

# telemedicine

in the post-COVID-19 world



# background

The unique and urgent demands of the COVID-19 pandemic have accelerated the use of telemedicine. As geographic areas experience surges in infections and brick-and-mortar health facilities need to minimize the risk to providers and patients of contracting the virus, virtual care—video, phone or online visits between patients and healthcare providers—has proven to be a crucial resource. The ability of providers to care for patients remotely is helping to reduce transmission, preserve personal protective equipment and other scarce supplies, and preserve continuity of care—and thus quality of care—for patients who wouldn't feel safe visiting health facilities.

The broad, positive experience gained with telehealth during the COVID-19 pandemic suggests its adoption as an important core element of care delivery going forward after COVID is resolved.

The purpose of this paper is to raise awareness of how telemedicine has evolved and to offer considerations – for both employers and policymakers – on how to best leverage telemedicine to support employer-sponsored health program strategies that support roughly half of the people in the US. Employers see virtual healthcare in all forms as key to improving health care quality and efficiency, and it is important they have a voice in policy decisions that will shape its future.

# 8,336%

Increase in telemedicine utilization  
year-over-year in April 2020



# how the pandemic changed telemedicine



## Employer response

Employers have actively promoted the use of telemedicine to their employees since the onset of the pandemic as a safe way to initiate care or receive medical advice. Most already provided a telemedicine service (such as Teladoc, MDLive or Doctor on Demand) prior to the pandemic; Mercer's 2019 survey found that 89% said their employees had access to telemedicine (although utilization was generally low, as will be discussed below). While employers' primary objective for telemedicine was typically to make healthcare more convenient and accessible to employees, many also hoped it would help manage health spending by providing a lower-cost alternative to in-person visits to a physician office, urgent care or emergency department. Prior to the pandemic, plan members typically did not have access to virtual visits with their own doctors or specialists – at least not in a fee-for-service setting. In capitated models such as HMOs, Accountable Care Organizations and advanced primary care practices, telemedicine and texting with physicians is more common.



## Government and private insurer response

Given the value of virtual care during the public health emergency, new policies were enacted to enable this alternative to office visits. The Centers for Medicare and Medicaid Services pays providers the same rate for virtual and in-person visits (which has potential unintended consequences noted later), and has waived the requirement that patients see only their established providers for virtual care. CMS also now allows providers to deliver virtual care from their own homes, without going through the traditional processes required for home-based virtual practice, and provided tool kits and \$200M in funding to support them in setting up virtual care capabilities.

Additionally, several states have passed legislation to support telemedicine, including requiring private insurers to pay providers the same amount for virtual visits as in-person care and to waive patient cost-sharing. Major private insurers are also voluntarily changing their policies. Aetna, Blue Cross Blue Shield, and UnitedHealthcare, among others, temporarily waived member co-pays for virtual visits.



## Consumer response

Before the pandemic, employers reported slow growth in the use of telemedicine. Those with active programs in place in 2019 reported an average utilization rate of 9%, up from 8% the prior year and 7% the year before that. One explanation for the generally low utilization is that telemedicine services are most often provided as an 'add-on' through the health plan and, prior to the pandemic, were not well promoted. It is worth noting that employers offering telemedicine through a specialty vendor saw higher average utilization, as did employers requiring low or no cost-sharing. Although a [survey](#) conducted by Mercer Marsh Benefits, Mercer, and Oliver Wyman of 2,000 US workers conducted in 2019 found that 77% said they were willing to try telemedicine, clearly far fewer were actually using it at the time of the survey. That changed in March 2020, as telemedicine utilization began climbing dramatically. [FAIR Health's Monthly Telehealth Regional Tracker](#) reports that telemedicine utilization grew by more than 8,336% year-over-year in April 2020. Further, results from a Mercer survey of more than 600 employers conducted in June 2020 found that the majority believe telemedicine services were able to meet employees' needs during the pandemic – 68% said they were satisfied with their telemedicine provider's response time and member service (27% were very satisfied). Bottom line, consumers tried it, had a good experience and will expect this type of convenience going forward.

