



Statement for the United States House of Representatives  
Subcommittee on Health

April 28, 2021

Charting the Path Forward for Telehealth

Submitted by  
National Association of Health Underwriters



I am writing on behalf of the National Association of Health Underwriters (NAHU), a professional association representing over 100,000 licensed health insurance agents, brokers, general agents, consultants and employee benefits specialists. The members of NAHU work daily to help millions of individuals and employers of all sizes purchase, administer and utilize health plans of all types. We are pleased to have the opportunity to submit comments to the subcommittee regarding the future of telehealth services.

There has never been a better time to discuss telemedicine. The COVID-19 pandemic has radically altered the way in which consumers think about healthcare and receive healthcare services. With millions of healthcare consumers looking for a way to see their physician without needing to leave their home, telemedicine has become crucial. Physical in-office doctor visits decreased by 50.2 percent (59.1 million visits) in the second quarter of 2020 compared with the second quarters of 2018 and 2019, while the percentage of overall doctor visits that were telemedicine visits increased from just 1.1 percent in 2018 and 2019 to 35 percent in 2020.<sup>1</sup> The majority of providers across the country experienced a large shift from in-person to online care. One example is TriHealth, a health system based in Cincinnati, Ohio, that experienced a 3,650-percent increase in telemedicine usage with primary care telehealth visits accounting for over 50 percent of all visits.<sup>2</sup>

Consumers have undoubtedly benefited from the widespread adoption of telemedicine throughout the pandemic. But what will telemedicine look like after the federal health emergency? We anticipate demand for telehealth services to continue even after the pandemic is long behind us; almost 88 percent of Americans want to continue using telehealth for non-urgent consultations after COVID-19 has passed, while almost 80 percent say it is possible to receive quality care through telehealth.<sup>3</sup> Telemedicine can increase access to care for consumers in underserved rural and urban areas and has the potential to lower healthcare costs in the short term for both consumers and providers. However, there are still significant barriers and inequities that exist within telemedicine that must be addressed while we chart the path forward.

## Improving Overall Access to Care

Health inequities were present in rural communities even prior to the pandemic. Compared with urban areas, rural populations have lower median household incomes, a higher percentage of children living in poverty, fewer adults with postsecondary educations, more uninsured residents under age 65, and higher rates of mortality.<sup>4</sup> One hundred eighty rural hospitals have closed since 2005.<sup>5</sup> The patient-to- primary care physician ratio in rural areas is only 39.8 physicians

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<sup>1</sup> Tajanlangit, Matthew, et al. [Use and Content of Primary Care Office-Based vs Telemedicine Care Visits During the COVID-19 Pandemic in the U.S.](#) *JAMA Netw Open.* 2020;3(10):e2021476. doi:10.1001/jamanetworkopen.2020.21476.

<sup>2</sup> Siwicki, Bill. [TriHealth Switches to Zoom for Pandemic, Sees 3,650% Increase in Telehealth Use.](#) *Healthcare IT News.* 4 November 2020.

<sup>3</sup> [Americans' Perceptions of Telehealth in the Era of COVID-19.](#) SYKES. March 2021.

<sup>4</sup> [Rural Health Snapshot \(2017\).](#) NC Rural Health Research Program, The Cecil G. Sheps Center for Health Services Research. May 2017.

<sup>5</sup> [Rural Hospital Closures.](#) The Cecil G. Sheps Center for Health Services Research. Accessed 26 April 2021.



per 100,000 people, compared to 53.3 physicians per 100,000 in urban areas,<sup>6</sup> so those who live on farms, ranches, reservations and frontiers often travel long distances to reach a provider. For specialists, the data is only starker; for example, as of 2014, 54 percent of rural counties did not have a hospital with obstetrics services.<sup>7</sup> Additionally, greater distances between hospitals result in longer wait times for rural emergency medical services. Because most rural health disparities are caused by barriers to in-person care, the recent rapid implementation of telehealth programs holds tremendous potential for addressing these disparities.

