GLG

OCTOBER 2020

THE RISE OF TELEMEDICINE

SURVEY AND PERSPECTIVES

Featuring

Sarah-Lloyd Stevenson, *former Policy Advisor to the White House Domestic Policy Council and former Policy Advisor at the US Department of Health and Human Services*

Elizabeth Bierbower, *GLG Council Member and former Segment President of Employer Group and COO of Specialty Benefits, Humana*

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INTRODUCTION

Michael Weissman, Vice President and Content Team Leader, Healthcare

The U.S. telemedicine market surged in the first half of 2020. A July HHS report showed an increase from 0.1% of all Medicare primary care visits being facilitated through telehealth in February exploding to 43.5% by April.

Decreased regulation coupled with lockdowns and limited access to traditional in-person care dramatically increased adoption. Companies quickly jumped at the opportunity, highlighted by the $18.5 billion merger of Teladoc Health and Livongo, and Amwell, GoodRx, and (forthcoming) Hims Inc. IPO's.

This eBook is a look at telemedicine, its adoption, and possible future. Included here:

TELEMEDICINE SURVEY: Patient and Physician Adoption – GLG conducted a survey of both patients and physicians to understand how they felt about telemedicine's efficacy, and whether they expected it to continue to be a part of medical practices for the foreseeable future, even after a COVID-19 vaccine.

TELEMEDICINE DYNAMICS: Regulatory Perspective – GLG talked with Sarah-Lloyd Stevenson, former Policy Advisor to the White House Domestic Policy Council and former Policy Advisor at the US Department of Health and Human Services, about the shifting legislative winds around telemedicine.

TELEMEDICINE DYNAMICS: Payer Perspective – GLG spoke with Elizabeth Bierbower, former Segment President of Employer Group and COO of Specialty Benefits, Humana, about how payers – from Medicaid to private insurers – have looked at telemedicine in the past, and how their likely to view it in the future.

Both the survey and our experts agree that the pandemic has given telemedicine a foothold to propel itself into the mainstream, while risks still exist in the form of regulation, coverage, and competition from traditional care, once the pandemic subsides.

GLG will continue to provide the perspectives you need to make the smartest decisions, as the landscape shifts. Stay tuned to the Insights section of GLG's website for updates on telemedicine, care delivery, and the factors that impact it.

TELEMEDICINE SURVEY:

Patient and Physician Adoption

GLG Surveys

Telemedicine, as a concept, has been around since at least 1925, when Hugo Gernsback, a radio and publishing pioneer, predicted that physicians would use radio and TV to communicate with patients. In the February 1925 issue of Science and Invention, Gernsback wrote an article anticipating a device called the "teledactyl," which would allow doctors to see their patients through a viewscreen and interact with them from a distance using the device's robot arms.

Gernsback guessed that technology wouldn't catch up to his teledactyl for at least 50 years, but rudimentary telemedicine technology began to appear in the late 1950s, when the University of Nebraska employed a kind of telemedicine that allowed it to send neurological exams and interact with patients. And by the end of the 1960s, the Nebraska Psychological Institute, working in conjunction with NASA, built telemedicine into a robust technology that could deliver real health care.

The pandemic is bringing telehealth into the mainstream.

Early on physicians saw that telemedicine had the potential to reach patients in difficult geographies who lacked health care resources, but it wasn't until about 2016 when it really entered the "mainstream." In that year, the United States invested $16 million to improve health care in rural areas, dedicating part of the investment expressly to telemedicine.

Telemedicine Adoption

Up until recently, telemedicine has been slower to catch on. Elizabeth Bierbower, former Segment President of Employer Group and COO of Specialty Benefits, Humana, told us that, while both Medicaid and Medicare payers covered a patient's telemedicine expenses, Medicaid's support came with "significant restrictions," a prime barrier to the true mainstreaming of telemedicine.

Simple awareness of telemedicine has also posed a problem. "Typically, when people have an issue, they want to call their doctor," Bierbower said. "If their doctor doesn't have [telemedicine], then their next thought is to go to the urgent care. Their natural impulse isn't to call a telehealth provider."

Further, provider adoption has proved challenging. Many physicians have not adopted telemedicine into their practice, and as Bierbower told us, "if [a patient's] provider doesn't offer [telemedicine], they may really be hesitant to go to a provider that they don't know."

