AMA AMERICAN MEDICAL ASSOCIATION

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State telehealth policy trends

2023 year in review

Advocacy Resource Center

Background

Three years following the onset of the COVID-19 public health emergency (PHE), states across the United States continue to enact permanent changes to telehealth laws that impact how physicians and other health care professionals can deliver care remotely. Nearly all states issued temporary policy flexibilities to swiftly expand access to telehealth at the onset of the PHE that accelerated the implementation, adoption, and widespread use of telehealth across the health care industry.[1] Telehealth has become embedded in the practice of medicine, with patients and physicians alike overwhelmingly in support of care via telehealth.[2,3] Starting in 2021, states shifted focus from temporary policy implementation toward assessing which pandemic-era policies should be continued on a permanent basis to support ongoing access to telehealth in a manner that meets the standard of care.

The American Medical Association (AMA), with its commitment to ensuring equitable and accessible telehealth services, has been closely tracking state legislative activity related to telehealth throughout 2023. Tracking efforts indicate that states generated the most legislative activity around the following telehealth policy trends:

- Coverage and payment parity
- Telehealth licensure
- Audio-only telehealth
- Medication abortion via telehealth

This report aims to provide a year-end snapshot of the current state of these policy trends, including an overview of each issue and a summary of 2023 legislative activity with examples of passed legislation.

1. Manatt Health, "Executive Summary: Tracking Telehealth Changes State-by-State in Res ponse to COVID-19" (accessed October 2023)
2. AMA, AMA digital health care 2022 study findings (accessed October 2023)
3. JD Power, "Telehealth Emerges as Preferred Channel for Routine Care While Increasing Access to Mental Health Treatment" (accessed October 2023)

Key legislative trends in telehealth, 2023

Coverage and payment parity

Overview: "Coverage parity" requires payors to cover a service via telehealth if it is also covered in-person and can be delivered remotely while meeting the standard of care. "Payment parity" requires payors to reimburse for telehealth at the same rate as the equivalent in-person service. Coverage and payment parity requirements are most frequently codified in state laws that outline coverage and reimbursement requirements for payors. These laws, and specifically coverage and payment parity, have enabled physicians to invest in new technologies and fully implement telehealth in their practice. The AMA considers fair and equitable coverage and reimbursement for telehealth services as essential to supporting implementation across the physician community and enabling access to care for all patient populations.

Coverage parity has been widely adopted across the United States—at the start of 2023, more than 40 states required payors to implement coverage parity.[4] While there is broad support for coverage parity across the United States, many states are still considering how to appropriately pay for telehealth in light of a lack of robust data as to whether telehealth services cost more or less to deliver than in-person services. By January 2023, more than 25 states had implemented payment parity; 21 states had implemented permanent payment parity, while five had implemented payment parity with caveats (e.g., temporary implementation with a sunset date; applied only to specific services, such as behavioral health).[5]

Legislative activity and state examples: There was minimal legislative activity in 2023 aimed at coverage parity as it was previously adopted by most states. A handful of states introduced legislation that included coverage parity language aimed a specific payors, but none were passed (e.g., North Dakota introduced Senate Bill 2160, which would establish coverage parity for public employee benefits; Michigan introduced House Bill 4579, which would establish coverage parity for state-regulated commercial plans).

By contrast, there was significant activity on the payment parity front—15 states introduced various types of payment parity legislation. Several bills sought to implement permanent payment parity (across all or select payors), some legislation proposed extensions to previously enacted temporary payment parity, and others aimed to selectively implement payment parity for specific specialties (e.g., behavioral health).

Three states passed new payment parity requirements this year:

