



# Issue Brief

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BY ANDREW WILFORD & ANDREW MOYLAN

## Telemedicine — Potentially Revolutionary, But Still Hampered By Outdated State Regulation

### Background: Telemedicine and 21st Century Health Care

As fears about the spread of COVID-19, better known as the coronavirus, mount, lawmakers across the country are evaluating the public health infrastructure that helps keep the American public safe. In general, the U.S. has a robust system to help identify and reduce the risk of such a disease spreading and causing widespread health and economic impacts. But one technological innovation that could serve as a “[force multiplier](#)” for public health efforts — telemedicine — is hampered by bureaucracy and red tape.<sup>1</sup> These restrictions serve as a significant barrier to interstate commerce and to improving individual health while making it harder to respond to major public health threats.

<sup>1</sup> Brodwin, Erin. “Telehealth Can Help Fight Coronavirus, but There Are Obstacles in the U.S.,” STAT News, February 28, 2020.

### Key Facts:



Telemedicine offers potentially revolutionary benefits to modern health care, such as lower prices, easier access to medical care, and reduced risk of disease transmission to physicians and fellow patients.



However, much of the medical regulatory landscape was designed for a different technological era, meaning that telemedicine faces unnecessary red tape and regulatory hurdles to implementation.



States should act quickly to reduce the barriers telemedicine faces in order to harness the benefits it promises to patients and doctors alike.

Public policy has a role to play in ensuring public health and safety in the health care industry. Unfortunately, regulations affecting telemedicine are often outdated and out of step with the state of the modern industry.

Telemedicine, the practice of connecting patients and providers remotely through technology, offers one way to begin to rein in out-of-control costs while simultaneously offering greater convenience to patients. Patients gain greater access to medical professionals, not needing to travel to the doctor's office for less serious concerns. It also provides an important tool for public health officials in encouraging initial consultation while limiting the risk of in-person transfer at hospitals or clinics.

But it has applications outside of minimizing disease transfer as well. Low-cost telemedicine services allow scarce resources to be redirected towards more serious cases that require inpatient visits, while patients with less immediate cases are encouraged to engage with medical professionals earlier and more often. It's a big reason why one study found that patients doing e-visits were able to experience [19 percent cost savings](#) compared to those doing inpatient visits.<sup>2</sup>

Telemedicine also offers a way to standardize access to medical professionals. With the growing ubiquity of computers and smartphones with internet access, many patients in rural areas or with physical disabilities have the same ability to discuss health care concerns quickly and easily over chat or video conference as any other. For these patients, telemedicine allows them to consult with a medical professional in cases where traveling to a doctor's office is infeasible.

This could go a long way to addressing issues with supplying physicians to underserved areas. The Department of Health and Human Services has [identified](#) 7,655 regions across the country as Health Professional Shortage Areas, with over 79 million Americans living in these areas. Of these, just under 63 percent are rural areas.<sup>3</sup> Americans in these areas are more likely to be uninsured and dealing with chronic conditions, but also more likely to be impoverished and struggle to access transportation to a health facility.

These factors make it [difficult to sustain](#) a medical practice in these areas.<sup>4</sup> But with telemedicine, of course, a physical practice is unnecessary.

## Legal Barriers

Too often, state regulatory regimes throw up hurdles that make it difficult for telemedicine to realize its full potential. Currently, taking advantage of the benefits that telemedicine offers requires navigation of a minefield of legal rules and technicalities.

## Licensing

The most significant of these barriers comes from state licensing requirements. Forty-nine states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands all [require physicians](#) to possess a medical license in the patient's state in order to provide telemedicine services (even if the physician is licensed in the state he or she is located in).<sup>5</sup>

<sup>2</sup> Lazare, Jaime. "Hospital at Home: Patient Care Model of the Future?" *Today's Geriatric Medicine*, March 2013.

<sup>3</sup> Bureau of Health Workforce, Health Resources and Services Administration (HRSA). "Designated Health Professional Shortage Areas Statistics: First Quarter of FY 2020." December 31, 2019. Retrieved from: <https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport> (Accessed March 5, 2020.)

<sup>4</sup> Sukel, Kayt. "Dealing With the Shortage of Rural Physicians," *Medical Economics*, August 29, 2019.

<sup>5</sup> "Telemedicine Policies by State." Federation of State Medical Boards, 2019. Retrieved from: [https://www.fsmb.org/siteassets/advocacy/key-issues/telemedicine\\_policies\\_by\\_state.pdf](https://www.fsmb.org/siteassets/advocacy/key-issues/telemedicine_policies_by_state.pdf).

