policies to cover the same services through telehealth that they do for in-person visits. Full-parity laws require insurance carriers to reimburse telehealth services at the same rate as the in-person service.⁴⁵ Unfortunately, full-parity laws "perpetuate the shortcoming of our current healthcare system" by concealing true costs from consumers and encouraging treatment plans that may not be in the best interest of patients.⁴⁶ States without parity laws have already shown that such laws are unnecessary for innovative state telehealth systems. Many southern states do not have full-parity laws but have nonetheless successfully deployed telehealth in a variety of ways.⁴⁷ Since 2016, for example, Anthem Blue Cross and Blue Shield customers in West Virginia have had the option to see Cleveland Clinic-affiliated nurse practitioners through virtual visits.⁴⁸

⁴⁰ Shahid Zaman, **CMS Issues CY 2021 Physician Fee Schedule Proposed Rule**, essentialhospitals.org, August 4, 2020; **Executive Order 13941 of August 3, 2020, Improving Rural Health and Telehealth Access**, *Federal Register*, Volume 85, Number 152 (August 6, 2020) p. 47881-47883.

⁴¹ **Executive Order 13941 of August 3, 2020, Improving Rural Health and Telehealth Access**, *Federal Register*, Volume 85, Number 152 (August 6, 2020) p. 47881-47883.

⁴² **July 2020 Data Book: Health Care Spending and the Medicare Program**, Medicare Payment Advisory Commission, July 17, 2020.

⁴³ *Ibid*; **Executive Order 13941 of August 3, 2020, Improving Rural Health and Telehealth Access**, *Federal Register*, Volume 85, Number 152 (August 6, 2020) p. 47881-47883.

⁴⁴ **State Telehealth Laws & Reimbursement Policies**, Center for Connected Health Policy, May 2020.

⁴⁵ Katherine Restrepo, **The Case Against Telemedicine Parity Laws**, The John Locke Foundation, January 15, 2018.

⁴⁶ *Ibid*.

⁴⁷ *Ibid*.

⁴⁸ *Ibid*.

Antiquated rules and public policies have prevented most patients from utilizing telehealth services. Unfortunately, it took a public health crisis to relax the restrictive regulations and reveal the hidden benefits and flexibilities that telehealth can provide. But now that patients and health care providers across the country have experienced these benefits for themselves, there should be no going back. State and federal policymakers should allow telehealth services and technologies to grow and mature, allowing all stakeholders to discover where they work best, where they do not, and how to maximize their value to patients.

ASSESSING TELEHEALTH'S CLINICAL- AND COST-EFFECTIVENESS

Medical experts have promoted telehealth's potential clinical and cost benefits for decades. The medical literature on the subject to-date shows telehealth's past clinical success and future promise in a wide variety of areas. Studies have also examined telehealth's cost-effectiveness, but those studies are fewer and far between, with inconclusive results highlighting the need for more data and research.

Clinical-Effectiveness of Telehealth

Several areas showed early promise for telehealth's clinical effectiveness and laid the foundation for its expanded use. One of telehealth's earliest applications was in treating trauma and stroke victims, allowing emergency patients to access acute care specialists and neurologists through remote video. After 15 years, "telestroke" became a mainstream treatment.⁴⁹ Over the same period (the early-2000s), use of telehealth by video or telephone was increasing for remote screening programs, while teleretinal health services had proven successful and were gaining in popularity. A teleretinal diabetic retinopathy screening program (*i.e.*, screening to detect early-onset blindness in diabetic patients) in Los Angeles, for example, led to "the elimination of the need for more than 14,000 visits to specialty care professionals, a 16.3% increase in annual rates of screening for DR [diabetic retinopathy], and an 89.2% reduction in wait times for screening. Teleretinal DR screening programs have the potential to maximize access and efficiency in the safety net, where the need for such programs is most critical."⁵⁰ Similarly, teleretinal health services were available before the 2020 pandemic,⁵¹ and a 2017 review noted that the high costs of conventional mental health drove rising

⁴⁹ E. Ray Dorsey and Eric J. Topol, "**State of Telehealth**," *The New England Journal of Medicine*, Volume 375, Number 2 (July 14, 2016), p. 154-161.

⁵⁰ Lauren P. Daskivich, Carolina Vasquez, Carlos Martinez Jr. et al., "**Implementation and Evaluation of a Large-Scale Teleretinal Diabetic Retinopathy Screening Program in the Los Angeles County Department of Health Services**," *JAMA Internal Medicine*, Volume 177, Issue 5 (May 2017) p. 642-649.

