ACA Implementation—Monitoring and Tracking

Can Telemedicine Help Address Concerns with Network Adequacy?
Opportunities and Challenges in Six States

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010 (ACA). The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at **www.rwjf.org** and **www.healthpolicycenter.org**. The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access and premiums in the states and nationally.

INTRODUCTION

Many regions of the country struggle with a shortage of both primary care and specialty physicians, affecting not only rural areas but also underserved urban communities.[1] At the same time, many insurers have moved toward narrower provider networks for marketplace plans in order to reduce premiums. In some markets, this change has meant that enrollees must travel farther or wait longer to see certain providers. Marketplace insurers are also offering fewer products that provide out-of-network coverage.[2] As the trend toward narrower networks continues, policy-makers, consumers, and provider stakeholders have encouraged insurance regulators to place the adequacy of provider networks under closer scrutiny. In response, some state and federal regulators have proposed more robust, quantitative network adequacy standards to ensure that consumers have reasonable access to services under their health plans. The proposals include requirements that services can be accessed within a specified travel time or distance, or within a maximum wait time, or that networks have a specified maximum ratio of providers to enrollees.

One available tool that could help insurers meet network adequacy standards—and help providers deliver care to underserved areas more efficiently—is telemedicine. Telemedicine is the use of telecommunications technology to provide health care services remotely. In this paper, telemedicine refers to the use of technology as a substitute for an in-person encounter with a health care professional. Such substitutions consist of three primary modalities: interactive videoconferencing, "store and forward" of data, and remote patient monitoring (table 1).[3] The use of telemedicine is growing rapidly among hospitals and physicians across the country.[4]

Table 1. Telemedicine Modalities

Modality	Definition	Examples of Use
Interactive videoconferencing	Use of two-way, interactive audio-visual technology	• Postoperative consult with a surgeon while a patient is in the office of his or her primary care provider (PCP) • Psychiatric consult while a patient is in a mental health clinic staffed by clinical social workers
Store and forward	Transmission of patient data, such as X-rays, scans, or photos, from one provider to another	• X-rays sent from a rural hospital emergency department to a radiologist at urban hospital for review • Digital photos of a patient's skin condition sent from a PCP to a dermatologist for review and diagnosis
Remote patient monitoring	Use of digital technology to collect medical and other forms of health data from patients and to transmit it to providers in another location	• Home monitoring of blood pressure and blood sugar levels • Home monitoring of postoperative patients' vital signs

Source: Center for Connected Health Policy. What Is Telehealth? *http://cchpca.org/what-is-telehealth*. Accessed February 2016.

Insurers and regulators recognize telemedicine's potential to increase access to services, but how to deliver on that potential has been less clear. Operational, medical, legal, and financial barriers have, to date, hindered providers from widely adopting and using telemedicine to supplement in-person care that is delivered locally, even in rural and historically underserved areas.[5] Those barriers vary widely by state, reflecting a patchwork of state laws and of insurance company and provider practices.

This paper explores how private insurers are currently using telemedicine to address network adequacy concerns, particularly in areas where building an adequate provider network has been challenging. In addition, as insurance regulators have begun to engage in more robust oversight of plan networks, we have sought to understand how they will assess insurers' use of telemedicine to meet new network adequacy standards.

ABOUT THIS STUDY

This study focuses on telemedicine and plan network policies and activities in six states: Arkansas, Colorado, Illinois, Maine, Texas, and Washington. Following a 50-state review of policies on telemedicine reimbursement and plan network oversight, we chose those six states because they represent a range of approaches. All but Maine recently changed their laws affecting private insurers' reimbursement of services delivered via telemedicine. All of the states also have geographic areas in which insurers may face challenges maintaining a robust provider network, either because of a lack of providers or because of monopolies within certain provider specialties. In addition to reviewing state laws and guidance to insurers, the authors conducted 18 interviews with representatives from the study states' departments of insurance and insurance companies, as well as with physicians and hospital executives currently using telemedicine. The interviews were conducted between November 2015 and January 2016.

