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TESTIMONY

MONTANA'S PROPOSED LEGISLATION TO LOOSEN RESTRICTIONS ON TELEHEALTH IS A WELCOME STEP

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Good afternoon Chair Howard, Vice Chairs Keenan and Gross, and members of the Committee on Public Health, Welfare and Safety. I am grateful for the invitation to testify on Montana's proposed telehealth legislation HB 43. My name is Kofi Ampaabeng, and I am a senior research fellow at the Mercatus Center at George Mason University, where my work focuses on identifying and examining state and federal regulations that impede access to quality and affordable healthcare.

My testimony today will focus on the following key points:

1. Telehealth is instrumental in improving access to quality healthcare for Montanans, particularly those in designated underserved areas.
2. Although telehealth is not new, its frontiers are limitless and continuously expanding, and it is therefore imperative that legislators do not get in the way of this expansion through overly restrictive laws. As much as possible, legislation should be permissive rather than restrictive to ensure that Montanans realize the full potential of telehealth.
3. The final bill should ensure that one of the key benefits of telehealth—lower costs, compared to traditional healthcare delivery—is not stymied. Cost savings might be at risk if insurers are mandated to treat all healthcare delivery in the same way regardless of the cost of providing particular services.

According to the US Department of Health and Human Services, as of September 2020, because of the shortage of healthcare providers, 110 areas in Montana are classified as underserved in terms of mental healthcare, 123 areas in terms of dental healthcare, and 138 areas in terms of primary healthcare.[1] Compared to its two neighbors Idaho and Wyoming, Montana has less access to healthcare owing to a shortage of health professionals. For example, only 11 percent of Montanans have their mental health needs met, whereas 24 percent of Idahoans and 31 percent of Wyomingites do. Similarly, for primary

1. Health Resources and Services Administration, "Shortage Areas," US Department of Health and Human Services, last updated February 15, 2021, https://data.hrsa.gov/topics/health-workforce/shortage-areas; "Primary Care Health Professional Shortage Areas (HPSAs)," Kaiser Family Foundation, last updated September 30, 2020, https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas.

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care, only one-third (33 percent) of Montanans have access, whereas more than half (54 percent) of Idahoans and Wyomingites have access. Finally, for dental care, only one-third (33 percent) of Montanans have access to care, whereas more than half of Idahoans and Wyomingites (53 percent and 52 percent, respectively) have access. Transportation remains one of the biggest barriers to receiving timely care, especially for residents in low density rural areas.[2]

In years past, healthcare was a relationship between providers and patients, and both parties had to be physically together. Technological innovation has enhanced this relationship in many ways, such as by providing simple consultations over the phone or by providing medical technology that aids in diagnosis to surgeries performed by robots in remote locations. The list is endless. In fact, technology is the driving force of many innovations in all sectors of the economy, and healthcare is no different. The widespread use of technology to connect patients to their providers over the years has led to telehealth (sometimes called telemedicine), virtual health, and digital health.

Although telehealth has been around for a long time, it has been only during the current COVID-19 pandemic that telehealth has been widely adopted. This is no accident. Before the pandemic, state and federal regulations limited the adoption and use of telehealth by restricting the eligible facilities, locations, and services that are reimbursable—and even when those facilities, locations, and services were reimbursable, different rates applied to telehealth and in-person service delivery. In addition, regulations narrowly defined what technology could count as telehealth. With the pandemic, these regulations have been waived or repealed outright. As a result, the adoption and utilization of telehealth has exploded.

Evidence shows that, as the federal government and state governments have relaxed regulations regarding the definition and use of telehealth in the delivery of healthcare services, the uptake of telehealth services has increased tremendously across all populations, including Medicare and Medicaid beneficiaries. According to the Centers for Medicare and Medicaid Services, states that expanded access to telehealth as a result of the COVID-19 pandemic generally reported

- reductions in no-show rates,
- decreases in non-emergency transportation costs,
- increases in the ability of providers to engage populations that historically have had difficulty getting access to care, and
- increases in the ability of beneficiaries with limitations on time off from work or with childcare concerns to attend appointments.[3]

In fact, in Montana, the use of telehealth for primary care, which was practically nonexistent before the COVID-19 pandemic, now comprises 27 percent of all primary care visits.[4] It is important that these gains be made permanent. Telehealth has shown itself to be very effective in the provision of mental health services.[5] Even before telehealth gained widespread adoption within the broader medical community, psychiatry had been utilizing telehealth very effectively. I have personal experience with

