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Policy Memo

Report of Telemedicine Trends, Regulation and Consumer Protection

Subject: Telemedicine: Current uses, and legal barriers to widespread adoption in the healthcare system

Summary:

The passage of the Affordable Care Act in 2010 ushered in a new era of healthcare in the United States. The law enacted a series of reforms to reduce healthcare spending and improve access to care. Many experts view telemedicine (which in this report will also be referred to as "telehealth") as a solution to both access and cost issues. There are still a number of barriers to the adoption of telehealth technology. This report provides a background on the current and projected use of telemedicine, issues with adoption and implementation of this technology. It concludes with a number policy solutions to address concerns about the role of competition in the changing healthcare technology industry.

Background:

There are discrepancies among different organizations about what qualifies as telemedicine. According to the American Telemedicine Association, "telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status."[1] Federal and State regulatory entities have yet to agree on a common definition. For example, Centers For Medicare and Medicaid Services (CMS) exclude contact by phone, email or fax as

telehealth practice, including only "two-way, real-time interactive communication between the patient and distant site physician."[2] It has been used in various forms for over 50 years in the healthcare industry, however, the rise in technology lead to a refocusing among telehealth experts on ways it can be used in medical care. It was originally used to increase access for rural populations by reducing informational distance between the patient and physician, but many of the efforts failed to get widely implemented.[3] Proponents of the technology state that it benefits patients by improving access, and reducing overall healthcare costs by decreasing follow-up visits, emergency room use, and decreasing administrative burden. There are drawbacks to telehealth technology, particularly issues of licensure, reimbursement policy and malpractice insurance. According to a study by Deloitte, only 18% of primary care physicians in the United States reported using telemedicine for follow-up with patients.[4]

The passage of the Patient Protection and Affordable Care Act ("ACA") revived discussion on use of telemedicine to cut costs and increase patient access to care. Telehealth is anticipated to grow from a $240 million to a $1.9 billion industry by 2018, an average 56% growth rate per year. Movement from fee-for-service and the rise of Accountable Care Organizations (ACOs) that incentivize providers to improve quality and reduce costs will drive the increase in telemedicine.[5]

Evidence:

Research for the document included an extensive literature review of current and historical uses of telemedicine, as well as the ACA provisions on cost reduction and

access promotion. The problem definition and policy solution sections also incorporate legal analysis of malpractice insurance policy for telemedicine. Forms of media included peer reviewed journal articles, newspaper articles, internal memos and guidelines. Search engines used were: Google Scholar, Google Search, EBSCOhost, JSTOR, and PubMed. Search terms include: "Telehealth/medicine History", "Telehealth/medicine Evaluation," "Telehealth/Medicine malpractice", "Telehealth/medicine malpractice insurance."

Problem:

Despite promise to improve access to care while reducing healthcare costs, there are a number of barriers preventing telemedicine from being widely adopted. The field faces problems with parity in reimbursement, licensure and scope of practice discrepancies, and legal and regulatory issues. Reimbursement is cited as the greatest barrier to widespread telemedicine use. However, there have been a number of policies enacted on ameliorating this problem. CMS revised and expanded the physician fee schedule under Medicare in FY 2014 to include more telehealth services.[6] Reimbursement issues reflect the fragmentation of the US healthcare system in general, since Medicare, Medicaid, and private insurers each have different payment policies for health services.

Specifically concerning to consumers of telehealth (i.e. patients) are legal and regulatory issues, particularly disparate malpractice standards for telehealth services. Medical Malpractice in the United States is defined as; "any act or omission by a physician during treatment of a patient that deviates from accepted norms of

practice in the medical community and causes an injury to the patient."[7] To demonstrate malpractice, the injured patient (plaintiff) must prove that (1) there was a professional duty owed to the patient, (2) duty was breached; (3) medical harm caused the breach; (4) resulting damages.[6] Malpractice laws are determined by states, and as such, physicians practicing in different states are subject to different laws. There is little case law regarding scope of practice, qualification of a patient-provider relationship, liability, and geographic location of the practitioner compared to the patient. HAGESETH v. Superior Court, in the 1st district Court of Appeals in California demonstrates the legal ambiguity for telehealth, and the tragic consequences of a non-uniform system.