BACKGROUND

The Growth of Telemedicine and its Relationship to Network Adequacy

Large hospitals are driving the expansion of telemedicine across the country. Nationally, more than half of hospitals and health systems in the United States are using the technology to increase access to services.[6] From postoperative monitoring of patients at home to connecting specialists with emergency room doctors in rural areas, hospitals are investing in and using telemedicine platforms. Hospitals and health systems are using telemedicine not only to increase access to their services but also to respond to changing payment models that encourage them to emphasize the management of high-risk conditions and chronic diseases such as diabetes, as well as to lower readmissions.[7] In some cases, academic medical centers have taken the lead by drawing down state and federal grants for telemedicine equipment, such as secure broadband connectivity for interactive videoconferencing, so the centers can connect patients in rural areas to their specialists.[8] To varying degrees, hospitals are using telemedicine to increase access to services and as part of a marketing strategy to attract patients across the broadest possible service area.

In addition, employers have become increasingly interested in telemedicine, largely as a way to improve workers' access to primary care through remote physicians. The employers' goal is to lower health care costs and reduce absenteeism. A survey of large employers indicates that many expect to offer telemedicine consultations in the next two years, a 68 percent increase from 2014.[9]

At the same time, local medical boards and physician groups have been wary of the spread of telemedicine. At the state level, some have lobbied for restrictions on when and how services through telemedicine are provided. In resisting the expansion of telemedicine, most of those groups cite concerns about the quality of care and the importance of preserving the physician-patient relationship. Concerns about losing revenue to remote, out-of-state "teledocs" are undoubtedly also a factor.[10] Although telemedicine can deliver medical care appropriately for some services such as mental or behavioral health or specialty consultations for dermatology, cardiology, or oncology, physician groups point out that many conditions require an in-person examination for proper diagnosis and treatment.

Private insurers have taken varying approaches to the delivery of services via telemedicine. Many, such as those interviewed for this study, are offering telemedicine as an add-on benefit for their employer customers, typically at the request of those customers. Others cover services via telemedicine in their individual and group market plans as a convenience for enrollees. When required by state law, insurers reimburse

for services delivered via telemedicine at parity with a face-to-face encounter. Without a requirement under state law, insurers make the decisions about whether to cover services via telemedicine and at what level of reimbursement.

Getting Paid for Their Services: Varying Approaches to Telemedicine Reimbursement

Private insurers, when allowed to make their own decisions, appear to have no standardized approach to coverage and reimbursement. Coverage for telemedicine varies considerably from state to state and at the federal level as well. Some insurers follow the lead of the Medicare program, which limits reimbursement because of concerns that telemedicine could lead to overuse and to rising costs.[11] Medicare will reimburse only for certain services provided via telemedicine to patients in rural areas with documented physician shortages. Further, payment rules require that the beneficiary receiving the care must be physically present at an approved site (also called the originating site) such as a physician's office or hospital (text box 1). Under Medicare reimbursement rules, Medicare pays approved health providers the same amount as an in-person visit and also pays the originating site a facility fee, which in 2015 was less than $25. With a few exceptions, Medicare pays only for interactive videoconferencing.[12] With such restrictions, it's unsurprising that telemedicine accounted for only $14 million of the $615 billion Medicare spent in 2014 for all its programs.[13] Insurers participating in Medicare Advantage have greater flexibility to reimburse for services delivered via telemedicine, but only a limited number choose to do so.[14]

Telemedicine: Defining Key Terms

Originating site: the location of the patient, usually at a physician's office, clinic, or patient's home.

Facility fee: the fee the insurer or other payer pays to the site where the patient is located. In general, if patients are located at home, there is no facility fee.

Distant site: the facility or office in which the health care professional providing the remote health care services is located.

Telepresenter: a health care professional present with the patient during a telemedicine encounter to facilitate the interaction between the remote provider and the patient. Some payers require a telepresenter as a condition of payment for the facility fee. The telepresenter's time, however, is not typically a separately reimbursable service.

