trek health

Telehealth Parity

Are you getting reimbursed when doing what's right for the patient?

April 2026

By Jordan Kassab
& Dilpreet Sahota

trekhealth.io

Executive summary

The rise of telehealth in modern medicine has simultaneously brought about the question of payment parity for these services. Analogous in-office and telehealth services are billed with the same code, differing only by a billing code modifier indicating place of service. With this, we analyzed paired codes across traditional and telehealth modalities to compare commercial reimbursement. Federally, advocates have pushed for payment parity between the two to ensure equitable access to care for patients; however, commercial payers operating outside federal mandates have largely been free to set their own rates — and our findings suggest they have used that latitude to systematically discount telehealth.

Table of contents

History of telehealth in medicine 3

Methodology of analysis 3

Telehealth reimbursement is systematically discounted 5

The commercial premium over medicare collapses for telehealth 5

Payer variation is substantial 6

Established patients face steeper discounts 6

State parity laws are not associated with improved commercial parity 7

Higher commercial market share does not predict better parity 7

The parity law paradox 8

BCBS as a policy signal 8

Implications for federal policy 9

History of telehealth in medicine

The expansion of synchronous telehealth as a standard care delivery modality is one of the most consequential shifts in American healthcare in the past decade. While **telephone-based communication has existed for over a century**, video-enabled virtual visits as a clinical norm emerged slowly before 2020 — constrained by regulatory barriers, reimbursement ambiguity, and institutional inertia. At the eve of the COVID-19 pandemic, **telehealth spending represented just 0.01% of total healthcare** expenditures.

That changed abruptly in 2020. Pandemic-era shutdowns rendered in-person care impossible across broad swaths of the health system, and utilization data reflects the scale of that shift: telehealth use **increased an estimated 766% during the first three months** of the public health emergency. In response, the federal government moved quickly to preserve access. The Centers for Medicare and Medicaid Services (CMS) issued emergency waivers expanding telehealth coverage, relaxing geographic restrictions, and authorizing payment for services delivered via alternative modalities. For millions of patients with no other avenue to care, and for providers working to maintain continuity during an unprecedented disruption, these interventions were essential.

Now, telehealth care has essentially become a mainstay in modern healthcare practices due to its flexibility across patient populations. However, **little is known about whether private payers value telehealth care compared to in office visits**. Because of this, we sought out to see how reimbursement compares across these two modalities across a spectrum of payers, specialties, and geographic locations.