⁵¹ Rachel Conrad, Harika Rayala, Rekah Diamond, Bianca Busch and Nicole Kramer, "**Expanding Teleretinal Health in Response to the COVID-19 Pandemic**," *Psychiatric Times*, April 7, 2020.

demand for telemental health.⁵² The same review concluded that telemental health care can provide effective solutions comparable to in-person care and may be particularly valuable in rural and “isolated communities.”⁵³

Other studies have yielded similar, encouraging results. Telehealth has proven successful in remotely monitoring patients suffering from heart failure, providing preliminary evidence of its potential to reduce hospital readmissions and health costs in the process.⁵⁴ And a Veterans Health Administration study found that its telehealth program kept 36 percent of the studied patients from entering long-term care—saving them nearly \$2,000 each, with 85 percent patient satisfaction.⁵⁵ A randomized control trial comparing patients receiving nursing services from home through face-to-face interactions versus video conferencing also concluded that video conferencing visits have the potential to improve outcomes while lowering costs for chronically ill patients.⁵⁶ In 2015, a meta-analysis of 93 studies using RPM or synchronous monitoring found that telemedicine services were at least as effective as in-person services for chronic conditions like cardiovascular disease and diabetes, and may improve blood glucose control among diabetics.⁵⁷ And a randomized control trial in England found that telehealth was associated with reduced mortality and lower rates of emergency room admissions among patients with chronic conditions.⁵⁸

⁵² Mostafa Langarizadeh, Mohen S. Tabatabaei, Kamran Tavkol, et al. “**Telemental Health Care, an Effective Alternative to Conventional Mental Care: a Systematic Review,**” *Acta Informatica Medica*, Volume 25, Issue 4 (December 2017) p.240-246; the study’s focus was clinical effectiveness, however, not cost-effectiveness.

⁵³ *Ibid.*

⁵⁴ Kathryn H. Bowles, Alexandra L. Hanlon, Henry A. Glick, et al., “**Clinical Effectiveness, Access to, and Satisfaction with Care Using a Telehomecare Substitution Intervention: A Randomized Controlled Trial,**” *International Journal of Telemedicine and Applications*, Volume 2011 (December 2011); Ambar Kulshreshtha, Joseph C. Kvedar, Abhinav Goyal, et al., “**Use of Remote Monitoring to Improve Outcomes in Patients with Heart Failure: A Pilot Trial,**” *International Journal of Telemedicine and Applications*, Volume 2010 (May 2010).

⁵⁵ Joseph Kvedar, Molly Joel Coye, and Wendy Everett, “**Connected Health: A Review of Technologies and Strategies to Improve Patient Care With Telemedicine and Telehealth,**” *Health Affairs*, Volume 33, Number 2 (2014), p. 194-199.

⁵⁶ Stanley M. Finkelstein, Stuart Speedie, and Sandra Potthoff, “**Home Telehealth Improves Clinical Outcomes at Lower Cost for Home Healthcare,**” *Telemedicine and e-Health*, Volume 12, Number 2 (April 18, 2006), p. 128-136.

⁵⁷ Gerd Flodgren, Antoine Rachas, Andrew J Farmer Marco Inzitari and Sahsa Shepperd, “**Interactive telemedicine: effects on professional practice and health care outcomes,**” *Cochrane Database of Systematic Reviews 2015*, Issue 9 (September 2015) p. 1-3.

⁵⁸ Adam Steventon, et. Al., “**Effect of telehealth on use of secondary care and mortality: findings from the Whole System Demonstrator cluster randomised trial,**” *British Medical Journal*, Volume 344 (June 21, 2012), p. 1-15.