That means that, in order to provide an expansive, country-wide telemedicine service, any given medical care provider would need to possess 52 separate medical licenses. The absurdity of a licensed medical care professional being legally qualified to video chat with a patient in Alabama but not one in Montana is hard to overstate.

States have not ignored the problems this creates, but their attempted workarounds often create legal quirks that highlight rather than ameliorate the problems. For example, consultation exemptions allow a medical professional licensed in State A to consult with another physician licensed in State B about a patient in State B's case even if the medical professional is not licensed in State B. Consultations, however, are [required to be infrequent](#) and the final decision on treatment must be up to the physician in State B, making them an impractical solution for widespread health care.<sup>6</sup>

Hybrid practices with both physical and telemedicine operations often run into these quirks as well. The Mayo Clinic, for example, has physical locations around the country, but often follows up with patients remotely. Physicians are permitted to do this for conditions that were treated on site, but are [barred from discussing new conditions](#) unless licensed in the patient's state.<sup>7</sup> It's easy to see how the difference between a new condition and a follow-up on a previously-treated issue can be a gray area, but doctors are incentivized to err on the side of caution to avoid legal jeopardy.

States have made efforts to increase reciprocity of licenses across state borders. Some states offer reciprocity for neighboring states, while 29 states, as well as the District of Columbia and Guam, have [joined](#) the Interstate Medical Licensure Compact (IMLC) to allow for expedited licensure for qualified physicians in member states.<sup>8</sup>

While this is a positive step, it remains imperfect. Approximately 20 percent of physicians do not qualify to use the IMLC. One of the reasons for this is the requirement that the physician spend at least [25 percent of his or her time](#) practicing in his or her own state.<sup>9</sup> In other words, while it supports some types of telemedicine, it would still require most physicians to spend a plurality of time treating patients in their home states.

And it's [far from cheap](#) for those that do qualify.<sup>10</sup> The IMLC requires a \$700 application fee, plus a fee for each state license. Per-state fees range from \$75 to nearly \$800 — becoming licensed in each state in the IMLC currently would cost over \$16,000 for the 29 participating states. Even that would only qualify a physician to practice telemedicine in a slim majority of states.

## Payment

For telemedicine to grow, it can't be treated by government health care bureaucrats as an inferior service. Yet [only 28 states](#) have policies in place mandating that Medicaid pay the same amount for telemedicine health care services as traditional in-person care.<sup>11</sup> Consumers and state and local governments would still experience cost savings through avoiding emergency room visits and hospital stays, as well as benefiting from improved illness prevention through increased ease of access to medical professionals.

<sup>6</sup> Gupta, Amar and Sao, Deth. "The Constitutionality of Current Legal Barriers to Telemedicine in the United States: Analysis and Future Directions of Its Relationship to National and International Health Care Reform." *Health Matrix: The Journal of Law-Medicine*. Vol. 21, Issue 2 (2012).

<sup>7</sup> Melinda Beck, "How Telemedicine Is Transforming Health Care," *The Wall Street Journal* June 26, 2016, <https://www.wsj.com/articles/how-telemedicine-is-transforming-health-care-1466993402>.

<sup>8</sup> "Interstate Medical Licensure Compact | A Faster Pathway to Medical Licensure." Interstate Medical Licensure Compact. Retrieved from: <https://imlcc.org/> (Accessed March 3, 2020).

<sup>9</sup> Faget, Kyle. "Direct-to-Patient Telemedicine Legal and Regulatory Considerations." NRTRC Regional Telehealth Conference October 2, 2018.

<sup>10</sup> "What Does It Cost?" Interstate Medical Licensure Compact. Retrieved from: <https://imlcc.org/what-does-it-cost/> (Accessed March 3, 2020.)

<sup>11</sup> "Annual Telehealth State of the States Report From ATA: Recognition, Policy and Reimbursement Vary Widely." ATA, July 18, 2019.

While every state reimburses for live-video care, what other services qualify for Medicaid reimbursement [varies by state](#) as well.<sup>12</sup> Just 14 states provide Medicaid reimbursement for store-and-forward, or electronic forwarding of a patient’s case to another site for evaluation. Twenty-two states reimburse for remote patient monitoring, or health professionals’ monitoring of patients’ vital signs or other medical information after being released to their homes. Just eight states guarantee Medicaid reimbursement for all three services.

