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CHCF Issue Brief

Telehealth Use and Experiences Among California Adults

The COVID-19 pandemic accelerated the use of telehealth to provide health care when in-person visits were prohibited or discouraged. National data show dramatic increases in telehealth use. For instance, the US Centers for Disease Control and Prevention reported a 154% increase in telehealth use nationally in the first quarter of 2020 compared to the previous year.[1] In Medicare, use of telehealth increased from 7% to 47% of fee-for-service beneficiaries between quarter one and quarter two of 2020. Use leveled off in 2022, but remained more than double the pre-pandemic levels at 15% in the third quarter of 2022.

In California, the Medi-Cal program saw a rapid increase in telehealth use during the pandemic, increasing from 300 per 100,000 claims in February 2020 to 12,000 per 100,000 in April 2020.[2] Use declined some during 2021, but it remained significantly higher than prepandemic levels at around 7,700 claims per 100,000 in December 2021.

California's Medi-Cal program is leveraging telehealth to meet patient needs. Many of the telehealth coverage and reimbursement flexibilities enacted during the pandemic were made permanent in 2022, including payment parity for services provided in person or by telehealth, such as phone visits.[3] With the end of the public health emergency, there are important questions about how telehealth is being used to meet patient needs and which flexibilities should remain in place over the long term.

This brief uses data from the 2021 California Health Interview Survey (CHIS) to explore how the use of telehealth varies across subpopulations of adults in the state and reports how people that have used telehealth think the experience compared to in-person care, separately for video and phone visits. The brief concludes with a discussion of potential policy implications of the findings, and areas for future data collection and research.

Telehealth Use Varies by Coverage Type, Race, and Language

In 2021, about half (49%) of all California adults reported having used telehealth in the past year (see Appendix A). It is helpful to understand whether and how the use of telehealth varies for subpopulations, but it is also important to understand telehealth use in the context of variation in health care use overall. Appendix A shows the percentage of California adults that received telehealth in the past year alongside the percentage of adults who reported having had at least one doctor visit in the past year, for different subpopulations.

In general, the patterns of telehealth use track with broader patterns of having seen a doctor in any setting. People on Medicare (both those dually covered by Medicaid and those only on Medicare) and people in poor health report more doctor visits in general and are more likely to use telehealth. Similarly, the uninsured, younger people, people with lower incomes, and those in better health report fewer doctor visits overall and less telehealth use. Put another way, people less likely to see a doctor in any setting also are

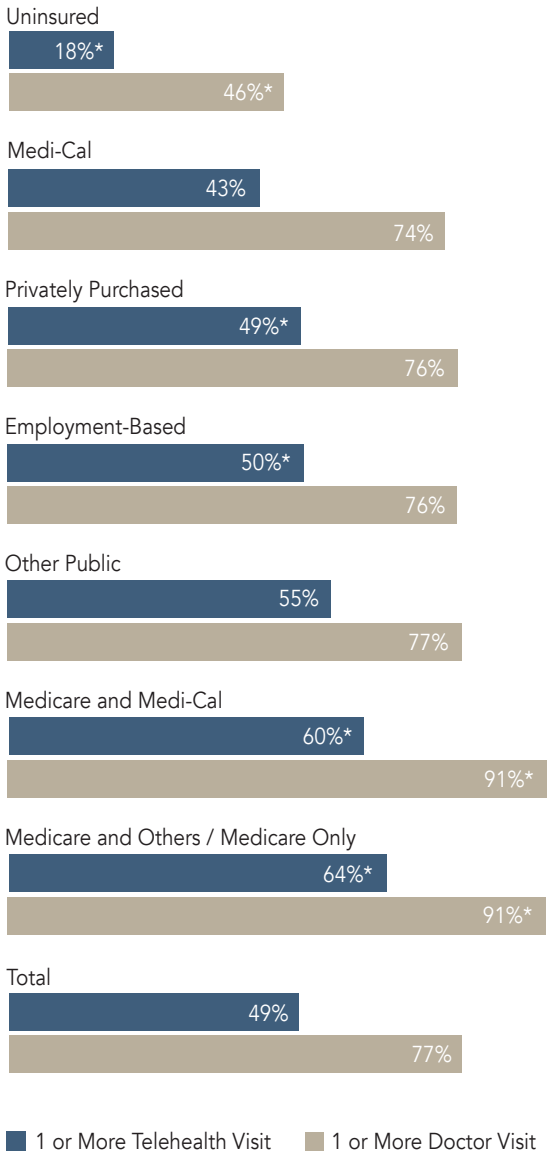
less likely to use telehealth. There were no differences in the use of telehealth by urban/rural status, which was also true for visits overall.