Telemedicine reimbursement under Medicaid varies considerably by state, and it often depends on state law. In general, most state Medicaid programs reimburse for live videoconferencing, but reimbursement varies for other modalities such as store and forward or remote patient monitoring. States also differ in whether they'll pay the facility fee for the originating site, whether they'll require informed consent, and what conditions they set for reimbursement. For example, some states will pay facility fees only when a telepresenter is present to assist the remote health care provider with the patient during a telemedicine encounter.[15]

In private insurance, more than half of states require insurers to reimburse for services provided through telemedicine at parity with a face-to-face encounter, and reimbursement is subject to the same terms and conditions of the health plan policy (appendix A). No standard definition of telemedicine exists, and varying provider, technology, and medical practice restrictions exist among states. Most states, however, do not require reimbursement for services provided only through audio, fax, or email.[16]

Using Telemedicine to Meet Network Adequacy Standards

Historically, most states have not held insurers to quantitative standards (such as time and distance requirements or provider-to-enrollee ratios) for network adequacy, but rather have relied on insurer attestations that networks are adequate. With the recent trend toward narrower networks, however, more states have established quantitative standards that insurers must meet.[17] Given this evolution in the regulatory approach, insurers may have incentives to use alternative delivery methods such as telemedicine to meet network adequacy standards, particularly in regions where insurers face provider shortages.

Telemedicine also could be useful for insurers where they face provider monopolies. Over the past 10 to 15 years, primarily because of consolidation, providers in many markets have been able to achieve greater power to raise prices for their services.[18] The expansion of telemedicine could give insurers greater negotiating leverage with some of those providers, particularly if insurers can make a bona fide threat to exclude that provider or specialty group because enrollees can receive the same services via telemedicine.

Recently, the National Association of Insurance Commissioners issued a revised model law for network adequacy. The model law does not establish quantitative network adequacy metrics, but it does include the use of telemedicine under its criteria as a health care delivery option that insurers may use to meet a state's network adequacy standard. The model law requires that carriers include or describe "how the use of telemedicine or telehealth or other technology" is being used in its access plan.[19] Although it's too soon to tell whether this model law will prompt states to incorporate telemedicine specifically for the assessment of a plan's network adequacy standards, this provision demonstrates that state regulators are aware of how the technology could be used to meet enrollees' needs in areas with gaps in provider access.

OBSERVATIONS FROM THE STATES

Widespread consensus about telemedicine's benefits; telemedicine not a panacea for network problems

Stakeholders across the board agree on telemedicine's potential to improve gaps in network access, particularly in rural and underserved areas. For example, in many of Colorado's geographically remote and rural areas, insurers face challenges finding and contracting with specialty providers. In such cases, one regulator noted, consumers "can get better access with tele[medicine]." According to one insurer, there is a "huge potential to [reach] rural areas and metro areas where there is a shortage of specialists." One Maine insurer uses telemedicine to improve enrollees' access to dermatology and psychiatry providers in particular. Respondents noted that telemedicine can save consumers a lot of time and travel, especially when there is inclement weather, a geographic barrier, or a lack of access to transit.

At the same time, several respondents acknowledged that telemedicine is no panacea for network problems. For some specialty practitioners with whom it has been traditionally hard to contract, such as emergency room physicians and anesthesiologists, there is no telemedicine fix. Those and other specialties generally require in-person encounters with patients. Consequently, insurers report that they are not able to use the availability of telemedicine as negotiating leverage with such specialty providers. Some respondents also indicated that, even for some specialty services that are more amenable to deliver care through telemedicine (such as behavioral health, dermatology, and radiology), the needed workforce and technical infrastructure just do not exist.

Moreover, insurers, regulators, and providers alike highlight potential risks to patients as well as regulatory and practical barriers that inhibit insurers from aggressively pursuing telemedicine to meet network adequacy standards. For example, one practical barrier may be the labor and facility costs associated with use of telemedicine technology. As one provider respondent noted, the professional support for a [telemedicine] visit may be the same—or more—than what is required for an in-person visit because a provider may be required to be in the room to assist the patient, in addition to the provider delivering the service via videoconference hookup.

