



UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Office of Policy Planning
Bureau of Competition
Bureau of Economics

March 25, 2016

Representative Steve Thompson
Co-Chair, House Finance Committee
Alaska State Legislature
State Capitol Room 515
Juneau, AK 99801

Dear Representative Thompson:

The staffs of the Federal Trade Commission's ("FTC") Office of Policy Planning, Bureau of Economics, and Bureau of Competition¹ (collectively, "FTC staff") appreciate the opportunity to comment on certain telehealth provisions in Senate Bill 74² ("SB 74") that were transferred to SB 74 from Senate Bill 98³ ("SB 98"). These provisions would allow licensed Alaska physicians located *out-of-state* to provide telehealth services in the same manner as licensed Alaska physicians located *in-state*, and would affirmatively allow certain Alaska-licensed behavioral health professionals to provide services remotely. The FTC staff offers no opinion on any aspect of SB 74 not directly addressed in this letter.

Telehealth, the use of telecommunications to provide health care services to remotely located patients,⁴ readily crosses jurisdictional boundaries. Because of the state's vast size, rural nature, and harsh conditions, telehealth has long been a staple of Alaskan health care delivery.⁵ FTC staff believes that the provisions in SB 74 that would allow out-of-state as well as in-state Alaska licensees to provide telehealth services without an in-person examination would represent a procompetitive improvement in Alaska's telehealth law. These provisions would likely increase the supply of telehealth providers, enhance competition, and reduce health care costs, thereby benefiting Alaskans, especially underserved populations with limited access to health care.

I. INTEREST AND EXPERIENCE OF THE FEDERAL TRADE COMMISSION

The FTC is charged under the FTC Act with preventing unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.⁶ Competition is at the core of America's economy,⁷ and vigorous competition among sellers in an open marketplace gives consumers the benefits of lower prices, higher quality products and services, and increased innovation. Because of the importance of health care competition to the economy and consumer welfare, anticompetitive conduct in health care markets has long been a key focus of FTC law enforcement,⁸ research,⁹ and advocacy.¹⁰

In the 2004 FTC & U.S. Department of Justice report, IMPROVING HEALTH CARE: A DOSE OF COMPETITION, the agencies considered the competitive effects of *State Restrictions on the Interstate Practice of Telemedicine*.¹¹ The central finding of that analysis is still accurate today: “When used properly, telemedicine has considerable promise as a mechanism to broaden access, lower costs, and improve health care quality.”¹² The report also observed that “the practice of telemedicine has crystallized tensions between the states’ role in ensuring patients have access to quality care and the anticompetitive effects of protecting in-state physicians from out-of-state competition.”¹³ Those conclusions, and the report’s recommendation to reduce barriers to telemedicine and competition from out-of-state providers,¹⁴ underpin our comments in this letter.¹⁵

II. CURRENT ALASKA LAW ALLOWING IN-STATE PHYSICIANS TO PROVIDE TELEHEALTH SERVICES WITHOUT AN IN-PERSON EXAMINATION, AND PROPOSED EXTENSION TO OUT-OF-STATE ALASKA LICENSEES

A. Current Alaska Law

In 2014, Alaska enacted a law, ALASKA STAT. § 08.64.364 (“the law”), designed to increase the availability of telehealth services in Alaska by allowing physicians licensed and *located in* Alaska to prescribe drugs without conducting a physical examination under certain circumstances.¹⁶ Specifically, the law prohibits the Alaska State Medical Board (“ASMB”) from disciplining a physician for prescribing drugs without conducting a physical examination,¹⁷ even though the ASMB’s unprofessional conduct regulation authorizes the ASMB to discipline a licensee for prescribing a “medication to a person without first conducting a physical examination of that person, unless the licensee has a patient-physician or patient-physician assistant relationship with the person.”¹⁸ While Section 08.64.364 expanded the availability of telehealth services in Alaska, it only applies “if the physician is *located in this state* and the physician or another licensed health care provider in the physician’s group practice is available to provide follow-up care[.]”¹⁹

B. Telehealth Provisions of SB 74

SB 74 would likely expand the availability of telehealth services by eliminating the requirement that Alaska-licensed physicians be physically located in-state.²⁰ This extension would treat out-of-state physicians the same as in-state physicians, giving Alaskans access to telehealth services provided by out-of-state Alaska-licensed physicians who have met identical standards for licensure as Alaska’s in-state physicians. In addition to eliminating the in-state requirement for physicians, SB 74 would authorize regulations that would establish a standard of care for physicians prescribing medications without a physical examination. As discussed below, we suggest that legislators consider whether special standards of care are needed for telehealth.²¹

SB 74 would also clarify that certain behavioral health providers may use telehealth to diagnose and treat patients remotely.²² Although telemedicine is often used in Alaska and elsewhere to provide behavioral health services,²³ current Alaska laws and regulations for these professionals have no provisions specific to telehealth. While SB 74 might encourage greater use

of telehealth by behavioral health professionals, its requirement that behavioral health professionals providing services remotely, unlike those providing services in person, share sensitive mental health records with a primary care provider could discourage its use for patients who wish to keep such records confidential.²⁴ In addition, as discussed below, we suggest that legislators consider whether special standards of care are needed for remotely provided behavioral health services.²⁵

III. POTENTIAL COMPETITIVE EFFECTS OF SB 74's TELEHEALTH PROVISIONS

Alaskans have long relied on telehealth to mitigate provider shortages and enhance access to care throughout the state. However, by allowing only physicians located in Alaska to prescribe medication without conducting a physical examination, current Alaska law unnecessarily restricts access to care from a substantial pool of providers. By eliminating the “in-state” requirement, SB 74 would potentially increase the supply of physicians and competition from lower-cost providers, reduce transportation costs, and improve access to quality care.

A. Telehealth Already Expands Access to Health Care in Alaska

Telehealth, including services from out-of-state providers, has long been a way to address health provider shortages and improve access to care in Alaska. Alaska has a longstanding and significant shortage of primary care and specialty physicians, including psychiatrists and non-physician behavioral health providers. The largest shortages are in rural Alaska.²⁶ Most of rural Alaska is designated a primary care physician Health Professional Shortage Area, with a total of 85 such designations. By meeting only 36% of the state’s need for primary care professionals, Alaska ranks 49th among the states and the District of Columbia.²⁷ Alaska’s shortage of behavioral health providers is even more extensive; almost all of Alaska is designated a Mental Health Care Health Professional Shortage Area, with the exception of small areas in the vicinity of Anchorage, Fairbanks, and Juneau. Alaska ranks 48th among the states and the District of Columbia in meeting only 23% of the state’s need for mental health professionals (some of whom are physicians).²⁸ These shortages are exacerbated by the difficulty of recruiting physicians to a region with an extreme climate that is distant from the rest of the United States.²⁹

