

FROM SAFETY NET TO SOLID GROUND

One in Three Adults Used Telehealth during the First Six Months of the Pandemic, but Unmet Needs for Care Persisted

Laura Barrie Smith and Fredric Blavin

Telehealth, health care provided via telephone or video, is increasingly viewed as a low-cost strategy to expand access to health care. Before the COVID-19 pandemic, telehealth use was modest but growing and varied significantly by a patient's health insurance coverage type and rurality (MedPAC 2018; Yu et al. 2018). The rate of telehealth use soared when the pandemic began and peaked at about 14 percent of outpatient visits in mid-April (Mehrotra et al. 2020; Patel et al. 2020; Ziedan, Simon, and Wing 2020). Though telehealth rates have since declined, they remain significantly higher than average, even as in-person visits have resumed; recent estimates show telehealth now constitutes 6 percent of outpatient visits, compared with less than 1 percent before the pandemic (Mehrotra et al. 2020).

During the pandemic, Medicare and other payers have made changes to payment and regulatory policies that incentivize both patients and providers to use telehealth, thereby increasing its use. Many insurers waived out-of-pocket costs for telehealth visits, and Medicare mandated payment for audio-only telephone visits and expanded telehealth visits to nonrural residents (Lee, Karsten, and Roberts 2020; Mehrotra, Wang, and Snyder 2020). Additionally, the Centers for Medicare & Medicaid Services permitted telehealth services to originate from a patient's home rather than a medical facility.¹

Though telehealth use has increased dramatically during the pandemic, continued reliance on it could exacerbate health care inequities (Mehrotra, Wang, and Snyder 2020). The resources and technology required for telehealth may be less accessible for people with low incomes or living in rural areas. For example, community health centers face disproportionate barriers to telehealth implementation because they often lack reimbursement, equipment, and training.²

In this brief, we provide nationally representative estimates of telehealth use among nonelderly adults six months into the pandemic, as of September 2020. We include both phone and video visits in our definition of telehealth. We use data from the second wave of the Urban Institute's Coronavirus Tracking Survey, fielded September 11 through 28, 2020. The survey contained questions about telehealth use, satisfaction with telehealth use, wanting telehealth but not getting it, not seeing a provider because telehealth was the only option, and reasons for not using telehealth. We analyze survey responses overall and by health and demographic characteristics. We find the following:

- One-third of adults reported having had a telehealth visit to discuss their own health care since the outbreak of the novel coronavirus began in March, and this varied substantially by patient characteristics. Adults in fair or poor health and adults with multiple chronic conditions were significantly more likely to use telehealth than their respective counterparts. In addition, Black adults and Hispanic/Latinx adults were more likely to use telehealth than white adults,* which is consistent with a survey of nonelderly adults in California (Joynt, Catterson, and Rabinowitz 2020). In addition, adults living outside metropolitan areas were less likely to have used telehealth than adults living in metropolitan areas.

* We use "Hispanic/Latinx" throughout this brief to reflect the different ways people self-identify. Also, we use the terms "white" and "Black" to refer to adults who do not identify as Hispanic/Latinx.

- › More than three-quarters of adults who used telehealth services were satisfied with their telehealth experiences, but adults in excellent or very good health were more likely to be satisfied than adults in fair or poor health.
- › Adults in fair or poor health, adults with chronic conditions, and Hispanic/Latinx adults were more likely to have wanted a telehealth visit but not received one than their counterparts (adults in excellent or very good health, adults with no chronic conditions, and white adults).
- › Compared with all other adults, adults who wanted a telehealth visit but had not had one since the coronavirus outbreak began were more likely to have an unmet need for care because of the pandemic.
- › Less than 10 percent of adults did not see a provider because their provider was only taking telehealth visits, and they did not want that type of visit. Adults in fair or poor health and adults with chronic conditions were more likely to have this experience than adults in excellent health and adults without chronic conditions. Adults with public health insurance coverage were more likely to have this experience than adults with employer-sponsored insurance (ESI) coverage.

Data and Methods

This brief uses data from the second wave of the Urban Institute's Coronavirus Tracking Survey, a nationally representative internet-based survey of nonelderly adults designed to assess how the pandemic is affecting adults and their families and how those effects change over time. A total of 4,007 adults ages 18 to 64 participated in the second wave, fielded September 11 through 28, 2020; 91 percent of respondents completed the survey by September 17. The first wave of the tracking survey was fielded May 14 through 27. Respondents for both waves were sampled from the 9,032 adults who participated in the most recent round of the Health Reform Monitoring Survey (HRMS), fielded March 25 through April 10, 2020. The HRMS sample is drawn from Ipsos's KnowledgePanel, the nation's largest probability-based online panel. The panel is recruited from an address-based sampling frame covering 97 percent of US households and includes households with and without internet access. Participants can take the survey in English or Spanish.