Cost-Effectiveness of Telehealth

Projects designed to measure telehealth’s cost-effectiveness took place in the early 1970s and were “prematurely terminated in a cloud of doubt” before “important questions about cost, access, and quality could be answered.”⁵⁹ Many of the shortcomings of those early efforts, including lack of institutional support, lack of familiarity and acceptance among patients and providers, and technological limitations remain persistent issues today. According to one 1995 review, telehealth appeared to hold promise, but researching its cost-effectiveness was difficult because care providers adopted telehealth practices slowly.⁶⁰

A 2002 review of previously published telehealth research, for example, found that despite a great deal of research showing telehealth’s clinical benefits very few studies provided enough detail to determine its cost-effectiveness, concluding “[t]here is no good evidence that telemedicine is a cost effective means of delivering health care.”⁶¹ Similarly, the authors of an extensive 2010 review of systematic reviews found mixed support for telehealth’s cost effectiveness and discussed the need for better economic analyses of emerging and complex treatment options.⁶² Another 2010 study focusing on telehealth video conferencing found it to be cost-effective for home-care and on-call hospital specialists, but found the evidence mixed or negative in other settings.⁶³ And in 2017, researchers again called for more analysis of the cost-effective telehealth treatments for a wide-range of situations.⁶⁴

The mixed and inconclusive findings regarding telehealth’s cost-effectiveness do not necessarily mean that telehealth services are not cost-effective. Rather, in

⁵⁹ Rashid L. Bashur, “**Telemedicine Effects: Cost, Quality, and Access**,” *Journal of Medical Systems*, Volume 19, Number 2 (April 1995) p. 81-91.

⁶⁰ *Ibid*; Douglas Perednia and Ace Allen, “**Telemedicine Technology and Clinical Applications**,” *The Journal of the American Medical Association*, Volume 273, Number 6 (February 8, 1995), p. 483-488.

⁶¹ Pamela S. Whitten, et al., “**Systematic review of cost effectiveness studies of telemedicine interventions**,” *British Medical Journal*, Volume 324, Number 7351 (June 15, 2002), p. 1434-1437; the authors use a broad definition of telemedicine.

⁶² Anne G Ekeland, Alison Bowes, and Signe Flottorp, “**Effectiveness of telemedicine: a systematic review of reviews**,” *International Journal of Medical Informatics*,” Volume 79, Issue 11 (November 2010), p. 741-742.

⁶³ Victoria A Wade1, Jonathan Karnon, Adam G Elshaug, and Janet E Hiller, “**A systematic review of economic analyses of telehealth services using real time video communication**,” *BMC Health Services Research*, Volume 10, Article 233 (2010).

⁶⁴ J. Scott Ashwood, Ateev Mehrotra, David Cowling and Lori Uscher-Pines, “**Direct-To – Consumer Telehealth May Increase Access To Care But Does Not Decrease Spending**,” *Health Affairs*, Volume 36, Number 3 (March 2017) p. 485-491.

many cases, researchers had not designed their studies to address both clinical- and cost-effectiveness.⁶⁵ Instead, practitioners and researchers have tended to focus their studies on how delivery through telehealth compares to traditional treatment *vis-a-vis* outcomes and patient satisfaction, without considering costs. Such research must continue, but more research on the costs of telehealth versus in-person visits will improve the medical community's understanding of when and where telehealth is most appropriate.

Regrettably, government regulations and the health system's relatively slow adoption of telehealth services have limited academic research on cost-effectiveness. Fortunately, after the recent emergency federal policy changes, Medicare expanded telehealth access to 85 additional services initially (and 135 as of this writing), and directed states to collect data on costs and the originating and distant sites in which services take place.⁶⁶ As a result, researchers will soon have more data to better inform best practices for telehealth going forward.

⁶⁵ *Ibid.*

⁶⁶ Jackie Drees, **CMS adds 85 more Medicare services covered under telehealth**, BeckersHospitalReview.com, March 31, 2020; **Trump Administration Proposes to Expand Telehealth Benefits Permanently for Medicare Beneficiaries Beyond the COVID-19 Public Health Emergency and Advances Access to Care in Rural Areas**, Centers for Medicare and Medicaid Services press release, August 3, 2020.

HOUSE BILL 679: ENCOURAGING BEST PRACTICES IN OHIO'S TELEHEALTH

With little indication that the new-found demand for telehealth services will subside, Ohio should continue to promote remote access to medical advice, doctor's visits, and testing by facilitating innovation and pursuing best practices in telehealth. Ohio's House Bill 679 takes significant strides in that direction, but several improvements can and should be made.⁶⁷

Generally, House Bill 679 rightly treats cost-sharing arrangements for telehealth services as it does in-person visits. Cost-sharing helps avoid overusing unnecessary services by forcing patients to share in the cost of their treatment. By treating cost-sharing for telehealth services the same as in-person services, House Bill 679 will encourage healthy competition between treatment options and make comparisons between the two treatments easier and more accurate.⁶⁸

Unfortunately, House Bill 679 waives cost-sharing for preventative care visits initiated by a professional with whom the patient has a prior relationship. The limited research on the clinical value of provider-initiated telehealth visits is mixed and inconclusive.⁶⁹ The General Assembly should leave cost-sharing requirements up to insurers and care providers to negotiate rather than prematurely removing cost-sharing as a matter of law from available fee structures. Doing so will help level the playing field between treatment options and make telehealth's overall

⁶⁷ **House Bill 679**, legislature.ohio.gov.