For decades, telehealth has played a role in responding to the challenges of provider shortages and caring for patients in remote, geographically isolated locations.³⁰ For example, the Indian Health Service (“IHS”) of the U.S. Department of Health and Human Services and the Alaska Native Tribal Health Consortium (“ANTHC”) routinely rely upon telehealth services to link community health aides at local clinics with distant primary care and specialty providers. ANTHC, which assumed responsibility for many IHS programs in Alaska, provides telehealth services through the Alaska Federal Health Care Access Network (“AFHCAN”); in 2013, about 16% of Alaska Natives received care through AFHCAN’s network.³¹ Alaska’s hospitals also routinely offer telehealth services as a way to enhance the care of remote patients.³²

Telehealth is also often used to provide behavioral health services to Alaskans because it can be readily provided through videoconferencing.³³ For example, the IHS Tele-Behavior Health Center of Excellence relies on remote psychiatrists to provide services to patients at its

clinics by videoconferencing.³⁴ Another provider of mental health services, the Alaska Psychiatric Institute's Telebehavioral Health Center, also relies on telehealth to provide services to about 26 towns or villages, most of which are not connected to the state's road system.³⁵ In addition, the state's Department of Corrections ("DOC"), the single largest provider of mental health care in Alaska, has used video conferencing since 2000 to facilitate counseling by psychiatrists and psychologists at prisoner facilities throughout the state.³⁶

B. SB 74 Is Likely to Promote Competition, Thereby Improving Access and Lowering Costs, Without Compromising Quality

By effectively prohibiting out-of-state Alaska-licensed physicians from providing telehealth services without an in-person physical examination, ALASKA STAT. § 08.64.364 creates a significant and unnecessary barrier to the use of telehealth services in Alaska.³⁷ Only one other state, Louisiana, has a similar requirement.³⁸ A number of Alaskan authorities have expressed concerns that ALASKA STAT. § 08.64.364's requirement that the physician be located in Alaska bars qualified practitioners from providing telehealth services, exacerbating the state's shortage of physicians.³⁹ For example, before the law was enacted, a DOC representative testified that the requirement "that the physician must be physically located in the state in order to render care over the phone or by other means" would hamper DOC's ability to provide telemedicine services in Alaska.⁴⁰ Similarly, state authorities have raised strong concerns about limits on the ability of out-of-state practitioners to provide behavioral health services, even though such services do not ordinarily involve a physical examination. According to the Alaska Department of Health & Social Services, "many Alaska health care providers have historically contracted with psychiatrists who are licensed by the State Medical Board to practice in Alaska, but who are physically located elsewhere."⁴¹ Thus, "some established providers are now unwilling to continue providing the same quality, appropriate, needed care through high-quality telehealth practice from outside the state for fear of sanction by the Board. *For this reason, it is critical to Alaska's behavioral health care system (as well as public health and safety in the state) that SB98's provision eliminating the in-state requirement from AS08.64.346(a)(2) becomes law – either through SB98 or another vehicle.*"⁴²

By allowing out-of-state physicians licensed in Alaska to provide telehealth services to Alaskans, SB 74 would expand access to telehealth services, supporting the goal of Alaska's telehealth program "to bring quality primary care and specialty services to remote areas of the state, where it might not otherwise be feasible to do so."⁴³ A potential expansion of access to telehealth services pursuant to SB 74 would also be consistent with the recommendations of the Alaska Health Care Commission ("AHCC"), which has identified telehealth as one of its top priorities for increasing health care value as well as enhancing access to behavioral health and primary care providers.⁴⁴ Similarly, the Institute of Medicine supports the expanded use of telehealth throughout the United States, because "[a]ccess to high-quality primary and specialty care for beneficiaries in medically underserved metropolitan and nonmetropolitan areas would be improved by increasing the availability of telehealth technologies."⁴⁵

Data on the relative numbers of in-state and out-of-state physicians licensed in Alaska support the conclusion that SB 74 could substantially expand access to telehealth services. If SB 74 eliminated ALASKA STAT. § 08.64.364's *in-state* requirement, it would approximately double

the supply of physicians who could provide telehealth services, based on estimates that approximately two thousand Alaska-licensed physicians have in-state addresses while another two thousand have out-of-state addresses.⁴⁶ As explained by a previous analysis of Alaska physician license records that also found that many Alaska licensees are located out-of-state, such licensees include physicians who sometimes work in-state, physicians who previously worked in-state but still maintain their Alaska license, physicians who provide telemedicine services for Alaska patients, and some who obtained a license but decided not to practice in the state.⁴⁷ In addition, Alaskan authorities predict that elimination of the in-state requirement would encourage out-of-state physicians who are not currently licensed in Alaska and wish to provide telehealth services to apply for Alaska licensure.⁴⁸ In sum, by eliminating the in-state requirement, SB 74 could immediately provide access to a variety of Alaska-licensed physicians located out-of-state, many of whom may have previously worked in Alaska and are familiar with the state's unique health care challenges.

This increase in the supply of practitioners likely has the potential to increase competition, enhance the quality of care readily available to remote patients, and reduce costs. Authoritative sources have found that health care prices in Alaska are high, in part due to insufficient competition. For example, the AHCC found that on average, “reimbursement for physician services in Alaska is 60% higher than in comparison states for all payers—69% higher for commercial health insurers.”⁴⁹ The AHCC attributed these high prices, in part, to “the relative lack of competition among practitioners, particularly in specialty care. . . . As a result, physicians can largely dictate the fees they are paid by commercial payers.”⁵⁰

By expanding the supply of telehealth services provided by Alaska-licensed but out-of-state practitioners, SB 74 could help reduce costs. Services provided by out-of-state providers are likely to cost less because of the provider's location. For example, use of an out-of-state provider could reduce costs for the Alaska Medical Assistance (Medicaid) program. If telehealth services provided by an out-of-state practitioner meet all requirements for reimbursement,⁵¹ Alaska Medical Assistance reimburses such services at the lesser of the “rate established by the Medicaid agency in the state where the services were provided;” or “the rate or payment methodology established by Alaska Medical Assistance.”⁵² Accordingly, use of an out-of-state Medicaid telehealth provider would cost no more than use of a provider in Alaska, and may cost less.⁵³ Similarly, Medicare's Geographic Adjustment Factor (“GAF”) for fee-for-service reimbursement of providers in Alaska is 1.29, the highest in the nation.⁵⁴ As a result, when an out-of-state physician provides covered telehealth services for an Alaska patient, Medicare reimbursement on average would be about 78% of what the reimbursement would have been, had the practitioner providing the services been located in Alaska.⁵⁵ Finally, if the relative reimbursement of in-state and out-of-state telehealth services by private sector payers is the same as what the AHCC found for overall reimbursement of physician services by commercial health insurers, private sector reimbursement of out-of-state providers of telehealth services would be only 59% of that paid to Alaska physicians.⁵⁶

By eliminating the in-state requirement in ALASKA STAT. § 08.64.364, SB 74 would also facilitate the expansion of services from nationwide direct-to-consumer telehealth companies that operate in most states and have recently begun offering services to Alaskan patients or are interested in doing so.⁵⁷ Such companies connect patients with a provider upon consumer

request, and may offer live, interactive audio/video or audio-only interaction via computer, mobile app, and by telephone; some offer email or internet services.⁵⁸ These companies, which usually provide services for common minor conditions, may offer a convenient and cost-effective alternative to in-person care for many patients,⁵⁹ especially in Alaska, where an in-person visit might entail a long trip under adverse conditions. The advertised costs of telehealth services offered by such companies do not appear to depend upon the location of the provider, and such services typically cost considerably less than in-person services.⁶⁰ Use of these services may be paid for by employers, private insurance, or out-of-pocket.⁶¹ To the extent that such services allow patients to avoid unnecessary and costly visits to physicians' offices, urgent care centers, or the emergency department, and to the extent they offer a safe and effective way to obtain certain types of care, these services can provide a convenient, low cost alternative while still satisfying legitimate safety and quality standards.⁶² Therefore, expanding the availability of such services can benefit consumers.

