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First, do no digital harm: Regulating telemedicine

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Telemedicine, whereby physicians use email, phone, text, or video for prescribing and consultations, is growing rapidly. Seeking to encourage faster uptake of telemedicine, many well-intentioned parties are prodding Congress to take actions which will likely have harmful unintended consequences.

So far, Congress has done well. With respect to regulating actual devices, the 21st Century Cures Act, passed by the House in 2015 with overwhelming bipartisan support, is forward thinking. If passed into law, the policies it would implement would lead to a responsible and responsive regulatory environment for mobile health apps.

However, there are other areas in which a Congressional take-over would do more harm than good. In recent testimony to the House Energy & Commerce Committee's Subcomittee on Commerce, Manufacturing and Trade, I encouraged Congress to *First, Do No Digital Harm*. Two of the most important areas of risk are federal interference in the practice of medicine and how Medicare pays for telemedicine.

State Licensing of Physicians. Historically, the practice of medicine has been regulated by the states. As telehealth has emerged, this has led some interested parties to conclude state licensing is (to some degree) obsolete. If technology permits a radiologist in Texas to read an image of a patient taken in any state, should that radiologist have to be licensed in every state? A short cut to solve this problem would appear to be to legislate a federal "safe harbor" for Medicare patients.

Writing in the *Wall Street Journal*, Professor Shirley Svorny of California State University, Northridge, and the Cato Institute argues that Congress should use the power granted by the U.S. Constitution\'s Commerce Clause to pre-empt states' historical power to regulate physicians\' scope of practice ("Telemedicine Runs Into Crony Doctoring" *Wall Street Journal*, July 22, 2016).

Professor Svorny urges Congress to legislate interstate portability of licensure. The state where a physician practices, not where the patient stands (or sits or lies) would be the locus of regulatory control. That is, Idaho would lose its sovereign power to regulate New York-licensed physicians delivering telemedicine to Idaho patients. This would not actually increase liberty. In the vignette

described above, Congress would take away the sovereign power of the Idaho legislature and give it to the New York legislature! It makes for a confounded federalism.

Could Congress really limit itself to legislating portability of physician licensure? At least one other issue would (legitimately) have to be brought into the mix: Medical malpractice, which is governed by state law. Once such a bill had made it through the countless hours of committee hearings and amendments require to pass any law, we would likely end up with a law a few hundred pages long that would require a new federal agency to administer and regulate.

Further, states appear to be addressing the problem. The American Telemedicine Association (ATA) produces a 50-state survey of telemedicine regulation. In its 2016 edition, it noted "twenty states averaged the highest composite grade suggesting a supportive policy landscape that accommodates telemedicine adoption and usage." Although the trend is not uniformly positive, it is better to allow states to adopt, adapt, and improve appropriate regulations while learning from each other.

Further, the Federation of State Medical Boards has established an Interstate Medical Licensure Compact. This approach preserves state sovereignty by allowing physicians licensed in any state belonging to the compact to practice in all states. Professor Svorny dismisses the compact. Nevertheless, it now has 17 states signed up, and legislation pending in nine more.

Medicare Payment for Telemedicine. "Parity" refers to having the same coverage for a medical service whether delivered in person or via telemedicine. Unfortunately, the notion of "parity" which governs advocacy for telemedicine reimbursement will not lead to cost reductions. There is little doubt telemedicine can often be delivered at significantly lower cost than in-person visits. However, just adding a bunch more billing codes to current list of Soviet-style administered prices is unlikely to save Medicare money.

Instead, Medicare must give up its futile efforts to determine fees for every single procedure a physician executes, whether in person or remotely. Instead, the rapid adoption of telemedicine should be exploited for opportunities where taxpayers, patients, and providers are all rewarded for reducing costs below those determined in the current system.

U.S. health care is in dire need of disruption. Success will be determined as much by what Congress restrains from doing, as much as what it does.