The Coronavirus Tracking Survey includes an oversample of Black and Hispanic/Latinx HRMS participants. Survey weights adjust for unequal selection probabilities and are poststratified to the characteristics of the national nonelderly adult population based on benchmarks from the Current Population Survey and

American Community Survey. We also adjust the September tracking survey weights to address differential nonresponse among participants in the March/April HRMS. Nonresponse in the September survey is greater among March/April HRMS participants experiencing negative employment effects and material hardship during the pandemic, and these effects differ based on demographic characteristics. Therefore, we adjust the weights so work status and employment and hardship outcomes reported in March/April among the September sample align with the outcomes reported among the full March/April HRMS sample, both overall and within key demographic subgroups. These adjustments make the September tracking survey sample better represent the sample initially drawn in March/April and mitigate nonresponse bias in estimated changes in the pandemic's effects over time.

The margin of sampling error, including the design effect, for the full sample of adults in the second wave of the tracking survey is plus or minus 2.0 percentage points for a 50 percent statistic at the 95 percent confidence level. Additional information about the March/April 2020 HRMS and the questionnaires for the HRMS and first and second waves of the Coronavirus Tracking Survey can be found at hrms.urban.org.

The survey contained several questions regarding respondents' use of telehealth. The first question was, "Since the coronavirus outbreak began, have you had a phone or video visit with a doctor, nurse, or other health care provider to talk about your own health? These types of visits are sometimes called telehealth visits." Importantly, this question includes both phone calls and video visits in the definition of telehealth without distinguishing between the two. We therefore use telehealth "use" and "visits" synonymously throughout this brief. The survey questions also did not specify whether telehealth visits were with clinicians with whom respondents had an established relationship or with third-party vendors with whom they lacked an established relationship. Thus, both are included in our definition of telehealth use.

Survey respondents who did not have internet access were provided tablets and internet access to complete the survey. These respondents could also use this technology for personal use, which could include telehealth visits. Thus, our results may not represent telehealth use among all people without internet access.

We analyze telehealth use, satisfaction with telehealth, wanting telehealth but not getting it, reasons for not getting telehealth, wanting care but not getting it because telehealth was the only option, and reasons for not wanting telehealth despite wanting care. We show results both overall and by selected health and