SB 74 could also help to reduce travel costs for both patients and providers in Alaska.⁶³ Telehealth services are not only convenient for many Alaskans, they may be a virtual necessity for patients in remote areas.⁶⁴ For example, the Alaska Department of Corrections found that the use of telemedicine "is more efficient and cost-effective" than having psychiatrists travel to remote facilities several times a month.⁶⁵ Improved access to telehealth services could also lead to substantial savings in transportation costs paid by Alaska Medical Assistance (Medicaid), which spent \$76.9 million for transportation services in 2015, more than half the amount that it paid for physician services (\$143.2 million), and nearly half of what it paid for mental health services (\$159.1 million).⁶⁶

In sum, by eliminating the "in-state" requirement in ALASKA STAT. § 08.64.364(a)(2), SB 74 would likely increase the supply of physicians, potentially increasing competition from lower-cost providers and improving access to quality care that would not otherwise be readily available to many Alaskans. The bill also has the potential to reduce transportation costs for patients and providers. These aspects of SB 74 are consistent with the recommendation of the AHCC to foster telehealth and design solutions to reduce barriers to its development and use.⁶⁷

Proponents of the requirement that only physicians licensed in Alaska and *located in the state* be permitted to prescribe medications without conducting a physical examination characterize the requirement as a "safeguard."⁶⁸ FTC staff urges the legislature to carefully consider this claim to determine whether the in-state requirement is necessary to protect patient health or safety. In particular, in a state as large as Alaska, even an in-state physician may not be able to provide follow-up care in-person. Likewise, a physician in Seattle is physically closer to some parts of Alaska than a physician in Anchorage.⁶⁹

It appears that the sole proffered justification for the in-state requirement is that out-of-state physicians, even if licensed in Alaska, may not be familiar with local conditions and may be unable to provide appropriate referrals.⁷⁰ FTC staff encourages the legislature to fully consider this purported justification.⁷¹ The legislature may also wish to consider whether a remote provider's understanding of local conditions and practitioners adds value when a patient receives telehealth services at a local clinic or health care facility.

Finally, we urge the legislature to consider the potential consequences of SB 74's proposed requirements that the relevant professional boards adopt regulations establishing special standards of care for physician and behavioral health practitioners who provide services remotely. The bill would require the ASMB to "adopt regulations establishing standards of care for a physician who is rendering a diagnosis, providing treatment, or prescribing, dispensing, or administering a prescription drug to a person without conducting a physical examination[.]"⁷² A telehealth provider who has not made a physical examination is already subject to the state's licensure requirements, including an obligation to meet the state's existing standard of care. The development of additional "safeguards" solely for telehealth providers might lead to the adoption of unnecessary restrictions that would only serve to restrict competition, and thereby undermine SB 74's goal of enhancing access to telehealth services.

We encourage the Alaska legislature to consider clarifying the proposed amendments to ensure that any subsequent regulations are narrowly tailored and would not undermine this goal of SB 74. In particular, the legislature may wish to include a provision expressly acknowledging that the physician-patient relationship can be established using telehealth communications.⁷³ Similarly, we encourage the legislature to consider whether the bill's requirements that behavioral health boards "adopt regulations restricting the evaluation, diagnosis, supervision, and treatment of a person" provided remotely by establishing standards of care, including standards for supervision, practice, and other matters, could lead to regulations that undermine the availability of telemental health services, and whether they are needed.⁷⁴

IV. CONCLUSION

By enacting ALASKA STAT. § 08.64.364, the Alaska legislature determined that Alaskans would benefit from increased access to telehealth services by eliminating the in-person physical examination requirement under certain circumstances. That provision did not extend to physicians licensed in Alaska, but located out-of-state. FTC staff urges the legislature to consider whether there are any legitimate health or safety justifications for prohibiting physicians licensed in Alaska, but located out of state, from providing telehealth services in the same manner as in-state physicians. By eliminating the "in-state" requirement, SB 74 would likely expand the supply of telehealth providers, promote competition, and increase access to safe and cost-effective care. It could also reduce transportation costs for Alaska patients and providers. For these reasons, the elimination of the "in-state" requirement by SB 74 appears to be a procompetitive improvement in the law that would benefit Alaska health care consumers, including its most vulnerable populations.

We appreciate your consideration of FTC staff's views.

Respectfully submitted,

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¹ This letter expresses the views of the Federal Trade Commission’s Office of Policy Planning, Bureau of Economics, and Bureau of Competition. The letter does not necessarily represent the views of the Federal Trade Commission or of any individual Commissioner. The Commission, however, has voted to authorize us to submit these comments.

² S.B. 74, 29th Leg., 2nd Sess., sec. 1-7, (Alaska 2016) (FIN Committee Substitute, amended, March 11, 2016), <http://www.legis.state.ak.us/PDF/29/Bills/SB0074E.PDF>.

³ S.B. 98, 29th Leg., 2nd Sess., (Alaska 2016) (L&C Committee Substitute, March 4, 2016), <http://www.akleg.gov/PDF/29/Bills/SB0098C.PDF>.

⁴ While there is no single, universally accepted definition of telehealth or telemedicine, both terms “describe the use of medical information exchanged from one site to another via electronic communications to improve the patient’s health status.” BOARD ON HEALTH CARE SERVICES, INSTITUTE OF MEDICINE, THE ROLE OF TELEHEALTH IN AN EVOLVING HEALTH CARE ENVIRONMENT: WORKSHOP SUMMARY 3, 134 (Tracy A. Lustig, Rapporteur) (2012) [hereinafter INSTITUTE OF MEDICINE, THE ROLE OF TELEHEALTH IN AN EVOLVING HEALTH CARE ENVIRONMENT], <http://www.nap.edu/catalog/13466/the-role-of-telehealth-in-an-evolving-health-care-environment>.