## Racial disparities in telemedicine utilization must be addressed

The pandemic is exposing, in the harshest possible light, disparities in health and health outcomes that have long existed. Centers for Disease Control data shows the age-adjusted death rate for Black people is 3.6 times that of white people, and the death rate for Hispanic/Latino people is 2.5 times that of white people, with particularly big gaps among working-age people. There are many intersecting factors behind these statistics, including access to care. A recent report on telemedicine use in March and April found that Black people were significantly less likely to access care through telemedicine than white people. Although Black use of telemedicine for urgent care increased overall, there is still significant opportunity for improvement in racial disparities in utilization.

# plan sponsor perspective

On the one hand, plan sponsors are encouraged that telemedicine utilization has increased more in a few months than they expected it to grow in five years. They recognize the value of primary care and behavioral healthcare, and see telemedicine as an important means of increasing access particularly for those in underserved communities. At the same time, they are concerned that decisions being made now, under the pressure of the pandemic, may have unintended consequences for the future of healthcare.



## Telemedicine programs vs. virtual visits

It is important to clarify the differences between traditional telemedicine services and virtual visits with providers in terms of service, price and value. For both the patient and provider, telemedicine services delivered via a vendor solution such as Teladoc and a virtual visit with a patient's own PCP or specialist are two very different encounters.

**\$40-50**

**Telemedicine services are designed to deliver urgent, episodic care, and typically cost \$40-\$50 per visit, but as a result of the Medicare telehealth expansion and existing fee schedule, telemedicine vendors have started to raise their prices.**



Virtual visits have the potential to deliver more complex care in the context of a longstanding provider-patient relationship, although it will require training and infrastructure such as HIPAA-safe technology and a new reimbursement framework (more on that below). Of course, as the market continues to evolve, the distinction between these two categories will blur. Many telemedicine vendors are attempting to pivot and brand themselves as virtual primary care. Whether this model can truly provide continuity of care, whether members can develop relationships with doctors they've never met and doctors can appropriately diagnose and treat patients they've never seen in person, are important questions still to be answered.

Many self-insured employers that offer traditional telemedicine services have chosen to waive employee cost sharing during the pandemic (if they required cost sharing formerly). Employers will want to be able to revisit the question of cost sharing at the appropriate time. For some, long-term strategies for managing total healthcare cost includes a hierarchy of digital and in-person care, and they will need the flexibility to use cost-sharing within their plan design features to incentivize appropriate utilization.

Thinking ahead to the use of virtual visits after the worst of the pandemic is over, employers are raising questions about cost and utilization:



### Right-sizing cost

Reimbursing providers for virtual care visits at the same rate as for in-person visits does not seem sustainable over the long term.

Some considerations:

- While virtual care requires physician practices to expand the ways that they provide care, it does not require the costly infrastructure of bricks-and-mortar facilities, and typically, less work is required of a doctor and staff because the patient is not physically present. Virtual care does not always justify equal payment.
- Existing medical codes reimburse a provider for performing a whole range of services that may occur in an office setting, including a physical examination. Using these existing codes for virtual care may result in payment for services that a provider cannot perform virtually.
- It is important to keep in mind that Medicare reimbursement is much lower than reimbursement to providers for patients covered in the commercial market. Health policy designed for Medicare may result in cost shifting to the commercial market.
- The greater ease and convenience of virtual care – for both the provider and patient – make it likely that virtual visits will not substitute for some in-person visits on a one-to-one basis, but rather that the combined number of virtual and in-person visits will increase. If virtual visits continue to be billed at the same rate as in-person visits, not only will we fail to realize savings from virtual care, but total healthcare spending will rise.



### Utilization

New coding with more precise and accurate descriptions of services provided may be needed to support virtual visits. This would allow for creativity in exploring the potential for using telemedicine and other types of virtual care to deliver value to the patient and reimbursement matched to the level of effort and value delivered. Controls will be needed to protect against abuse such as upcoding – or simply to provide clear guidelines for providers. Inconsistencies clearly exist today: A provider may charge the same amount for a 15-minute phone visit as for a 45-minute office visit – but then a phone call with a patient to discuss lab results is not billed. And what about consultations that are essentially triage – a patient calling a doctor's office to determine whether she should have a phone visit, an in-person visit, or simply wait for additional symptoms? Will that call generate a charge? Physicians are currently under serious financial pressure given the dramatic drop in routine care, which could be a factor in potential over-use and upcoding for telemedicine encounters.



### Employers seeking supportive policy changes

In addition to moving quickly in the early days of the pandemic to boost telemedicine in the public sector, Congress and the Administration have taken steps to support employers' ability to offer telemedicine services, but employers are urging additional changes.