⁶⁸ Brook, Robert H., Emmett B. Keeler, Kathleen N. Lohr, Joseph P. Newhouse, John E. Ware, William H. Rogers, Allyson Ross Davies, Cathy D. Sherbourne, George A. Goldberg, Patricia Camp, Caren Kamberg, Arleen Leibowitz, Joan Keeseey, and David Reboussin, *The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate*, RAND Corporation, 2006; Morgan Bailie, Tyler Barton, Joann Donellan, et. al., *Confronting Rural America's Health Care Crisis*, Bipartisan Policy Center, April 2020; Andrea Willis, senior vice-president and chief medical officer, BlueCross BlueShield of Tennessee, Testimony before the U.S. Senate Committee on Health, Education, Labor and Pensions, "**Telehealth: Lessons from the COVID-19 Pandemic**," June 17, 2020.

⁶⁹ D G Goulis, G D Giaglis, S A Boren, I Lekka, E Bontis, E A Balas, N Maglaveras and A Avramides, "**Effectiveness of home-centered care through telemedicine applications for overweight and obese patients: a randomized controlled trial**," *International Journal of Obesity*, Volume 28 (2004) p. 1391-1398; Ah-Ram Sul, Da Hyun Lyu, Don-Ah Park, "**Effectiveness of telemonitoring versus usual care for chronic obstructive pulmonary disease: A systematic review and meta-analysis**," *Journal of Telemedicine and Telecare*, Volume 26, Issue 4 (May 2020) p. 189-199.

value clearer. Economic research in Japan, for example, suggests that patients are willing to pay reasonable sums for the additional value that telehealth offers and that substituting telehealth for in-person visits is associated with lower overall medical expenditures.⁷⁰

House Bill 679 does not require that telehealth services be offered through virtual video services. Many telehealth services can be provided effectively by telephone and experts agree that the full range of technology options should be available for patients and care providers to use as appropriate.⁷¹ Such flexibility and availability are especially important for rural areas where some specialists and care providers are less common.

Instead of requiring virtual video services, House Bill 679 requires that services delivered through telehealth be consistent with the “standard of care” for that provider. State medical boards issue “standard of care” rules for care providers, and although the bill does not require virtual video services, this provision allows the State Medical Board of Ohio and other medical licensing boards to limit patient access to some telehealth services before researchers have fully evaluated the costs and benefits of competing treatment options. The medical board may elect, for example, to classify some telehealth services within the standard of care of one professional but not another for reasons that have nothing to do with the practitioner’s expertise or ability. Such restrictions do not help patients, but benefit some professions at the expense of others—a recurring issue in the licensing of health professionals.⁷²

Research on the costs and benefits of telehealth will continue, but the medical and policy literature shows that it is important not to introduce or reintroduce artificial restrictions before patients, providers, and insurers learn how best to operate with telehealth’s new tools.⁷³ Services available through telehealth should be as broad

⁷⁰ Masatsugu Tsjuji, Wataru Suzuki and Fumio Taoka, “**An empirical analysis of a telehealth system in terms of cost-sharing,**” *Journal of Telemedicine and Telecare*, Volume 9, Issue 1 supplement (June 1, 2003) p. 41-43; Yuji Akematsu and Masatusugu Tsjuji, “**An empirical approach to estimating the effect of e-health on medical expenditures,**” *Journal of Telemedicine and Telecare*, Volume 16, Issue 4 (May 28, 2010) p. 169-171.

⁷¹ Morgan Bailie, Tyler Barton, Joann Donellan, et al., *Confronting Rural America’s Health Care Crisis*, Bipartisan Policy Center, April 2020.

⁷² Catherine Dower, Jean Moore and Margaret Langelier, “**It Is Time To Restructure Health Professions Scope-Of-Practice Regulations To Remove Barriers To Care,**” *Health Affairs*, Volume 32, Number 11 (November 2013) p. 1971-1976.