⁵ See *infra* notes 30-36 and accompanying text. See also THE KAISER COMM. ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., PUTTING MEDICAID IN THE LARGER BUDGET CONTEXT: AN IN-DEPTH LOOK AT THREE STATES IN FY 2015 AND 2016, 4 (Oct. 2015), <http://files.kff.org/attachment/issue-brief-putting-medicaid-in-the-larger-budget-context-an-in-depth-look-at-three-states-in-fy-2015-and-2016> (“Alaska’s vast size, rural/frontier nature and arctic climate add a unique level of complexity in providing health care services to its residents.”).

⁶ Federal Trade Commission Act, 15 U.S.C. § 45.

⁷ *Standard Oil Co. v. FTC*, 340 U.S. 231, 248 (1951) (“The heart of our national economic policy long has been faith in the value of competition.”).

⁸ See generally FTC STAFF, OVERVIEW OF FTC ANTITRUST ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS (2013), <https://www.ftc.gov/system/files/attachments/competition-policy-guidance/hcupdaterev.pdf>.

⁹ See, e.g., FTC & U.S. DEP’T OF JUSTICE (“DOJ”), IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), <http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf>.

¹⁰ FTC and staff advocacy can include letters or comments addressing specific policy issues, Commission or staff testimony before legislative or regulatory bodies, amicus briefs, or reports. See, e.g., FTC Staff Comment to the West Virginia House of Delegates Regarding SB 597 and the Competitive Implications of Provisions Regarding “Cooperative Agreements” Between—and Possible Exemptions From the Federal Antitrust Laws For—Health Care Providers (March 10, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-west-virginia-house-delegates-regarding-sb-597-competitive-implications-provisions/160310westvirginia.pdf; Brief of the Fed. Trade Comm’n as Amicus Curiae, In Support of No Party, In re Nexium (Esomeprazole) Antitrust Litig., No. 15-2005 (1st. Cir. Feb. 12, 2016), https://www.ftc.gov/system/files/documents/amicus_briefs/re-nexium-esomeprazole-antitrust-litigation/160212nexiumbrief.pdf; FTC STAFF, POLICY PERSPECTIVES: COMPETITION AND

THE REGULATION OF ADVANCED PRACTICE NURSES (March 2014), https://www.ftc.gov/system/files/documents/advocacy_documents/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf.

¹¹ See FTC & DOJ, *supra* note 9, ch. 2, at 30 (section on “*State Restrictions on the Interstate Practice of Telemedicine*”).

¹² *Id.* Executive Summary, at 23.

¹³ *Id.* ch. 2, at 32.

¹⁴ *Id.* Executive Summary, at 23 (discussing uniform licensing standards and reciprocity compacts as mechanisms to reduce barriers).

¹⁵ This advocacy also draws on knowledge acquired during the 2014 FTC workshop, *Examining Health Care Competition*, <https://www.ftc.gov/news-events/events-calendar/2014/03/examining-health-care-competition>. The transcript of the panel on *Innovations in Health Care Delivery*, which covered telehealth, is on pages 67-122 of the transcript of the proceedings on March 20, 2014, https://www.ftc.gov/system/files/documents/public_events/200361/transcriptmar20.pdf.

¹⁶ See Alaska H.B. 281, An Act relating to prescription of drugs by a physician without a physical examination (2014) (codified at ALASKA STAT. § 08.64.364 (2015)), at <http://www.legis.state.ak.us/PDF/28/Bills/HB0281Z.PDF>. See also Rep. Lynn Gattis, HB 281 Sponsor Statement, http://www.legis.state.ak.us/basis/get_documents.asp?session=28&docid=24232 (explaining that the goal of HB 281 is to facilitate access to telemedicine).

¹⁷ ALASKA STAT. § 08.64.364(a)(1) prohibits the ASMB from imposing “disciplinary sanctions on a physician for prescribing, dispensing, or administering a drug to a person without conducting a physical examination if (1) the prescription drug is (A) not a controlled substance; or (B) a controlled substance and is prescribed, dispensed or administered by a physician when an appropriate licensed health care provider is present with the patient to assist the physician with examination, diagnosis, and treatment.”

¹⁸ ALASKA ADMIN. CODE tit. 12, § 40.967(29) (2015).

¹⁹ ALASKA STAT. § 08.64.364(a)(2) (emphasis added). To allow physicians in distant practices to provide telehealth services as the law intends, the requirement of availability for follow-up care must be interpreted as care provided by telehealth technology, regardless of whether the practitioner is located in- or out-of-state. FTC staff respectfully suggests that the legislature consider clarifying the law to expressly provide that “follow-up care” may be provided remotely, by telehealth service.

²⁰ S.B. 74, 29th Leg., 2nd Sess., sec. 4, § 08.64.364(a)(2) (Alaska 2016) (FIN Committee Substitute, amended, March 11, 2016). According to the sponsor of SB 98, the bill’s provisions “address[] some challenges with the implementation of [ALASKA STAT. § 08.64.364] that continue to provide barriers to the effective delivery of telemedicine healthcare services in Alaska,” by “eliminat[ing] the requirement that the physician is located in the state, and retain[ing] the requirement that physicians be licensed by the Alaska Medical Board.” Sen. Peter A. Micciche, SB 98 Sponsor Statement, http://www.akleg.gov/basis/get_documents.asp?session=29&docid=51380. Because SB 74 would not modify the requirement of Alaska licensure for out-of-state physicians who provide telehealth services to Alaska patients, this FTC staff comment does not address that specific issue. We note generally, however, that the necessity of multi-state licensure for physicians who practice across state lines is often considered a barrier to the deployment of telehealth services, and that less restrictive alternatives could reduce the burdens of practicing across state lines yet maintain appropriate standards of safety, quality, and effectiveness. See *supra* notes 11-14 and accompanying text. In addition, this comment expresses no opinion on S.B. 74, 29th Leg., 2nd Sess., sec. 5, § 08.64.364(d)(1) (Alaska 2016) (FIN Committee Substitute, amended, March 11, 2016).

²¹ See *infra* notes 72-73 and accompanying text.

²² SB 74 would amend the practice acts for a number of behavioral health professionals who do not have prescriptive authority and do not conduct physical examinations (professional counselors (ALASKA STAT. § 08.29.400); marriage and family therapists (ALASKA STAT. § 08.63.210); psychologists and psychological associates (ALASKA STAT. § 08.86.204); and social workers (ALASKA STAT. § 08.95.050)). These professionals are not currently prohibited

from providing telehealth services in- or out-of-state. In general, the amendments to these sections provide that the relevant board may not impose disciplinary sanctions on a licensee for the evaluation, diagnosis, or treatment of a person through audio, video, or data communications when physically separated from the person if the licensee or another licensed provider is available to provide follow-up care and if the licensee sends records of the encounter to the patient's primary care provider, with the patient's consent. The provisions requiring a patient's records to be sent to a primary care provider are similar to ALASKA STAT. § 08.64.364(a)(3), which apparently assumes that telehealth services might be sought in lieu of an in-person visit to a patient's primary care provider, and thus allows a physician to prescribe drugs without a physical examination only if the patient "consents to sending a copy of all records of the encounter to the person's primary care provider if the prescribing physician is not the person's primary care provider, and the physician sends the records to the person's primary care provider." FTC staff urges the legislature to consider whether this provision might act as a barrier to care for patients who do not have a primary care provider.

