Int. J. Sci. R. Tech., 2026 3(4)
A Multidisciplinary peer-reviewed Journal
www.ijsrtjournal.com [ISSN: 2394-7063]

Original Article

Evaluating The Inclusion Of Telehealth Providers In Health Insurance Plans: A Payer Perspective

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ABSTRACT

Telehealth began as an emergency response to the pandemic but is now a sustained component of U.S. healthcare. As telehealth becomes permanent, health insurers must strategically integrate it to balance access and costs. This study specifically examines whether expanding telehealth within insurance networks yields outcomes that are financially and clinically justified, using real-world data.

Current evidence confirms that telehealth increases access, especially for behavioral health and chronic disease care. However, expanding network participation alone does not automatically reduce costs, as payment parity laws often increase total utilization. The main question for payers is whether increased provider participation brings sufficient value to offset potential cost growth.

The central policy dilemma is whether the financial benefits of wider access outweigh added costs. For instance, if payment parity triggers 1,000 more visits at $100 each, the insurer pays $100,000. If those visits prevent 200 costly ER trips, the value is clear. If new visits are low impact, the justification is weaker. Payers must explicitly quantify benefits versus costs to decide when expanding telehealth is reasonable.

Our analysis recommends a targeted, outcome-driven approach. Rather than blanket coverage or uniform reimbursement, health plans should prioritize contracting with telehealth providers in areas with clear access gaps. Implement value-based payment models that reward positive outcomes rather than visit volume and enforce quality metrics to ensure virtual care drives measurable health improvements. The goal is to align payment structures with clinical needs and closely monitor overall usage.

Keywords: Telehealth, telemedicine, health insurance, reimbursement policy, payment parity, utilization management, behavioral health, value-based care.

INTRODUCTION

This study addresses a pivotal decision for insurance analysts: under what practical circumstances should telehealth providers join the network? Rather than exploring telehealth's clinical merits, the analysis focuses on economic and operational realities, asking when these partnerships support affordability, access, and quality without unsustainable growth in claims volume.

The stakes are higher than you might think. As of 2025, 44 states plus DC, Puerto Rico, and the Virgin Islands have passed laws governing private insurer telehealth reimbursement[3]. Twenty-four of those jurisdictions require payment parity—meaning insurers must pay telehealth visits at the same rate as in-person visits. This patchwork of regulations makes it impossible to implement a single national strategy and limits payers' control over their cost structure.

These decisions affect insurers in many ways. Choosing telehealth vendors shapes medical cost trends, network adequacy, behavioral health capacity, competitiveness with employers, and product offerings. About 54% of Americans use virtual care each year. Over 71% of doctors now include telehealth in their weekly routines. (Henry, 2025) This rise in participation means telehealth can help meet network adequacy requirements and improve members' timely access to care. Growing usage shows virtual care is now a must-have for competitive plan offerings. Telehealth is no longer a pilot; it is now a standard part of healthcare.

While much research focuses on clinical outcomes, few studies address insurers' operational questions:

Relevant conflicts of interest/financial disclosures: The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

does telehealth substantively reduce costs, alter utilization, or enable contract structures that align incentives? This study directly addresses those questions, using recent payer-driven evidence to inform strategic decisions.

METHOD OF THE STUDY

We did not conduct our own claims analysis, as this would reflect only one plan's experience. Instead, we used a broader approach. This study reviews recent research, policy reports, and empirical studies on telehealth from an insurer's view. We focused on work from 2024 to 2026 to capture the post-pandemic period, when telehealth became a permanent part of care.

Our sources included scoping reviews of insurance payment models, empirical studies analyzing commercial claims data, policy briefs from organizations such as the Bipartisan Policy Center, and state regulatory reports tracking reimbursement laws[1][2][6][7]. We specifically looked for studies that examined utilization patterns, cost impacts, and payer mix effects rather than clinical outcomes alone.

Our analysis covers five questions for health plans. Does telehealth improve access in areas with gaps? Do virtual visits replace in-person care, or do they add to the number of visits? Which payment models make sense financially? Does telehealth reach all members fairly? What does implementation look like in practice?

In this context, "inclusion" refers to three approaches: contracting with standalone telehealth companies such as Teladoc, reimbursing virtual visits provided by existing network providers, or including telehealth access as a covered service in benefit design[1][3].

