

**TO:** The Federal Trade Commission

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**RE:** The Government's Role in Telemedicine

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**EXECUTIVE SUMMARY:**

Telemedicine plays an increasingly important role in the delivery of medicine in today's society, but its growth has been stymied by state medical licensure in some instances. This memo presents three recommendations for the Federal Trade Commission to consider when evaluating the future role that the government will play in regulating telemedicine. It may implement a federal mandate to restrict the use of telemedicine or use this same power to promote the use of telemedicine. Conversely, it may be in the best interest of the government to maintain state-based licensing, while promoting telemedicine in other ways.

**BACKGROUND:**

For better or worse, telemedicine has changed the face of healthcare in the United States and throughout the world. 13% of all intensive care unit beds are supported by telemedicine technology (Kvedar, Coye & Everett, 2014), while millions of Americans are receiving their primary care from telehealth providers (Gorton, 2008). These providers are not just confined to U.S. borders. In 2006, Indian telehealth providers made up 2% of the U.S healthcare market (McLean & Richards, 2006). By 2018 the market for telemedicine systems and software is expected to surpass \$2.5 billion (Finn, 2012).

This technological revolution in healthcare is not without necessity. The rising cost of healthcare, shortage of primary care doctors, population-wide increases in chronic illnesses and the baby boomers entering their "high maintenance health care years" are all very serious concerns (Kvedar et al., 2014). Therefore, it is critical that the medical community come up with innovative and cost-effective solutions to overcome these obstacles.

Despite the many benefits that telemedicine offers, there is also much cause for concern. For instance, provider video conferencing certainly expands access to care, but there are still those who question the quality of care that telemedicine patients receive (Kvedar et al., 2014). If the quality does turn out to be substandard, health systems that outsource provider services to countries like India, run the risk of assuming all medical malpractice liability (McLean & Richards, 2006). Lastly, at a time when over-the-counter pharmaceuticals are already dangerously over-prescribed, many in the medical community feel that we should limit, rather than expand, access to these prescriptions (Cotet & Benjamin, 2012).

It seems inevitable that the telemedicine industry will continue to grow, but it is still unclear what role the government will play in its development. While the Affordable Care Act may indirectly promote telemedicine by requiring coordinated payment and delivery across settings (Grabowski & O'Malley, 2014), much of the legislation regarding telemedicine is currently at the state level. Although many states are opening up to the idea of physicians practicing across borders, other states limit telemedicine reimbursements for Medicaid or Medicare to certain services or certain rural areas (American Telemedicine Association [ATA], 2014).

### **EVIDENCE:**

Research was conducted via PubMed, Google Scholar, Columbia University's Health Sciences Library, Scientific American, Bloomberg News, and the official websites of: The American Telemedicine Association, The American Medical Association and the Telehealth Resource Center.

### **PROBLEM:**

While telemedicine has largely been left to the states to regulate, the implementation of the Affordable Care Act has arguably elevated the status of telemedicine on the national policy agenda. Indicators such as the rising cost of healthcare, increases in the prevalence of chronic diseases and physician shortages have further pushed policy makers' attention towards telemedicine.

For example, one-quarter of Americans live in rural areas where chronic disease tends to be more prevalent and only 9% of physicians practice (Finn, 2012). For centuries these remote areas were medically underserved, but with the advent of telemedicine, they may now have remote access to care.

Feedback from various studies over the past decade has concluded that telemedicine offers a cost-effective solution to the "healthcare crisis." One study found that the home telemonitoring of congestive heart failure resulted in a 44% decrease in hospital admissions and over \$10 million in savings over a six-year period (Kvedar et al., 2014). Despite the proven success and cost savings of telemedicine, many health systems are disinclined to adopt it due to the upfront cost (Kvedar et al., 2014).

However, feedback also indicates that there are flaws within the telemedicine system, which may benefit from governmental regulation. Under current legislation, foreign telehealth providers not only make hospitals vulnerable to catastrophic medical malpractice suits, but also violate Medicare regulations by illegally diverting funds to foreign providers (McLean & Richards, 2006). On the domestic front, interstate commerce laws prevent telemedicine providers from treating across some state lines (ATA, 2014).

The ACA has helped to define access to care and the rising cost of healthcare as problems that the government should fix. Therefore, if telemedicine is the most viable solution to these critical problems, then the federal government may have to promote its use through incentives, while protecting patients and providers through regulation.

### **POLICY OPTIONS:**

## **Federal Mandate Overseen by FTC to Restrict Use of Telemedicine**

The federal government may have the authority to regulate telehealth under the Commerce Clause of the Constitution, which limits the states ability to prevent interstate trade, including the practice of healthcare (Telehealth Resource Center). If this interpretation stands, then the federal government may choose to use this power to restrict the use of telemedicine in the following ways:

Teleradiology and other consultation services should be limited to the Domestic and “Nighthawk” models. This would assure patients that their physician was licensed in the U.S. and providers would not have to fear a crippling malpractice suit. Such a mandate would be in compliance with Medicare regulations (McLean, 2006).

The proscribing of over-the-counter medications should be prohibited without a prior physical examination (Cotet & Benjamin, 2012). In 2013 there were over 15,000 deaths attributed to prescription painkillers (Jacobson, 2013). Many prescription drug abusers gain access to medication through “doctor shopping” (Jacobson, 2013). Telemedicine could foreseeably make it even easier for such prescription drug abusers to access multiple prescriptions (Cotet & Benjamin, 2012).