⁷³ Nicol Turner Lee, Jack Karsten and Jordan Roberts, *Removing regulatory barriers to telehealth before and after COVID-19*, The Brookings Institution and The John Locke Foundation, May 6, 2020; Carmel Shachar, Jaclyn Engel and Glyn Elwyn, “**Implications for**

as possible, consistent with the latest medical research, and not limited to certain treatments, conditions, or providers. Ohio’s medical board should adopt language similar to North Carolina’s medical board, which acknowledges telehealth’s value and holds providers to the same standards as in-person care, but does not endorse a separate standard of care for telehealth.⁷⁴ Such an approach would leave the treatment decision up to the patient and provider while still holding the licensee accountable to the board.

House Bill 679, fortunately, does not mandate payment parity for telehealth services as some states do.⁷⁵ Private insurers have recognized the promise of telehealth and have already shown a willingness to expand telehealth coverage, but they are still learning where the true potential and value for telehealth really lies.⁷⁶ A payment parity requirement at this early stage would prematurely signal that telehealth treatment options are interchangeable with in-person visits in terms of cost and quality. Medical studies, however, do not warrant this conclusion or pricing structure inasmuch as there are still many areas in which telehealth’s medical value is not yet established. Insurers and care providers may be justifiably reluctant to extend coverage for telehealth services that are not proven effective. And although many patients prefer telehealth, that preference is not universal and should remain part of the negotiation process.

In other words, requiring payment parity would lead to misleading price signals and undermine the competitive process that is unleashing telehealth’s latent potential.⁷⁷ Just as the existing fee-for-service system encourages overuse and overpayment,⁷⁸ payment parity requirements would impose the same dynamic upon a new treatment option, possibly benefitting insurers and providers, but not patients or the health system as a whole.

Telehealth in a Postpandemic Future: Regulatory and Privacy Issues, JAMA, Volume 323, Number 23 (May 2020) p. 2375-2376.

⁷⁴ **Position Statements: Telemedicine,** NCMedBoard.org (Last visited June 25, 2020).

⁷⁵ Y. Tony Yang, **“Telehealth Parity Laws,”** *Health Affairs*, Health Policy Brief, August 15, 2016.

⁷⁶ Andrea Willis, senior vice-president and chief medical officer, BlueCross BlueShield of Tennessee, Testimony before the U.S. Senate Committee on Health, Education, Labor and Pensions, **“Telehealth: Lessons from the COVID-19 Pandemic,”** June 17, 2020.

⁷⁷ Rashid L. Bashur, **“Telemedicine Effects: Cost, Quality, and Access,”** *Journal of Medical Systems*, Volume 19, Number 2 (April 1995) p.81-91; and Mark Sullivan, **“Telehealth’s future is bright, Here’s what it’ll look like in 2025,”** FastCompany.com, May 5, 2020.

⁷⁸ Robert Pearl, **“Healthcare’s Dangerous Fee-For-Service Addiction,”** *Forbes*, September 25, 2017.

Ways to Further Enhance Telehealth’s Value to Patients

In addition to relaxing some telehealth regulations in response to the pandemic, Ohio has also made it easier for health care professionals to work across state lines and provide services up to their full level of training.⁷⁹ Many medical groups and experts agree that state and federal authorities should make practicing medicine across state lines as convenient as possible.⁸⁰ Ohio lawmakers can accomplish this by allowing professionals licensed in other states to treat patients in Ohio, rather than requiring an Ohio license or imposing other administrative hurdles such as the Interstate Medical Licensure Compact.⁸¹

Short of permanent changes to state licensing policies, Ohio could consider amending rules in order to allow Ohioans to consult with medical professionals across state lines during a public health emergency. The current pandemic has not overwhelmed Ohio’s health care system, but the dangers posed by pandemics have proven difficult to predict and may vary significantly by locality. Since the outbreak, patients and providers have attested to the value of seeing each other

⁷⁹ Rea S. Hederman Jr., *Policy Solutions for the Pandemic: Lifting Restrictions on Nurses to Fight COVID-19*, The Buckeye Institute, April 8, 2020.