States also exercise significant control over private insurers, creating further mazes for health care professionals to navigate. Sixteen states mandate [payment parity between in-person and telehealth services](#) for private payers, creating a different market environment for telemedicine in these 16 states than in others.<sup>13</sup>

## Malpractice and Legal Liability

Practicing medicine of any kind always carries the risk of malpractice lawsuits, but these issues are more complex for telemedicine providers. One major question remains unanswered — should a physician in State A be sued for malpractice by a remote patient in State B, it is [not clear](#) which state has the jurisdiction to try the case.<sup>14</sup>

Should remote patients alleging injury from telemedicine providers attempt to sue for malpractice in their home states, this could create significant burdens for telemedicine providers that traditional providers might not face. Telemedicine providers could need to travel across the country to defend themselves in other jurisdictions with different legal standards regarding care — ironically, the very travel that telemedicine is designed to bypass. Additionally, they could face greater issues in obtaining malpractice insurance.

Malpractice insurance is provided by private entities, but they are still regulated by state governments. While insurers can easily set premiums to hold enough cash on hand to satisfy a provider’s home state regulatory requirements, this calculation becomes [far more difficult](#) when a patient suing for malpractice could do so in any state or territory across the country.<sup>15</sup> [Additional exposure to risk and complication](#) could result in insurers setting higher rates for physicians that practice across state lines.<sup>16</sup>

## Privacy

Federal law sets standards for protection of patient information confidentiality through the Health Insurance Portability and Accountability Act (HIPAA). But while HIPAA sets minimum standards that health care providers must comply with, it does not preclude states from [setting more stringent standards](#).<sup>17</sup>

States with stricter privacy protections than HIPAA can create compliance headaches for telemedicine providers. While traditional providers must concern themselves with the laws of state in which they reside only, telemedicine providers must effectively comply with the strictest state privacy laws in the country, or else comply on a state-by-state basis.

<sup>12</sup> “Telemedicine Policies by State.” Federation of State Medical Boards, 2019. Retrieved from: [https://www.fsmb.org/siteassets/advocacy/key-issues/telemedicine\\_policies\\_by\\_state.pdf](https://www.fsmb.org/siteassets/advocacy/key-issues/telemedicine_policies_by_state.pdf).

<sup>13</sup> “Annual Telehealth State of the States Report From ATA: Recognition, Policy and Reimbursement Vary Widely.” ATA, July 18, 2019.

<sup>14</sup> Gonzalez, Gloria. “Telemedicine Expands Care, Adds Exposures.” Business Insurance, November 4, 2018.

<sup>15</sup> *Ibid.*

<sup>16</sup> Ackerman, Bonnie. “Medical Malpractice Issues With Telemedicine.” National Law Review, April 17, 2019.

<sup>17</sup> Gupta and Sao, “The Constitutionality of Current Legal Barriers to Telemedicine in the United States: Analysis and Future Directions of Its Relationship to National and International Health Care Reform.”

The same applies in the case of privacy breaches. States can set stricter rules governing provider obligations in the case of a data breach — and telemedicine providers must effectively comply with the strictest laws they could potentially run afoul of. Not only does this create heavy compliance burdens for telemedicine providers, it puts them at a disadvantage compared to traditional providers.

## Conclusion

The health care industry, in particular, is ripe for an overhaul. Despite spending far more per capita than other developed countries, the American health care system fails to produce better health care outcomes in many ways.<sup>18</sup> Across the board, the U.S. health care system suffers from higher costs and prices — higher drug prices, higher health care professional salaries, and higher hospital administration costs.

Telemedicine has the potential to revolutionize health care, offering greater access to health care professionals, eliminating regional access disparities, and lowering costs. It could also offer significant public health benefits in the face of future disease outbreaks similar to coronavirus, given the ability to offer initial consultations outside the context of hospitals and clinics, where the risk of spread is significant.

However, it cannot realize this potential unless state governments get out of the way. States should take every step to usher along the growth of telemedicine rather than hampering it through needlessly complex and overlapping laws and regulations. The potential for innovative changes is too great to waste on bureaucratic technicalities.

## About the Authors

*Andrew Wilford and Andrew Moylan lead the Interstate Commerce Initiative at the National Taxpayers Union Foundation (NTUF), a project which seeks to protect taxpayers from the pernicious effects of states attempting to exercise power outside their borders. NTUF is a nonpartisan research and educational organization that shows Americans how taxes, government spending, and regulations affect them.*

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<sup>18</sup> Anderson, Gerard et al. “It’s Still The Prices, Stupid: Why The US Spends So Much On Health Care, And A Tribute To Uwe Reinhardt.” Health Affairs, January 2019; and Jeter, Amy and Palosky, Craig. “US Improving in Health Care Quality, But Still Lagging Behind Other Countries, New Analysis Finds.” The Henry J. Kaiser Family Foundation, September 10, 2015.



*2020 National Taxpayers Union Foundation*  
122 C Street NW, Suite 650, Washington, DC 20001  
[ntuf@ntu.org](mailto:ntuf@ntu.org)