Although the patterns of use of telehealth across subpopulations are broadly similar to the use of doctor visits overall, there are differences. For example, findings suggest particular access challenges related to telehealth for people on Medi-Cal and those with less English proficiency. The findings also point to opportunities to leverage telehealth even more effectively to narrow disparities in access to health care — for example, Black patients are more likely to use telehealth than other populations in California, although this is not true for doctor visits overall (for other racial and ethnic groups, use of telehealth tracks with doctor visits overall). These findings are discussed in more detail below.

People on Medi-Cal Use Less Telehealth

Figure 1 shows that the use of telehealth varies considerably by coverage type, from 18% among the uninsured to 64% among people with Medicare (alone or combined with a supplemental or employer plan). Unlike doctor visits overall, people on Medi-Cal were less likely than those with employer or privately purchased coverage to use telehealth. This may suggest there are still access barriers to using telehealth unique to people with Medi-Cal. Interestingly, the differences in use do not extend to those with both Medicare and Medi-Cal (dually eligible enrollees); use of telehealth for this group was 60%, which was statistically higher than the rate for people with Medi-Cal alone and not statistically different from the rate among people with Medicare alone or Medicare and a supplemental or employer plan (64%).

Figure 1. Doctor Visits and Telehealth in Past Year by Coverage Type, California Adults, 2021



* Statistically significant difference from Medi-Cal at the 95% level.

Notes: *Medicare and Others / Medicare only* is Medicare alone or in combination with employer or supplemental plan. Source uses *African American.*

Source: SHADAC analysis of California Health Interview Survey data.

Less English Proficiency Is Associated with Less Telehealth Use

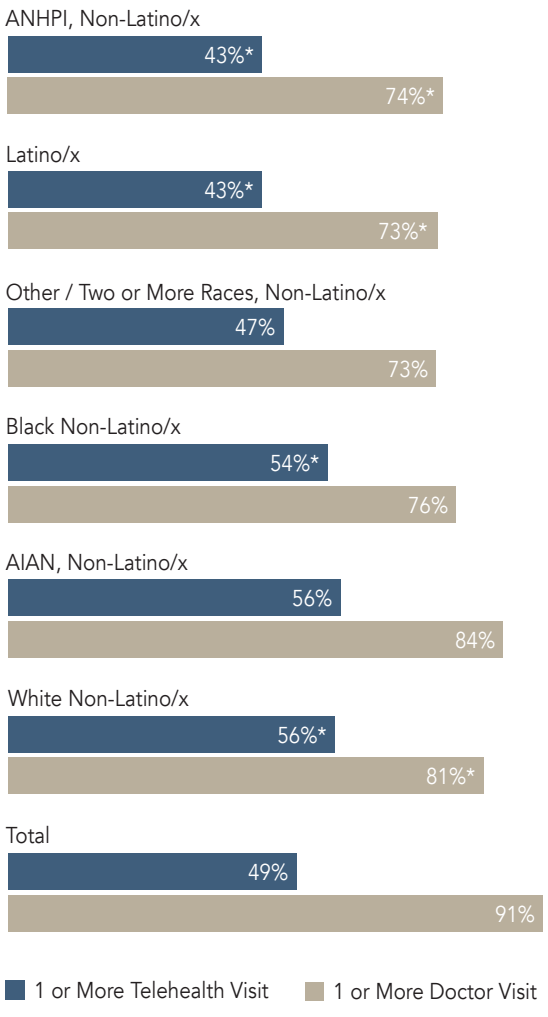
Among people who speak a language other than English, those who speak English "not well" were less likely (38.3%) to have used telehealth than those who speak English "very well" or "well" (43.5%). This

pattern differs from use of doctor visits overall, where there were no statistically significant differences by English proficiency (see Appendix A). This may suggest that people with less English proficiency experience barriers such as interpretation services being less accessible for telehealth than in-person services.