Literature search strategies included PubMed/PMC databases, healthcare policy organizations (Bipartisan Policy Center, Center for Connected Health Policy), professional association reports (American Medical Association, American Hospital Association), and healthcare analytics sources (Epic Research, FAIR Health), with a focus on commercial insurance perspectives. Inclusion criteria prioritized studies with commercial payer data, cost analysis, utilization measurement, and policy implementation evaluation. The review applies a payer analytical lens to determine whether telehealth availability creates net value through lower-cost care substitution or generates incremental utilization that supplements existing care pathways[2][8].

ANALYSIS

Access Enhancement and Network Adequacy

Telehealth works best when it helps members get care they might otherwise skip, delay, or get in a costlier setting. In behavioral health, finding an in-network therapist can take weeks, but virtual visits fill this gap quickly. The same is true for routine follow-ups, medication checks, minor issues, and chronic disease monitoring. Easier access means members seek help before problems worsen.

For health plans, this can mean better member retention, higher satisfaction scores, better quality ratings, and fewer emergency room visits for issues that could be managed earlier. The main value is to keep members healthier and address problems before they become costly.

The numbers show strong adoption. In 2024, 87% of U.S. hospitals had telemedicine, up from 73% in 2018. Among doctors, weekly telehealth use reached 71.4% in 2024, almost matching the pandemic peak and well above 25% before 2020. (Fact Sheet: Telehealth, 2025)

Telehealth use varies by specialty. Psychiatrists lead, with 86% offering virtual visits weekly and 57% doing over 20% of visits virtually. This trend fits therapy and medication management. Neurology, endocrinology, gastroenterology, and family medicine show adoption rates from 20% to 32%.

Specialties that require physical exams or procedures use telehealth much less often. Ophthalmology is at 1.8%, dermatology at 3.7%, emergency medicine at 4.3%, and orthopedic surgery at 4.7%. (Henry, 2025) Some care cannot be given virtually, so telehealth adds value only where clinically suitable.

Insurers should prioritize telehealth partnerships in behavioral health, where access challenges are still significant despite increasing demand[8][9]. Mental health accounts for 62% of all telehealth visits, more than all other categories combined [13]. After that, the percentages decrease sharply: acute respiratory issues

account for 2.5%, endocrine disorders 2.2%, obesity management 2.0%, and sleep disorders 1.9%[13].

This concentration matters for network strategy. Telehealth vendors must address behavioral health capacity well; other issues are less important.

Utilization Patterns and Substitution Effects

A key concern for actuaries is whether telehealth replaces existing visits or simply adds new ones. This issue is important for the medical loss ratio. A 2025 study of commercial claims from 2019 to 2021 found that when states enacted payment parity laws, telehealth visits increased as expected, but total outpatient visits also rose[2]. In-person visits did not decrease proportionally, suggesting that parity led to new utilization rather than just shifting care from one setting to another[2][8]. If payment parity had not been implemented, historical patterns suggest that overall outpatient utilization would likely have remained stable, with telehealth serving primarily as a partial substitute for in-person care rather than driving additional demand. In that counterfactual scenario, insurers may have seen telehealth visits replace a larger share of office visits, resulting in either flat or only marginally changed overall visit volumes. By comparing these trends, it becomes clearer that parity laws have the potential to alter baseline utilization patterns and contribute to incremental demand beyond what would have occurred if only in-person care or non-parity telehealth had remained available.

For payers, this outcome is mixed. While access and member satisfaction may improve, total spending can also increase if the additional visits do not prevent more costly care later on.

The key question is whether these additional visits are cost-effective. If telehealth helps catch problems early, improves medication adherence, or prevents emergency room visits, then it can be financially beneficial[2][8]. However, if it only adds convenient check-ins without improving outcomes, it may increase costs. Evidence on the total cost of care is still developing[14][15]. Some studies show net savings, while others do not. Results depend on the population, clinical scenario, and how well the telehealth vendor integrates with care management programs.

Recent data through mid-2024 offers some positive news. Total visit volume has not increased dramatically across the system[16]. Even in specialties with high telehealth adoption, overall visit counts remained stable, suggesting that substitution is occurring. A pre-pandemic study on direct-to-consumer telehealth for common issues such as respiratory infections and UTIs found similar results: virtual visits mostly replaced in-person care rather than creating new demand[17].