The unnecessary prescription of antibiotics is also a serious threat that has caused many strains of antibiotics to become resistant. The Centers for Disease Control estimates that antibiotic resistance was responsible for over 23,000 deaths and \$20 billion in excess direct healthcare costs last year (Srinivasan, 2014). Many of the leading telemedicine provider services prescribe antibiotics without a prior in-person physical examination and without a follow-up examination to ensure that the patient appropriately complied with treatment (Uscher-Pines & Mehrota, 2014)

However, to entirely eliminate these practices would result in the termination of access to care for millions of Americans. Contracting with foreign radiologists and other specialists is the only way that many hospitals can afford these services. Without the “Indian Model” many hospitals would lose their accreditation status, and Americans living in remote communities would be forced to travel great distances for a consultation (McLean & Richards, 2006).

While the over-prescription of medication is a serious concern, to not electronically proscribe certain live-saving medications may result in preventable deaths. In one study, the physician examination requirement led to a 1% increase in mortality and an 18% increase in days lost each month to illness (Cotet & Benjamin, 2012).

## **Federal Mandate to Promote Use of Telemedicine**

As previously stated, the federal government may have authority to regulate telemedicine through the Commerce Clause. However, rather than use this power to restrict the reach of telemedicine, it should cautiously expand it.

The Federal Trade Commission estimates that telemedicine will lower the cost of care through increased price competition (McLean & Richards, 2006) and many studies have shown that telemedicine decreases health spending by lowering readmission rates (Kvedar et al., 2014). Given the shortage of physicians, rises in

chronic disease and millions of newly enrolled Americans looking for healthcare services, the government must sponsor cost-efficient solutions such as telemedicine.

While more research should be done on the quality of care that telemedicine patients receive, recent studies show that ICU care provided by remote intensivists decreased mortality by upwards of 20% (Kvedar et al., 2014). Other studies have concluded that interactive video conferencing with physicians results in faster problem resolution and “very high” quality of care (Kvedar et al., 2014).

Without incentives from the federal government, many health systems will choose not to adopt telemedicine (Grabowski & O’Malley, 2014). Many physicians remain resistant to the practice of telemedicine and although video conferencing equipment may be priced as low as \$5,000 per unit, this expense still impedes some health systems from buying in (Finn, 2012). Therefore, it is suggested that the government offer financial incentives to remote health systems that could benefit from the use of telemedicine services.

If the government is willing to alter its current Medicare regulations, it will be safer for hospitals to contract with international providers, as the government may list which foreign accreditations are reliable. Furthermore, the risk of overprescribing medication may also be regulated in a centralized system, which monitors patients and providers for questionable prescription practices (Jacobson, 2013).

While federal promotions are desirable, one substantial disadvantage would be the infeasibility of taking authority over health maintenance away from the states. Under Article 10 of the Constitution, states have the authority to regulate activities that affect health. Therefore, any substantial shift in power would likely result in many years of debate and a Supreme Court hearing.

### **Continue With State-Based Regulation While Promoting a National Standard**

It may be argued that state medical licensure requirements should be maintained. Cases of fraudulent and incompetent practitioners have increased over the past two decades (American Medical Association [AMA], 2014) and states are entitled to choose whether or not to allow out-of-state telemedicine providers to offer services to their residents. Many states have gradually decided to embrace telemedicine practice and many more may elect to do so as more conclusive evidence on the effectiveness of telemedicine emerges (ATA, 2014).

However, the federal government may also promote the use of telemedicine for all reasons aforementioned by setting national standards through Medicaid, Medicare and the Affordable Care Act. The ACA is currently offering financial incentives to providers that form Accountable Care Organizations, Managed Care services and Integrated Care Demonstrations (Grabowski & O’Malley, 2014). Not only will coordinating services make telemedicine options more affordable for a collective group of providers, but the health system will have a financial incentive to invest in telemedicine technology if it will result in higher reimbursements.

In addition to financial incentives, the federal government has further jurisdiction over Medicare and Medicare programs and can require specific standards of practice. Such standards may specifically include the use of telemedicine services to promote efficiency (Telehealth Resource Centers).

The federal government may also establish laws that affect specific health and safety concerns (Telehealth Resource Centers). For example, the National All Schedules Prescription Electronic Reporting Act (NASPER) required states to report their prescription drug statistics and flag patients and providers who have a suspicious prescription drug history (Jacobson, 2013). Such a measure is both within the current scope of the federal government and has resulted in reductions in abuse practices (Jacobson, 2013). A similar act may be implemented to enforce better practice in global telemedicine.

The disadvantage of this recommendation is that the adoption of telemedicine across the country may take years. At a time when improved access to care is critical and cost-saving solutions are in high demand, the government may not be willing to wait for each state to embrace telemedicine on its own.

#### **RECOMMENDATION:**

#### **Continue With State-Based Regulation, While Promoting a National Standard**

To maintain state based regulation of telemedicine, while promoting a national standard of its use, is the most feasible option. State governments have extensive experience with medical licensure, and states such as Hawaii, Indiana, Maryland and New Jersey are already working towards reimbursement flexibility for telemedicine providers (ATA, 2014). While this option may not mandate the utilization of telemedicine, it responsibly develops its use by promoting and incentivizing a national standard. To increase access while decreasing the cost of care, the United States must adopt a solution that studies have shown to be effective—telemedicine.

It is recommended that the FTC offer the states suggestions towards expanding their use of telemedicine and recommend that Congress reenact NASPER and promote telemedicine through the ACA, Medicaid and Medicare.

#### **WORKCITED**

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