Black Californians Are More Likely to Use Telehealth

There is also considerable variation in the use of telehealth by race/ethnicity, though the range is narrower than what is seen by coverage type. Figure 2 shows that, compared to the total population of adults in California, Latino/x and Asian, Native Hawaiian, and Pacific Islander adults were less likely to use telehealth in 2021, while White and Black people were more likely. The key difference in patterns of telehealth use by race/ethnicity compared to doctor visits overall is for Black adults in California — they were more likely to use telehealth, even though they were not more likely than the overall population to have had a doctor visit in the past year. This may suggest that telehealth is a more desirable or accessible route for Black adults.

Figure 2. Doctor Visits and Telehealth in Past Year by Race/Ethnicity, California Adults, 2021



* Statistically significant difference from Medi-Cal at the 95% level.

Notes: *AIAN is American Indian and Alaska Native. ANHPI* is Asian, Native Hawaiian, and Pacific Islander.

Source: SHADAC analysis of California Health Interview Survey data.

Most Californians That Use Telehealth Like It as Much or Better Than In-Person Care

Another important question for policymakers and health care providers is whether there is a difference in how patients experience telehealth compared to in-person care. The CHIS asks people who had a telehealth visit in the past year how they felt it compared to in-person care. These results are discussed separately for video and phone visits below.

Video Visits

CHIS data indicate there was a high level of satisfaction with video visits. Nearly three-quarters (73.4%) of adult Californians who had a video visit reported that it was "about the same," "somewhat better," or "much better" compared to in-person care. For most groups, this neutral or positive experience did not vary significantly by subpopulation (Appendix B). There were no significant differences in the share reporting that their video visit was "about the same," "somewhat better," or "much better" than in-person care by income, urban/rural status, age, English proficiency, or health status. Also compared were the experiences with video visits for people who used telehealth for mental health care to those who used telehealth for some other purpose, and no significant differences were found in the experience of video visits for this group, either.

These are some of the significant differences in reported experience with video visits compared to in-person care:

- On average, those without coverage report being less satisfied with video visits than the population overall: Slightly more than half of the uninsured (58.5%) reported that their experience was "about the same," "somewhat better," or "much better" compared to 73.4% of the population overall. There were no other significant differences by coverage type.
- For Black Californians, experience with video visits was better than the experience reported by the population overall (73.4%): 80.1% of Black adults reported that their video visit was "about the same," "somewhat better," or "much better" than in-person care. There were no other significant differences by race/ethnicity.

Phone Visits

Like video visits, the CHIS data indicate there was a high level of satisfaction with phone visits, with nearly three-quarters (71.2%) of all adult Californians reporting that their experience was "about the same," "somewhat better," or "much better." Also similar to video visits, for most groups, this positive or neutral experience did not vary significantly by subpopulation. There were no significant differences in the share reporting that their phone visit was "about the same," "somewhat better," or "much better" than in-person care by coverage type, income, urban/rural status, English proficiency, health status, or for people who reported that their telehealth was for mental health care (see Appendix C). Significant differences in reported experience with phone visits compared to in-person care include these:

- Like video visits, Black adults report higher levels of satisfaction with phone visits than the population overall. White adults report lower satisfaction.
- There were no other significant differences by race/ethnicity.
- Older people report better experiences with phone visits: People over age 65 were more likely (73.9%) to report that their experience was "about the same," "somewhat better," or "much better" than people age 26–64 (70.9%).

Conclusion

Our findings suggest that in many ways, telehealth use follows the variation in the use of doctor visits overall. People who tend to report more doctor visits also tend to use more telehealth, and people less likely to go to the doctor also tend to use less telehealth overall, with some important exceptions, including by coverage type, race/ethnicity, and language. This shows that in many circumstances, telehealth does not exacerbate overall health care access disparities. However, this also shows while many people report that telehealth improves access to care, more significant telehealth use did not eliminate access to care disparities at the population level during the pandemic.[4] This is likely due to the persistence of structural barriers, such as limited provider availability, even as telehealth use has grown.

Understanding variation in telehealth use can be helpful for stakeholders seeking to expand access to care and to develop strategies that address structural and financial barriers to care. For example, people on Medi-Cal are less likely to use telehealth than those with other coverage types. It would help to track telehealth use for different subgroups in California over time and gather more data to understand what may drive the differences. One example of more data collection that could help would be to ask people directly whether they wanted to use telehealth but could not access it and why. This would enable researchers to understand more directly which groups are facing barriers to telehealth, rather than inferring potential access issues from use alone.