²³ See *infra* notes 33-36 and accompanying text; see also Adam Darkins, U.S. Department of Veterans Affairs, in INSTITUTE OF MEDICINE, THE ROLE OF TELEHEALTH IN AN EVOLVING HEALTH CARE ENVIRONMENT, *supra* note 4, at 99, 103 ("Mental health care is a major reason for implementing telehealth.").

²⁴ See, e.g., *Prescription without Physical Examination: Hearing on S.B. 98 Before the S. Comm. On Health & Social Services*, 29th Leg., 1st Sess. 8-9 (Alaska, April 13, 2015) (detailed minutes of hearing) (statement of Rebecca Ling, Director of Recovery Services, Cook Inlet Tribal Council), <http://www.legis.state.ak.us/PDF/29/M/SHSS2015-04-131336.PDF> (describing the "reluctance of patients to sign releases to share records with primary care physicians, which is required by the law."). FTC staff encourages the legislature to consider whether including the record transfer requirement in the practice acts of the behavioral health providers serves a valid health and safety purpose, or whether it might unnecessarily restrict telemental health services that may be more convenient and perhaps less costly than comparable in-person services.

²⁵ See *infra* note 74 and accompanying text.

²⁶ See, e.g., SECTION OF HEALTH PLANNING & SYSTEMS DEVELOPMENT, ALASKA DEP'T OF HEALTH & SOCIAL SERVICES, HEALTH CARE IN ALASKA 13, 21-23 (April 14, 2014) (prepared for the Alaska Health Care Comm'n), <http://dhss.alaska.gov/dph/HealthPlanning/Documents/pdf/Health%20Care%20in%20Alaska%20-%202014%20update.pdf> (discussing concerns about current and future physician and other health professional shortages, and explaining that physicians (especially specialists) are located in urban areas); ALASKA PHYSICIAN SUPPLY TASK FORCE, SECURING AN ADEQUATE NUMBER OF PHYSICIANS FOR ALASKA'S NEEDS 1 (Aug. 2006), <http://www.alaska.edu/health/downloads/PSTFweb.pdf> ("Alaska has a shortage of physicians. . . . Up to 16% of rural physicians were vacant in 2004 . . . Several important specialties are in serious shortage in Alaska.").

²⁷ See The Henry J. Kaiser Family Found., Primary Care Health Professional Shortage Areas (HPSAs) (April 28, 2014), <http://kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/>; Health Resources & Services Admin., U.S. Dep't Health & Human Services, Data Warehouse, Map Tool, <http://datawarehouse.hrsa.gov/Tools/MapTool.aspx?tl=HPSA>=State&cd=02&dp=PC> (accessed Mar. 3, 2016).

²⁸ See The Henry J. Kaiser Family Found., Mental Health Care Health Professional Shortage Areas (HPSAs) (April 28, 2014), <http://kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/> (reporting 63 Mental Health HPSA Designations); Health Resources & Services Admin., U.S. Dep't Health & Human Services, Data Warehouse, Map Tool, <http://datawarehouse.hrsa.gov/Tools/MapTool.aspx?tl=HPSA>=State&cd=02&dp=MH> (accessed Mar. 3, 2016). Mental Health HPSA designations are based on population-to-health professional ratio of psychiatrists and "core mental health professionals," including psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists. See Health Resources & Services Admin., U.S. Dep't Health & Human Services, Mental Health HPSA Designation Criteria, <http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/mentalhealthhpsacriteria.html>. See also SECTION OF HEALTH PLANNING & SYSTEMS DEVELOPMENT, *supra* note 26, at 25 ("2012 Alaska Health Workforce Vacancy Study showed that the vacancy rates for all behavioral health occupations were about 10%, and the psychiatrist vacancy rate [was] 22% statewide.").

²⁹ See, e.g., MARK A. FOSTER & SCOTT GOLDSMITH, INSTITUTE OF SOCIAL AND ECONOMIC RESEARCH, ALASKA'S HEALTH-CARE BILL: \$7.5 BILLION AND CLIMBING 8 (2011),

<http://www.iser.uaa.alaska.edu/Publications/RevisedHealthcare.pdf> (explaining that Alaska is at a competitive disadvantage with other states for attracting physicians and other healthcare professionals because “[i]t’s isolated; it has long harsh winters; and many of its communities aren’t even on the road system.”).

³⁰ See, e.g., Thomas S. Nesbitt. *The Evolution of Telehealth: Where Have We Been and Where Are We Going?*, in INSTITUTE OF MEDICINE, THE ROLE OF TELEHEALTH IN AN EVOLVING HEALTH CARE ENVIRONMENT, *supra* note 4, at 11, 12 (“Alaska has been a model for the development and use of telemedicine for decades”).

³¹ See, e.g., Mark Carroll, *Indian Health Service*, in INSTITUTE OF MEDICINE, THE ROLE OF TELEHEALTH IN AN EVOLVING HEALTH CARE ENVIRONMENT, *supra* note 4, at 104, 105 (since the 1970s, the Indian Health Service and other federal agencies have used telehealth in Alaskan village clinics and in other states); Howard Hays et al., *State of the Art and Science: The Success of Telehealth Care in the Indian Health Service*, 16 AM. MED. ASS’N J. ETHICS, 986 (2014) (AFHCAN, which has been in operation since 2001, operates at 250 sites throughout Alaska, most with a population of fewer than 300 residents).

³² See Stewart Ferguson, *American Telemedicine Association*, in INSTITUTE OF MEDICINE, THE ROLE OF TELEHEALTH IN AN EVOLVING HEALTH CARE ENVIRONMENT, *supra* note 4, at 117 (“Alaskan hospitals embrace telehealth as part of their strategies and business plans.”); ALASKA DEP’T OF HEALTH & SOCIAL SERVICES & ALASKA STATE HOSPITAL & NURSING HOME ASS’N, TELEHEALTH IN ALASKA HOSPITALS—IDENTIFIED ISSUES, NEEDS & OPPORTUNITIES 7 (2014) (listing the types of telehealth services utilized by specific Alaskan hospitals (e.g., telebehavioral health, telestroke, and teledermatology), <http://dhss.alaska.gov/ahcc/Documents/meetings/201412/Public%20Comment%20Attachments%20from%20ASHNHA%20and%20Boards.pdf>).

³³ See, e.g., Jay H. Shore, *Critical Relationships in Telehealth with American Indians and Alaskan Natives*, in INSTITUTE OF MEDICINE, THE ROLE OF TELEHEALTH IN AN EVOLVING HEALTH CARE ENVIRONMENT, *supra* note 4, at 108, 109.