However, the 2019-2021 claims analysis serves as a warning. Payment parity can increase total utilization depending on market conditions, benefit design, and member behavior patterns[2].

When substitution does occur, the savings are real. Telehealth visits average $113, versus $161 for in-person encounters—a meaningful difference [18]. Member cost-sharing is lower, too: $24 out-of-pocket for virtual visits compared to $33 for in-person visits [18]. Other sources peg the gap even wider, with virtual appointments averaging $79 versus $146 for traditional office visits[18]. Medicare found that 30-day costs were $82 lower per beneficiary when initial visits occurred via telehealth rather than in person [18].

However, these savings are realized only if telehealth actually replaces the more expensive option [8][14]. If it simply adds convenience without changing where members would have sought care, cost savings are not achieved.

Reimbursement Model Implications

Payment models are an area where health plans have some control. The way telehealth is reimbursed is more important than simply deciding to cover it[1][14]. Payment parity encourages provider participation by removing financial barriers. However, it may not be the best long-term strategy for insurers, since virtual visits have lower overhead costs than in-person encounters[2][14]. Paying the same rate for both may not be justified when one is less expensive to deliver.

Reimbursement Model	Payer Implications
Payment Parity	Increases provider participation and telehealth volume but may stimulate incremental utilization; eliminates cost differential between virtual and in-person care; required by law in 24 U.S. jurisdictions[3]
Differential Fee Schedule	Allows payers to reimburse based on resource intensity; may reduce provider adoption; creates cost savings opportunity when substitution occurs
Value-Based/Episode Payment	Aligns incentives with outcomes rather than volume; supports appropriate utilization; requires measurement infrastructure and risk adjustment
PMPM Capitation	Provides budget predictability; incentivizes efficient care delivery; may limit access if capitation rates insufficient
Hybrid Models	Combines volume-based payment with quality bonuses; balances access and utilization management; requires administrative complexity

Table 1: Telehealth Reimbursement Models and Payer Considerations

Many researchers now support value-based or targeted payment models instead[2][8]. A 2026 systematic review stated that paying the same rate for all services may not be sustainable[14]. The review recommends linking payment to outcomes and appropriate utilization, rather than matching in-person rates for all services. This could involve episode-based payments, quality bonuses, or hybrid models that reward efficiency and effectiveness instead of just volume.

A more effective approach for payers may be to use service-line-specific reimbursement. Behavioral health may justify parity or near-parity rates because virtual therapy is clinically effective and access is limited[9][13]. However, routine follow-ups, medication checks, and care coordination calls may be better suited to lower rates that reflect their actual delivery costs[8]. The main goal is to align payment with clinical appropriateness and resource use, rather than applying the same rules to all services.

Equity and Population Health Considerations

Telehealth inclusion does not uniformly improve access across all populations, requiring payers to consider equity implications in benefit design and network strategy[6][19]. Research examining clinic payer mix found that higher proportions of Medicaid-reimbursed visits were associated with lower telehealth utilization rates and faster declines in telehealth use over time, suggesting that reimbursement levels and infrastructure conditions can limit access for vulnerable populations[6].

This finding indicates that health insurers should not assume that including telehealth vendors automatically improves equitable access. Digital literacy, broadband availability, device access, language support, provider cultural competency, and reimbursement adequacy continue to influence whether underserved populations benefit from virtual care expansion[6][19]. For health plans serving diverse populations, telehealth inclusion should be accompanied by targeted member outreach, multilingual support services, digital navigation assistance, and integration with community-based provider networks to avoid widening existing disparities[8][19].

The state policy environment further complicates equity considerations, as telehealth laws vary substantially across jurisdictions[3]. For multi-state insurers, this regulatory patchwork creates administrative complexity in benefit design, claims adjudication, provider credentialing, and network contracting[3]. A telehealth strategy that is financially sustainable in one state may become margin-compressive in another if payment parity mandates eliminate the payer's ability to negotiate differentiated reimbursement for lower-overhead virtual care[3][14].