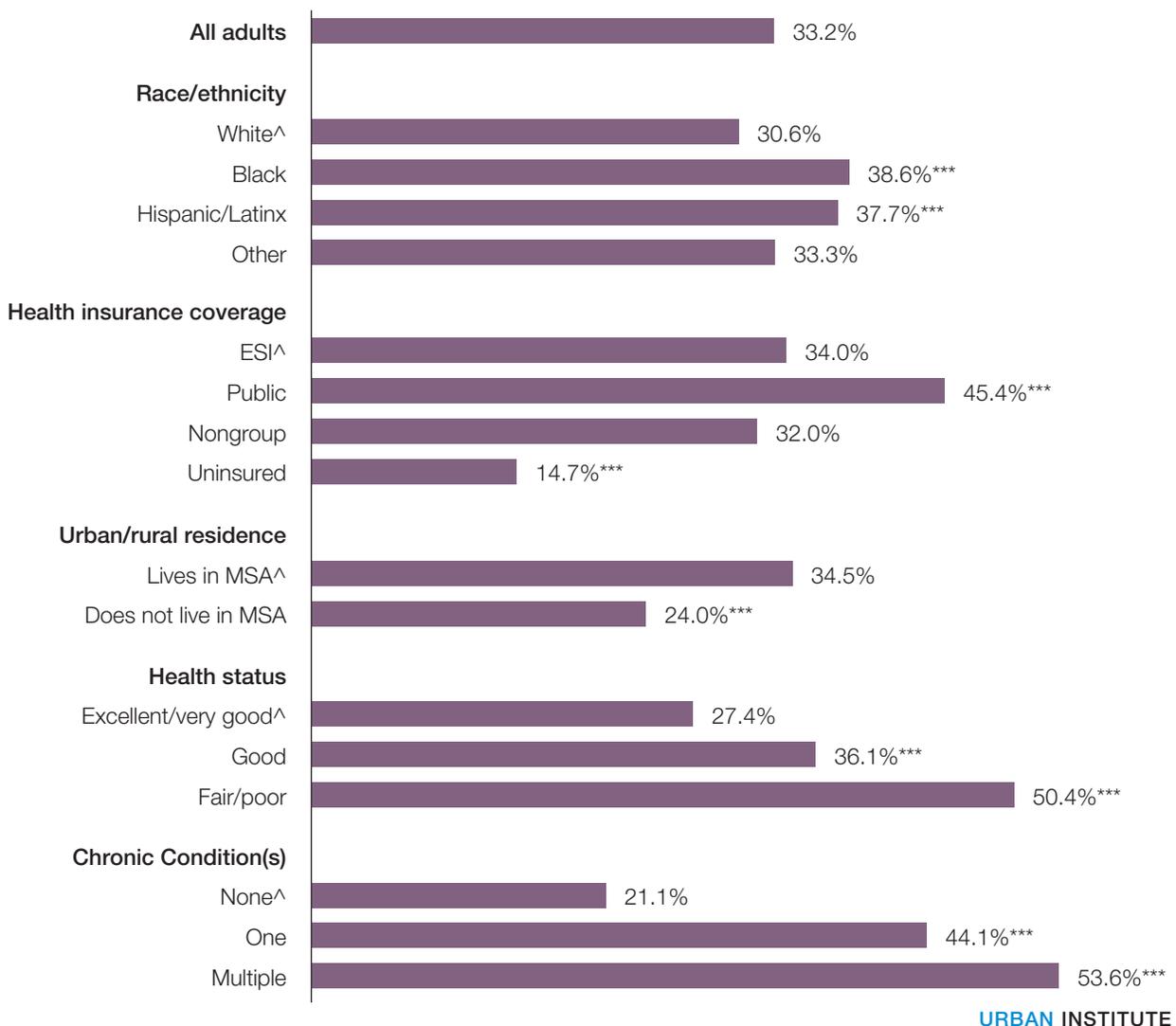
demographic characteristics: race and ethnicity, insurance coverage, living in or outside a metropolitan statistical area, health status, and number of chronic conditions. Additionally, we calculate regression-adjusted rates for each outcome, using multivariate regression models that control for each key health and demographic characteristic. Findings from the regression-adjusted models, which are not shown, are consistent with the unadjusted results unless otherwise noted.

Results

Use of Telehealth

One-third of adults reported having had a telehealth visit to talk about their own health since the coronavirus outbreak began in March, and this differed substantially across subgroups (figure 1). Health status and the presence of chronic conditions were strongly associated with whether an adult had a telehealth

Figure 1. Use of Telehealth among Adults Ages 18 to 64 since the Coronavirus Outbreak Began, Overall and by Selected Characteristics, September 2020



Source: Urban Institute Coronavirus Tracking Survey, wave 2.

Notes: ESI is employer-sponsored insurance. MSA is metropolitan statistical area. "Other" is adults who are not Hispanic/Latinx, Black, or white and adults identifying as more than one race. The survey was conducted September 11 through 28, 2020, and 91 percent of respondents completed the survey by September 17.

*/**/*** Estimates differ significantly from the reference group (^) at the 0.10/0.05/0.01 level, using two-tailed t-tests.

visit. Those in fair or poor health were 23.0 percentage points more likely to have used telehealth than those in excellent or very good health (50.4 percent versus 27.4 percent), and those with multiple chronic conditions were 32.5 percentage points more likely to have used telehealth than those without any chronic conditions (53.6 percent versus 21.1 percent).