³⁴ Howard Hays et al., *supra* note 31, at 990.

³⁵ See, e.g., CHARLES TOWNLEY & RACHEL YALOWICH, NATIONAL ACADEMY FOR STATE HEALTH POLICY, IMPROVING BEHAVIORAL HEALTH ACCESS & INTEGRATION USING TELEHEALTH & CONSULTATION: A HEALTH CARE SYSTEM FOR THE 21ST CENTURY (2015), <http://www.nashp.org/wp-content/uploads/2015/11/Telemedicine.pdf>.

³⁶ See SECTION OF HEALTH PLANNING & SYSTEMS DEVELOPMENT, *supra* note 26, at 20, 25, 30.

³⁷ Indeed, HB 281, which became ALASKA STAT. § 08.64.364, apparently provided that only physicians located in Alaska could prescribe medications without conducting a physical examination because “Alaska doctors said they wanted to protect Alaskan doctors.” *Prescription without Physical Examination: Hearing on H.B. 281 Before the S. Comm. On Health & Social Services*, 28th Leg., 2nd Sess. 13 (Alaska, April 14, 2014) (detailed minutes of hearing) (statement of Rep. Lynn Gattis), at <http://www.legis.state.ak.us/pdf/28/M/SHSS2014-04-141330.PDF>.

³⁸ See LA. REV. STAT. ANN. § 37:1271(B)(2)(b)(i), (iii) (limiting an exemption from Louisiana’s in-person patient history or physical examination requirement to licensed Louisiana physicians who maintain “a physical practice location within the state of Louisiana” or affirm to the board that they have made an arrangement with a local physician for follow-up care).

³⁹ See Dep’t of Health & Social Services (“DHSS”), 29th Alaska State Legislature—Work Draft Review, SB 98, Prescription Without Physical Examination (Jan. 22, 2016) [hereinafter DHSS, Work Draft Review, SB 98,] http://www.akleg.gov/basis/get_documents.asp?session=29&docid=51389 (The requirement in ALASKA STAT. § 08.64.364(a)(2) that a licensee be “physically located in the state at the time the prescription is made” . . . “has, unfortunately, brought a damaging unintended consequence: it has exacerbated the state’s shortage of available psychiatric care”).

⁴⁰ *Prescription without Physical Examination: Hearing on H.B. 281 Before the H. Comm. On Labor & Commerce*, 28th Leg., 2nd Sess. 11-12 (Alaska, Mar. 26, 2014) (detailed minutes of hearing) (statement of Robert Lawrence, Chief Medical Officer, Inmate Health, Department of Corrections), <http://www.legis.state.ak.us/pdf/28/M/HL!C2014-03-261539.PDF> (testimony about HB 281, which became ALASKA STAT. § 08.64.364).

⁴¹ DHSS, Work Draft Review, SB 98, *supra* note 39, at 1. *See also Prescription without Physical Examination: Hearing on H.B. 281 Before the H. Comm. On Labor & Commerce*, 28th Leg., 2nd Sess. 12-14 (Alaska, Mar. 26, 2014) (detailed minutes of hearing) (statement of Kate Burkhart, Executive Director, Alaska Mental Health Board, Dep't of Health & Social Services) (Alaska's community behavioral health centers and federally qualified health centers often contract with Alaska-licensed psychiatrists from the University of Washington and Children's Hospital to provide tele-psychiatry services); *Prescription without Physical Examination: Hearing on S.B. 98 Before the S. Comm. On Health & Social Services*, 29th Leg., 1st Sess. 8 (Alaska, April 13, 2015) (detailed minutes of hearing) (statement of Rebecca Ling, Director of Recovery Services, Cook Inlet Tribal Council) (testimony on "the success of tele-psychiatry service for behavioral health issues provided by physicians outside the state, but licensed in Alaska. She said the services have been provided by the University of Colorado for seven years.").

⁴² DHSS, Work Draft Review, SB 98, *supra* note 39, at 1 (emphasis in original).

⁴³ DIV. OF HEALTH CARE SERVICES, DEP'T OF HEALTH & SOCIAL SERVICES, ALASKA MEDICAID 2015 ANNUAL REPORT 43 (2016) [hereinafter , ALASKA MEDICAID 2015 ANNUAL REPORT] <http://dhss.alaska.gov/dhcs/Documents/PDF/Alaska-Medicaid-Annual-Report-SFY2015.pdf>.

⁴⁴ STATE OF ALASKA HEALTH CARE COMMISSION, TRANSFORMING HEALTH CARE IN ALASKA, ANNUAL REPORT OF THE ALASKA HEALTH CARE COMMISSION iv, 20 (2014) [hereinafter 2014 ANNUAL REPORT OF THE ALASKA HEALTH CARE COMMISSION], <http://dhss.alaska.gov/ahcc/Documents/2014Annual%20ReportFINAL.pdf>.

⁴⁵ COMMITTEE ON GEOGRAPHIC ADJUSTMENT FACTORS IN MEDICARE PAYMENT, INSTITUTE OF MEDICINE, GEOGRAPHIC ADJUSTMENT IN MEDICARE PAYMENT: PHASE II, IMPLICATIONS FOR ACCESS, QUALITY, AND EFFICIENCY 84 (Margaret Edmunds & Frank A. Sloan, Eds.) (2012), <http://iom.nationalacademies.org/Reports/2012/Geographic-Adjustment-in-Medicare-Payment-Phase-II.aspx>. *See also* Hilary Daniel & Lois Snyder Sulmasy, *Policy Recommendations to Guide the Use of Telemedicine in Primary Care Settings: An American College of Physicians Position Paper*, 163 ANN. INT. MED. 787 (2015) ("Research shows that telemedicine can potentially reduce costs, improve health outcomes, and increase access to primary and specialty care.").

⁴⁶ FTC Staff analysis of active physician (MD and DO) professional licenses from the Alaska Department of Commerce, Community, and Economic Development, Division of Corporations, Business & Professional Licensing (March 1, 2016), <https://www.commerce.alaska.gov/CBP/Main/SearchInfo.aspx>. *See also Prescription without Physical Examination: Hearing on S.B. 98 Before the S. Comm. On Health & Social Services*, 29th Leg., 1st Sess. 8 (Alaska, April 13, 2015) (detailed minutes of hearing) (statement of Alaska State Sen. Peter Micciche, sponsor of SB 98) (because ALASKA STAT. § 08.64.364 "does not allow stateside physicians to practice telemedicine across state lines, . . . the pool of physicians that can provide this service is greatly diminished").

⁴⁷ *See* ALASKA PHYSICIAN SUPPLY TASK FORCE, SECURING AN ADEQUATE NUMBER OF PHYSICIANS FOR ALASKA'S NEEDS 24 (Aug. 2006) (According to the State of Alaska Division of Occupational Licensing, 1501 physicians have Alaska addresses, but "[n]early 1,000 additional physicians (MD and DO) have active licenses to practice in Alaska but do not have Alaska addresses. These include physicians who work periodically as *locum tenens* practitioners, some who visit the state to provide specialty services on an itinerant basis, physicians licensed in Alaska in order to provide telemedicine consults for Alaska patients, others who may not visit on any regular basis, some who have left the state but maintain their license, and some who have obtained a license but decided not to practice in the state.").