Operational Implementation Considerations

From an operational perspective, telehealth provider inclusion requires infrastructure for credentialing, claims processing, care coordination, quality measurement, and fraud prevention[1][8]. A 2024 international scoping review examining health

insurance payment for telehealth across multiple countries found that, while more healthcare systems are incorporating telehealth into insurance coverage, reimbursement standards, coverage scope, and supervision mechanisms vary significantly [1]. The review concludes that policy refinement and stronger quality oversight are necessary to bridge the gap between telehealth and in-person care, particularly for health plans considering external telehealth companies that may operate somewhat separately from existing provider ecosystems[1][8].

For health insurers, operational considerations include:

- **Network Integration:** Ensuring telehealth providers share encounter data, coordinate referrals, and support care continuity with primary care and specialty networks[1][8]
- **Quality Measurement:** Establishing metrics for repeat-visit rates, referral conversion, emergency department follow-up, medication adherence, and member satisfaction to compare telehealth performance with in-person benchmarks[8]
- **Utilization Management:** Defining clinical use cases eligible for telehealth reimbursement and implementing guardrails against low-value or duplicative services[2][8]
- **Member Experience:** Providing clear communication about telehealth benefit availability, covered services, cost-sharing, and provider selection[8]
- **Credentialing Standards:** Ensuring telehealth providers meet licensure, quality, and scope-of-practice requirements consistent with in-person network standards[1]

Strategic telehealth inclusion should focus on vendors that demonstrate interoperability, performance transparency, and clinical integration, rather than only considering reimbursement rates[1][8].

RESULTS

Selective telehealth inclusion delivers value only when closely tied to measurable outcomes and disciplined network management. The evidence synthesized in this study indicates that including telehealth providers in health insurance plans is strategically justified under disciplined reimbursement and network management conditions[1][2]. Telehealth inclusion appears most valuable when it addresses documented access bottlenecks, particularly in outpatient behavioral health and chronic disease management services, and when the insurer can channel utilization toward clinically appropriate, lower-cost alternatives to in-person care[8][9].

Metric	Telehealth	In-Person
Mean Encounter Cost	$112.80	$161.40
Patient Out-of-Pocket Cost	$23.80	$32.70
Average Visit Cost (2025 Data)	$79.00	$146.00
30-Day Medicare Costs Post-Visit	$82 lower	Baseline

Table 2: Cost Comparison: Telehealth vs. In-Person Care Encounters

The literature does not support the assumption that simple inclusion or payment parity automatically reduces total medical spending, because parity policies can increase overall outpatient utilization even while expanding access[2]. The strongest positive outcome for payers is improved service availability and member convenience, which can strengthen plan competitiveness in employer-group markets and reduce care delays[9][11]. Telehealth reimbursement policies demonstrably incentivize providers to offer more virtual services, materially expanding access in markets where provider availability is constrained[2][14].

However, inclusion strategies not tied to outcome measurement may increase costs through incremental utilization, particularly when telehealth visits supplement rather than substitute for office-based care[2][8]. A critical finding is that reimbursement design matters more than telehealth availability alone[1][14]. While payment parity can encourage provider participation, it may not constitute the optimal long-term reimbursement model for insurers because it weakens the economic distinction between lower-overhead virtual encounters and more resource-intensive in-person care[2][14].

To illustrate this dynamic, a simple scenario analysis can help compare cost impacts under different utilization patterns. For example, consider three potential outcomes for adding telehealth visits:

Scenario 1: Pure Substitution – Of every 1,000 telehealth visits at $80 each, these fully replace in-person visits that would have cost $150 per encounter. Total spend drops from $150,000 to $80,000, resulting in $70,000 in savings.

Scenario 2: Partial Substitution – Of every 1,000 new telehealth visits, only half replace in-person visits, while the others are net new. Here, 500 telehealth visits replace 500 in-person ($75,000 down to $40,000), but the remaining 500 are incremental ($40,000). Total spend rises to $80,000 (telehealth) plus $75,000 (remaining in-person), for a total of $115,000. The modest savings evaporate if new visits do not prevent downstream high-cost events.

Scenario 3: Pure Addition – All 1,000 telehealth visits are net new, layered on top of usual in-person volume. Total outpatient spend jumps from $150,000 to $230,000, highlighting the risk of cost growth when telehealth does not substitute for but supplements traditional care.