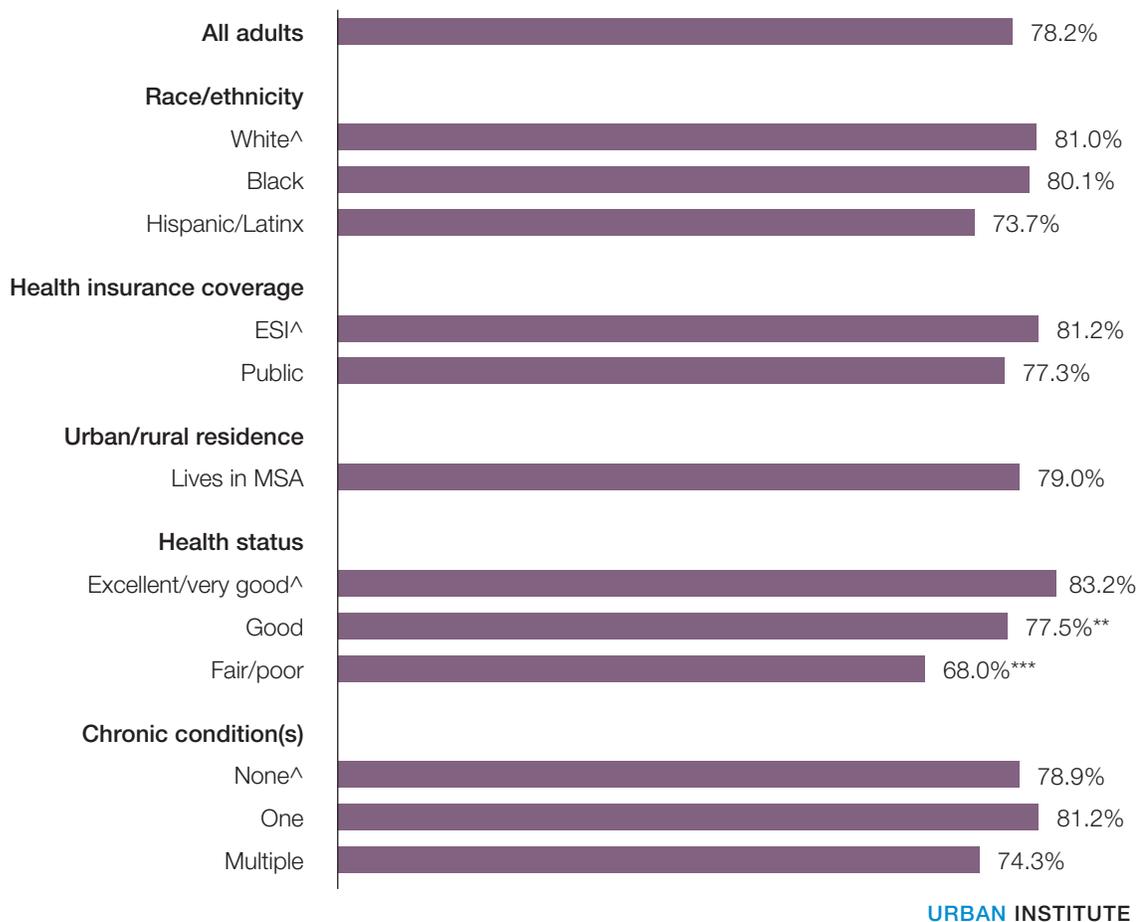
Telehealth use also varied by race and ethnicity. Black adults (38.6 percent) and Hispanic/Latinx adults (37.7 percent) were more likely to have used telehealth than white adults (30.6 percent). This difference is consistent with findings from a survey of nonelderly adults in California conducted by the California Health Care Foundation and NORC at the University of Chicago (Joynt, Catterson, and Rabinowitz 2020).

Adults living outside metropolitan areas were less likely to have used telehealth than adults living in metropolitan areas (24.0 versus 34.5 percent). In addition, adults with public insurance coverage were more likely to have used telehealth (45.4 percent) and uninsured adults were less likely to have used telehealth (14.7 percent) than adults with ESI (34.0 percent). The difference in telehealth use between those with public insurance and those with ESI is not statistically significant after adjusting for other characteristics (data not shown).

Satisfaction with Telehealth

Most adults who had a telehealth visit were very or somewhat satisfied with their most recent visit (78.2 percent), and this varied by health status (figure 2). Adults in excellent or very good health were more likely to be very or somewhat satisfied than adults in fair or poor health (83.2 percent versus 68.0 percent).

Figure 2. Share of Adults Ages 18 to 64 Satisfied with Their Most Recent Telehealth Visit, Overall and by Selected Characteristics, September 2020



Source: Urban Institute Coronavirus Tracking Survey, wave 2.

Notes: ESI is employer-sponsored insurance. MSA is metropolitan statistical area. Estimates reflect the share of respondents who had a telehealth visit and were "very satisfied" or "somewhat satisfied" with their most recent visit. Black and white adults are not Hispanic/Latinx. Sample sizes were too small to report satisfaction with telehealth for some subgroups (adults with nongroup coverage, the uninsured, those not residing in MSAs, adults identifying as more than one race, and adults who are not Hispanic/Latinx, Black, or white). The survey was conducted September 11 through 28, 2020, and 91 percent of respondents completed the survey by September 17.