⁴⁸ *See* Alaska Dept. of Commerce, Community and Economic Development, Fiscal Note 2 (Feb. 24, 2016), http://www.akleg.gov/basis/get_documents.asp?session=29&docid=51406 (SB 98 "would dramatically increase the number of applicants [for physician licensure], [and] the geographic reach of applicant licensure . . .").

⁴⁹ STATE OF ALASKA HEALTH CARE COMM'N, TRANSFORMING HEALTH CARE IN ALASKA, ANNUAL REPORT OF THE ALASKA HEALTH CARE COMMISSION iv,13 (2011) [hereinafter 2011 ANNUAL REPORT OF THE ALASKA HEALTH CARE COMMISSION], http://dhss.alaska.gov/ahcc/Documents/2011_report%201-15-12_final.pdf. *See also* FOSTER & GOLDSMITH, *supra* note 29, at 8 (Private insurance payments to doctors for a typical office visit are about 35% higher than the average payment in the rest of the U.S.); *Prescription without Physical Examination: Hearing on S.B. 98 Before the S. Comm. On Health & Social Services*, 29th Leg., 1st Sess. 8 (Alaska, April 13, 2015) (detailed minutes of hearing) (statement of Alaska State Sen. Peter Micciche, sponsor of SB 98) (Alaska's Dep't of Health &

Social Services “has been using stateside physicians for years to deliver health care via telemedicine to Alaskans at a far more reasonable rate and it has worked out very well”).

⁵⁰ 2011 ANNUAL REPORT OF THE ALASKA HEALTH CARE COMMISSION, *supra* note 49, at 14. The Report also explains that “Physician discounts are low in Alaska relative to the comparison states, an indication that physicians in Alaska have more market power relative to pricing.” *Id.* at 13. It also states that, “Alaska’s higher medical prices are due in part to higher operating costs for providers resulting from a higher cost of living, more costly employee benefits, transportation and shipping costs, fuel prices, and workforce shortages.” *Id.* at iv. *See also* FOSTER & GOLDSMITH, *supra* note 29, at 8 (the small markets in hundreds of Alaska communities “mean providers can’t take advantage of economies of scale and have limited competition. Those factors don’t entirely explain Alaska’s high health-care spending, but they help put it in context.”).

⁵¹ *See* ALASKA ADMIN. CODE tit. 7 §§ 110.620, 110.625, 110.630, 110.635, 110.639.

⁵² *Out-of-State Services*, ALASKA MED. ASSISTANCE HEALTH ENTERPRISE PORTAL, http://manuals.medicaidalaska.com/physician/general_program_info_section_iii/out_of_state_services.htm (last updated June 2012).

⁵³ Out-of-state costs may well be less. Alaska’s Medicaid costs per enrollee are the highest in the nation. *See* Henry J. Kaiser Family Found., Medicaid Spending per Enrollee (Full or Partial Benefit), FY2011, <http://kff.org/medicaid/state-indicator/medicaid-spending-per-enrollee/>.

⁵⁴ *See* Addendum D, Final CY 2016 Geographic Adjustment Factors (GAFs), CTRS. FOR MEDICARE & MEDICAID SERVS. (Nov. 2015), <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/CY2016-PFS-FC-Addenda.zip> (CMS-1631-FC, Revisions to Payment Policies under the Physician Fee Schedule). Thus, the GAF for Alaska is 129% of the average GAF for services provided anywhere in the United States. *See id.* Medicare’s Physician Fee Schedule and other payment systems use GAFs “to improve the accuracy of Medicare payments to providers in various areas of the country by accounting for the differences in prices for certain expenses (such as clinical and administrative staff salaries and benefits, rent, malpractice insurance, and other defined costs) from region to region.” COMMITTEE ON GEOGRAPHIC ADJUSTMENT FACTORS IN MEDICARE PAYMENT, INSTITUTE OF MEDICINE, GEOGRAPHIC ADJUSTMENT IN MEDICARE PAYMENT: PHASE I, IMPROVING ACCURACY 1 (Margaret Edmunds & Frank A. Sloan, Eds.) (2012), <http://www.nap.edu/catalog/13138/geographic-adjustment-in-medicare-payment-phase-i-improving-accuracy-second>.

⁵⁵ The GAF for covered telehealth services is based on the location of the provider, not the patient. *See* CTRS FOR MEDICARE & MEDICAID SERVS., MEDICARE CLAIMS PROCESSING MANUAL: CHAPTER 12: PHYSICIANS/NONPHYSICIAN PRACTITIONERS, sec. 190 (2015), <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf> (section on telehealth services, § 190.1, “payment for the professional service performed by the distant site practitioner (i.e., where the expert physician or practitioner is physically located at [the] time of telemedicine encounter) is equal to what would have been paid without the use of telemedicine;” § 190.6, “Claims for telehealth services are submitted to the contractors that process claims for the performing physician/practitioner’s service area.”).

⁵⁶ *See supra* note 49 and accompanying text.

⁵⁷ *See, e.g.*, Letter from Sheela Tallman, Premera, Blue Cross Blue Shield of Alaska, to Senator Peter Micciche, Alaska State Senate (April 12, 2015), http://www.akleg.gov/basis/get_documents.asp?session=29&docid=29143 (Premera launched a virtual care benefit in 2015); Letter from Henry DePhillips, Teladoc, to Senator Peter Micciche, Alaska State Senate (April 2, 2015), http://www.akleg.gov/basis/get_documents.asp?session=29&docid=51390.

⁵⁸ *See, e.g.*, AMERICAN TELEMEDICINE ASS’N, PRACTICE GUIDELINES FOR LIVE, ON DEMAND PRIMARY AND URGENT CARE 6 (2014), <http://www.americantelemed.org/docs/default-source/standards/primary-urgent-care-guidelines.pdf?sfvrsn=4> (covering “real-time, interactive technologies, including mobile devices,” but excluding instant messaging and email); Lori Uscher-Pines & Ateev Mehrotra, *Analysis of Teladoc Use Seems to Indicate Expanded Access to Care for Patients without Prior Connection to a Provider*, 33 HEALTH AFF. 258 (2014); Ateev Mehrotra et al., *A Comparison of Care at eVisits and Physician Office Visits for Sinusitis and Urinary Tract Infections*, 173 JAMA INT. MED. 72, 73 (2013).

⁵⁹ See, e.g., Mehrotra et al., *supra* note 58, at 73; Ateev Mehrotra, *The Convenience Revolution for Treatment of Low-Acuity Conditions*, 310 JAMA 35 (2013).