These hypothetical outcomes demonstrate why CFOs and health plan leaders must closely analyze utilization patterns and reimbursement structures. Only by measuring the actual proportion of substitution versus addition can payers design telehealth arrangements that deliver sustainable value rather than simply increase total cost.

Evidence demonstrates that telehealth inclusion has heterogeneous effects across populations and plan types[2][6]. Commercial insurance analysis shows differential impacts between self-funded and fully insured arrangements, while clinic-level research suggests that payer mix and population vulnerability influence telehealth uptake patterns [2][6]. Therefore, insurers should not evaluate telehealth providers using uniform frameworks; segment-specific performance metrics and implementation strategies are necessary[2][6].

Specialty	% Using Telehealth Weekly	% with >20% Virtual Visits
Psychiatry	85.9%	56.9%
Neurology	N/A	32.2%
Endocrinology	N/A	24.2%
Gastroenterology	N/A	20.4%
Family Medicine	N/A	20.1%
Urology	N/A	18.7%
Overall Physicians	71.4%	15.7%

Table 3: Telehealth Adoption Rates by Medical Specialty (2024 Data)[5][13]

Specialty-specific adoption patterns reveal that telehealth is most clinically appropriate and widely adopted in behavioral health, neurology, endocrinology, and primary care, suggesting these service lines represent priority areas for health plan inclusion strategies[5][13]. In contrast, specialties requiring physical examination or procedural intervention show minimal telehealth adoption, indicating limited substitution potential in these categories[5].

DISCUSSION

For health insurance organizations, the strategic question is not whether telehealth belongs in plan design, but how to include it without undermining affordability or care continuity[1][8]. The evidence supports including telehealth providers when they complement existing provider networks, improve time-to-care access, and fill documented capacity gaps [8][9]. Inclusion is most defensible when telehealth serves as a substitute for more expensive or less accessible care rather than merely functioning as an additional convenience channel generating incremental utilization[2][8].

Telehealth Inclusion by Product Line

Commercial: In employer-sponsored and individual commercial plans, telehealth can be leveraged to

improve member satisfaction, address network adequacy requirements, and differentiate product offerings. Plans have more flexibility with benefit design and may selectively contract with telehealth vendors in areas with documented provider shortages, especially for behavioral health services. Reimbursement strategies can include value-based models and targeted utilization management incentives.

Medicare Advantage (MA): MA plans must comply with CMS regulations and are subject to federal telehealth coverage rules. Payment parity has generally expanded telehealth options for MA beneficiaries, but network adequacy standards and quality rating metrics also play a significant role. Telehealth can enhance chronic care management and reduce avoidable hospitalizations. Equity considerations are increasingly important for plans serving older and dual-eligible populations, who may face digital literacy barriers.

Medicaid: State-level regulatory variation creates significant differences in telehealth inclusion strategies for Medicaid managed care organizations (MCOs). State policies may drive reimbursement rates, covered services, and provider participation. Telehealth can extend access in underserved communities, but successful deployment depends on support for digital navigation, multilingual member services, and partnerships with community-based providers. Special attention should be given to ensuring that telehealth investments reduce rather than exacerbate disparities in care.

This finding has important implications for payer contracting strategy[3][8]. Health plans should favor telehealth arrangements that require interoperability with claims systems, care management platforms, and provider directory infrastructure, along with performance guarantees for access improvements, quality metrics, follow-up completion rates, and appropriate site-of-care utilization[1][8]. A telehealth vendor unable to share encounter data, coordinate referrals, or support longitudinal care continuity may create more administrative and clinical fragmentation than value[1].

The analysis suggests that health insurers should move beyond narrow reimbursement debates and frame telehealth inclusion as a comprehensive care model design issue[1][14]. Payment parity may be appropriate during market transition periods or in service lines with severe access shortages, but it should not become the default endpoint for payer strategy because it can incentivize volume without necessarily rewarding outcomes[2][14]. Insurers should instead pilot tiered reimbursement models, episode-based payment structures, virtual-first care bundles, or shared-savings arrangements in service lines where telehealth is clinically appropriate and outcomes are measurable[8].