The findings also suggest that, among people who use telehealth, the experience is as good or better compared to in-person care. Also, this relatively high level of satisfaction varied little for groups that have been historically underserved by the health care system, with one notable exception: Uninsured Californians were less likely to report a neutral or positive experience with video visits than people with coverage. But Black Californians were *more* likely than the total population to report a positive or neutral experience with both video and phone telehealth. The data do not provide insights about why these groups experience telehealth differently, but they do suggest the need for further research to understand how telehealth can be most effectively leveraged to address ongoing health disparities in the state.

It is also important to note that the CHIS data presented here do not address the quality of telehealth services beyond self-reported experience. Research has suggested that live video services may offer important advantages over phone services in many clinical contexts and that disparities in technology and broadband internet access are important barriers to equitably distributing access to these services.[5] In addition, these data do not tell us about the volume of telehealth services used; the findings might differ if the experiences of people that use telehealth once or twice a year could have been compared to the experiences of those that use telehealth much more often. Data that can address these and other, more nuanced policy questions will be critical for successfully leveraging telehealth to improve access to high-quality health care for all Californians.

Appendix A. Telehealth Utilization and Doctor Visits Among Adults in California, 2021

	ONE OR MORE DOCTOR VISIT	SIGNIFICANT DIFFERENCE	ONE OR MORE TELEHEALTH VISIT	SIGNIFICANT DIFFERENCE
Total	76.6%		49.0%	
Coverage Status				
Medi-Cal	73.9%	Reference group	42.6%	Reference group
Uninsured	46.5%	*	17.7%	*
Medicare & Medi-Cal	91.3%	*	60.0%	*
Medicare & Others/Medicare Only	91.0%	*	63.9%	*
Employment Based	76.1%		50.1%	*
Privately Purchased	76.2%		49.5%	*
Other Public	76.8%		54.7%	
Race/Ethnicity†				
Latino/x	73.1%	*	43.1%	*
American Indian/Alaskan Native, Non-LatinX	84.2%		56.5%	
Asian/Native Hawaiian/Pacific Islander, Non-LatinX	74.0%	*	43.2%	*
Black Non-LatinX	76.2%		54.3%	*
White Non-LatinX	80.9%	*	55.6%	*
Other / Two or More Races, Non-Latino/x	72.8%		46.8%	
Income, % FPG				
0–138	74.0%	*	43.5%	*
139–249	74.8%	*	46.9%	*
250–399	76.9%		49.5%	
400+	78.4%	Reference group	52.3%	Reference group
Geography				
Urban	76.4%		49.0%	
Rural	78.7%	Reference group	48.3%	Reference group
Age				
19–25	67.8%	*	35.7%	*
26–64	74.1%	Reference group	47.9%	Reference group
65+	90.4%	*	61.4%	*
English Proficiency, Among Those Speaking a Language Other Than English				
Very Well / Well	72.7%	Reference group	43.5%	Reference group
Not Well	74.1%		38.3%	*
Not at All	76.5%		36.7%	
Health Status				
Excellent / Very Good	73.7%	Reference group	43.5%	Reference group
Good/Fair	79.0%	*	54.0%	*
Poor	90.2%	*	67.9%	*

Notes: *AIAN* is American Indian and Alaska Native. *ANHPI* is Asian, Native Hawaiian, and Pacific Islander.
Source: SHADAC analysis of California Health Interview Survey data.
* Significant difference from reference group at the 95% level.
† Tested against total population.

