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P.O. Box 12267
Portland, OR 97212
p: 503.775.4931
www.PPAOregon.org

Planned Parenthood Advocates of Oregon

February 4, 2021

Chair Prusak, Vice-Chairs Salinas and Hayden, and Members of the House Committee on Health Care,

Planned Parenthood Advocates of Oregon urges strong support for HB 2508, which supports and advances access to health care through updating telemedicine statutes. We believe that access to high quality health care is a fundamental human right that should not be limited by geography or transportation barriers. HB 2508 codifies many of the advancements achieved in telemedicine policy during the COVID-19 pandemic. The temporary removal of restrictions and increased public and private coverage for telemedicine during the public health emergency has dramatically expanded access to necessary care and has allowed safety-net providers to better and more broadly provide essential health services to the Oregonians most vulnerable to gaps in care, including rural communities, homebound patients, houseless patients, and those working to manage behavioral health issues, including substance use disorder. HB 2508 provides Oregon with the opportunity to make those telemedicine expansions permanent and to ensure that patients, providers, and carriers can utilize telemedicine to its fullest potential.

Telehealth has long been recognized as a promising way to expand health care, including highly-specialized care, to rural and otherwise underserved communities, but over the course of the pandemic, telehealth has transitioned from a nice-to-have, add-on service to a central means of care. The American Hospital Association has concluded that telemedicine "is vital to our health care delivery system, enabling health care providers to connect with patients and consulting practitioners across vast distances,"[1] and the American Medical Association "strongly encourages the adoption of telemedicine as a responsible way for physicians to meet anticipated demands for care and treatment."[2]

Prior to the pandemic, Oregon Planned Parenthood health centers had been diligently working to use telemedicine to expand access to sexual and reproductive health care, including STI screens, primary care, and family planning services. In addition to addressing geographic barriers, telemedicine has also facilitated walk-in visits and minimized appointment scheduling delays in health centers where wait times can average two weeks for an appointment due to overwhelming need for care. When the public health emergency was first declared, Planned Parenthood Columbia Willamette and Planned Parenthood of Southwestern Oregon quickly transitioned services where possible to telemedicine to maintain and expand access to care while preserving PPE supplies; reducing incidents of COVID-19 exposure; flattening the curve; and protecting hospital capacity by keeping patients out of urgent care and emergency rooms. Even as the state slowly re-opens, the volume of telemedicine visits remains higher than pre-pandemic levels showing that telemedicine continues to be a key part of ensuring access to and continuity of essential health care.

HB 2508 comprehensively updates Oregon's telehealth statutes for physical, behavioral, and oral health and outlines coverage requirements for public and private insurance. The bill clarifies that telemedicine services—both audio-only and videoconferencing—should be covered and reimbursed at the same scope and level as in-person visits. Providing clarity within statute that telemedicine services have coverage and reimbursement parity with in-person services will bolster and support providers' utilization of virtual care within their practices and allow more patients the choice of participating in telemedicine. HB 2805 also stipulates that enrollee benefits –

[1] Am. Hosp. Ass'n, The Promise of Telehealth For Hospitals, Health Systems and Their Communities, (Jan. 2015), https://www.aha.org/system/files/research/reports/tw/15jan-tw-telehealth.pdf.
[2] Am. Med. Ass'n, *AMA Supports Telehealth Initiative to Improve Health Care Access* (Mar. 19, 2020), https://www.ama-assn.org/press-center/press-releases/ama-supports-telehealth-initiative-improve-health-care-access.

co-pays, deductibles, prior authorizations, etc. – should not differ between telehealth and other means of care and that special accessibility accommodations, interpretation, and culturally and linguistically appropriate services must be made available via telehealth just as they would be for in-person services.

In 2018, an estimated 79 million Americans in rural and urban areas lived in federally designated primary care Health Professional Shortage Areas.[3] Women living in rural areas experience higher rates of death due to cerebrovascular disease and ischemic heart disease, as well as higher rates of obesity, suicide, and cervical cancer.[4] Telephone-only appointments have been an essential tool in expanding access to telehealth for rural communities as well as for very low income, houseless, and elderly patients who are not able to utilize video technology. Many of these patients do not have video technology or reliable Internet service and/or may lack digital literacy. For these individuals, the issue is not a video-visit versus a phone-visit, but rather a phone appointment or no appointment at all.

Due to systemic racism and a long history of discriminatory public policy, low-income and patients experiencing homelessness are disproportionately BIPOC, making parity for telephone appointments a critical factor of racial equity. African Americans make up just 2% of the population in Oregon, but 6% of the houseless population; Native Americans make up 1.1% of the total population and 4.2% of the houseless population. In Multnomah County, for example, 48% of people who are unsheltered are BIPOC while making up only 30% of the population, and nearly three out of four people experiencing homelessness are people with disabilities. To allow safety-net health clinics to continue to serve all patients, it is critical that telehealth visits, including telephonic, be reimbursed at the same rate as in-person visits. Furthermore, limiting reimbursement parity to video-only will only exacerbate the digital divide's impact on who can or cannot choose to utilize telemedicine.

Reimbursement parity has not been shown to lead to greater costs since telehealth likely saves costs overall. When access to telehealth is expanded, cost savings for payors can still be observed even when the payor is reimbursing telehealth services at the same rate as in person services. Telehealth avoids reimbursement for costlier in-person care. For example, many telehealth encounters result in avoided urgent care or ER visits. With telehealth, unnecessary ER visits and often subsequent follow-up office visits may be avoided, as patient issues are able to be resolved during the initial telehealth visit an average of 83% of the time.[5]

Since the pandemic started, Delaware, Colorado, Vermont, Maryland, Maine, and other states have already enacted comprehensive telemedicine legislation.[6] With HB 2508, Oregon has the chance to join these states in passing proactive, future-looking legislation that will take crucial steps toward addressing a serious access issue impacting Oregonians across the state. Planned Parenthood Advocates of Oregon respectfully urges your support for HB 2508.

Sincerely,

An Do
Interim Executive Director
Planned Parenthood Advocates of Oregon

[3] Bureau of Health Workforce, Health Resources and Services Administration, U.S. Department of Health and Human Services (HHS), Designated health professional shortage areas statistics: First quarter of fiscal year 2019 designated HPSA quarterly summary, 2018, https://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR5...
[4] Am. Coll. of Obstetricians and Gynecologists (ACOG), *Committee Opinion No. 586: Health Disparities in Rural Women* (Feb. 2014, reaffirmed Apr. 2016), http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Health%20Care%20for%20Underserved%20Women/co586.pdf?dmc=1&ts=20140307T1701041677.
[5] Dale H. Yamamoto, *Assessment of the Feasibility and Cost of Replacing In-Person Care with Acute Care Telehealth Services*, Red Quill Consulting (December 2014), http://connectwithcare.org/wp-content/uploads/2014/12/Medicare-Acute-Care-Telehealth-Feasibility.pdf
[6] H.R. 348, 150 Gen Assemb. (Del. 2020); H.R. 20-1092, 72 Gen. Assemb., 2020 Reg. Sess. (Co. 2020); H.R. 742, 2019-2020 Gen. Assemb. (Vt. 2020); H.R. 448, 441 Gen. Assemb., 2020 Leg. Sess. (Md. 2020); S. 676, 129th Me. Leg., 2d Reg. Sess. (Me. 2020).