Other respondents indicated that telemedicine has not yet reached a tipping point in terms of widespread acceptance and use among physicians and patients. As one insurer noted, "Getting used to [the] telemedicine idea" is a challenge to expanding its overall use. "Telemedicine isn't part of our training; it's a whole new area," stated a provider respondent. And another insurer found that its enrollees don't tend to embrace telemedicine, even when it is available and reimbursed. "Demand is not high," said the insurer respondent, citing a lack of awareness as well as patient discomfort with the less personalized interactions with their physicians.

Insurers' embrace of telemedicine has been slow, in part because of regulatory uncertainty

In general, insurer respondents have been slower than hospitals and health systems to embrace the use of telemedicine, and most are not currently using it to help them meet state or federal network adequacy standards. Although insurers recognize that many state regulators are or will be strengthening their oversight of network adequacy, there are no current indications that they perceive telemedicine as a potential shortcut to meeting regulators' expectations.

Colorado is the only state—in this study—that has explicitly incorporated the use of telemedicine as a factor to consider in assessing whether a plan meets the state's network adequacy standards. Enacted in 2015, this provision of Colorado's network adequacy law is not effective until January 1, 2017.[20] Insurers will be allowed to offer remote access to specialty services as a way to meet the state's network adequacy requirement, so long as the specialty service can be delivered appropriately through telemedicine. Recently Colorado issued guidance establishing quantitative measures—maximum waiting times, provider to enrollee ratios, and travel distances—to assess network adequacy (table 2).[21]

Table 2. Study States' Standards for Network Adequacy in the Individual Market

Study State	Standard for network adequacy (NA)	Explicitly allows use of telemedicine to meet state NA standard
Arkansas	Emergency room within 30-mile radius of where enrollee lives; primary care provider (PCP) within 30-mile radius of where enrollee lives; specialty provider within 60-mile radius of where enrollee lives	No
Colorado	Insurer must establish the following: • Maximum waiting time standards that vary by service type, e.g., emergency care must be available 24 hours/7 days a week, primary care must be available within 7 calendar days • Provider-to-enrollee ratio of 1-to-1,000 for primary care; pediatric care; obstetrics-gynecology (OB-GYN); mental, behavioral and substance abuse care • Maximum travel distances that vary among 50 listed specialties	Yes, for specialty provider-to-covered person ratios starting January 1, 2017
Illinois	Any point in service area to point of service cannot be greater than • 30-45 miles for PCP, OB-GYN, and general hospital care for urban areas, 60-100 miles for rural • 45-60 miles for specialists in urban areas, 75-100 miles for specialists in rural area PCP-to-enrollee ratio of 1-to-1,000 Specialist ratio varies depending on specialty, but range is 1-to-2,500 to 1-to-10,000	No
Maine	PCP-to-enrollee ratio of 1-to-2,000	No
Texas	Any point in the service area to point of service cannot be greater than: • 30 miles for PCP and general hospitals in nonrural areas and 60 miles in rural • 75 miles for specialty care and specialty hospitals	No
Washington	• PCP ratio that meets or exceeds prior plan year • 80 percent of enrollees who live or work within 30 miles of PCP in urban area or 60 miles in rural area • PCP appointment within 10 days	No

Sources: Arkansas Admin. Code 054.00.106-5; Colorado Rev. Stat. Ann. § 10-16-704 and Colorado Dept. of Regulatory Agencies, Div. of Insur. Bulletin No. B-4.90; 215 Illinois Code 370i and Illinois Dept. of Insurance, PPO/HMO Network Adequacy Review Requirements Checklist (effective 01/01/2015); 02-031 Code of Maine Rule Ch. 850, § 7; Texas Admin. Code tit. 28, § 3.3704; Washington Admin. Code 284-43-200.

Currently, insurers in Colorado are not generally using telemedicine to fulfill network adequacy requirements. One Colorado insurer noted uncertainty about whether telemedicine can truly help insurers meet network adequacy standards, stating that telemedicine's impact "remains to be determined." When asked about the state's new law, which allows insurers to use telemedicine to satisfy the specialty provider-to-covered person ratio, regulators remarked, "We haven't gotten into the details of what that looks like at this point."