Appendix B. Experience with Video Visits Among Adults in California, 2021

	ABOUT THE SAME / SOMEWHAT BETTER / MUCH BETTER THAN IN-PERSON VISIT	SIGNIFICANCE
Total	73.4%	N/A
Coverage Status		
Medi-Cal	75.2%	Reference group
Uninsured	58.5%	*
Medicare and Medi-Cal	76.3%	
Medicare and Others / Medicare Only	72.9%	
Employment-Based	74.0%	
Privately Purchased	71.2%	
Other Public	66.9%	
Race/Ethnicity†		
Latino/x	73.8%	
AIAN, Non-Latino/x	80.1%	
ANHPI, Non-Latino/x	76.1%	
Black, Non-Latino/x	80.1%	*
White Non-Latino/x	71.5%	
Other / Two or More Races, Non-Latino/x	74.8%	
Income, % FPG		
0–138	73.4%	
139–249	74.9%	
250–399	74.8%	
400+	72.6%	Reference group
Geography		
Urban	73.4%	
Rural	73.9%	Reference group
Age		
19–25	68.6%	
26–64	74.2%	Reference group
65+	73.8%	
English Proficiency, Among Those Speaking a Language Other Than English		
Very Well / Well	74.4%	Reference group
Not Well	66.2%	
Not at All	72.1%	
Health Status		
Excellent / Very Good	74.3%	Reference group
Good/Fair	72.4%	
Poor	76.4%	
Video Visit for Mental Health		
Yes	72.6%	Reference group
No	73.6%	

Notes: *AIAN* is American Indian and Alaska Native. *ANHPI* is Asian, Native Hawaiian, and Pacific Islander.
Source: SHADAC analysis of California Health Interview Survey data.
* Significant difference from reference group at the 95% level.
† Tested against total population.

Appendix C. Experience with Phone Visits Among Adults in California, 2021

	ABOUT THE SAME / SOMEWHAT BETTER / MUCH BETTER THAN IN-PERSON VISIT	SIGNIFICANCE
Total	71.2%	N/A
Coverage Status		
Medi-Cal	71.7%	Reference group
Uninsured	64.9%	
Medicare and Medi-Cal	75.7%	
Medicare and Others / Medicare Only	73.4%	
Employment-Based	70.5%	
Privately Purchased	66.2%	
Other Public	66.6%	
Race/Ethnicity†		
Latino/x	73.2%	
AIAN, Non-Latino/x	67.3%	
ANHPI, Non-Latino/x	71.7%	
Black, Non-Latino/x	77.6%	*
White Non-Latino/x	68.6%	*
Other / Two or More Races, Non-Latino/x	71.7%	
Income, % FPG		
0–138	71.2%	
139–249	72.8%	
250–399	73.3%	
400+	70.0%	Reference group
Geography		
Urban	71.2%	
Rural	71.6%	Reference group
Age		
19–25	65.9%	
26–64	70.9%	Reference group
65+	73.9%	*
English Proficiency, Among Those Speaking a Language Other Than English		
Very Well / Well	71.5%	Reference group
Not Well	66.0%	
Not at All	81.0%	
Health Status		
Excellent / Very Good	71.0%	Reference group
Good/Fair	71.1%	
Poor	75.2%	
Video Visit for Mental Health		
Yes	70.3%	Reference group
No	71.4%	

Notes: *AIAN* is American Indian and Alaska Native. *ANHPI* is Asian, Native Hawaiian, and Pacific Islander.
Source: SHADAC analysis of California Health Interview Survey data.
* Significant difference from reference group at the 95% level.
† Tested against total population.

About the Author

Lacey Hartman is a senior research fellow at the State Health Access Data Assistance Center (www.shadac.org), where she leads a range of projects aimed at helping states use data to inform policy. She holds a bachelor's degree in women's studies and political science from Macalester College in St. Paul and a master's degree in public policy from the University of Minnesota.

About the Foundation

The California Health Care Foundation (CHCF) is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system. CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Endnotes

1. "Trends in the Use of Telehealth During the Emergence of the COVID-19 Pandemic — United States, January–March 2020," *Morbidity and Mortality Weekly Report* 69, no. 43 (Oct. 30, 2020): 1595–99.
2. *DHCS Telehealth: Research and Evaluation Plan* (PDF), California Dept. of Health Care Services (DHCS), December 19, 2022.
3. *Post-COVID-19 Public Health Emergency Final Telehealth Policy Proposal* (PDF), DHCS, December 2022.
4. Jen Joynt, *Telehealth Experiences and Preferences Among Californians with Low Incomes*, California Health Care Foundation, May 3, 2023.
5. Madjid Karimi et al., *National Survey Trends in Telehealth Use in 2021: Disparities in Utilization and Audio vs. Video Services* (PDF) (Research Report no. HP-2022-04), US Dept. of Health and Human Services, February 1, 2022.