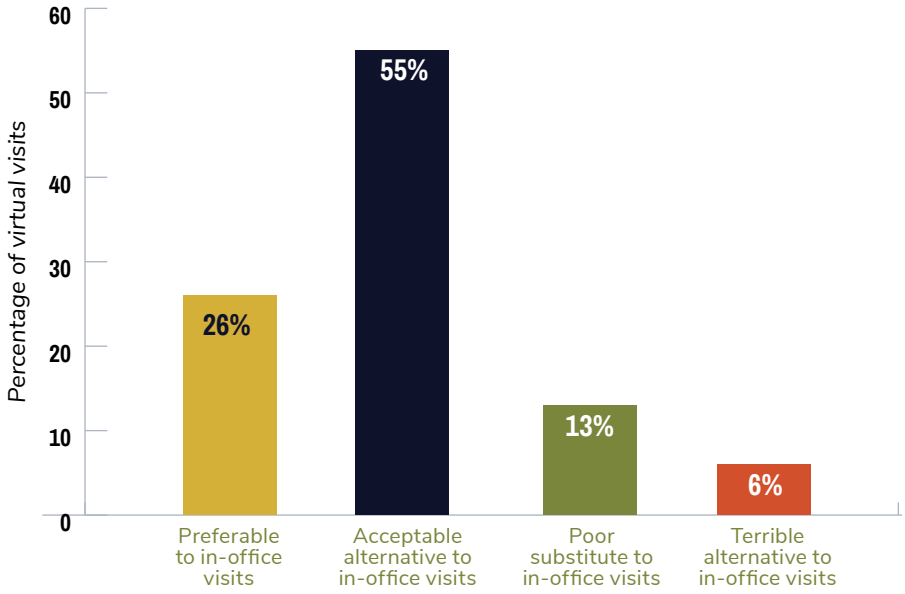
But the pandemic is changing how the public, physicians, and payers look at telemedicine. "Up to now," said Bierbower, "we've needed more awareness around this, and now the pandemic is bringing telehealth into the mainstream."

Patients: Telemedicine Sentiment

GLG recently conducted a survey to take the temperature of the current landscape. We wanted to know how both patients and physicians regarded telemedicine. Was it a viable option? How did the two groups compare?

We asked a sample of 502 patients in the United States to rate what they thought about telemedicine for routine visits and follow-ups. The majority (55%) thought it was an "acceptable alternative to in-office visits," while 26% regarded it as "preferable to in-office visits." Only 19% regarded it as either a "poor" or "terrible" alternative.

For routine visits and follow-ups, do most patients find telemedicine to be...

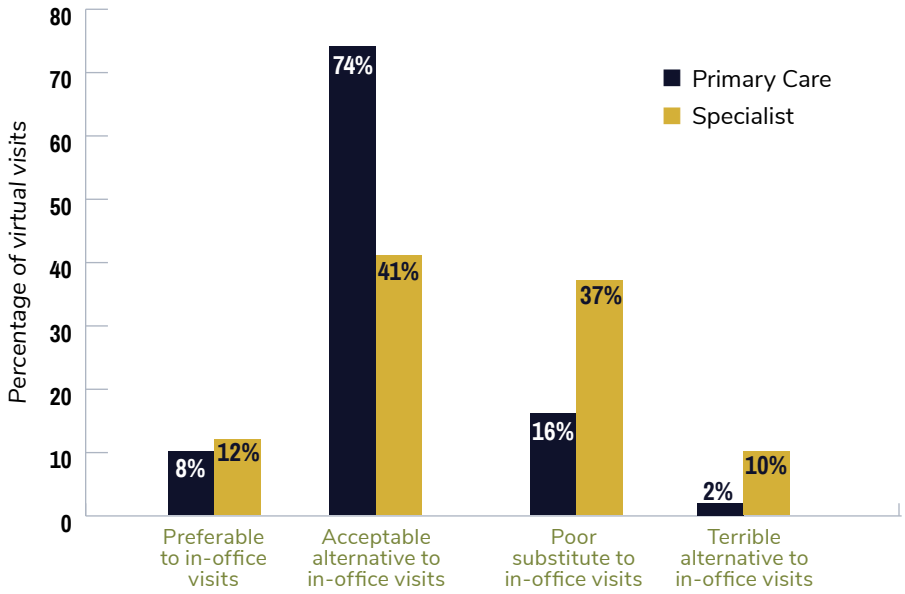


Physicians: Telemedicine Sentiment

GLG also surveyed 505 American doctors — a sample comprising 255 specialists and 250 primary care physicians — about how they believed their patients would rank telemedicine. The doctors largely agreed with the patients that telemedicine was an "acceptable" alternative, but diverged (10%) about whether it was "preferable" to an office visit. Instead, a quarter of those we surveyed (27%) said it was a poor substitute. Just 6% said it was a "terrible" alternative.