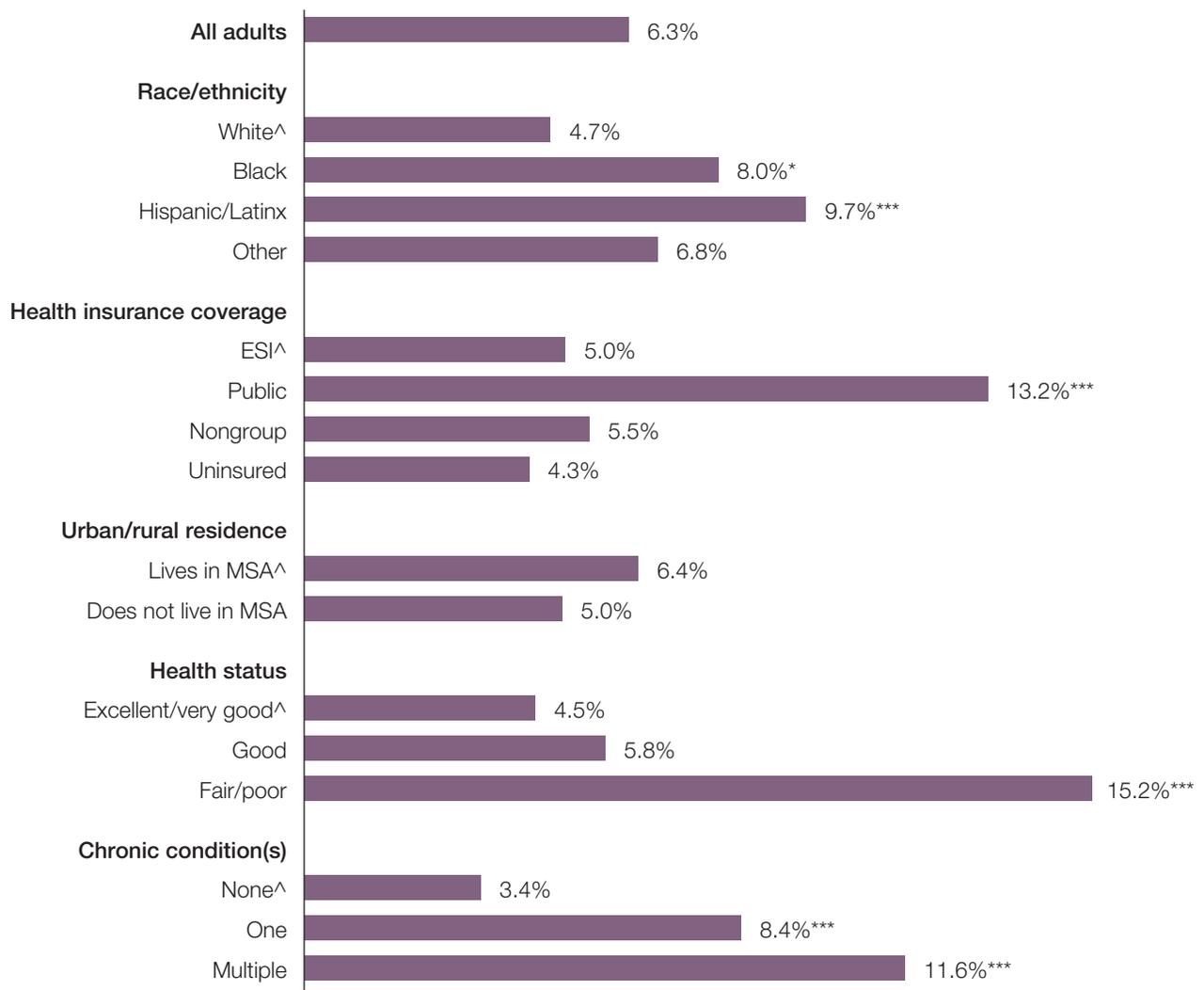
*/**/*** Estimates differ significantly from the reference group (^) at the 0.10/0.05/0.01 level, using two-tailed t-tests.

Wanting Telehealth but Not Getting It

Overall, 6.3 percent of adults reported wanting a telehealth visit to talk about their own health but not having one since the coronavirus outbreak began, and this varied by health status and race and ethnicity (figure 3). Adults in fair or poor health were more than 10 percentage points more likely to have wanted but not had a telehealth visit than adults in excellent or very good health (15.2 percent versus 4.5 percent). Similarly, adults with one chronic condition (8.4 percent) and multiple

chronic conditions (11.6 percent) were more likely to have wanted but not had a telehealth visit than adults with no chronic conditions (3.4 percent). Hispanic/Latinx adults (9.7 percent) and Black adults (8.0 percent) were more likely than white adults (4.7 percent) to have wanted but not had a telehealth visit. And adults with public insurance coverage (13.2 percent) were more likely to have had this experience than adults with ESI (5.0 percent), though this was statistically insignificant in the regression-adjusted model (data not shown).