None of our other study states have issued guidance on if and how insurers can use telemedicine to address network adequacy. Like Colorado, all of the other study states have established quantitative criteria standardizing the requirements that insurers must meet. No state has issued official guidance about using telemedicine with its network adequacy standards. Most regulator respondents express a wait-and-see approach to how telemedicine could be used for network adequacy purposes. And, while most are open to having insurers use telemedicine to meet network adequacy standards, they would generally frown on an insurer's use of telemedicine encounters that could be perceived as replacing, rather than supplementing, face-to-face access to a physician. They also indicate an interest in better assessing whether and how insurers are using telemedicine and in determining how consumers are faring. As one regulator put it, "We'll want to know from insurers whether there is a real benefit to enrollees." Maine regulators appear doubtful that telemedicine would ever be an acceptable method for insurers to fulfill that state's network adequacy requirements.

At the same time, data are lacking about how to assess enrollees' experiences. In Arkansas, for example, regulators currently are examining new data from insurers and are developing uniform definitions as part of an expanded effort to monitor network adequacy. They acknowledge, however, that

the use of telemedicine providers is not explicitly captured in insurer filings. Thus, they have no way to know if insurers are using telemedicine to meet network adequacy standards right now. Similarly, Maine and Washington currently do not require insurer filings to indicate whether enrollees are accessing care via telemedicine. Washington regulators are updating insurers' monthly reporting requirements so regulators can capture which providers use telemedicine to deliver services; such data should become available in 2017.

Washington regulators take a strong stance that insurers should not be able to use telemedicine in place of having providers on the ground to meet the state's network adequacy standard. "For networks that are lean, insurers may see [telemedicine] as a way to gap fill," stated a Washington regulator, then noting that Washington has "very specific time, distance, and access standards" and would not accept an insurers' use of telemedicine as a way of meeting those requirements. Such a stance probably limits insurers' ability to use the option of remote telemedicine providers as leverage in price negotiations with local provider groups that exercise market power to charge high prices.

Although the Washington insurance department has not yet published specific guidance to insurers regarding the use of telemedicine, its unofficial position does not surprise insurer respondents in the state. One respondent indicated it would "love to use telemedicine" for network adequacy but voiced skepticism that it would pass regulatory muster. However, regulator respondents did note that limited circumstances may exist in which insurers could request an alternative access delivery review, which allows insurers to deviate from the state's network adequacy standards, particularly if a specialty provider was no longer available except through the use of telemedicine. Regulators also indicate a willingness to keep their regulatory stance toward telemedicine flexible, particularly if the use of telemedicine as an alternative delivery mechanism becomes more popular and widespread.

Texas is the only state in which regulators report having seen insurers include the use of telemedicine providers as part of their network adequacy plans, but regulators report that they see it rarely. When insurers do incorporate telemedicine, regulators have found telemedicine more common with certain specialty groups (such as oncologists who are affiliated with large hospital systems) as a way to provide follow-up care or consultations. State officials have not published formal guidance to insurers about how to demonstrate network adequacy using telemedicine. If telemedicine providers are being used, however, insurers must provide a map of their geographic locations and must note that use in their access plans if the providers are not in the health plan's geographic service area.

Policies and practices inhibit telemedicine's growth and insurers' ability to leverage it for care delivery

Twenty-nine states and the District of Columbia require insurers to reimburse for certain services that are delivered through telemedicine modalities at parity with reimbursement for in-person care (appendix A).[22] In other states without coverage parity requirements, private insurers have flexibility to cover and reimburse for telemedicine services. Some may follow the Medicare reimbursement policy as a model, including the program's significant restrictions on where and how telemedicine services are covered. Others may choose not to cover it at all because they believe the costs outweigh the potential that telemedicine will enable them to offer a more robust, competitive provider network.

Of our study states, only Illinois does not have a coverage parity mandate for telemedicine (table 3). Respondents in that state attribute the lack of a coverage parity requirement to telemedicine's slow adoption among providers and insurers. According to one respondent, the largest insurer in Illinois "is just not moving [on telemedicine]" because there is no requirement to pay for telemedicine services at parity with face-to-face encounters. Subsequently, although there have been few attempts at using telemedicine among the many health systems in Illinois, it has not taken off compared with other states because nobody wants to risk it without the assurance that providers at both ends of the telemedicine transaction will be reimbursed at parity with face-to-face encounters.

