America's Health Insurance Plans
Testimony on audio-only tele-health
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During the pandemic, all care, whether in-person, audio/visual or audio only was reimbursed equally.

Moving forward, there should be a separation and recognition of the differing levels of care offered by these three options. We support value based payment.

Pricing decisions should be data driven. If we have learned anything during this pandemic it is that policy should be based on well-defined data. Pricing should be a decision between the providers and insurers. As you have already heard, the office visit payment includes what is assumed to be work required outside of the actual office visit and the costs associated with having an actual office, the bricks and mortar and employees. They include things like reading and interpreting test results, extra phone consults if necessary, setting up additional appointments with other providers so some of these audio only appointments would already be covered under this in-person patient payment.

Patients may avoid coming in for in-person visits if they want to avoid some difficult conversations that may happen due to routine in-take evaluations like weight, blood pressure and possibly blood tests around diabetes.

However, the State could incidentally discourage the growth of telehealth by making short-term policy decisions that have long-term unintended, negative impacts on individuals who need affordable health care. If policymakers require employers, individuals, and taxpayers to subsidize providers for bricks and mortar infrastructure as part of virtual visits, the cost-saving potential that telehealth promises will be jeopardized. Two recent sources of information show that the average telemedicine visit costs less compared to an in-person visit. Teladoc Health data shows the average telemedicine visit costs $45 compared to $141 for in-person and according to Health Affairs, the average telehealth visit costs $79 compared to $146 in-office. A mandate requiring that health care purchasers pay the same for the telehealth visit as the in-person visit will likely impact affordability. For telehealth to realize its potential, government should not be burdening it with the same cost structure as brick and mortar health care settings.

And here is a white paper on Telehealth from the National Governor's Association.

NGA: The Future of State Telehealth Policy (https://www.nga.org/center/publications/the-future-of-state-telehealth-policy/)
The National Governors Association (NGA) recently released a white paper that summarizes the types of telehealth policy flexibilities provided by states and the federal government during the COVID-19 pandemic and longer-term considerations. During the pandemic, state and federal governments eased restrictions on telehealth, allowing for rapid growth in utilization. As states think about long-term policies, the NGA urged states to look at access, cost, and quality of care, with considerations for provider accountability, payment mandates, regulations on distant and originating sites, and outcomes-based models of care. The NGA also highlighted the need to close the "digital divide" and how governors must consider the appropriateness of policy permanence beyond the pandemic.)

Additionally, telehealth visits do not always require the same level of intensity, same amount of time, or the same equipment as in-person visits and are not a replacement for all in-person visits. Creating a one-

size-fits-all policy measure for care that should and must be patient-centered and individually based is not only the wrong direction but could increase costs for America's health care consumers.

Whenever we require payment for new services or parity for differing care, we raise the over-all cost of care. As Vermont moves toward capitated payments through the ACO this kind of thinking actually moves us in the wrong direction.

ERISA plans complied with paying for all tele-health care during the pandemic but will not be likely to do so in the future. This sets Vermonters further apart moving forward. It would be nice if all payer modalities would be aligned including Medicaid and Medicare.

- Teladoc Health, Comment Letter on Proposed Legislation Oregon H 2693 (Jan. 28, 2019).;
- Ashwood, J. Scott, et al. "Direct-To-Consumer Telehealth May Increase Access To Care But Does Not Decrease Spending." Health Affairs, Vol. 36, No. 3: Delivery System Innovation, Mar. 2017, www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1130.

Here is a link to who AHIP's members are:

https://www.ahip.org/our-member-organizations/?_ga=2.13808823.1699146970.1612365981-2107642752.1612365981&_gac=1.159629903.1612366295.CjwKCAiAsOmABhAwEiwAEBR0Zu-k6pcMESaWigcM-B4wZByNK7UaV5WBp8lKi7NGiqghyZsgn1TBnRoCKKQQAvD_BwE

And a brief overview:

https://www.ahip.org/about-us/