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2. Mary K. Wolfe, Noreen C. McDonald, and G. Mark Holmes, "Transportation Barriers to Health Care in the United States: Findings from the National Health Interview Survey, 1997-2017," *American Journal of Public Health* 110, no. 6 (2020): 815–22.
3. Arielle Bosworth et al., *Medicare Beneficiary Use of Telehealth Visits: Early Data from the Start of the COVID-19 Pandemic*, 2019; Centers for Medicare and Medicaid Services, "CMS Fast Facts" (dataset), last updated December 16, 2020, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Fast-Facts; Alvarez & Marsal, *The New "Normal" for Virtual Medicine*, September 9, 2020.
4. Bosworth et al., *Medicare Beneficiary Use of Telehealth Visits*; "CMS Fast Facts" (dataset); Alvarez & Marsal, *The New "Normal."*
5. Steven Chan, Michelle Parish, and Peter Yellowlees, "Telepsychiatry Today," *Current Psychiatry Reports* 17, no. 11 (2015): 1–9.

this benefit, as a parent with children who have used telehealth to great effect in Maryland, a state that has also expanded the use of telehealth. This is one reason that I believe HB 43 is timely, and I fully support its objectives.

HB 43 seeks, among other things, to

1. broadly define telehealth to include more services and technologies,
2. remove limitations on the location where telehealth services can be provided,
3. end differentiation between rural and urban areas,
4. forbid providers from requiring that patients must have established a prior relationship with a provider before using telehealth services, and
5. expand the list of health insurance plans that must offer coverage for telehealth services.

These legislative actions will benefit Montanans, as has been demonstrated in other places and in Montana during the COVID-19 pandemic. In approving HB 43, Montana would be joining a host of states, including Colorado, Idaho, Missouri, and Utah, that have moved to enact temporary regulatory changes into law to consolidate the benefits of telehealth.

As the Montana Senate considers this proposed bill, it should pay special attention to the issue of payment parity, which could be a double-edged sword. Although payment parity would encourage the adoption of telehealth by more providers, it could also undercut one of the key benefits of telehealth. It is widely known that telehealth visits are cheaper than in-person visits. According to one study, the average cost of a telehealth visit ranges from $40 to $50, compared to $136 to $176 for in-person acute care visits.[6] The low cost of telehealth visits has been one of the biggest barriers to telehealth adoption because providers earn less per visit. But if telehealth is cheaper to provide, then the price should reflect that, rather than being set artificially high.

Because the technology powering the adoption of telehealth is evolving at breakneck speed, and because regulators and legislators have limited knowledge about future trends, it is important to be as broad as possible when defining telehealth technology. As proposed, HB 43 strives not only to refrain from restricting which plans can or must offer telehealth coverage, it also attempts to avoid restricting coverage on the basis of on location and technology. Such restraint fosters innovation as the telehealth frontier keeps expanding. This aspect of the legislation is necessary—because the role of remote technology in connecting patients to providers is evolving at such a fast pace, the definition of telehealth keeps changing.

For now, the World Health Organization defines telehealth to include "the delivery of health care services, where distance is a critical factor, by all healthcare professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities." Even this definition does not factor in an even more critical component known as digital health. Digital health comprises the use of software applications and devices that use artificial intelligence to connect

6. Bosworth et al., *Medicare Beneficiary Use of Telehealth Visits*; "CMS Fast Facts" (dataset); Alvarez & Marsal, *The New "Normal."*

patients, service providers, and other stakeholders to provider services and that enable providers to receive data from patients for diagnosis and treatment.[7]

Digital health and telehealth offer an incredible opportunity to deliver affordable, accessible, and effective healthcare to all, provided that regulators do not get in the way but actively work to remove barriers to the adoption of innovative solutions. HB 43, as currently proposed, goes a long way toward removing such barriers while not adding new ones. It is particularly important that rules requiring parity do not unnecessarily encumber the exciting opportunities that are in store for all.

7. Kushal Kadakia, Bakul Patel, and Anand Shah, "Advancing Digital Health: FDA Innovation during COVID-19," *npj Digital Medicine* 3, no. 1 (2020): 161–63.