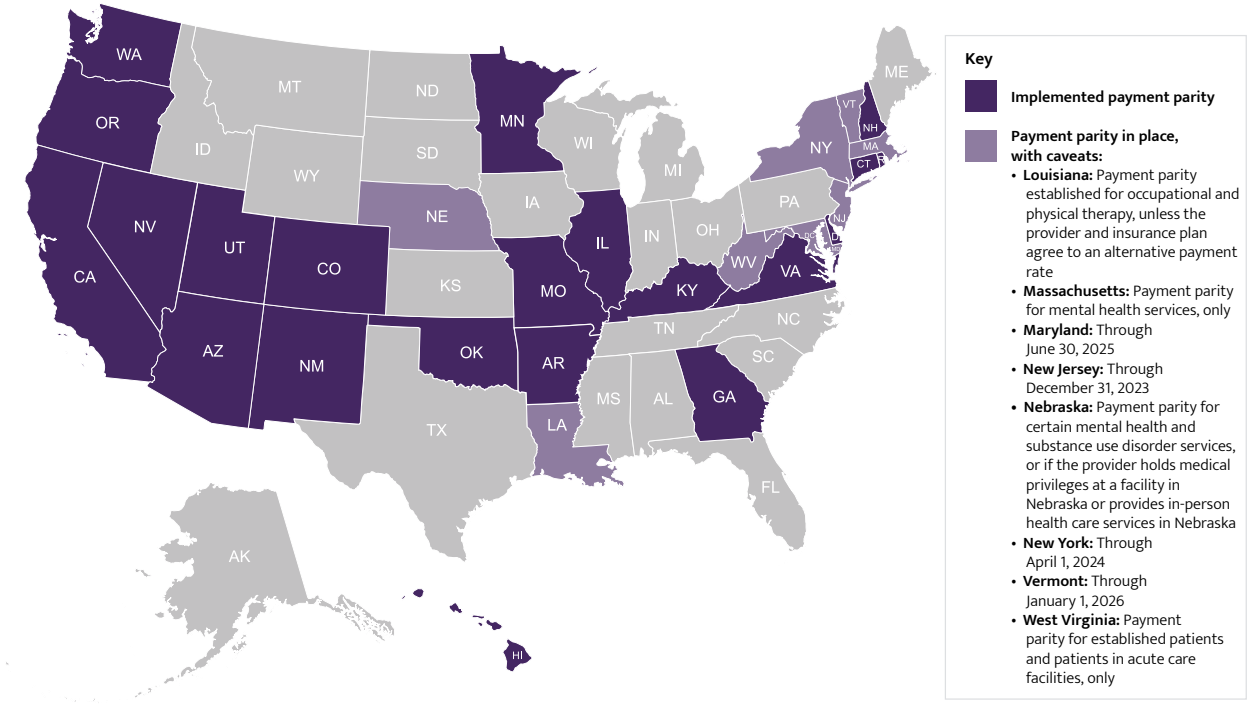
- **Colorado** passed House Bill 1088, which established permanent payment parity for behavioral health services delivered via telehealth to Veterans.
- **Hawaii** passed House Bill 907, which, in addition to many other changes, required payment parity for services delivered through "interactive telecommunications systems,"[6] and established that audio-only services "for the purposes of diagnosis, evaluation, or treatment of a mental health disorder" will be reimbursed at 80% of comparable in-person rates through December 31, 2025.
- **Nevada** passed Senate Bill 119, which implemented telehealth payment parity under certain circumstances, including when the services: (1) are delivered to patients located in rural areas or are

4. Center for Connected Health Policy, Policy Finder: Parity (accessed December 2022)
5. Manatt Health, "Executive Summary: Tracking Telehealth Changes State-by-State in Response to COVID-19" (accessed December 2022)
6. Hawaii defines an "interactive telecommunications system" as, at a minimum, audio and video, with the exception of mental health services, which may be covered and reimbursed if conducted via audio-only.

furnished by certain health care facilities (i.e., federally qualified health centers) and are not via audio-only, or (2) are for behavioral health (e.g., mental health and substance use disorder) counseling or treatment, including when the services are delivered via audio-only. Through 2024, originating sites also include the patient's home.

As of October 2023, 21 states have implemented policies requiring payment parity, eight states have parity in place with caveats (e.g., temporary parity, applied to select service types) and 21 states have no payment parity.[7]

FIGURE 1. Map of states with laws requiring insurers to implement telehealth payment parity[8] (as of October 2023)



Telehealth licensure

Overview: During the PHE, several federal and state licensure requirements were waived, which enabled physicians and other health professionals to work across state lines and provide care in areas hardest hit by the pandemic without having to apply for a license in those states. Some states issued broad reciprocity waivers permitting physicians and other health professionals possessing an active license and in good standing in another state to provide care without obtaining a license, temporary or otherwise, in that state. Other states required registration with, or approval by, the state medical board. A few states specified that telehealth could be used by out-of-state physicians to provide continuity of care to patients in that state or by physicians in contiguous states that have existing patient relationships with state residents.

7. Manatt Health, "Executive Summary: Tracking Telehealth Changes State-by-State in Response to COVID-19" (accessed October 2023)
8. For the purposes of this map, telehealth payment parity refers to video visits.

After the PHE, nearly all states lifted those temporary licensure flexibilities. However, many states are exploring new policies that seek to ensure states have the continued authority to regulate and oversee the practice of medicine for their residents while also taking into consideration modern-day realities of patient movement, physician shortages, and the regionalization/nationalization of health care delivery as telehealth becomes more commonplace.

