March 8, 2016

Pension and Health Benefits Review Commission
50 West State Street
PO Box 295
Trenton, NJ 08625-0295

Re: A1464 (Lampitt) Authorizes health care practitioners to provide health care services through telemedicine

Dear Commission Members:

The American Telemedicine Association (ATA) appreciates the opportunity to comment on the importance of advancing telemedicine legislation like A1464 and S291 (Vitale), in New Jersey. We believe that the Pension and Health Benefits Review Commission (Commission) has a strong and vital interest in taking advantage of health care delivery innovations that improve quality, reduce costs, improve timely access to needed care, and improve consumer satisfaction.

ATA is a non-profit organization that promotes telemedicine, sometimes referred to as telehealth, e-health, mobile health or connected care and resolves barriers to its deployment. Founded in 1993, members of ATA include over 8,000 physicians, administrators and other health care professionals as well as over 300 health systems and vendors of telecommunications and advanced technology.

Telemedicine is an innovative delivery method used to complement in-person care. It is not a separate service nor a clinical specialty and should not be treated with different or unbalanced standards. ATA believes that New Jersey residents and healthcare providers should not be penalized or unfairly discriminated against for using such cost-saving and quality-improving methods like telemedicine to enrich population health.

For the Commission’s consideration, we highlight three policy areas that any state, including New Jersey, should address to remove artificial barriers and to ensure that health care providers and patients can fully integrate telemedicine into their care plans: Health insurance coverage parity for all state regulated health plans including private insurance, Medicaid, state employee health plans and workers compensation; comparable practice standards for all state licensed health care professionals, and licensure portability.

The truth is that telemedicine today is used in many forms in every state and practically every hospital and health system. It can take the form of video-conferencing, remote patient monitoring, or remote image capturing solutions just to name a few. Telemedicine is also supported by digital diagnostic medical device peripherals including an otoscope, pulse oximeter, glucometer, stethoscope, and blood pressure cuff. In fact, physicians are using a variety of popular consumer devices to provide quality care including smartphones and tablets. Some examples include tele-mental and behavioral health, primary and urgent care, teleICU, dermatology, cardiology, neurology for stroke diagnosis, maternal and fetal medicine, kidney dialysis, teleradiology and pathology, and correctional care.

Last year, seven states enacted telemedicine parity laws which brings us to 29 states and Washington D.C. with enacted parity laws which prevent private insurers from engaging in discriminatory practices like denying claims for covered services because telemedicine was used, in lieu of an in-person encounter. Almost half of these states have had 10 years or more successful experience with telemedicine.

Parity legislation does not increase covered services, but explicitly recognizes telemedicine as a way to deliver existing covered services. Moreover, telemedicine parity provisions act as a consumer protection against deviant
industry practices. If a health insurance company states that they will cover a healthcare service, then a consumer should expect for that service to be covered whether delivered in-person or via telemedicine. These statutes also prevent private insurers from instituting arbitrary barriers that impede access to telemedicine such as requiring higher deductibles, copayments, or coinsurance than that of in-person services.

Actual cost analyses for telemedicine parity rarely show a significant impact. In May 2015, The New Jersey Office of Legislative Services (OLS) reported a telemedicine bill (A4231) had minimal fiscal impact, and estimated that “the implementation of telemedicine may result in decreased expenditures in the long term due to improved management and coordination of treatment for chronic diseases”. For example, in 2012, Vermont legislators were considering a parity bill that would cover private insurance and Medicaid. One of the state’s third party administrators for the state employee health insurance plan claimed that if passed, the bill would cause an increase in provider consultations and ultimately a .1-.2 percent increase in premiums. Alternatively, Maine, which considered a parity bill in 2009, reported that parity would have no direct fiscal impact on State agencies and programs. Legislators in both states successfully enacted their parity bills into law. Other states like Mississippi and Montana recently passed their respective parity bills with overwhelming bipartisan support and without issuing fiscal notes.