Operational Safeguards and Implementation Recommendations

Several operational safeguards are advisable when adding telehealth providers to health plan networks[3][8]:

1. **Define Clinical Use Cases:** Establish clear coverage policies specifying service categories eligible for telehealth reimbursement, such as behavioral health, medication follow-up, low-acuity urgent concerns, and chronic care management[8]

2. **Require Performance Reporting:** Mandate quality and utilization reporting, including repeat-visit rates, referral conversion, emergency department follow-up, medication adherence, and member satisfaction, to enable comparison with in-person care benchmarks[8]

3. **Monitor Equity Indicators:** Track utilization patterns across member demographics, geographic regions, and socioeconomic characteristics to ensure reimbursement expansion does not widen access disparities[6][19]

4. **Implement Utilization Management:** Establish protocols to identify low-value or duplicative telehealth encounters that supplement rather than substitute for appropriate care[2][8]

5. **Ensure Care Coordination:** Require telehealth vendors to share clinical documentation with primary care providers and participate in care management programs for complex patients[1][8]

For commercial health plans, selective expansion is recommended rather than universal inclusion [1][8].

Telehealth providers should be added when they address clear access problems, demonstrate data-sharing capabilities, and can be reimbursed through performance-based contracts[1][8]. Plans should focus on areas such as behavioral health and chronic disease follow-up and require evidence that telehealth either replaces higher-cost care, improves adherence, or demonstrates measurable quality improvement [8][9].

STUDY LIMITATIONS

Several limitations should be noted when interpreting these findings[1][2]. This study relies on secondary literature and policy analysis rather than primary claims database analysis or actuarial modeling specific to individual health plans[1][2]. Some empirical findings are derived from specific populations, states, or time periods and may not generalize to all insurer membership bases or regulatory environments [2][6]. The rapid evolution of telehealth policy, particularly regarding Medicare coverage extensions and state payment parity legislation, means that findings may require periodic updating as the regulatory landscape shifts[3].

Future research directions include conducting health-plan-specific claims analysis to quantify telehealth's impact on total cost of care, emergency department utilization, specialist referral patterns, and quality metrics within distinct member populations[2][8]. Longitudinal studies examining whether initial utilization increases stabilize over time and whether telehealth improves outcomes for specific chronic conditions would provide additional evidence for payer decision-making[8]. Additionally, comparative effectiveness research examining outcomes of telehealth versus in-person care across diverse clinical scenarios would strengthen the evidence base for coverage policy development [1].

Strategic Implications for Health Insurers

The analysis supports a strategic framework for telehealth inclusion based on three principles: selective targeting, performance accountability, and continuous evaluation. Health plans should identify service lines where telehealth addresses documented access barriers, negotiate contracts with quality and utilization performance requirements, and establish measurement systems to assess whether telehealth inclusion achieves intended access, cost, and quality objectives[1][8].

For employer-group products, telehealth can serve as a competitive differentiator when positioned as enhancing convenience and access rather than merely reducing costs[9]. For Medicaid and Medicare Advantage products, telehealth inclusion should be designed with particular attention to equity considerations and digital access barriers that may limit utilization among vulnerable populations[6][19].

The telehealth market continues to grow substantially, with the U.S. market valued at $42.54 billion in 2024 and projected to grow at 23.8% compound annual growth rate through 2030[20]. For health insurers, this growth trajectory suggests that telehealth will increasingly become a standard component of healthcare delivery rather than a supplemental offering, requiring sophisticated strategies for network management, reimbursement, and quality oversight[1][8].

CONCLUSION

This study provides evidence-based guidance for health insurance organizations considering the inclusion of telehealth providers in commercial and managed care plans. Most evidence supports selective telehealth inclusion through value-based contracts, defined service categories, quality measurement, and utilization management, rather than broad payment parity. Telehealth clearly improves access to behavioral health, chronic disease management, and follow-up care, especially when virtual visits replace higher-cost or less accessible in-person care. However, payers need to use operational safeguards to prevent unnecessary utilization, ensure care coordination, and maintain quality. The best telehealth strategy for insurers involves segment-specific implementation, performance accountability, and ongoing evaluation of cost, quality, and access to ensure network expansion creates lasting value for both the plan and its members.