Telemedicine increases access for some individuals in urban areas as well. While the primary physical obstacle for rural communities is distance from a provider, the primary obstacle for some in urban areas is means of transportation. Transportation barriers routinely lead to rescheduled or missed appointments, delayed care, and missed or delayed medication use. Studies have consistently shown that those who do not have access to a vehicle often delay care, and lack of personal vehicle is more common in urban areas than rural ones.<sup>8</sup>

While access to care is critical, access means little if the quality of care is low. Some may be concerned with the quality of care consumers receive in telemedicine visits relative to in-person visits. However, research so far shows that patient satisfaction with video visits is high.<sup>9</sup> Research also suggests that patients who use telemedicine are more likely to follow up with their physician. One study shows that 10.3 percent of the patients first seen through a direct-to-consumer telehealth visit had a visit in the following week, compared to 5.9 percent of those whose first visit was in-person.<sup>10</sup>

## Inequities within Telemedicine

While telemedicine can increase access to care generally, there is still a substantial amount of evidence exposing inequities in accessing telemedicine that must be addressed moving forward. There is still a “digital divide” between urban and rural areas that impedes upon rural consumers’ ability to utilize telehealth. As of 2019, one in five rural adults say accessing high-speed Internet is a problem for their family, and without reliable, broadband high-speed Internet access, rural communities are unable to properly reap the benefits of telehealth expansion.<sup>11</sup> NAHU recommends looking at methods to eliminate this “digital divide” so that rural communities can better access all of the advantages that come with telemedicine.

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<sup>6</sup> Hing, E, Hsiao, C. U.S. Department of Health and Human Services. [State Variability in Supply of Office-based Primary Care Providers: United States 2012](#). NCHS Data Brief, No. 151, May 2014.

<sup>7</sup> Hung, Peiyin et al. “[Access to Obstetric Services in Rural Counties Still Declining, With Nine Percent Losing Services, 2004–14](#).” *Health Affairs*. September 2017.

<sup>8</sup> Syed, Samina T et al. “[Traveling towards Disease: Transportation Barriers to Health Care Access](#).” *Journal of Community Health* vol. 38, 5 (2013): 976-93. doi:10.1007/s10900-013-9681-1.

<sup>9</sup> Ramaswamy Ashwin, et al. [Patient Satisfaction with Telemedicine During the COVID-19 Pandemic: Retrospective Cohort Study](#) *J Med Internet Res* 2020;22(9):e20786

<sup>10</sup> Yinran Li, Kathleen, et al. “[Direct-to-Consumer Telemedicine Visits for Acute Respiratory Infections Linked to More Downstream Visits](#).” *Health Affairs*. April 2021.

<sup>11</sup> Neighmond, Patti. “[With Rural Health Care Stretched Thin, More Patients Turn to Telehealth](#).” *NPR*. 7 July 2019.



It is not just rural communities that struggle with access in this regard. Outside of the urban and rural divide, recent studies show that there is work to be done in closing other gaps in telehealth. Unfortunately, many older adults and people with disabilities lack access to video-enabled devices or struggle to use the more complex video-enabled devices even if they have them. Likewise, many in ethnic and low-income communities lack access to broadband or video-enabled devices, which only expands the health inequities in the U.S. Video use for telemedicine visits was found to be significantly lower among Black and Latinx patients and among patients with a median household income below \$50,000, likely due to decreased accessibility to broadband Internet, connected devices and video-capable technologies. Lower-income patients and patients from minority groups are less likely to own a computer, to have reliable cellphone data plans, and to have broadband Internet in the home.<sup>12</sup> For these reasons, we believe that for appropriate healthcare services, that audio only care also be available to bridge the gap in communities that may not have access to or feel comfortable with technology that relies on broadband Internet.