The "patient", a resident of California, filled an online order form for Prozac, on an international website. The site forwarded the patient's information to a processing company located in both Florida and Texas. The processing company sent the information to a "physician subcontractor" in Colorado, who approved the request for Prozac. The prescription was filled in Mississippi, and shipped to California. The patient died several weeks later, and both alcohol and Prozac were found in his system post-mortem. The plaintiff alleges that the practitioner committed a felony by practicing medicine in CA, without a license to do so by signing off on the online prescription.[8]

This case represents a number of problems with malpractice and telemedicine. First, telemedicine can be practiced across state lines, and malpractice is under the jurisdiction of individual states. Second, there is a disincentive for physicians to practice telemedicine for fear of being sued, and many malpractice insurance plans do not cover telemedicine, leading to licensure issues. Third, standard of care issues exist depending on where the physician practices, and the patient lives.[2] Altering current malpractice standards for telemedicine will have dual benefits, first

incentivizing more physicians to take part in telehealth services and second offering patients greater protection.

Policy Options:

1. **Tort Reforms to protect physicians practicing telemedicine from trivial lawsuits, which will promote further adoption of telehealth services.**

Malpractice is the fastest growing area in tort costs, averaging an 11.7% increase per year since 1975.[9] As an expanding field, particularly after the passage of the ACA, telemedicine is an easier target for lawsuits. According to a brief from New York Law School, "Traditionally in tort cases, an important jurisdictional determination is where a tort occurred. Telemedicine complicates this determination because the doctor and patient are physically separated." Policymakers should consider laws that create uniform standards of care, or a set policy, i.e. the home state of the patient controls malpractice litigation. Currently, there are some initiatives to clarify the legal ambiguity over malpractice in telemedicine. Some states have already defined the state of the patient as the location of the "telemedicine act," a number of states has also generated telemedicine specific malpractice statutes. These efforts reduce some of the legal information asymmetry for physicians.[2] Telemedicine is a growing field, and updating malpractice laws will reduce barriers to entry to the telemedicine market for physicians as well as provide a standard for victim's of malpractice. There are a number of special interest groups, including physicians and nurses groups who support malpractice reform. However, malpractice reform is also politically contentious congress.

2. **Change Licensure so physicians can practice telemedicine in multiple states, but are still restricted to clinical ("face to face") medicine in their home state.**

HAGESETH vs. Superior Court demonstrated the legal obscurity with geographical location and practice. A physician must notify his or her medical liability insurer as to where the patient receives care. If a physician does not comply, he or she could be denied liability coverage in a lawsuit, and face penalty for practicing medicine in a state without a license.[10] There are a number of solutions that benefit both patients and physicians. First, lowering the licensure fee for the practice of interstate medicine lowers market barriers to entry into for physicians. It also mitigates interstate malpractice issues, provided the physician practice electronically in states in which he or she is qualified. Second, creating special licensure for telemedicine that would alter the scope of practice, and create a unified standard procedure/protocol for interstate telehealth practitioners. This also benefits patients if they want to see physicians out of state electronically. The final option is a "consultation exemption" for out-of-state physicians who can give second-opinions, or supplement typical medical care.[2] Decreasing the burdensome licensure process will induce providers, such as ACOs to enter the telemedicine market. This decreases costs for patients by expanding the market, and ensuring competitive pricing for telehealth services.

3. **Status Quo: Allow present telemedicine malpractices to continue and wait for more cases to establish legal precedent for practice.**

There is potential that the rising prevalence of Telemedicine will not lead to an increase in malpractice cases. Many medical negligence cases already concern parties from multiple states, so the interstate malpractice field is not new to telemedicine.[11] This option also allows for provider freedom in choosing a course of action. For example, a hospital network may choose to give a telemedicine consent form. Physicians can sign up for medical liability insurance plans that protect against malpractice in telemedicine. This option does little to advance the field, protect patient quality or access. It is politically feasible because it requires little action, but it does not benefit patients since telemedicine providers will be limited, and reimbursement rates are disparate.

Recommendation:

Policymakers have discussed tort reform as a way to decrease healthcare costs. Continuing on this trend, and including telehealth services within the broader context of malpractice will have a number of benefits for patients, providers and payers. This issue is highly politicized since actors want to protect quality of care, state's rights, and also promote competition. Though the protection of state jurisdiction over medical malpractice is critical, for telehealth services, a unified standard of care, and definition of "duty to patient" will reduce parity between states in litigious issues. Advocating for malpractice reform engages a number of stakeholders including state and federal officials, physician groups, Attorneys, payers and patient rights groups. Coalescing these stakeholders to generate a comprehensive reform package will ensure quality delivering health services. As the healthcare technology and communications field expands, and as new trends of

quality assurance and cost reduction converge, telemedicine offers a promising opportunity to improve patient's health and wellness.

Citations

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