A provision enacted in March 2020 as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, for example, allows HSA-eligible plans to temporarily cover telemedicine on a pre-deductible basis (regulators provided similar relief). Employers want Congress to make this change permanent.

Some employers also want to offer telemedicine as a stand-alone employee benefit, apart from health coverage, but must contend with rules requiring telemedicine benefits to be offered as part of full medical benefits that must comply with numerous Affordable Care Act requirements. While employers are generally limited in their ability to offer telemedicine as a standalone option to anyone not enrolled in the full medical plan, recent guidance from the Administration provides limited relief during the COVID-19 emergency period. While an important first step, employers are asking lawmakers to designate stand-alone telemedicine programs an "excepted benefit" under current rules so that these services can be offered to more employees and their families.

Employers also recommend that Congress remove a thicket of state barriers to telemedicine, including a requirement in many states that the patient and provider reside in the same state, limiting telemedicine to specific technologies, and requiring that patients have a pre-existing relationship with the provider.

In addition, employers are urging Congress to reject any mandates relating to telemedicine that would impede employers' flexibility to innovate and pursue value-based care. Pending legislation would, for example, require ERISA health plans and insurers to cover telemedicine services for any service that is covered in person, as well as mandate that payment for those services be the same whether provided via telemedicine or in person.

# the post-COVID future of virtual care and supportive payment

There is no turning back the clock. Having been steered to virtual healthcare during the pandemic, health plan members will expect virtual visits to continue to be available. In the ongoing shift to more virtual modes of working and conducting business, it is natural they would expect those efficiencies to translate into healthcare delivery.

Visionary plan sponsors, health plans and provider organizations see virtual care as the next wave in health care. They see a hybrid model – more virtual care, balanced with the appropriate level of in-person care – leading to better outcomes, lower health care costs, and can greatly improve monitoring patients with chronic conditions. This would generate greater value to both the plan sponsor and to the end user.

Fee schedules can handle payments for well-defined, relatively infrequent, high-priced services; however, telemedicine visits and other types of digital and virtual interaction are not ideally suited for fee-for-service payment methods. The cost to document and bill for often poorly defined, frequent, and low-priced services, including a lot of telehealth communications, can exceed the payment to provide the care. The imperative to pay appropriately for telehealth services provides an opportunity to redesign how we pay for primary care, potentially using a blended payment model like the [Medicare CPC+ Track 2](#) demonstration approach, which is a blend of a reduced fee schedule and a per capita payment for patients aligned with a practice.

Health systems are already working to realize the potential of virtual care. “Hospital at home” is one of the ways hospitals created capacity during COVID, Mayo Clinic has announced an at-home advanced care model, and E-consults – doctor to doctor consultations – are already used to support specialties and address deficiencies in care access in some areas of the country.

**For that vision to become a reality, we will need to right-size reimbursement and ensure equitable payment for the intensity of the service provided.**

**Some telemedicine visits could be avoided with AI triage to screen symptoms and direct a patient to a care access point or to self-care.**

These types of solutions are already available (examples include Buoy and 98point6) and have played an important role in return-to-the-workplace efforts.

One problem with the US healthcare system – perhaps the central problem – is that the many stakeholders do not have a mechanism to invest collectively in value. The pandemic has made it clear that we would all benefit from having healthcare resources that can meet the needs of our communities in a crisis. We need planning, connectivity and a ready capacity. Virtual care can play a vital role in expanding primary care access and building a stronger, more resilient healthcare system – but only if all stakeholders treat it as a means to drive greater efficiency and value.

in conclusion

## Telehealth recommendations for policymakers

1

Make permanent the provision under the Coronavirus Aid, Relief, and Economic Security (CARES) Act allowing HSA-eligible high-deductible health plans to cover telehealth services on a pre-deductible basis.

2

Ensure that an employer's more robust offer of telehealth services does not result in violations of the ACA's market reforms to the extent the benefits provided give rise to an ERISA health plan and provide significant benefits in the nature of medical care.

3

Remove state barriers to telehealth care, such as requiring that patients have a pre-existing relationship with the provider, and allow licensed providers to deliver services to patients in other states via telehealth.

4

Reject mandates that would require parity in payments to providers for virtual and in-person services and thereby impede employers' flexibility to innovate and pursue value-based care.

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