This changed when we broke the survey results between primary care physicians and specialists. Of the primary care doctors we surveyed, 74% of them said that they thought their patients would perceive telemedicine as "acceptable," where only 41% of specialists said the same. The specialists in our survey also felt that telemedicine was a "poor" substitute to an in-office visit. Only 16% of primary care doctors felt the same.

For routine visits and follow-ups, do most patients find telemedicine to be...



Telemedicine: Blip or Here to Stay?

GLG's survey indicates that Bierbower was indeed correct in her assessment of telemedicine's adoption. What's interesting is that age of the practice is a factor in both its adoption and post-pandemic usage.

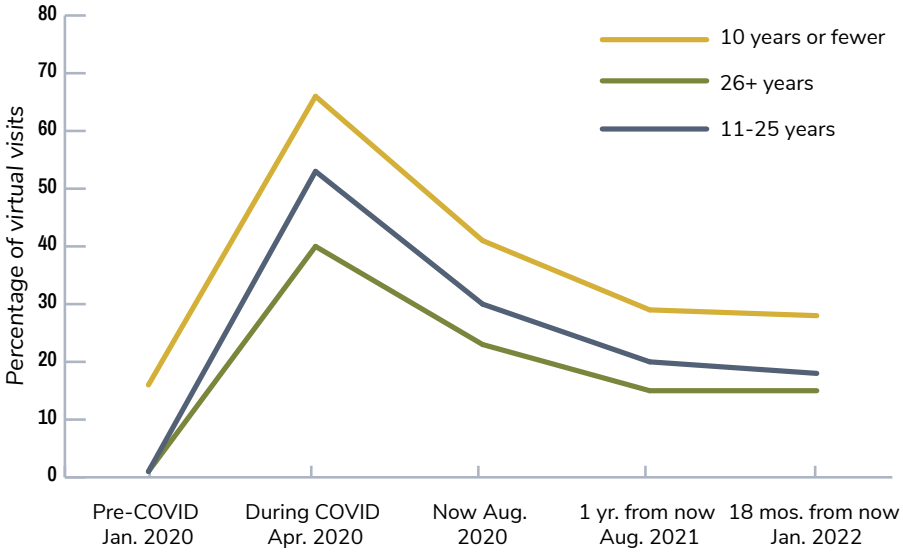
Anticipating telemedicine's usage over time, 17% of the patients at the youngest practices (10 years or fewer) had already adopted the technology, while only 3% of those practices of more than 11-25 years and 4% of those of more than 26 years said the same.

Unsurprisingly, the pandemic drove telemedicine to surge in April, when lockdown orders were in effect, but the decline since has not returned it to pre-pandemic levels, and none of the physicians we surveyed think it will drop that far again. Demand will drop, but our survey indicates that telemedicine will have gained more mainstream acceptance.

Telemedicine: The Regulatory Perspective

The surge that our survey shows in April could be a direct result of regulatory moves in March 2020. Sarah Lloyd-Stevenson, former Policy Advisor to the White House Domestic Policy Council and former Policy Advisor at the U.S. Department of Health and Human Services, told us that up until then, "the Social Security Act [was] very restrictive as to how telehealth services can be reimbursed in the Medicare program. With these [March] laws, HHS has been able to waive many Medicare restrictions and statutes across the country. This spurred the tidal wave of telehealth use that we've seen in the last few months."

Patient telemedicine usage relates to age of physician's practice



The question is whether Congress will act to make these waivers permanent. Lloyd-Stevenson told us that the waivers are something that she — and people like her — have been advocating for years, "and it's working. Patients are using it. Providers are using it. It's well received." Hopefully, she said, Congress will realize that "while they've given the authority to grant access to telehealth, it could go away if they don't act."

TELEMEDICINE DYNAMICS:

Regulatory Perspective

Sarah-Lloyd Stevenson, former Policy Advisor to the White House Domestic Policy Council and former Policy Advisor at the US Department of Health and Human Services

Prior to the pandemic, Medicare and Medicaid had tight restrictions on coverage of telehealth service. But given its usefulness during the long lockdown in the United States, Congress and the administration waived many restrictions, allowing for payment for telehealth services that became increasingly essential as patients couldn't get out to see their doctors. Now, as COVID-19 outbreaks lessen in some parts of the country, the question is whether policymakers should make the reimbursement changes permanent after seeing the benefits it holds for those with less access to specialized health care.