Figure 3. Share of Adults Ages 18 to 64 Who Wanted a Telehealth Visit but Had Not Had One since the Coronavirus Outbreak Began, Overall and by Selected Characteristics, September 2020



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Source: Urban Institute Coronavirus Tracking Survey, wave 2.

Notes: ESI is employer-sponsored insurance. MSA is metropolitan statistical area. "Other" is adults who are not Hispanic/Latinx, Black, or white and adults identifying as more than one race. Black and white adults are not Hispanic/Latinx. The survey was conducted September 11 through 28, 2020, and 91 percent of respondents completed the survey by September 17.

*/**/*** Estimates differ significantly from the reference group ([^]) at the 0.10/0.05/0.01 level, using two-tailed t-tests.

As noted, 6.3 percent of adults wanted a telehealth visit but had not had one since the coronavirus outbreak began. The top reasons for this were taking too long to get an appointment (27.2 percent), needing care that could only be provided in person (26.9 percent), having a provider that was not taking visits by phone or video (22.2 percent), and not having the technology needed for that type of visit (16.7 percent). Table 1 shows a complete tabulation of respondents' reasons for not having gotten a telehealth visit despite wanting one.

Table 1. Reasons for Not Getting a Telehealth Visit since the Coronavirus Outbreak Began Despite Wanting One among Adults Ages 18 to 64, September 2020

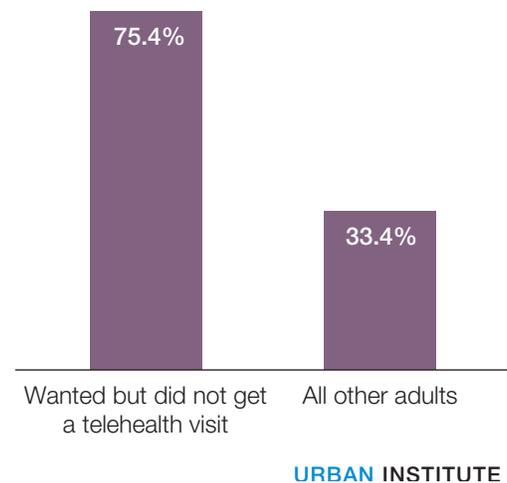
Reason	Share of adults
Took too long to get appointment	27.2
Needed test, treatment, or medication that could only be provided in person	26.9
Provider was not taking visits by phone or video	22.2
Did not have technology needed for this type of visit	16.7
Visit would not be covered by health insurance	14.9
Could not afford copayment or other out-of-pocket costs	13.8
Other	11.6
Did not want to use too much data under cell phone data plan	11.4

Source: Urban Institute Coronavirus Tracking Survey, wave 2.

Notes: N = 266. When answering this question, respondents were asked to consider the most recent time they wanted a telehealth visit but did not get one. Percentages total more than 100 because respondents were asked to select all responses that applied. The survey was conducted September 11 through 28, 2020, and 91 percent of respondents completed the survey by September 17.

Figure 4 compares shares of adults with unmet health care needs because of the coronavirus outbreak (because of concerns about exposure to the virus or providers having limited services). Among those who wanted but had not had a telehealth visit, 75.4 percent had an unmet health care need, compared with 33.4 percent of all other adults.

Figure 4. Share of Adults Ages 18 to 64 with an Unmet Health Care Need Because of the Coronavirus Outbreak among Those Who Wanted a Telehealth Visit but Had Not Had One and All Other Adults, September 2020



Source: Urban Institute Coronavirus Tracking Survey, wave 2.