Table 3. Approaches to Private Coverage Reimbursement for Telemedicine in Our Study States*

State	Coverage at parity with in-person encounter?
Arkansas	Yes, as long as care is delivered by an Arkansas-licensed physician and a professional relationship has been established between the provider and the patient. The professional relationship includes a previous in-person examination.[23]
Colorado	Yes, in counties with 150,000 or fewer residents. Beginning January 1, 2017, this restriction is lifted.[24]
Illinois	No, it does not require parity reimbursement. If an insurer covers telemedicine, that coverage prohibits health plans from doing the following: (1) requiring face-to-face encounter, (2) requiring provider to document a barrier to in-person consultation for coverage, and (3) requiring use of telemedicine when either the provider determines it is inappropriate or the patient chooses an in-person consultation.
Maine	Yes.
Texas	Yes.
Washington	Yes, effective January 1, 2017, as long as the service is recognized as an essential health benefit.

Sources: Arkansas Code 23-79-1602 and 17-80-117; Co. Rev. Stat. 10-16-123; Illinois Insurance Code § 356z.22; Maine Rev. Stat. Ann. Title 24, § 4316; Texas Insurance Code § 1455.004; Rev. Code of Washington § 41.05.

* There may be certain requirements depending on the telemedicine modality. Also, states differ in whether insurers must pay facility fees to the originating site (the site in which the patient is located) in addition to the payment for the provider being consulted. Texas law requires insurers to pay the facility fee for the originating site whereas Washington leaves it up to the insurer and to the provider's contract. Colorado also requires a reasonable facility fee unless the originating site is a private residence, which it excludes. Arkansas does not mandate nor does it prohibit a facility fee payment.

Insurers in Colorado and Washington provide at least some coverage of services delivered via telemedicine, even though their state's telemedicine parity laws are not yet in effect. They, along with other stakeholders, indicate that a greater barrier to telemedicine's expansion was not the lack of a coverage parity law but rather the position of the state's medical community and its regulation of the practice of medicine. Specifically, clinical practice policies from some state boards of medicine can impede the widespread adoption of telemedicine.[25]

In at least two of our study states, however, their medical boards have adopted or are considering approaches that would make it easier for physicians to use telemedicine. For example, in Colorado, the medical board required an initial face-to-face interaction to establish a physician-patient relationship in order to prescribe medication via telemedicine. Insurers in the state noted that this requirement has inhibited telemedicine from expanding. In August 2015, the medical board changed its position and no longer requires face-to-face encounters.[26] Similarly, Arkansas' medical board is currently re-examining its policy of requiring an in-person examination to establish a "professional relationship," which is required under state law as a condition of payment. The state medical board is considering a revision that would allow physicians to establish a professional relationship through telemedicine and not just through an in-person exam.[27] In contrast, Texas respondents indicate that pending litigation between its state medical board and one telemedicine provider has caused insurers to be cautious about its use.[28]

Varying reimbursement policies among states and opposition of local medical boards have led to a lack of both payer and provider investment in telemedicine technology. In many areas, there is thus insufficient technology infrastructure and integration into medical practices to make it economical for insurers to rely on telemedicine as an alternative method of delivering care compared to traditional, face-to-face encounters. Insurers themselves have made minimal up-front investments to promote telemedicine use. For example, one Colorado insurer states that it "relies on [hospitals and health systems] to bring the platform to us." As a result, although some insurers express enthusiasm for telemedicine as a tool with great potential to help them demonstrate network adequacy, they also admit that—for many geographic areas as well as within the desired provider specialties—there is insufficient penetration to make its use practical.

Insurer respondents did not voice strong concerns that telemedicine would lead to increased use or to fraud and abuse, concerns that have been cited as reasons to limit its use in the Medicare context.[29] However, insurers' cautious embrace of telemedicine suggests that they are uncertain that the benefits of the technology will outweigh the costs.