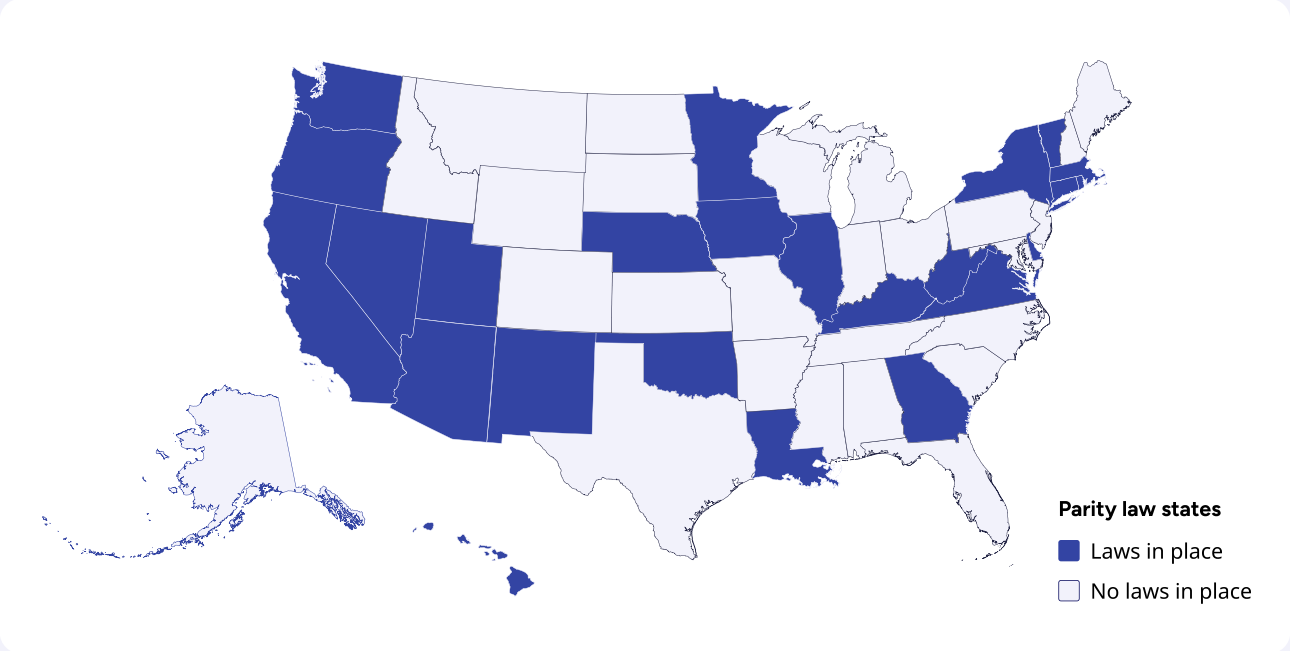
Methodology of analysis

We used Q1 2026 negotiated rate data from Transparency in Coverage machine-readable files published by Aetna, Blue Cross Blue Shield (BCBS), Cigna, and UnitedHealthcare (UHC). These four payers collectively represent the majority of commercial insurance enrollment in the United States and provided the most complete geographic and specialty coverage in the TiC data.

We focused on outpatient evaluation and management (E&M) services, the most commonly billed codes in both in-person and telehealth settings. Six CPT codes were included: established patient visits (99213, 99214, 99215) and new patient visits (99203, 99204, 99205). These codes span the range of visit complexity and represent the core of outpatient primary and specialty care billing. Twenty physician taxonomy codes were included: Allergy & Immunology, Cardiology, Dermatology, Diagnostic Radiology, Emergency Medicine, Endocrinology, Family Medicine, Gastroenterology, Internal Medicine, Medical Oncology, Neurological Surgery, Neurology, Obstetrics & Gynecology (OBGYN), Ophthalmology, Orthopedic Surgery, Otolaryngology, Pediatrics, Psychiatry, Surgery, and Urology.

Delivery modality was identified using place-of-service (POS) and modifier codes. Telehealth services were defined as claims billed with modifiers 02 (telehealth provided other than in the patient's home) or 10 (telehealth provided in the patient's home). In-office services were defined as claims billed with modifier 11 (office). Parity ratios were calculated as the telehealth negotiated rate divided by the in-office negotiated rate for the same CPT code, payer, specialty, and state.

States were classified as having or not having telehealth payment parity laws based on published legal surveys as of Q1 2026. Parity law status was treated as a binary variable in regression analyses.



Map 1: Map of telehealth parity law states

Descriptive statistics summarized parity ratios at the payer, specialty, patient type (new vs. established), and state levels. Multivariable linear regression models assessed the association between state parity law status and parity ratios, with fixed effects for payer and specialty and adjustment for state-level commercial insurance market share. A secondary analysis examined parity ratios relative to Medicare non-facility rates to characterize the commercial premium over the government benchmark for telehealth versus in-office services.

Telehealth reimbursement is systematically discounted

Across all payer-specialty-state observations, telehealth reimbursement was lower than the equivalent in-office rate in 98% of cases. The mean parity ratio was approximately 0.91, indicating that providers are reimbursed roughly $0.91 for each telehealth dollar relative to what they would receive for an identical in-person service. This discount is consistent across visit types, geographies, and specialties, suggesting that below-parity telehealth reimbursement is a structural feature of commercial contracting rather than an artifact of specific market conditions.

The commercial premium over medicare collapses for telehealth

In-office commercial reimbursement for established patient E&M visits (99213-99215) was 170-184% of Medicare non-facility rates, a meaningful premium reflecting the leverage commercial contracts typically afford providers relative to the government benchmark. Via telehealth, that premium compressed to 101-114% of Medicare non-facility rates — barely above the Medicare floor. In practical terms, providers delivering care via telehealth under commercial contracts are receiving near-Medicare rates despite operating within what should be premium commercial arrangements. For specialties and practices that have built their financial models around the commercial-to-Medicare differential, this compression represents a material threat to the economic viability of telehealth.

Payer variation is substantial

Significant variation in parity ratios was observed across the four payers. Cigna demonstrated the largest mean telehealth discount at approximately 22% below in-office rates, the worst performance among the four. UHC discounted telehealth by approximately 5% and Aetna by approximately 7%. BCBS was a notable outlier in the opposite direction: it reimbursed telehealth above in-office rates in approximately 74% of observations, with a mean parity ratio of 1.07. BCBS's approach to telehealth reimbursement represents a potential model for achieving payment equity within the existing commercial contracting framework and merits further investigation into the contractual mechanisms that underlie this pattern.

Payer	Telehealth discount (Mean)	Benchmark target
Aetna	7% below in-office	Moderate
BCBS	7% above in-office	Highest
Cigna	22% below in-office	Lowest
UHC	5% below in-office	Moderate

Table 1: Discounted telehealth payments compared to in-office by payer

Established patients face steeper discounts

Parity ratios were modestly but consistently worse for established patient visits (99213-99215) compared to new patient visits (99203-99205). This finding has significant practical implications: established patient E&M codes are the backbone of telehealth utilization, particularly for the chronic disease management and follow-up care that telehealth is best suited to support. Providers with panel-heavy practices — those most likely to offer ongoing telehealth access to their patient populations — face the steepest systematic discounts.