To find out more, GLG spoke with Sarah-Lloyd Stevenson, former Policy Advisor to the White House Domestic Policy Council and former Policy Advisor at the US Department of Health and Human Services. Below are a few select excerpts from our broader discussion.

Can you give us an overview of changes we've seen to telemedicine as a direct result of the COVID-19 public health crisis?
Back in March, Congress signed into law the first of what ended up being three large and then two smaller subsequent COVID relief packages. The first, called the Coronavirus Supplemental Act, gave the Health and Human Services (HSS) Secretary unprecedented new authority to waive statutory restrictions around the provision of telehealth in the Medicare program. While that law provided the first waiver, each subsequent bill provided additional flexibilities and expanded that waiver authority.

The Social Security Act, section 1834(m) is very restrictive as to how telehealth services can be reimbursed in the Medicare program. With these laws, HHS has been able to waive many Medicare restrictions and statutes across the country. This spurred the tidal wave of telehealth use that we've seen in the last few months.

The US Senate Committee on Health, Education, Labor & Pensions recently held a hearing on telehealth where Committee Chairman Lamar Alexander suggested that the originating site rule and the expansion of covered telehealth services by Medicare and Medicaid should be made permanent. What would you say is the likely scenario coming out of this?
Let me take it two steps back. Most of this waiver authority falls into one or two buckets — one, a statutory restriction that the secretary could waive during the

pandemic or rather during the specific public health emergency, or two, it was a regulatory change that HHS already had technically the authority to do but just wasn't doing it before. But nearly every change we've seen so far has been temporary during the public health emergency.

The statutory changes for telehealth are contingent on the current public health emergency. Right now, we're all waiting kind of on the edge of our seats to see if HHS is going to continue the public health emergency at the end of July. I think that they will. *[Ed. note: the HHS has since extended the public health emergency until October 22, 2020.]*

Once the public health emergency does end, these authorities will go away. Some of them fall into the regulatory bucket where they could continue those on their own. I can talk you through which ones are regulatory and which ones are statutory.

Let's focus first on the statutory pieces. Right now, there's a lot of conversation on Capitol Hill about how patients are using telehealth in the Medicare program for the first time ever. It's something that many of us have been advocating for years, and it's working. Patients are using it. Providers are using it. It's well received. Congress seems to realize that, while they've given the authority to grant access to telehealth, it could go away if they don't act.

So, what's going to happen? What we heard from Chairman Alexander is there's a bit of a tug and pull right now in Congress. Some are arguing that they need to change the underlying statutory problems — what I would call arbitrary restrictions in 1834(m) of the Social Security Act — or do we just go into an extended waiver authority period?

Utilization in telehealth went up in the last few months, but it will eventually start to slide off.

There have been some pieces of legislation introduced. I'll put it in kind of three buckets right now.
Number one, there are many offices and members of Congress interested in some sort of data collection. Essentially, their argument is we can't make a final permanent policy change until we know how telehealth has really been used, how costs have gone up or gone down, how patient safety has or has not been compromised, how privacy's been compromised, etc. We can't make that decision until we have data, according to some.

I believe that there's a problem with that strategy because the data could take years to come, as well as it's kind of unfair to judge a modality of care like telehealth from a pandemic. It's not really apples to apples. Utilization in telehealth went up in the last few months, but it will eventually start to slide off, and we're actually starting to see that.

Number two, perhaps we extend this waiver authority indefinitely, but with the idea that the extension is advisable. That would provide a sort of sliding transition back to normal, or a transition into something that's more permanent.

Number three is more ambitious. We change the underlying statute. Let's get into 1834(m), change the specific issues around geographic restriction, originating site restriction, and a few others to just fix the problem where it

starts. This is something that most of the industry wants right now. Just today we saw approximately 340 organizations in this space — telehealth providers, patient organizations, patient advocacy groups — write to Congress to say the issue needs fixing. Change the underlying statute so we can move forward.

That's what Chairman Alexander was talking about at the hearing. It was huge news in this little world of telehealth that the chairman of the health committee may be interested in championing this issue. It would be very welcome considering his years of leadership. *[Ed. note: on July 30, Chairman Alexander introduced the Telehealth Modernization Act to make many of these temporary telehealth policies permanent.]*

How much might health plans stand to benefit from the regulatory changes we've seen to date and the potential that some of these changes might remain permanent?