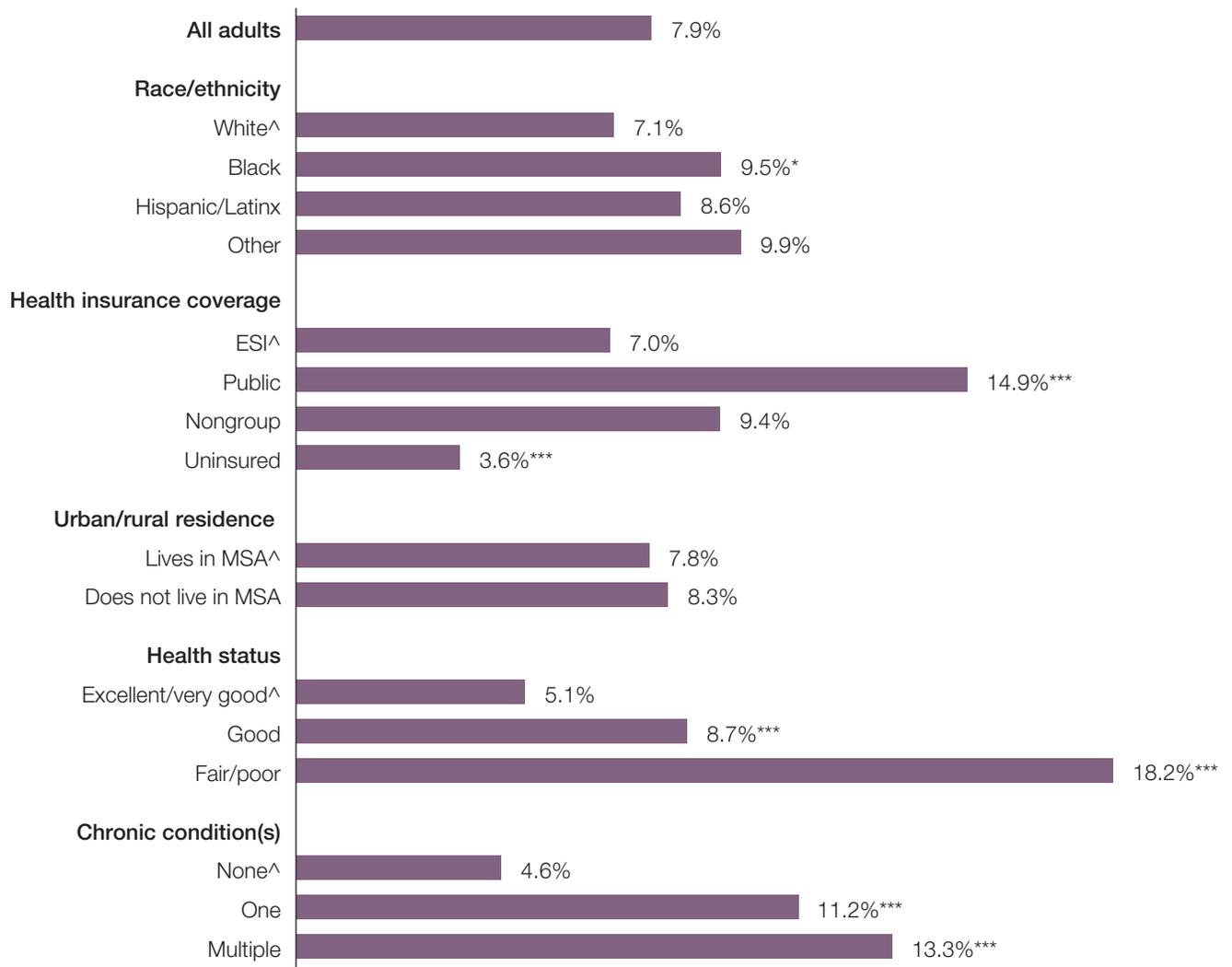
Notes: "Because of the coronavirus outbreak" refers to fears about exposure to the novel coronavirus or providers having limited their services. The survey was conducted September 11 through 28, 2020, and 91 percent of respondents completed the survey by September 17.

Wanting to See a Provider but Not Wanting Telehealth

Overall, 7.9 percent of adults had avoided seeing a provider at least once to talk about their own health since the coronavirus outbreak began, because their provider was only taking telehealth visits and the respondent did not want that type of visit. This experience varied by health status and insurance coverage type (figure 5). Adults in fair or poor health were more than 10 percentage points more likely to not want telehealth

than adults in excellent or very good health (18.2 percent versus 5.1 percent). Similarly, adults with one chronic condition (11.2 percent) or multiple chronic conditions (13.3 percent) were more likely to not want telehealth than adults without chronic conditions (4.6 percent). Adults with public insurance coverage were also more likely to not want telehealth than adults with ESI (14.9 percent versus 7.0 percent).

Figure 5. Share of Adults Ages 18 to 64 Who Avoided Seeing a Provider at Least Once since the Coronavirus Outbreak Began Because They Did Not Want a Telehealth Visit, Overall and by Selected Characteristics, September 2020



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Source: Urban Institute Coronavirus Tracking Survey, wave 2.

