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TESTIMONY

MAKING TELEHEALTH WORK FOR ARIZONANS

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Arizona State Legislature, Senate Committee on Finance

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Good afternoon, Chair Livingston, Vice Chair Mesnard, and members of the Committee on Finance. I am grateful for the invitation to testify on Arizona's proposed telehealth legislation, HB 2454. 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 Arizonans, particularly those in underserved areas.
2. Given that the benefits from telehealth for patients and providers are widely recognized, it is imperative that legislators do not impede the growth of this service with overly restrictive laws.
3. Mandating payment parity between in-person visits and telehealth visits would remove one of the key advantages of telehealth.

According to the US Department of Health and Human Services, as of September 2020, because of the shortage of healthcare providers, only 41 percent of Arizonans had their primary health care needs met, less than Nevada (48 percent), Texas (59 percent), and Utah (60 percent). Arizona would need 560 primary care physicians to make up for the shortfall. Telehealth provides an opportunity for residents in underserved areas to access healthcare from all over the country.[1]

Healthcare has traditionally been a relationship between providers and patients, and both parties normally have 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. Although telehealth has been around for a long time, it has been only during the current COVID-19 pandemic that

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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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 which technology could count as telehealth. During the pandemic, these regulations have been waived or repealed outright. As a result, the adoption and utilization of telehealth has exploded. In fact, in Arizona, the use of telehealth for primary care, which was nonexistent before the COVID-19 pandemic, now constitutes 34 percent of primary care visits by Medicare beneficiaries.[2]

Evidence shows that, as the federal 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]

It is important that the improvements in outcomes resulting from increased access to telehealth be made permanent.

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. Doing so would foster 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, and it is important that Arizonans do not have to repeatedly seek permission from their legislators in order to benefit from technological advancements in healthcare.

As the Arizona Senate considers this proposed bill, it should pay special attention to the issue of payment parity, which could undercut one of the key benefits of telehealth. Telehealth has been shown to cost less than in-person care. According to one study, the average cost of telehealth visits ranges from $40 to $50, compared with $136 to $176 for in-person acute care visits.[4] This is simple economics: telehealth is less expensive to provide, and this cost will be reflected in a lower price than in-person appointments. Setting artificial prices for healthcare would only disrupt the market at the expense of patients.

Thank you again for the opportunity to speak on this proposed bill.

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2. Arielle Bosworth et al., *Medicare Beneficiary Use of Telehealth Visits: Early Data from the Start of COVID-19 Pandemic* (Washington, DC: US Department of Health and Human Services, July 2020); 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.
3. Bosworth et al., *Medicare Beneficiary Use of Telehealth Visits*; Centers for Medicare and Medicaid Services, "CMS Fast Facts" (dataset).
4. Dale H. Yamamoto, *Assessment of the Feasibility and Cost of Replacing In-Person Care with Acute Care Telehealth Services* (Barrington, IL: Red Quill Consulting, December 2014), 1.