⁶⁰ See, e.g., Patrick T. Courneya, Kevin J. Palattao & Jason M. Gallagher, *HealthPartners' Online Clinic for Simple Conditions Delivers Savings of \$88 Per Episode and High Patient Approval*, 32 HEALTH AFF. 385, 386, 388-89 (2013); Daniel & Sulmasy, *supra* note 45, at App. 4 (“An e-visit typically costs approximately \$40 (vs. \$73 for an in-person visit”).

⁶¹ See, e.g., Uscher-Pines & Mehrotra, *supra* note 58, at 261 (study of CALPers enrollees offered the option of using Teladoc); Daniel & Sulmasy, *supra* note 45, at App. 4 (employers and insurance companies may reimburse direct-to-patient telemedicine services).

⁶² See, e.g., Patrick Brunett et al., *Use of voice and video internet technology as an alternative to in-person urgent care clinic visits*, 21 J. TELEMED. TELE CARE 219 (2015) (patient-initiated online Internet visits are an alternative to urgent and primary care). Cf. Uscher-Pines & Mehrotra, *supra* note 58, at 263 (Teladoc visits are highly likely to be less expensive than office visits and the emergency department, but “it is unclear to what extent Teladoc visits are substituting for office or ED visits and to what extent they represent new use of health care for conditions that would have resolved themselves without intervention.”).

⁶³ See ALASKA MEDICAID 2015 ANNUAL REPORT, *supra* note 43, at 43 (telehealth “brings more timely services to the patient when time is of the essence, it saves the patient the inconvenience of traveling to receive care, and it reduces Medicaid program travel expenditures..”)

⁶⁴ See, e.g., Innovations Exchange Team, Agency for Healthcare Research and Quality, U.S. Dep’t of Health & Human Services, *Telehealth Improves Access and Quality of Care for Alaska Natives*, <https://innovations.ahrq.gov/perspectives/telehealth-improves-access-and-quality-care-alaska-natives> (“Air travel, which is expensive and weather-dependent, is required for most village inhabitants to reach a clinic, health center, or hospital outside their village. Roads simply do not exist between most villages. Patients would typically fly on a small airplane to a regional location to connect with a jet airplane to fly to Anchorage to receive treatment . . .”).

⁶⁵ *Prescription without Physical Examination: Hearing on H.B. 281 Before the H. Comm. On Labor & Commerce*, 28th Leg., 2nd Sess. 38 (Mar. 17, 2014) (detailed minutes of hearing) (statement of Laura Brooks, Health Care Administrator, Department of Corrections), <http://www.akleg.gov/pdf/28/M/HL!C2014-03-171519.PDF>

⁶⁶ See ALASKA MEDICAID 2015 ANNUAL REPORT, *supra* note 43, at 43, 54, 56 (Alaska’s telehealth program “reduces Medicaid program travel expenditures.”). See also SECTION OF HEALTH PLANNING & SYSTEMS DEVELOPMENT, *supra* note 26, at 29, 30 (“It has been estimated that telehealth consultations eliminated the need to travel in 75% of patients involved in specialty consultations and 25% of patients involved in primary care.”); The Innovations Exchange Team, Agency for Healthcare Research and Quality, *supra* note 64 (estimate that the AFHCAN telehealth program “saved the state of Alaska \$8.5 million in travel costs for Medicaid patients”). States that receive federal Medicaid funds are required to ensure transportation for Medicaid beneficiaries to and from medical appointments. 42 C.F.R. § 431.53.

⁶⁷ See 2014 ANNUAL REPORT OF THE ALASKA HEALTH CARE COMMISSION, *supra* note 44, at iv, 12, 20-21.

⁶⁸ *Prescription without Physical Examination: Hearing on S.B. 98 Before the S. Comm. On Health & Social Services*, 29th Leg., 1st Sess. 8 (Alaska, April 13, 2015) (detailed minutes of hearing) (statement of Mike Haugen, Executive Director, Alaska State Medical Association). See also Letter from Michael Haugen, Executive Director, Alaska State Medical Association, to the Hon. Mia Costello, Alaska State Senate 1 (Feb. 25, 2016), http://www.akleg.gov/basis/get_documents.asp?session=29&docid=51405 (describing the requirement that the physician be located in Alaska as a “patient protection sidebar[]”).

⁶⁹ For example, Ketchikan is more than 1,600 miles from Anchorage by road, while Seattle is only about 1,100 miles from Ketchikan.

⁷⁰ See Letter from Michael Haugen, *supra* note 68, at 2 (“Alaska-based physicians will be better equipped to make appropriate referrals to local physicians than a physician based in the Lower 48.”).

⁷¹ As discussed above, some physicians licensed in Alaska but located out-of-state have previously worked in Alaska, and could have as much knowledge of local conditions as in-state practitioners. *See supra* note 47 and accompanying text.

⁷² S.B. 74, 29th Leg., 2nd Sess., sec. 3, § 08.64.101(6) (Alaska 2016) (FIN Committee Substitute, amended, March 11, 2016).

⁷³ Although we take no position on the telemedicine policies of the Federation of State Medical Boards (“FSMB”) and the American College of Physicians (“ACP”), we note that under both policies, a physician-patient relationship can be established during a telemedicine encounter. *See* FED’N OF STATE MEDICAL BOARDS, MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE 5 (2014), https://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/FSMB_Telemedicine_Policy.pdf (the physician-patient relationship to “be established using telemedicine technologies so long as the standard of care is met.”); Daniel & Sulmasy, *supra* note 45, at 788 (ACP takes the position that “a telemedicine encounter itself can establish a patient-physician relationship”). The FSMB policy also concluded that physicians using telemedicine may, in their professional discretion, recommend treatment and prescribe medications in the absence of a physical examination “in accordance with current standards of practice and . . . [with] the same professional accountability as prescriptions delivered during an encounter in person.” FSMB MODEL POLICY, *supra* at 8.

⁷⁴ S.B. 74, 29th Leg., 2nd Sess., sec. 1, § 08.29.400(c); sec. 2, § 08.63.210(d); sec. 6, § 08.86.204(d); sec. 7, § 08.95.050(c) (Alaska 2016) (FIN Committee Substitute, amended, March 11, 2016). Under current law, the only supervision requirements for behavioral health practitioners are during periods of supervised practice leading to full licensure. For two of the behavioral health practitioners, such supervision may be conducted remotely. *See* ALASKA ADMIN. CODE tit. 12, § 18.115(d) (clinical social workers) ALASKA STAT. §§ 08.29.110(a)(6), 08.29.490(2) (professional counselors). The legislature may wish to consider whether to expressly allow marital and family therapists, psychologists, and psychological associates to be supervised remotely when fulfilling requirements for full licensure. *See* ALASKA STAT. § 08.63.110(b)(1) (requiring direct supervision of marital and family therapists during supervised practice leading to full licensure); ALASKA ADMIN. CODE tit. 12, § 60.080 (supervised experience for psychologists and psychological associates).