Notes: ESI is employer-sponsored insurance. MSA is metropolitan statistical area. "Other" is adults who are not Hispanic/Latinx, Black, or white and adults identifying as more than one race. Black and white adults are not Hispanic/Latinx. The survey was conducted September 11 through 28, 2020, and 91 percent of respondents completed the survey by September 17.

*/**/*** Estimates differ significantly from the reference group ([^]) at the 0.10/0.05/0.01 level, using two-tailed t-tests.

Most commonly, adults who avoided seeing a provider because they did not want a telehealth visit did so because they needed care that could only be provided in person (45.9 percent). The next most common specified reasons were not being comfortable with using technology required for that type of visit (33.2 percent) and being concerned about privacy (13.4 percent). Table 2 presents a complete tabulation of respondents' reasons for not wanting telehealth.

Table 2. Reasons for Not Seeing a Provider Only Taking Telehealth Visits since the Coronavirus Outbreak Began among Adults Ages 18 to 64 Who Did Not Want a Telehealth Visit, September 2020

Reason	Share of adults
Needed test, treatment, or medication that could only be provided in person	45.9
Not comfortable with using technology for that type of visit	33.2
Other reason	13.7
Concerned about privacy	13.4
Did not have technology needed for this type of visit	11.3
Could not afford out-of-pocket costs	10.8
Visit would not be covered by insurance	6.2
Did not want to use too much data under cellular data plan	4.9

Source: Urban Institute Coronavirus Tracking Survey, wave 2.

Notes: *N* = 342. When answering this question, respondents were asked to consider the most recent time they did not see a health care provider because the provider was only taking telehealth visits. Percentages total more than 100 because respondents were asked to select all responses that applied. The survey was conducted September 11 through 28, 2020, and 91 percent of respondents completed the survey by September 17.

Discussion

In September 2020, one-third of nonelderly adults reported having used telehealth since the coronavirus outbreak began, and the majority were satisfied with their experiences. Health status had the strongest association with telehealth use; adults in fair or poor health were the most likely to have used telehealth. Telehealth use was also more common among adults living in metropolitan areas than adults living in nonmetropolitan areas and among Black and Hispanic/Latinx adults than among white adults.

Our findings suggest telehealth was generally accessible for adults during the first six months of the pandemic, consistent with other work documenting considerable increases in telehealth use over this period (Mehrotra et al. 2020; Patel et al. 2020; Ziedan, Simon, and Wing 2020). However, adults in fair or poor health, Hispanic/Latinx adults, and adults with public health insurance coverage were more likely to have wanted but not gotten a telehealth visit. And adults who wanted a telehealth visit but had not had one were more likely to have an unmet health care need than all other adults. People who did not use telehealth cited barriers such as long wait times, difficulty finding a telehealth provider, and lack of access to or comfort with using the required technology, suggesting more efforts are needed to ensure equitable access to telehealth.

Many view telehealth as a low-cost alternative to in-person care. When the pandemic began, policymakers strongly incentivized its use to minimize exposure to the virus from in-person care. However, continued reliance on telehealth could exacerbate health inequities. Further, traditional fee-for-service payment methods present many challenges in telehealth, and persistently high rates of telehealth use, even as in-person care resumes, would likely lead to long-term increases in health care utilization and spending (Ashwood et al. 2017).³ Policymakers must carefully consider these trade-offs when drafting regulatory and payment policies for telehealth use after the pandemic.

Notes

- 1 Robert Berenson and Adele Shartzter, "The Mismatch of Telehealth and Fee-for-Service Payment," *JAMA Health Forum*, October 2, 2020, <https://doi.org/10.1001/jamahealthforum.2020.1183>.
- 2 June-Ho Kim, Eesha Desai, and Megan B. Cole, "How the Rapid Shift to Telemedicine Leaves Many Community Health Centers Behind during the COVID-19 Pandemic," *Health Affairs Blog*, June 2, 2020, <https://www.healthaffairs.org/doi/10.1377/hblog20200529.449762/abs/>.
- 3 Lori Housman, Zoë Williams, and Philip Ellis, "Telemedicine," *CBO Blog* (Congressional Budget Office), July 29, 2015, <https://www.cbo.gov/publication/50680>; Berenson and Shartzter, "The Mismatch of Telehealth and Fee-for-Service Payment," *JAMA Health Forum*.

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