It's a little tough to say, because for the most part they have had the authority to do this all along. If they wanted to provide telehealth to their beneficiaries, they could've been doing it. It's just whether or not the state was requiring it to be covered or reimbursed at parity.

Employers have been providing telehealth or covering telehealth services for years because they see that added benefit. Employers definitely see a benefit, for example, if their employees don't have to leave the workplace for medical appointments. If it keeps employees healthier longer, or keeps them out of the ER, an employer or a health plan can see implicit benefits.

The data pretty much supports that. But the tricky thing is that generally we have anecdotal cases and specialty-specific arguments around how avoiding the ER reduces costs, but there's little data for broader care. But COVID might change that.

I'd like to make a final Medicare Advantage (MA) point because, obviously, MA plans are private plans funded through Medicare. MA, starting in plan year 2020, has been allowed to have telehealth as a base benefit.

This was enacted in 2017 and came into effect January 1, 2020. So, you would think, "Great, they're going to see this benefit for patients that they have to pay a capitated rate for." But it hasn't really been the uptick that we all expected. That's largely because the Medicare program was not allowing telehealth visits to count toward Medicare Advantage risk-adjustment rates.

But now, during the pandemic, the Centers for Medicare & Medicaid Services (CMS) is allowing that to count. And I know there are a lot of people out there who are hopeful that will count moving forward. This is something that will likely not require a statutory change. CMS can move forward without an actual act of Congress.

This article is adapted from the June 29, 2020, webcast "Telemedicine Regulatory Dynamics: Impact of COVID-19."

TELEMEDICINE DYNAMICS:

Payer Perspective

Elizabeth Bierbower, former Segment President of Employer Group and COO of Specialty Benefits, Humana

Before the pandemic, telemedicine was slow to catch on. But as COVID-19 persists, it's become a more viable way of getting much-needed health care without having to visit a doctor's office or hospital. Many insurers, reluctant to pay for a wide range of telemedicine services pre-pandemic, waived their restrictions and paid the full cost of teleservices. But as the COVID-19 outbreak subsides, the question is will they continue to pay for these services? Or, is telemedicine just another part of the new normal for patients, doctors, and insurers? To learn more, GLG talked to Elizabeth Bierbower, former Segment President of Employer Group and COO of Specialty Benefits, Humana. Below are a few select excerpts from our broader discussion.

Can you share your thoughts on the growth in telemedicine we've seen to date and what you see as the tailwinds from the payer perspective? Obviously, because of the pandemic, telehealth has exploded seemingly overnight. In the past we've seen approximately three barriers to telehealth growth. The first barrier has been coverage. Coverage is really varied. Medicare — as you probably know — has significant restrictions on coverage.

The second has been awareness. Typically, when people have an issue, they want to call their doctor. If their doctor doesn't have that service, then their next thought is to go to the urgent care. Their natural impulse isn't to call a telehealth provider. Up to now we've needed more awareness around this, and now the pandemic is bringing telehealth into the mainstream.

The third barrier has been provider adoption. When people have an issue, they really want to go to their provider. But if the provider doesn't offer that service, they may really be hesitant to go to a provider that they don't know, even if it is convenient.

The tailwinds going forward? Telehealth has proved very effective during a major pandemic; we've seen exponential growth. That's what's captured people's attention, whether it's Congress or whether it's in the administration saying, "Wait a minute, we need to do something to make sure that people can continue to have access."

Let's dig deeper into reimbursement. What business lines have had access to telemedicine, and how does that differ between commercial risk, administrative services only (ASO), Medicare, Medicaid, etc. Are there examples of some using the per member per month (PMPM) model whereas others might use visit fee only?
Most payers covered telehealth. Even many Medicaid payers covered it. Medicare's coverage — as I said — came with restrictions. Health plans in general really wanted people to have access to these services. When used appropriately, telehealth can be effective and have positive outcomes while reducing cost. As a result, we saw many health plans embedding telehealth services into their benefit plan design for their fully insured members. If they had clients that were self-funded, it would be up to the client whether or not that client wanted to embed the telehealth services into their benefits plan. Many of those ASO clients did embed telehealth services into their plans.

In terms of the actual reimbursement between the health plans and the telehealth companies, they varied significantly. Many of them continue to operate on a fee-for-service basis and the telehealth provider would just submit a claim as any other provider would. Some of them considered PMPM pricing. Early on, health plans gravitated more toward fee for service because uptake wasn't where it needed to be, and fee for service felt like the right approach to take when they were still testing to see what the uptake would be.