Legislative activity and state examples: Over 20 states introduced various types of telehealth licensure legislation. There were three key themes of both introduced and passed legislation: (1) out-of-state licensure exceptions; (2) creation of temporary telehealth licensure pathways or telehealth registries; and (3) continued growth of the Interstate Medical Licensure Compact (IMLC).

First, several bills outlined exceptions that would enable a physician or other health care professional not licensed in a state to provide telehealth services to an in-state patient. Please note that, while these laws provide exceptions to licensure requirements, they generally still subject the physician to the laws of the state as well as the regulatory authority of the state medical board:

- **Idaho** passed House Bill 162, which allows a provider that is licensed and in good standing in another state—but not licensed in Idaho—to provide services when the provider (1) has established a patient-provider relationship with a patient who is in Idaho temporarily; (2) has established a patient-provider relationship with a patient and provides temporary or short-term follow-up services to ensure continuity of care; (3) is employed by, or contracted with, an Idaho facility or hospital for which the provider has been privileged and credentialed; (4) provides emergency care in a time of disaster and follow-up services to ensure continuity of care; or (5) consults with or refers a patient to an Idaho-licensed provider.

- **Idaho** passed House Bill 61, which allows mental and behavioral health providers not licensed in Idaho to provide telehealth services to Idaho residents (or persons located in Idaho), provided that they (1) hold a current, valid, and unrestricted license from a state, district, or territory with substantially similar licensing requirements; (2) are not subject to any past or pending disciplinary proceedings; (3) act in full compliance with applicable Idaho laws; (4) act in compliance with requirements regarding the maintenance of liability insurance; or (5) consent to Idaho jurisdiction; (6) biennially register in Idaho to provide telehealth services.

- **Oregon** passed Senate Bill 232, which allows out-of-state physicians that are not licensed in Oregon, but have an established physician-patient relationship, to provide temporary or intermittent follow-up care.

- **Virginia** passed House Bill 1754. Existing law allows physicians who are licensed in another state or the District of Columbia to provide telehealth services when (1) the purpose of services is to ensure continuity of care; (2) there is a preexisting physician-patient relationship; and (3) the physician has performed an in-person examination in the past 12 months. New legislation expands these provisions to allow another practitioner of the same subspecialty, at the same group practice, and with access to the patient's treatment history to provide telemedicine services if the patient's primary provider is unavailable.

Second, several bills outlined how out-of-state physicians or other health care professionals could provide telehealth services in-state either through temporary licenses or telehealth registrations:

- **Louisiana** passed Senate Bill 66, which aligns language with the Louisiana Telehealth Access Act (RS 40:1223.1 et seq.), which directs the relevant professional or occupational licensing boards to promulgate regulations that create a telehealth registration/licensure process for providers who are fully licensed and in good standing in another state. Louisiana exempts consultative services from licensure requirements.
- **Utah** passed House Bill 159, which allows for the issuance of temporary licenses to individuals who (1) have a "nonresident health care license" (i.e., a medical license issued by another state, district, or territory) and (2) have completed an application for a license by endorsement in Utah, but (3) the license application will not be able to be processed within 15 days of being submitted. Individuals with a temporary license are eligible to provide telemedicine services if the telemedicine service is a service the physician is eligible to provide under their current "nonresident health care license," the patient is located in Utah and performing the telemedicine service would not otherwise violate state law.
- **Vermont** passed House Bill 411, which allows physicians (and other health care professionals listed here) who are appropriately licensed and in good standing in another state to obtain a temporary telehealth registration to provide telehealth services to patients located in Vermont until the telehealth licensure and registration system established in 26 V.S.A. Chapter 56 by 2022 Acts and Resolves No. 107 is operational.

Third, two states, Hawaii (Senate Bill 674) and Missouri (Senate Bill 70), passed legislation to join the IMLC, which now has 39 states plus the District of Columbia and Guam as members. The IMLC provides a streamlined and expedited process for physicians licensed in a member state to obtain a full and unrestricted license to practice medicine in other member states, including the ability to provide care to patients via telehealth.

Audio-only telehealth

Overview: Prior to the PHE, audio-only was not a commonly recognized or covered form of telehealth. Very few state Medicaid programs covered audio-only, Medicare offered limited coverage for a narrow set of virtual check-in services,[9] and state insurance laws related to telehealth carved out audio-only services from the definition of "telehealth." For example, many states would define the term "telehealth" to include two-way video visits and exclude communications between providers and patients delivered via telephone (audio-only), fax and e-mail. By excluding audio-only from the definition of telehealth, states effectively limited the scope of telehealth coverage and reimbursement policies, including coverage and payment parity, to apply only to two-way video visits.