State parity laws are not associated with improved commercial parity

Contrary to policy intent, states with telehealth payment parity laws did not demonstrate significantly better commercial parity ratios than states without such laws. In multivariable models controlling for payer and specialty mix, parity law status had no statistically significant effect on commercial reimbursement equity. For new patient visits specifically, parity law states showed marginally worse parity ratios than non-parity states — the opposite of the expected direction.

> ***Contrary to policy intent, states with telehealth payment parity laws did not demonstrate significantly better commercial parity ratios than states without such laws.***

This finding is consistent with the structural limitations of state parity frameworks described above. Because the Employee Retirement Income Security Act (ERISA) preemption exempts self-funded employer plans from state insurance mandates, parity laws in practice reach only a subset of the commercial market. In states where large employers and self-insured plans account for a substantial share of commercial enrollment, parity laws may produce no meaningful improvement in the aggregate parity ratios captured in TiC data.

Higher commercial market share does not predict better parity

States with higher proportions of commercially insured residents showed lower telehealth parity ratios, not higher. This counterintuitive result suggests that commercial market concentration does not translate into provider leverage on telehealth rates the way it does for in-office reimbursement. The mechanisms driving this relationship warrant further investigation, but one plausible explanation is that large commercial markets also tend to have higher proportions of self-insured employer plans — precisely the population excluded from state parity protections.

The collapse of the commercial premium for telehealth visits is perhaps the most economically significant finding. Providers negotiate commercial rates at a meaningful premium over Medicare in part to cross-subsidize lower-margin government payers. When that premium disappears for telehealth, the financial calculus changes: a practice that derives a substantial share of its revenue from virtual visits is effectively operating on near-Medicare margins for that segment, reducing the return on investment for telehealth infrastructure and raising questions about long-term sustainability.

The parity law paradox

The finding that state parity laws are not associated with improved commercial parity ratios is important and should not be interpreted as evidence that these laws are without value. For state-regulated insurance products, these mandates likely produce the intended effect. The problem is one of scope: because ERISA preemption removes the largest segment of the commercial market from state jurisdiction, parity laws cannot deliver population-level parity even when they are well-designed and faithfully enforced.

The marginally worse parity ratios observed in new patient visits within parity law states may reflect selection effects: states with more market activity and larger self-insured populations may be more likely to have enacted parity legislation as a political response to a visible access problem, while the underlying commercial dynamics remain governed by ERISA-preempted plans. Disentangling this relationship requires more granular data on plan type that is not currently available in TiC files.

BCBS as a policy signal

The finding that BCBS reimburses telehealth above in-office rates in the majority of observations is notable precisely because it demonstrates that commercial parity is achievable without federal mandate.

BCBS's approach — whether driven by network strategy, value-based contracting philosophy, or explicit parity commitments — provides proof of concept that the structural constraints of ERISA and federal inaction are not the only barriers. Understanding the contractual and actuarial mechanisms that produce BCBS's above-parity rates could inform both voluntary industry adoption and regulatory design.

Implications for federal policy

The limitations of state parity frameworks and the demonstrated scale of commercial telehealth discounting together make a strong case for federal intervention in the payment dimension of telehealth policy, moving beyond the current scope of just access to these services. Several legislative pathways exist: Congress could extend parity requirements to self-funded employer plans through ERISA amendment; CMS could condition network adequacy standards on telehealth rate parity for qualified health plans; or federal price transparency requirements could be strengthened to require parity ratios as a disclosed metric, creating accountability without direct rate regulation.

The political viability of these approaches varies, and none is straightforward. But the evidence presented here suggests that continuing to rely on state parity laws as the primary policy mechanism for commercial reimbursement equity is unlikely to achieve meaningful results for the majority of commercially insured Americans.

Commercial telehealth reimbursement in the United States is systematically below in-office rates, with the commercial premium over Medicare effectively eliminated for virtual visits. State parity laws, while symbolically important, are structurally unable to close this gap for the majority of commercially insured Americans due to ERISA preemption of self-funded employer plans. Payers vary substantially in their approach, and BCBS's above-parity performance suggests that equitable telehealth reimbursement is commercially viable. Federal policy focused on payment equity, as opposed to solely access, is necessary to ensure that telehealth remains financially sustainable for providers and accessible for patients over the long term.

Commercial telehealth reimbursement in the United States is **systematically below in-office rates**, with the commercial premium over Medicare effectively eliminated for virtual visits.

trekhealth.io