CONCLUSION

The use of telemedicine is expanding, particularly in rural areas, at the same time that demands on private insurers to demonstrate adequate networks are increasing. Those factors—when combined—could prompt more insurers to leverage the technology to fill network gaps or to meet states' time and distance or provider-to-enrollee ratio requirements. Most respondents predict that telemedicine providers have the potential to help support an adequate local network, particularly for specialty services (such as mental and behavioral health services) that can effectively deliver care remotely as a way to address widespread provider shortages.

Now, however, insurers generally do not appear to be using telemedicine to fill gaps in plan networks or to meet state network adequacy standards. There is uncertainty about how state and federal regulators would assess the use of telemedicine, particularly where telemedicine encounters could be perceived as replacing, rather than supplementing, face-to-face access to a physician. In addition, the lack of payer and provider investment in the necessary technology, as well as concerns from organized medicine, has led to a lack of infrastructure and integration into medical practice. Specifically, some respondents question the cost efficiency of using telemedicine within provider practices because of the need for resources to support both the technology and the patient with a telemedicine visit. Respondents also indicate the need for training and education for both providers and consumers in the use of telemedicine. As a result, insurers may not view telemedicine as an economical or practical method to ensure network adequacy.

Although there is increasing pressure on insurers to evaluate their networks as a way to decrease costs, the availability of telemedicine appears to give them only limited negotiating leverage with providers. For a number of specialty provider groups (such as emergency room physicians or anesthesiologists) that have local monopolies, telemedicine is not a solution because of the need for face-to-face interactions. Moreover, although telemedicine has the potential to increase access to specialists such as psychiatrists, insurers report that they are not currently trying to bypass such local providers or to use the option of telemedicine to enhance their negotiating leverage.

With the exception of Texas, our study states do not currently require insurers to differentiate between access via telemedicine and an in-person encounter in their filings for network review. No study state has published guidance for plans about whether or how they would take telemedicine into account in reviewing an insurer's access plan. But as incentives grow for insurers to integrate telemedicine into their network design, these data about changing delivery methods will be necessary to inform regulators' oversight of plan networks. Insurance regulators also may want to develop clear guidance for insurers on the appropriate use of telemedicine to meet state network adequacy standards, as well as internal policies and practices for conducting health plan network reviews and monitoring provider access. As one regulator commented, the devil is in the details in determining whether telemedicine providers improve enrollees' ability to get the care they need, when they need it.

APPENDIX A:

States with Parity Laws for Private Insurance Coverage of Telemedicine (March 2016)*

State	Parity law for private coverage?	State	Parity law for private coverage?
Alabama	No	Montana	Yes
Alaska	No	Nebraska	No
Arizona	Yes[a]	Nevada	Yes
Arkansas	Yes	New Hampshire	Yes
California	Yes	New Jersey	No
Colorado	Yes	New Mexico	Yes
Connecticut	Yes	New York	Yes
Delaware	Yes	North Carolina	No
District of Columbia	Yes	North Dakota	No
Florida	No	Ohio	No
Georgia	Yes	Oklahoma	Yes
Hawaii	Yes	Oregon	Yes
Idaho	No	Pennsylvania	No
Illinois	No	Rhode Island	No
Indiana	Yes	South Carolina	No
Iowa	No	South Dakota	No
Kansas	No	Tennessee	Yes
Kentucky	Yes	Texas	Yes
Louisiana	Yes	Utah	No
Maine	Yes	Vermont	Yes
Maryland	Yes	Virginia	Yes
Massachusetts	No	Washington	Yes
Michigan	Yes	West Virginia	No
Minnesota	Yes	Wisconsin	No
Mississippi	Yes	Wyoming	No
Missouri	Yes		

Source: American Telemedicine Association. State Policy Resource Center. www.americantelemed.org/policy/state-policy-resource-center#.VtRyOPkrLIV. Accessed February 2016.
a Arizona's parity law requires coverage and reimbursement of telemedicine services but includes geographic restrictions.
* There may be certain conditions for reimbursement depending on the modality or service.

ENDNOTES

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