REFERENCES

1. Patel, S., & Lee, R. (2024). Health insurance payment for telehealth services: Scoping review. JMIR Publications, advance online publication.

https://pmc.ncbi.nlm.nih.gov/articles/PMC11668521/

2. Chen, M., Rodriguez, A., & Williams, K. (2025). Telehealth payment parity and outpatient service utilization. PMC - National Institutes of Health. https://pmc.ncbi.nlm.nih.gov/articles/PMC12013821/
3. Center for Connected Health Policy. (2025). State telehealth laws and reimbursement policies report, Fall 2025. https://www.cchpca.org/resources/state-telehealth-laws-and-reimbursement-policies-report-fall-2025/
4. SecureVideo. (2025). Telehealth statistics in 2025: Usage, growth, and patient satisfaction. https://securevideo.com/telehealth-statistics-in-2025-usage-growth-and-patient-satisfaction/
5. American Medical Association. (2025). New data details how telehealth use varies by physician specialty. AMA Policy Research Perspectives. https://www.ama-assn.org/practice-management/digital-health/new-data-details-how-telehealth-use-varies-physician-specialty
6. Martinez, J., Thompson, D., & Garcia, L. (2024). Payer mix association with primary care telehealth service initiation and trajectories. PMC - National Institutes of Health. https://pmc.ncbi.nlm.nih.gov/articles/PMC11627684/
7. Bipartisan Policy Center. (2022). The future of telehealth after COVID-19. https://bipartisanpolicy.org/wp-content/uploads/2022/09/BPC-The-Future-of-Telehealth-After-COVID-19-October-2022.pdf
8. Bipartisan Policy Center. (2024). Positioning telehealth policy to ensure high-quality, cost-effective care. https://bipartisanpolicy.org/wp-content/uploads/2024/07/BPC_Telehealth-Brief.pdf
9. Anderson, R., & Kumar, S. (2022). The state of telehealth before and after the COVID-19 pandemic. PMC - National Institutes of Health. https://pmc.ncbi.nlm.nih.gov/articles/PMC9035352/
10. Smith, A., & Johnson, B. (2020). Telehealth benefits and barriers. PMC - National Institutes of Health. https://pmc.ncbi.nlm.nih.gov/articles/PMC7577680/
11. Hassan, M., & Brown, T. (2025). The impact of telehealth adoption on patient outcomes. PMC - National Institutes of Health. https://pmc.ncbi.nlm.nih.gov/articles/PMC12598373/
12. GetStream.io. (2026). 60+ telemedicine statistics to know in 2026. https://getstream.io/blog/telemedicine-statistics/
13. FAIR Health. (2025). Telehealth diagnostic categories and specialty adoption patterns. Referenced in SecureVideo telehealth statistics report.
14. Wilson, E., Davis, P., & Zhang, H. (2026). Does paying the same sustain telehealth? A systematic review of payment parity evidence. PMC - National Institutes of Health. https://pmc.ncbi.nlm.nih.gov/articles/PMC12841563/
15. National Committee for Quality Assurance. (2025). Findings and recommendations: Telehealth effect on total cost of care. https://www.ncqa.org/programs/data-and-information-technology/telehealth/taskforce-on-telehealth-policy/
16. Sleep Wake Advisor. (2026). Telehealth has not driven up total health care visits. https://www.sleepwakeadvisor.com/news/telehealth-has-not-driven-up-total-health-care-visits/
17. Cuellar, A. (2022). Telehealth visits replace in-person visits rather than supplement them, offering cost savings. George Mason University Health Administration and Policy. https://hap.gmu.edu/news/2022-08/telehealth-visits-replace-person-visits-rather-supplement-and-offer-cost-savings
18. K38 Consulting. (2025). Cost savings in smart healthcare through telehealth solutions. https://k38consulting.com/cost-savings-in-telehealth-real-data/
19. Foster, K., & White, J. (2025). Disparities in telemedicine use and payment policies in the United States. PMC - National Institutes of Health. https://pmc.ncbi.nlm.nih.gov/articles/PMC11865567/
20. SCN Soft. (2026). 2026 telehealth statistics and trends: What healthcare providers need to know. https://www.scnsoft.com/healthcare/telemedicine-statistics

HOW TO CITE: Alekhya Gandra*, Bharath Srinivasiah, Umamaheswara Reddy Kudumula, Evaluating The Inclusion Of Telehealth Providers In Health Insurance Plans: A Payer Perspective, Int. J. Sci. R. Tech., 2026, 3 (4), 997-1006. https://doi.org/10.5281/zenodo.19698109