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TESTIMONY

PROPOSED TELEHEALTH LEGISLATION IS A POSITIVE STEP

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Good afternoon Chair Osbourne, Vice Chair Cobb, and members of the Committee on Health and Human Services.[1] I am grateful for the invitation to testify on Arizona's proposed telehealth legislation (HB 2454). My name is Robert Graboyes, and I am a senior research fellow at the Mercatus Center at George Mason University, where my work focuses on the question of how America can make healthcare as innovative in the next 30 years as information technology was in the past 30 years.[2]

Today, I offer the following takeaways:

1. Telehealth stands poised to provide better health for more people at lower cost, year after year, particularly for communities that are currently underserved.
2. Flexibility in reimbursement and other features are essential for America to take advantage of the benefits of telehealth.
3. The benefits of telehealth can be expanded by continuing to ease limits on patients and providers.

THE NEED TO BEND THE COST CURVE

In 2013, John Cochrane, then a professor at the University of Chicago and now a professor at Stanford University, wrote my favorite quote on healthcare policy: "What's the biggest thing we could do to 'bend the cost curve,' as well as finally tackle the ridiculous inefficiency and consequent low quality of health-care delivery? Look for every limit on supply of health care services, especially entry by new companies, and get rid of it."[3]

HB 2454 effectively follows that advice.

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1. Portions of this testimony are adapted from Robert F. Graboyes, CMS's Proposed Rule Is an Admirable First Step toward Removing Healthcare Supply Barriers" (Public Interest Comment, Mercatus Center at George Mason University, Arlington, VA, October 2, 2020).
2. Some of my ideas on the issue are explained in Robert F. Graboyes, "Fortress and Frontier in American Health Care" (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, 2014).
3. John H. Cochrane, "After the ACA: Freeing the Market for Health Care" (working paper, February 6, 2013), 9.

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THE BENEFITS OF TELEHEALTH

For all the misery that COVID-19 has foisted on America and the world, it has forced patients and providers alike to recognize the strengths of this technology.[4] The virtues of telehealth are legion. These remote technologies offer instantaneous care from most locations 24/7/365.

Telehealth is especially good for those who have traditionally had difficulty receiving timely care (rural communities, inner-city communities, foreign-language speakers, people with limited mobility, those with busy schedules, those with childcare responsibilities, and anyone who has a health issue after hours or on weekends).[5] Even when in-person encounters are feasible, telehealth offers advantages—or potential advantages. Advantages include reduced exposure to pathogens in waiting rooms and examining rooms, reduced no-shows for appointments, and greater patient compliance for treatment regimens (particularly with respect to psychological health).[6] For patients, telehealth dispenses with the time and stress of transit.

For those who see telehealth as an essential component of 21st-century medicine, HB 2454 offers some highly positive steps forward, including the following:

- It uses the term "telehealth" instead of "telemedicine," signaling that virtual technologies should be open to physicians and nonphysician providers (e.g., nurse practitioners) alike. Such a substitution also implies that patient-provider encounters include more than simply physician appointments.
- It substitutes the more comprehensive word "encounter" for the word "consultation," with the new word implying a more equal relationship between patient and provider.
- It effectively puts remote and in-person healthcare encounters on equal footing.
- It recognizes that best practices for telehealth and in-office visits differ somewhat and establishes a sensible process for developing telehealth standards.
- It limits excessive documentation requirements that inhibit the development of telehealth.
- It adds audio-only encounters (i.e., telephone calls) to the definition of telehealth.
- It establishes reimbursement standards for telehealth encounters.
- It includes asynchronous (store-and-forward) technologies in the definition of telehealth.

PAYMENT AND COSTS IN TELEHEALTH

The bill establishes reimbursement for telehealth at parity with in-office encounters—similar to what the Centers for Medicare and Medicaid Services adopted on an emergency basis in August 2020.[7] I recommend that some consideration be given to a more flexible reimbursement policy for telehealth encounters.

Two coauthors and I produce the Mercatus Center's Healthcare Openness and Access Project (HOAP), which provides comparative data on each state's openness to telehealth and other aspects of healthcare.[8] In a recent paper for that project, we wrote the following: "We take it as beneficial that in some states Medicaid will pay for telemedicine. But [payment] parity itself is problematic. One

4. Robert F. Graboyes, "Telemedicine Before, During, and After COVID-19," *Discourse*, March 31, 2020.
5. Robert F. Graboyes and Conor Norris, "On the Virtues of Telemedicine," *Inside Sources*, August 28, 2019.
6. Robert F. Graboyes, "Telepsychiatry — Serving the Underserved," *Inside Sources*, October 9, 2018.
7. Advisory Board, "The 2021 Medicare Physician Fee Schedule Proposal: What You Need to Know," *Daily Briefing*, August 5, 2020.
8. Jared M. Rhoads, Darcy N. Bryan, and Robert F. Graboyes, "Healthcare Openness and Access Project 2020: Full Release" (Project Overview, Mercatus Center at George Mason University, Arlington, VA, December 2020), 9.

argument for telemedicine is that it is less costly than traditional office visits. Therefore, if Medicaid pays the same amount for both, it may be depriving telemedicine practices of the ability to compete on the price dimension to push costs downward."[9]

It would be worthwhile to consider, in lieu of rigid parity (i.e., telephysicians being paid the same as in-person physicians), whether a more flexible version of parity might be in order. For example, telephysicians could be allowed to charge up to the level of parity but could, if costs of provision were lower, charge less in order to expand their market share. The economic literature on reference-based pricing and reward-based programs (which reward patients for choosing lower-cost providers) offer a rich vein of ideas to explore in this regard.[10] With reference-based pricing, payers agree to pay up to a certain price but possibly less. With reward-based programs, patients receive direct financial benefits for using lower-cost providers.

Finally, one of the greatest boosts to telehealth would come from allowing Arizonans to tap into broad categories of telehealth providers anywhere in the United States.[11] Doing so would increase the ease of obtaining help at any hour of the day or night, especially during periods of peak demand within Arizona. Arizona's pathbreaking accomplishments in professional licensure make the state a natural place for similar innovation on the telehealth front.

9. Rhoads, Bryan, and Graboyes, "Healthcare Openness and Access Project 2020," 14–15.
10. John O'Shea, "How to Increase Transparency and Promote Value in Healthcare" (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, June 2020).
11. Robert F. Graboyes, "State Versus Federal Licensure in Telemedicine," *Inside Sources*, December 23, 2019.