Assembly
California Legislature

ASSEMBLY COMMITTEE ON HEALTH
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ASSEMBLYMEMBER, EIGHTEENTH DISTRICT

Oversight Hearing

BACKGROUND PAPER

Outcomes Review of AB 744 (Aguiar-Curry), Statutes of 2019: Health care coverage: telehealth and AB 32 (Aguiar-Curry), Statutes of 2022: Telehealth

Date: Tuesday, August 4, 2026
Time: 1:30 p.m.
Location: 1021 O Street, Room 1100

INTRODUCTION

This paper provides background for the Outcomes Review of AB 744 (Aguiar-Curry), Statutes of 2019 and AB 32 (Aguiar-Curry), Statutes of 2022, both related to telehealth. The purpose of the Outcomes Review process is to assess, review, and improve implementation of key enacted legislation to ensure the laws passed by the Legislature continue to improve the lives of Californians.

Telehealth is the use of electronic information and telecommunication technologies to support the delivery of direct health care services to patients and to enable clinician-to-clinician consultations. Telehealth can be real-time or "synchronous," such as when care is delivered via video or over the telephone, or "asynchronous." Asynchronous telehealth, sometimes called "store-and-forward," can be used when a real-time interaction is not needed. It includes sending, reviewing, and responding to images, messages, and other information, allowing providers and patients to interact when it suits their schedule. Telehealth can be used for discrete and one-time interactions, such as an over-the-phone consultation for pink eye or to allow a radiologist to review and assess a particular diagnostic image. It can also be deployed together with in-person care in a hybrid model; for instance, it can allow patients and providers who have an ongoing relationship to collaboratively decide whether an in-person or telehealth modality is suitable for a particular type of appointment.

While telehealth has been used in California for decades, its availability and prevalence increased significantly during the COVID-19 Public Health Emergency (PHE). In pre-pandemic 2018, 12.4% of California adults used telehealth. By 2021, that share had grown to 49% — nearly half of all adults.

EVOLUTION OF CALIFORNIA TELEHEALTH POLICY

California law first recognized telehealth 30 years ago with passage of the Telemedicine Development Act. Since that time, a number of legislative, administrative, and advocacy efforts created a robust telehealth policy environment that predated the expansion of telehealth through the PHE. This policy environment positioned California well to leverage telehealth during the PHE, when telehealth was increasingly used to provide care when in-person medical visits were limited. The increased use of telehealth, including audio, video, and asynchronous modalities, to address a range of medical needs has continued well after the PHE.

Key developments in the evolution of telehealth in California include:

- 1996: Medi-Cal begins covering selected telehealth services with the passage of the Telemedicine Development Act [SB 1665 (M. Thompson), Chapter 864, Statutes of 1996].

- 2011: AB 415 (Logue), Chapter 547, Statutes of 2011, recasts telehealth-related provisions in state law and dramatically expands coverage of telehealth services. AB 415 prohibits Medi-Cal and health plans and insurers from requiring in-person contact for services appropriately provided through telehealth, allows all licensed health providers to provide services via telehealth, removes a requirement that providers document a barrier to in-person care to be reimbursed for telehealth, and removes a requirement for written patient consent, among other changes.

- 2019:

    - AB 744 (Aguiar-Curry) requires payment parity between telehealth and in-person services, allows plans/insurers to apply copayments or coinsurance to telehealth services, and subjects telehealth services to the same deductibles and annual/lifetime dollar maximums as comparable in-person services.

    - AB 1494 (Aguiar-Curry), Chapter 829, Statutes of 2019, specifies that face-to-face contact is not required in an enrolled community clinic for Medi-Cal beneficiaries during an emergency.

    - The Department of Health Care Services (DHCS) releases a major update to Medi-Cal telehealth billing and reimbursement policy, making most services reimbursable through telehealth if the telehealth service meets applicable standards of care.

- 2020: In response to the COVID-19 pandemic, DHCS receives federal approval to implement additional telehealth flexibilities via waivers and state plan amendments.

- 2021: Pursuant to AB 133 (Committee on Budget), Chapter 143, Statutes of 2021, DHCS convenes a series of public Telehealth Advisory Workgroup meetings to inform post-PHE Medi-Cal telehealth policies.

- 2022: SB 184 (Committee on Budget and Fiscal Review), Chapter 47, Statutes of 2022, the 2022 Health budget trailer bill, codifies a comprehensive Medi-Cal telehealth policy framework, including, among other provisions:

- Medi-Cal coverage of telehealth, including video, audio-only, asynchronous, remote patient monitoring or other virtual communication modalities meeting certain criteria, including in federally qualified health centers and rural health centers (FQHCs/RHCs);

- Requiring providers who furnish telehealth services to also offer or refer to in-person care;

- Requiring providers who furnish telehealth services to also provide audio-only telehealth services and to also offer those same health care services via video to preserve beneficiary choice;

- Authorizing the establishment of new patients using telehealth and prohibiting the establishment of new patients using other telehealth modalities, but allowing DHCS to make specific exceptions to this prohibition;

- Requiring DHCS to reimburse video, audio-only, and asynchronous store and forward telehealth at parity with in-person services, so long as the services or settings meet the applicable standard of care and meet the requirements of the service code being billed; and,

- Authorizing DHCS to allow a Medi-Cal managed care plan to use telehealth as a means of demonstrating compliance with the time or distance standards.

AB 744 AND AB 32

Consumer experience with telehealth, evolving research, advances in technology, and changes within the health care system led to numerous legislative and administrative initiatives to promote the adoption of telehealth. This hearing is focused on the impact of two specific pieces of legislation: AB 744 and AB 32.