⁸⁰ Shirley Svorny, *Liberating Telemedicine: Options to Eliminate the State-Licensing Roadblock*, Cato Institute, November 15, 2017; Joseph C. Kvedar, president, American Telemedicine Association, professor, Harvard Medical School, senior advisor, Virtual Care, Mass General Brigham (Partners HealthCare), Testimony before the U.S. Senate Committee on Health, Education, Labor and Pensions, “**Telehealth: Lessons from the COVID-19 Pandemic**,” June 17, 2020; Karen S. Rhueban, professor of pediatrics, senior associate dean for continuing medical education and external affairs, director, University of Virginia Center for Telehealth, UVA Health, **Testimony** before the U.S. Senate Committee on Health, Education, Labor and Pensions, June 17, 2020.

⁸¹ Nicol Turner Lee, Jack Karsten and Jordan Roberts, *Removing regulatory barriers to telehealth before and after COVID-19*, The Brookings Institution and The John Locke Foundation, May 6, 2020; Morgan Bailie, Tyler Barton, Joann Donellan, et. al., *Confronting Rural America’s Health Care Crisis*, Bipartisan Policy Center, April 2020; Joseph C. Kvedar, president, American Telemedicine Association, professor, Harvard Medical School, senior advisor, Virtual Care, Mass General Brigham (Partners HealthCare), Testimony before the U.S. Senate Committee on Health, Education, Labor and Pensions, “**Telehealth: Lessons from the COVID-19 Pandemic**,” June 17, 2020; Karen S. Rhueban, professor of pediatrics, senior associate dean for continuing medical education and external affairs, director, University of Virginia Center for Telehealth, UVA Health, **Testimony** before the U.S. Senate Committee on Health, Education, Labor and Pensions, June 17, 2020; Andrea Willis, senior vice-president and chief medical officer, BlueCross BlueShield of Tennessee, Testimony before the U.S. Senate Committee on Health, Education, Labor and Pensions, “**Telehealth: Lessons from the COVID-19 Pandemic**,” June 17, 2020.

through telehealth services.⁸² And although Ohio has many fine medical establishments, much of Ohio’s population lives within easy driving distance of medical professionals in neighboring states, and Ohio’s policies should not prevent them from seeing their chosen care providers.

Allowing care providers to practice across state lines in Ohio was a temporary rule change brought on by the pandemic. But making these changes permanent would provide patients with more treatment options and make it easier for them to see the best doctor for their situation. When the state allows patients and care providers to negotiate on the basis of their needs and situations—without artificial geographical limitations—research and recent experience show that health care systems can adapt quickly and innovatively to better serve patients.⁸³

⁸² Reed Abelson, **Is Telemedicine Her to Stay?** *The New York Times*, August 3, 2020; and Tom Murphy, **Telemedicine shines during pandemic but will glow fade?** Associated Press, August 10, 2020.

⁸³ Kameron Matthews, assistant under secretary for health for community care, **VA Telehealth During and Beyond Covid-19: Challenges and Opportunities in Rural America**, Testimony before the Senate Committee on Veterans’ Affairs, July 29, 2020; and Katherine Restrepo, **The Case Against Telemedicine Parity Laws**, The John Locke Foundation, January 15, 2018.

CONCLUSION

As Ohio's telehealth policies evolve in response to the popularity of and surging demand for expanded telehealth access, state policymakers and the State Medical Board of Ohio should not impede this burgeoning field. Old rules and regulations should not be reinstated, but should be reassessed as new research informs decision-making. Telehealth services offer significant advantages to patients and care providers, and public policy should be designed carefully to enhance those benefits. Policymakers should not prematurely restrict which telehealth services can or cannot be reimbursed through private and public insurances. Those decisions should remain with providers and patients as the true capabilities and value of telehealth services become available. Rules governing telehealth access and reimbursement should be flexible, encourage innovation, and be crafted to promote best practices that will be clinically- and cost-effective for patients.

ABOUT THE AUTHOR



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Woodward's research has been instrumental in some of Buckeye's most impactful research. He was a co-author of ***Healthy and Working: Benefits of Work Requirements for Medicaid Recipients***, which revealed that Medicaid work and community engagement requirements could increase the lifetime earnings for people who transition off of Medicaid by nearly \$1 million. He was also a co-author of ***Sustaining Economic Growth: Tax and Budget Principles for Ohio***, which outlined principles that Ohio policymakers should use to guide their decisions on the state's budget. Additionally, Woodward was a co-author of a number of papers that analyzed the economic impact of tax proposals being considered by government bodies in **Iowa**, **Alaska**, and **Arizona**.

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Access to Health Care Made Easier: Promoting Best Practices in Ohio's Telehealth Policy

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