Older patients and non-English-speaking patients also had lower rates of telemedicine use.<sup>13</sup> Older age is associated with lower Internet availability, lower usage of digital health technology, and slower rates of technology adoption. Impaired eyesight, hearing and motor skills may also make telehealth challenging for older individuals. For those who do not speak English as a first language, language barriers to care via telemedicine platforms can be prohibitive.

In addition to these disparities, one major area in telemedicine that needs to be addressed is cross-state-border restrictions. This remains one of the largest most complex barriers within the telemedicine space. NAHU recommends easing cross-state-border restrictions on telehealth, as well as adopting technology-neutral requirements, and permitting use of different types of technology platforms that are designed for telehealth.

## Reducing Healthcare Costs

NAHU is always searching and advocating for new and innovative ways to lower healthcare costs. Telemedicine visits can generate cost savings for the patient and the provider, primarily by diverting patients away from more costly care settings. According to a 2019 study, diverting patients from emergency departments with telemedicine can save more than \$1,500 per visit.<sup>14</sup> Additionally, since telehealth services can save time for employees while reducing costs for employers, employers can therefore also save money by reducing the number of emergency-room or urgent-care visits employees have.

## Making Medicare Changes Permanent

Towards the beginning of the pandemic, CMS broadened access to Medicare telehealth services with the intent of offering beneficiaries a wider range of services from their providers without having to travel to a healthcare facility. This

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<sup>12</sup> Eberly Lauren, et al. [Patient Characteristics Associated with Telemedicine Access for Primary and Specialty Ambulatory Care During the COVID-19 Pandemic](#). *JAMA Netw Open*. 2020;3(12):e2031640. doi:10.1001/jamanetworkopen.2020.31640

<sup>13</sup> Ibid

<sup>14</sup> Rising, Kristin et al. [On-Demand Synchronous Audio Video Telemedicine Visits Are Cost Effective](#). *The American Journal of Emergency Medicine*. 7 August 2018.



was done on a temporary and emergency basis under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act. Under this new waiver, Medicare began to pay for office, hospital and other visits furnished via telehealth across the country, including in patients' places of residence. In October 2020, CMS expanded the list of reimbursed telemedicine services, and in its 2021 payment rule, CMS temporarily added 144 telehealth services to be covered by Medicare.

Prior to the public health emergency, approximately 13,000 beneficiaries in fee-for-service Medicare received telemedicine in an average week. According to CMS, during the week of April 26, 2020, nearly 1.7 million beneficiaries received telehealth services.<sup>15</sup> In 2016, only one-quarter of one percent of all Medicare beneficiaries used a telehealth service in a year; between March and June 2020, over 20 percent of Medicare beneficiaries utilized telemedicine.<sup>16</sup> The data plainly suggest that Medicare beneficiaries are taking advantage of these flexibilities and will likely continue to do so in the future.

A final rule released under the Trump Administration made 60 of the 144 telehealth services newly offered during the COVID-19 pandemic permanent, including services for group psychotherapy, cognitive assessment and care planning, psychological and neuropsychological testing, and domiciliary, rest-home or custodial-care services for established patients. While we are pleased that CMS has permanently added these services, the remainder are currently set to expire in December. NAHU recommends making all telemedicine flexibilities in Medicare, which are set to expire at the end of the federal emergency period, permanent.

We appreciate the opportunity to provide these comments and would be pleased to respond to any additional questions or concerns of the committee. If you have any questions about our comments or if NAHU can be of assistance as you move forward, please do not hesitate to contact me at either (202) 595-0639 or [jtrautwein@nahu.org](mailto:jtrautwein@nahu.org).

Sincerely,

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<sup>15</sup> Verma, Seema. [Early Impact of CMS Expansion of Medicare Telehealth During COVID-19](#). *Health Affairs*. 15 July 2020.

<sup>16</sup> Siwicki, Bill. [How Do Providers Strike the Right Balance Between in-Person Care and Telehealth?](#) *Healthcare IT News*. 21 April 2021.