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Telemedicine… across state borders

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Telemedicine is changing the way health care is delivered. Perhaps the fastest growing component is direct-to-consumer care. Already, half of all encounters at innovation-minded Kaiser Permanente (an HMO health care insurer serving nine states) make use of some sort of telecommunications technology. Two-way video provides access in underserved rural areas, saving trips to urban facilities and keeping rural hospitals in business. Telemedicine is used in hospitals when access to prompt care is critical and also offers a fix for facilities short on specialists willing to serve on call.

Given concerns about access to care, you might expect state regulators to do everything possible to move telemedicine forward. But you'd be wrong. Although it's legal for a patient who lives in Wyoming to fly to Chicago to obtain care from an Illinois-licensed physician, state laws preclude the same patient-physician encounter, via telemedicine, unless the physician has secured a license to practice medicine in Wyoming. In fact, to participate in a national telemedicine practice, a physician would need a slew of state licenses.

The most obvious problem here, of course, is all the paperwork and fees required to practice medicine in multiple states. But the barriers are, in fact, more daunting because clinical practice standards and continuing medical education requirements vary by state.

These requirements discourage physician participation in interstate telemedicine, reducing access to care and competition that would lower prices. They reduce opportunities for physicians to gain experience by managing a large number of similar cases – a big deal in light of the consensus that repetition is key to improving patient outcomes. And they may deny access to care altogether for rare pathologies that only a handful of physicians across the country are qualified to diagnose and treat, and for which the patients themselves are too sick or too poor to hop on a plane.

Pulling back state-level regulation to create a national market has lowered prices and improved services in other industries; it could be expected to do as much for health care consumers.

The Nuclear Option

Pressures levied on state legislators by special interest groups that benefit from the existing regulatory environment make reform illusive. The alternatives? If it were up to me, I

would eliminate state licensing altogether. If that seems over the top, give me a minute to convince you.

Most people don't know that, in practice, state boards do not define or limit what physicians are allowed to do. State boards frequently fail to sanctionmalfeasant physicians. Moreover, physicians with drug and alcohol problems or those who have engaged in sexual misconduct are typically allowed to continue in practice while in treatment.

So who's really minding the store? As a practical matter, the constraints on physicians' behavior are really determined by other health care parties that have a stake in the outcome of treatment including hospitals, physician groups, insurance companies that include physicians in their networks and medical liability insurers.

I would shift the investigative function of the state medical boards to agencies already involved in criminal prosecution of physician misconduct. Indeed, it has already been considered in one bellwether state: in 2013, California lawmakers proposed shifting misconduct investigations to the office of the state attorney general.

Beyond facilitating interstate telemedicine, eliminating state licensing would allow innovation in the structure of health care. Providers would no longer be restricted to the one-size-fits-all definition of medical education set by the Liaison Committee on Medical Education, which all states accept as the arbiter of what constitutes adequate training. The Liaison Committee is run by the American Medical Association and the Association of American Medical Colleges, two organizations that benefit from restricting competitive entry and that are inclined to protect the status quo. Note, moreover, that without the LCME, the incentives to assure patient protection on the part of other liable market participants would remain.

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Plans B and C

A second option would be for states to adopt agreements that made licenses portable across states. There has been some movement in this direction – but not much. Despite its name, the Interstate Medical Licensure Compact (which covers 22 states) does not facilitate practice across states on the basis of one's home state license. The Compact only aims to expedite the initial issuance of multiple state licenses.

A third option would be for individual states to act unilaterally on behalf of consumers, opening their borders to physicians licensed in other states. In fact, in 2016 the Florida House of Representatives did pass a bill that included a provision to allow out-of-state physicians to practice via telemedicine in Florida. The lawmakers were apparently keen on making the state a

more attractive vacation venue by giving the million or so snowbirds (many of them seniors) access to their home-state caregivers. But the bill did not survive lobbying in the Florida Senate.

Feds to the Rescue?

While I am generally inclined to give states maximum leeway in making policy for their residents, there are some cases (like school desegregation) in which federal preemption makes sense. And legal scholars suggest that federal action to promote interstate telemedicine is justified based on the Commerce Clause of the U.S. Constitution.

One federal option would be for Washington to go into the business of licensing telemedicine providers. But there is a glaring drawback: a federal licensing agency, like the state medical boards, would be subject to special interest lobbying that would likely result in restrictive regulations that served as barriers to market entry.

The other federal option finesses this problem. Congress could pass a law defining the location of the practice of medicine as the location of the physician. Doctors would rely on their home-state license to practice in multiple states. This was proposed for Medicare patients in the Telehealth Promotion Act of 2012 (H.R. 6719), but pushback from opponents led lawmakers to focus on issues related to telemedicine reimbursement. Currently, the Veterans Administration is moving to allow its physicians to treat veterans via telemedicine in any location in the country without securing additional state licenses.

There is solid precedent for this approach: certification when it comes to hospital privileging and credentialing of physicians. A 2011 ruling by the federal Centers for Medicare and Medicaid allows hospitals on the receiving end of telemedicine services to rely on the physician privileging and credentialing efforts of the hospital at which the telemedicine doctor is located.

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Probably the best reason to believe that interstate telemedicine will prevail sooner rather than later is the growing demand for services, largely driven by population aging and the growth of federal funding of state Medicaid programs. What's more, the innovation serves the interests of most of the stakeholders in the industry: insurers, employers, patients, Washington – and, for that matter, physicians who wish to extend the reach of their

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