AB 744. As noted in the timeline above, AB 744 was a key piece of telehealth legislation requiring payment parity that was enacted before the COVID-19 pandemic. While the bill wasn't effective until 2021, after the PHE was declared, it set payment parity in motion and ensured coverage of telehealth services for both commercial and Medi-Cal enrollees during a critical period.

AB 32. AB 32 was introduced to codify Medi-Cal telehealth policy broadly, but as most changes were codified through trailer bill (SB 184, described above), the final version of AB 32 made narrow but important changes to the Medi-Cal telehealth policy codified through SB 184. Specifically, AB 32 allows health care providers, FQHCs, and RHCs to establish new patient relationships via audio-only synchronous communication (e.g., phone calls) in two circumstances:

1) When the visit involves sensitive services, including mental/behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender-affirming care, or intimate partner violence; and,

2) When the patient requests an audio-only modality or attests they lack video access.

Both pathways require compliance with DHCS requirements and applicable federal and state law. AB 32 also authorizes DHCS to consider broadband availability when granting exceptions to the general requirement that providers offer both audio and video options.

KEY FINDINGS ON TELEHEALTH IN CALIFORNIA

The California Health Care Foundation (CHCF) published "Telehealth Evolution in California: Progress, Challenges, and Opportunities" in 2025. The following summarizes key findings from the CHCF report.

Growth in use. California's early work to establish telehealth laws and policies before the pandemic positioned the state to expand telehealth access during and after the COVID-19 emergency. More patients are using telehealth, and a growing share of health care visits occur through telehealth. On average, in 2019 there were 649 monthly telehealth visits per 100,000 Medi-Cal members; by 2022, that average had grown to 9,850 visits per 100,000 members, or nearly 10% of all outpatient services.

Patient and provider experience. Telehealth reduces barriers to care, such as missed work for appointments and transportation challenges. Some patients, including those with substance use disorders, mental health conditions, or experiencing homelessness, may feel more comfortable receiving care through telehealth than in traditional settings. Patients report that telehealth builds relationships with providers, supports engagement in their own care, and expands their options of providers; studies show 80% of patients were satisfied with their telehealth visit, and 70% would choose telehealth over an in-person visit. Providers similarly support telehealth: in a 2020 survey of California providers, more than 80% said telehealth was an effective way to care for their patients.

Clinical effectiveness. Telehealth has increased access to behavioral health services and may encourage patients to seek treatment as it can be particularly effective in identifying social anxiety and substance use disorder. There is clear and convincing evidence that video telehealth is as effective as in-person care for managing behavioral health conditions, including post-traumatic stress disorder, depression, and anxiety. Studies also show that hybrid care, a mix of in-person and telehealth appointments, achieves outcomes similar to in-person care for several conditions, including behavioral health, rheumatoid arthritis, and reproductive health. There is also clear evidence of increased and more timely access to specialty care through eConsult, which connects two or more health professionals on a patient's case, reduces costs, and allows more care to be delivered by primary care providers.

Workforce. While California faces an overall shortage of health care workers, telehealth has the potential to help address workforce challenges, particularly in rural and low-access areas.

Access and equity. Despite this progress, disparities remain. CHCF noted that Medi-Cal patients face greater barriers to telehealth than those with commercial health plans, resulting in inequitable access, and Medi-Cal enrollees use less telehealth than those with Medicare or private insurance. Safety net providers also report confusion about the regulations, payment, and billing requirements associated with telehealth services. Disparities exist by age as well, with older patients less likely to use telehealth; rates of use for Medi-Cal members age 65 and older are half the rate of members age 50 to 64, though many older adults are willing to try telehealth

when offered support. Variation in use by race and ethnicity has been observed but is not consistent across studies; in 2022, the highest average rate of telehealth use for Medi-Cal members was among white enrollees, followed by Black enrollees, while Native Hawaiian and Pacific Islander enrollees had the lowest rate. Language access also affects use, as individuals with limited English proficiency are less likely to use telehealth.

CONCLUSION

California's early investment in telehealth policy — including payment parity requirements, Medi-Cal telehealth standards, and expanded flexibilities for sensitive services — positioned the state to rapidly scale telehealth access during the COVID-19 pandemic and to sustain elevated use in the years since. Patients and providers alike report high satisfaction with telehealth, and a growing body of research shows that telehealth, and hybrid models that combine telehealth with in-person care, can match in-person outcomes for a range of conditions, including behavioral health. Despite these gains, there are disparities in telehealth access and use, particularly for Medi-Cal enrollees, older adults, and individuals with limited English proficiency.

In assessing the outcomes of AB 744 and AB 32, the Legislature and stakeholders may wish to discuss the following questions:

1) Do AB 744's requirements for payment parity expand access and willingness of physicians to invest in telehealth, especially in rural areas?

2) Has AB 32's authority to establish new patients via audio-only telehealth improved access to care, particularly in rural areas, for sensitive services, and for people who lack access to high-speed internet required for video telehealth?

3) Is the state's telehealth policy environment sufficient to ensure access to telehealth services, considering the state's overall health care worker shortage, particularly in rural and low-access areas?

4) What are the drivers behind disparities in telehealth usage between commercial and Medi-Cal patients? Do the disparities reflect that Medi-Cal members prefer or need in-person care more often than commercial patients, or do they reflect barriers in access to telehealth that are specific to Medi-Cal members? If disparities reflect barriers to telehealth access, are these barriers related to Medi-Cal telehealth policy or to other issues such as lack of broadband or technology access?

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