Here are a few notable telemedicine trends across the country:

- Some of your own health plans have proactively included telemedicine coverage. The New Jersey Individual Health Coverage and Small Employer Health Benefits Programs approved new language covering “telemedicine”, “e-visits”, and “virtual visits” under individual health and small employer plans. This new policy goes into effect for plans issued or renewed in 2016. Further, in its 2014 Annual report, the New Jersey Department of Corrections indicated that “Telemedicine continues to produce cost savings, as some 150 telemedicine sessions take place each month. According to departmental data, telemedicine has saved hundreds of thousands of dollars in manpower and transportation costs.” (http://www.state.nj.us/corrections/pdf/annual_report/2014_Annual_Report.pdf)
- In December 2013, New Jersey Medicaid issued a newsletter on telepsychiatry to advise mental health clinics and hospitals that “Telepsychiatry may be utilized by mental health clinics and/or hospital providers of outpatient mental health services to meet their physician related requirements including but not limited to intake evaluations, periodic psychiatric evaluations, medication management and/or psychotherapy sessions for clients of any age.” (https://www.njmmis.com/downloadDocuments/23-21.pdf)
- Also New Jersey’s State Broadband Initiative (SBI), Connecting NJ, has recognized that “The expansion of broadband access and usage in healthcare can greatly increase the quality of service and can enhance patient care through the use of telemedicine, electronic prescriptions, electronic medical records and broader means of communication and sharing patient care responsibilities. It removes geographical barriers and allows people to receive the medical care they need when and where it's needed.” (http://connectingnj.state.nj.us/it/connectingnj/benefits/healthcare/)
- To address public health issues such as high-risk pregnancy and high infant mortality, Pennsylvania’s Medicaid plan has reimbursed for telemedicine-provided consultations by maternal-fetal medical specialists since 2007. The agency instituted this policy reform due to the statewide shortage of maternal-fetal medical specialists and to improve the quality of care for expectant mothers.
- New York enacted a telemedicine parity law in 2014. The law was leveraged largely on the success of innovative telemedicine demonstrations covered under the Medicaid program. To address the burgeoning Medicaid costs for the state’s most chronically ill residents, New York enacted legislation covering home telemedicine services. Covered services include: monitoring of patient vital signs; patient education; medication management; equipment management; review of patient trends and/or other changes in patient condition necessitating professional intervention; and other activities deemed necessary and appropriate according to the plan of care. The Home Care Association of New York State studied telemedicine programs of four home care providers over the course of one year. The results were impressive. There was an average 13 percent decrease in avoidable hospital readmissions, and average annual savings of over $217,000.
- In fact, half of the state Medicaid programs reimburse for telemedicine-provided services in the home, and 16 reimburse for services provided in schools.
- In an effort to reduce inmate population and the rate of recidivism, South Dakota has implemented a telemedicine substance abuse treatment program for nonviolent adult offenders. The program connects drug and alcohol treatment counselors with those on parole and probation for individual and group counseling. They connect to services using smartphones, tablets, and laptops and even use sites like public libraries.
Accommodating dynamic clinical models such as these and patient preferences for 24/7/365 on-demand access to care will require a more malleable understanding and expansive envisioning of 21st century health care. A clinician using telemedicine, a 21st century approach to enhance the delivery of care, must comply with the same standards established for in-person medical practice, and is accountable to the respective boards in which he or she is licensed.

ATA strongly supports the mission of state licensing health care professional boards “to ensure the protection of the public's health, safety and welfare”, as well as other mechanisms that assure patient safety and promote that all health services delivered either in-person or via telemedicine are of the highest quality and provided in a safe manner. Specifically with regard to clinical practice rules, we believe that, as much as possible, the practice of telemedicine should not be regulated differently from in-person care. While there are important clinical differences that should be recognized, allowed, and appropriately regulated, the provision of telemedicine should not be held to a different standard than in-person care.

The impact of telemedicine goes beyond healthcare professions. Patients lead mobile lives. They travel within-New Jersey and out-of-New Jersey for personal reasons including work, leisure, education, sports and to engage in commerce. As a result, they often receive services from more than one physician, including providers across state lines. Large healthcare systems have responded to this need for more accessible care by establishing provider networks across multiple states. There is an increasing belief that the existing system of requiring a medical license each time a physician or other health provider examines and treats a patient located in another state needs repair.

In closing, we know that inequities in coverage for telemedicine delay the adoption of cost-saving and quality-improvement measures available through advanced technology. They also restrict consumer access to specialized services in underserved areas. This Commission can take immediate steps to prevent discriminatory practices against telemedicine users, by requiring comparable professional practice standards and coverage parity for telemedicine-provided services to that of in-person services. This would be seen as a proactive step to alleviate New Jersey’s prevailing health disparities.

Thank you for the opportunity to present these comments. With the Commission’s consideration of our comments, we believe that New Jersey policies will certainly serve as a model for other states to follow. I and members of ATA are happy to be a resource to you and the other members of the Commission to make advances and reform policies in order to help the residents of New Jersey take advantage of the promise of telemedicine.

Sincerely,

Latoya S. Thomas
Director, State Policy Resource Center

Cc: The Honorable Joseph F. Vitale
The Honorable Pamela R. Lampitt