State policymakers significantly increased coverage and reimbursement of audio-only services temporarily in response to the PHE; as of June 2020, audio-only was covered by 38 state Medicaid programs.[10] Audio-only becomes essential to helping connect providers to patients without reliable broadband internet,

9. Under Medicare, virtual check-ins include services that would not normally occur in-person; they are brief communications paid at a lower rate.
10. J. Marks Smith, J. Augenstein, M. Savuto, "Audio Telehealth Services Post-Pandemic – An Update on Emerging Policy Trends," Manatt Health, February 16, 2021.

including those located in rural communities, as well as individuals who are otherwise unable to participate in a two-way video visit. Temporary coverage and reimbursement of audio-only services was broad during the PHE, and states have since narrowed coverage as they consider: (1) what types of services can most appropriately be delivered via audio-only while still meeting the standard of care and (2) appropriate payment levels for audio-only.

Legislative activity and state examples: Fourteen states introduced legislation pertaining to audio-only coverage in the past year. There were no consistent trends among the introduced bills; however, several were aimed at establishing reimbursement rates for audio-only services (either at parity or a percentage of in-person rates) or including audio-only within the definition of "telehealth" under state law.

Five states passed new audio-only legislation during 2023:

- **Florida** passed House Bill 267, which amended the state's definition of "telehealth" to include audio-only.
- **Hawaii** passed House Bill 907, which included the following audio-only policy changes in effect through December 31, 2025:
  - Specified that reimbursable telehealth services must be conducted through an "interactive telecommunications system" (i.e., two-way video) except for behavioral health services, which may be covered and reimbursed if conducted via audio-only;
  - Established that audio-only services "for the purposes of diagnosis, evaluation, or treatment of a mental health disorder" will be reimbursed at 80% of comparable in-person rates; and,
  - Specified that to receive reimbursement for audio-only services, "the health care provider shall first conduct an in-person visit or a telehealth visit that is not audio only, within six months prior to the initial audio-only visit, or within twelve months prior to any subsequent audio-only visit."
- **Maryland** passed Senate Bill 534 (and companion Senate Bill 582 and House Bill 1148) which extended payment parity for telehealth services, including audio-only through June 30, 2025.
- **Utah** passed House Bill 437, which requires the Medicaid program to reimburse for audio-only services.
- **Washington** passed Senate Bill 5036, which extends the time frame (from January 2024 to July 2024) in which two-way video visits may be used to establish a relationship for the purpose of providing care via an audio-only modality for certain select behavioral health services (e.g., mental health and substance use disorder services).

Medication abortion via telehealth

Overview: Medication abortion via telehealth describes a medication abortion where the patient consultation is conducted, and a prescription is written, during a telemedicine visit. While medication abortion has been approved by the Food and Drug Administration (FDA) since 2000, medication abortion via telehealth was only more recently allowed under FDA regulations. Specifically, prior to 2021, a physician was required to dispense medication abortion pills in person, which would inhibit medication abortion via telehealth services. The in-person dispensing requirement was suspended during the PHE and, at the end

of 2021, the FDA permanently removed the in-person dispensing requirement, thus enabling patients to be seen via telehealth platforms and for medication abortion pills to be dispensed by mail.[11]

The use of medication abortion as a percentage of overall abortion procedures in the United States has grown steadily since its approval in 2000, accounting for more than 50% of abortions conducted in 2020.[12] The percentage of medication abortions via telehealth has also increased, from 4% of all abortions in April 2022 to 11% of all abortions in December 2022.[13]

Access to medication abortion services via telehealth is informed by both the abortion laws and the telehealth laws of each state; a state may have expansive access to telehealth services but more restrictive abortion laws (or vice versa) which would limit access to medication abortion services via telehealth. For example, 14 states have a near-total ban on abortion services, which inherently restricts access to medication abortion via telehealth.[14]

Generally, states that restrict telehealth for medication abortion also limit abortion by gestational age. As of September 2023, two states[15] that ban abortion after approximately six weeks of pregnancy have at least one restriction on telehealth for medication abortion (e.g., requires at least one in-person visit); nine states[16] that ban abortion between 12 and 22 weeks of pregnancy have at least one telehealth medication abortion restriction.[17] Conversely, 24 of the 25 states and the District of Columbia that allow abortion until fetal viability or at any stage of pregnancy have no medication abortion via telehealth restrictions.[18] Only one state—Alaska—that allows abortion at any stage of pregnancy requires abortion medication to be administered in-person, thus precluding the use of telehealth.[19]

