Telemedicine Authorization and Reimbursement Act (TARA)

NCOIL Health Insurance & Long-Term Care Issues Committee

September 24, 2020

Josh Archambault

Senior Fellow

Foundation for Government Accountability

Asw. Pamela Hunter

The Foundation for Government Accountability (FGA) writes to applaud your effort to expand telehealth. FGA's policy work in numerous states has provided some best practices that we wanted to share with the hope that it can help to improve the *Telemedicine Authorization and Reimbursement Act (TARA).* Overall, the bill is a step in the right direction, but the payment parity mandate will increase costs that will harm vulnerable patients and harm small businesses and should be removed.

Suggested Change:

Strike Section 4(D):

> ~~"(D) An insurer, corporation, or health maintenance organization shall reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis that the insurer, corporation, or health maintenance organization is responsible for coverage for the provision of the same service through in-person consultation or contact."~~

Or amend to:

> "(D) An insurer, corporation, or health maintenance organization shall **negotiate the reimbursement level with** ~~for~~ the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services, **or their employer.** ~~on the same basis that the insurer, corporation, or health maintenance organization is responsible for coverage for the provision of the same service through in-person consultation or contact.~~"

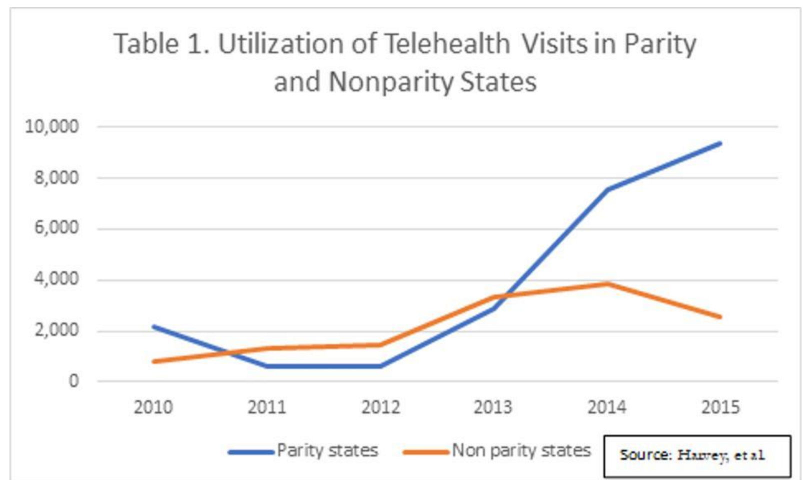
Background:

COVID-19 is shining a bright light on the benefits of telehealth. Yet, as this happens, payment and coverage mandates can have large, unintended, long-term consequences on affordability for patients.

Parity Laws Spike Utilization

A study of claims from states that have passed parity laws has shown that it increases utilization.[i] While at first glance increasing utilization may sounds like a good outcome, it becomes less laudable if money is being spent on services that don't add value (see MEDPAC report on this subject).[ii] It also can become concerning if paired with payment parity spending spikes.

Table 1 compares telehealth claims data from 2010-2015 in parity state vs. non-parity states. The researchers moved states into the parity category once a state passed a law, regardless of the kind of parity the state passed. Many of the parity states included in the study passed parity laws in 2012 and 2013, which is the start of a significant utilization spike.



In an age of COVID-19, utilization has grown exponentially. The long-term question is if policymaker will maintain mandated higher rates in states that have embraced them during this pandemic and force patients to pay inflated rates forever.

Paying In-Office Rates for a Telehealth Visit (i.e. Payment Parity) Spikes Spending

One of the advantages of telehealth is that services can be rendered from any setting. This includes for the provider. For providers offering tele-services from a home office or any office setting, there are significant savings on administrative costs, overhead, and there is no cross subsidizing. So, it makes little sense that policy should mandate the same payment rate, including in many cases a facility fee, even if the service is delivered from a home office.

One of the driving forces behind the growing popularity of telehealth pre-pandemic, was the lower cost to access care. Payment parity undercuts this potential going forward.

Payment Parity Harms Patients and Small Companies

Payment parity also harms patients and employers as it artificially increases the cost of care. No one thinks what we need is more expensive health care, yet payment parity mandates that patients with a deductible will lose more money out-of-pocket to receive care, and employers will have to divert more money towards health care costs instead of hiring a new staff member or using this saved money to keep their business alive during this uncertain economic time.

Big businesses that are self-insured can decide how much they pay for services and are regulated by federal ERISA law. Small companies are at the mercy of the state laws and policies of the insurers in their local market. Mandate higher prices, and they will be forced to pay higher premiums and more out-of-pocket putting them at a competitive disadvantage when compared to the big companies.

Payment Parity Bakes in Unjustified Price Differences

It is well documented that high prices in health care are not correlated with higher quality care.[iii] In fact, the opposite is often true. Yet by mandating payment parity, it will cement current price variation between name brand institutions vs. community-based or rural facilities or providers without any consideration of the quality of care being provided to a patient.

Payment Parity Will Slow Patient-Centered Innovation and Delivery Reform

Mandating insurers to pay the same way as an in-person visit also anchors in "old way" reimbursement methods into the practice of telehealth. It would discourage innovations like dynamic pricing (different costs based on demand or the time of the service being performed) or other innovative care models such as team-based practices as payment rates are instead tied to how "we have always practiced medicine" or how they do it at the facility. Parity can discourage investments in technology that can bring cost efficiencies as they have in so many other industries.

Embrace Telehealth, But Smartly

The telehealth revolution should change the face of the health care system to be more patient focused, and to be less costly. Payment parity mandates spike spending, mandate that patients and small companies pay inflated rates for care, cement payment inequity, and slow innovation like team-based care in telehealth. The mandate should be removed.

Any telehealth and telemedicine framework should allow providers of *all* kinds to utilize these services and allow easy across state line access without any mandates. That is an encouraging future of telehealth and what this bill could be with this one tweak.

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i Jillian Harvey, et al, "Utilization of Outpatient Telehealth Services in Parity and Nonparity States 2010-2015," Telemed J E Health, (2019), 25(2):132-136. doi:10.1089/tmj.2017.0265
ii MEDPAC, "Report to Congress: Medicare Payment Policy," MEDPAC (2018), http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch16_sec.pdf?sfvrsn=0
iii Massachusetts Attorney General, " Investigation of Health Care Cost Trends and Cost Drivers," Office of the Attorney General (2010), https://www.mass.gov/files/documents/2016/08/ub/prelim-2010-hcctcd.pdf
Peter Hussey, et al, "The Association Between Health Care Quality and Cost: A Systematic Review," Annals of Internal Medicine (2013), https://doi.org/10.7326/0003-4819-158-1-201301010-00006
Reed Abelson, "In Health Care, Cost Isn't Proof of High Quality," The New York Times (2007), https://www.nytimes.com/2007/06/14/health/14insure.html