Should telehealth lose reimbursement parity within office face-to-face visits, what kind of impact do you expect that shift back to have on telemedicine adoption post-pandemic?
Number one, it depends on what the ultimate reimbursement is. Number two, what types of services that a provider bills for. Now that providers have had access to telehealth and have started to use it, they may find even if parity doesn't exist, it is really effective in remote monitoring. Why not use remote monitoring for certain patients who are eligible and would benefit by it? Now that providers have really had a taste of it, I think you will see them stepping back and saying, "Well, okay, what other services could I be providing and feel like I'm getting fair reimbursements warrant using telehealth?" I would expect that people are going to continue to look for ways to leverage this technology.

For what services or modalities does it make sense to reimburse telehealth at parity?
There are many that make sense — including many primary care services, especially as you can have connected devices. My primary care physician, for example, teases me and says, "I listen to your heartbeat because I know that's what people expect." Instead, there is a lot of information that physicians can get by looking at patients and by collecting data from them, in terms of changes. Physical therapy is another example. We can be almost or just as effective when the physical therapist shows you what to do via telehealth. There are many opportunities.

The provider community will likely recognize that they can extend their reach and get to hard-to-access places if they really think about how to use it. Some hospitals put telehealth in with the EMT. They're in the ambulance and very, very effective, so that they can have real-time connectivity with physicians. There are many potential use cases. You will likely be seeing and hearing more about those going forward.

As we look to the spectrum of health care services from urgent care, ER, primary care to even specialties like dermatology, where do you see the greatest use and growth of telemedicine?
I've seen areas where there's a real access barrier. Practices where there are long wait times: behavioral health, psychiatry, cardiology. In some areas, it is very difficult to get in to see a cardiologist. If you are not seeing that cardiologist within 14 days, you're likely going to the ER.

Dermatology — another practice that sometimes has long wait times — is also a good example. But think of a telehealth visit for a patient with suspected skin cancer. You could have a consult with the primary physician in the room, something that would pay off if you need to get the person into the right kind of treatment.

How should payers evaluate the competitive landscape between consumer-focused telemedicine providers and those that are more provider-focused?
Many payers now also have provider practices that they're closely affiliated with. A payer will need to consider the experience for its members. Is it going to be easy? That is really going to be the driving thing for them. Number one, is it a simplified experience?

The provider community will likely recognize that they can extend their reach and get to hard-to-access places if they really think about how to use it.

They need to consider the kind of data they're going to be able to get back from the telehealth platform. Besides the claim, is there going be other data that they're going to get? They need to look for a partner. One vendor may be just more provider-focused versus consumer-focused and they have to decide which might give them more benefit. If I were a telehealth platform vendor, I'd be having lots of conversations with my health plan partners and saying, "What are your additional use cases?"

That's how I think about it, not just what can I get now, but who will be able to partner with me over the long term, as I determined that there are more opportunities to deploy this to have better access to my members.

This article is adapted from the July 9, 2020, webcast "Telemedicine Dynamics: Payer Perspective."

ABOUT OUR COUNCIL MEMBERS

ELIZABETH BIERBOWER

Elizabeth Bierbower is a strategic leader with more than 30 years of proven executive-level experience in the health insurance industry with experience in all product lines, including commercial and Medicare Advantage. She most recently served as Segment President and a member of Humana's Executive Management Team, overseeing the Group and Specialty Segment generating over $7 billion in revenue and covering 11 million individual, employer group, and military health members. Prior, Beth held the position of Chief Operating Officer of Humana's Specialty Benefits division and was an Enterprise Vice President leading Humana's Product Development and Innovation teams.

SARAH-LLOYD STEVENSON

Sarah-Lloyd Stevenson is currently a Director at Faegre Drinker Consulting, working with health and life sciences stakeholders. Prior to this, she served as Policy Advisor to the White House's Domestic Policy Council and its Office of Science and Technology Policy until July 2019, providing policy reports, recommendations, and updates to the West Wing on a daily basis. Before that, she worked as Policy Advisor at HHS and gained insight into the agency processes and collaborations that drive health policy. She reviewed, edited, and approved agencies' regulations, funding opportunity announcements, reports, budget documents, press pieces, and other correspondence, working with various agencies including the Centers for Disease Control and Prevention, Food and Drug Administration, and National Institutes of Health. Sarah-Lloyd's policy career began in the office of Sen. Roger Wicker (R-Mississippi), where she served as a key advisor on domestic and global health policy.

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