Legislative activity and state examples: As described above, a state's general abortion and telehealth policies impact the ability to provide medication abortion via telehealth services; regulations outlining abortion and/or telehealth provisions are more common than provisions specifically targeting medication abortion via telehealth. While many states introduced language specifically attempting to expand or restrict access to abortion services, only seven states introduced legislation directly referencing medication abortion via telehealth. The primary theme of introduced language was to either explicitly allow or prohibit providers from prescribing abortion-inducing drugs via telehealth. Of those introduced, only one bill passed: **Florida's** Senate Bill 300 prohibits the use of telehealth to perform an abortion and mandates that any medications intended for use in an abortion be dispensed in-person.

11. U.S. Food & Drug Administration, Questions and Answers on Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation (accessed October 2023)
12. Jones, R., Kirstein, M., Philbin, J., Abortion incidence and service availability in the United States, 2020, 54 Perspectives on Sexual and Reproductive Health 4, 128-41 (Dec. 2022). https://doi.org/10.1363/psrh.12215.
13. Society of Family Planning, WeCount Report (accessed September 2023)
14. KFF, The Availability and Use of Medication Abortion (accessed October 2023)
15. Georgia and South Carolina prohibit abortion after fetal cardiac activity is detected, approximately six weeks of pregnancy.
16. Nebraska, North Carolina, Florida, Arizona, Utah, Iowa, Kansas, Ohio,* Wisconsin prohibit abortion between 12 and 22 weeks of pregnancy. *However, on November 7, 2023, Ohio voters approved a constitutional amendment that is expected to invalidate the state's laws that prohibit abortion based on the gestational age of the fetus.
17. KFF, The Availability and Use of Medication Abortion (accessed October 2023)
18. KFF, The Availability and Use of Medication Abortion (accessed October 2023)
19. KFF, The Availability and Use of Medication Abortion (accessed October 2023)

What's next & AMA 2024 priorities

Looking ahead, the AMA anticipates that coverage and payment parity, telehealth licensure, audio-only telehealth, and medication abortion via telehealth will each continue to remain important priorities for state legislatures in 2024. However, given that there have been a few years since the onset of the COVID-19 pandemic, and several states created permanent telehealth policies that either evolve from or directly reflect the COVID-19 temporary policies, there may be fewer new regulations or legislation brought forth than in the past few years.

- **Coverage and payment parity**: States are predicted to continue progressing legislation for both coverage and payment parity, albeit at lower volumes than in recent years. The AMA supports coverage parity and fair and equitable reimbursement rates for telehealth services regardless of whether the service is performed via telehealth or in-person. For more information on the AMA's position on telehealth payment, please review the AMA's Supporting Equitable Payment for Telehealth Issue Brief and Model Telehealth Coverage and Payment Act.

- **Telehealth licensure**: The cross-state licensure of physicians providing telehealth remains top of mind for states and physicians and will likely continue to evolve in the coming years. The AMA supports the role of state medical boards in overseeing and regulating the practice of medicine and care provided to patients within their borders. However, recognizing the costs and burdens associated with obtaining a license to practice medicine in multiple states, the AMA has long supported streamlining the process and reducing the cost for physicians, including through the IMLC. In addition, the AMA recognizes several commonsense limited exceptions to licensure, including for example in an emergency, consultations between physicians, and to support continuity of care. For more information on the AMA's position on telehealth licensure, please review the AMA's Telehealth Licensure Issue Brief and Model Telehealth Licensure Act.

- **Audio-only telehealth**: 2023 legislation regarding audio-only telehealth had a wide variety of goals (e.g., audio-only payment parity, including audio-only in the definition of telehealth, etc.), and it is likely that 2024 will continue to see a range of ways that states are deliberating on the most appropriate and efficient ways to integrate audio-only telehealth into the provision of telehealth services. The AMA supports the use of audio-only as a telehealth modality when clinically appropriate and believes payment should be equitable regardless of whether the service is performed via audio-only, two-way video, or in-person.

- **Medication abortion via telehealth**: The national abortion landscape is—and continues to remain—uncertain. As such, laws regarding medication abortion via telehealth will likely remain similarly evolving and nascent. The AMA supports a physician's right to provide, and a patient's right to receive, reproductive health care services, including abortion services.