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Bring down barriers to interstate telemedicine

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The COVID-19 pandemic has created a natural experiment for telemedicine as patients have chosen the service over in-person appointments.

Many governors waived restrictions on cross-state practice, concerned that a heavy load of COVID patients would require access to additional clinicians. Yet we should not overlook that, even during normal times, telemedicine serves a multitude of functions.

In particular, interstate telemedicine—in which physicians serve patients in other states—can facilitate access to care for patients with rare medical problems and to those in underserved parts of the country. It can increase competition across the country, make providers more responsive to patients and help to control healthcare costs. But a current barrier to interstate telemedicine is that physicians must be licensed in every state in which they practice.

To remedy this restriction, Congress could define the location of the practice of medicine as that of the physician. Obtaining care from a physician in another state via telemedicine would be like traveling to that state for care. The physician's home state license would suffice.

Yet in the wake of the pandemic, recommendations by major telemedicine advocates fail to mention this option. Instead, to facilitate cross-state telemedicine, the recommendations focus on state action. Two groups, the eHEALTH INITIATIVE'S COVID-19 Federal Policy Work Group and the Alliance for Connected Care recommend state participation in interstate licensing compacts that incorporate mutual recognition of state medical licenses. And the Taskforce on Telehealth Policy suggests licensure reciprocity between states.

The problem is that states have failed to move in this direction. The lack of interest in reciprocity or mutual recognition reflects the fact that each state uses licensing to protect its own physicians from competition. Blocking competition hurts consumers through higher costs and lower quality. But state legislators do not have an incentive to solve it. They face pressures from concentrated interests – typically those of physicians – and there is no one to speak for the in-state consumers who would benefit from access to interstate telemedicine. It doesn't help that state medical boards benefit from the current system; they collect revenues from physicians who seek licenses in multiple states.

The existing Interstate Medical Licensure Compact offers a coordinated process to obtain licenses in multiple states. The Compact does not, however, eliminate the requirement that physicians be licensed in every state in which they treat patients. The high cost of maintaining multiple licenses discourages physicians from offering services in other states.

The recommendations put forth by the aforementioned groups ultimately get low marks for focusing on reciprocity, mutual recognition, and the Interstate Medical Licensure Compact rather than congressional action to define the location of the practice of medicine as that of the physician.

State licensing is much ado about nothing when it comes to concerns about cross-state practice. State medical boards cannot assure a high standard of care, they do not review physicians on a regular basis, nor do they evaluate clinicians at the point of care.

It is provider liability that results in oversight that protects consumers, and even that is imperfect. Before they employ or associate with individual physicians, providers confirm the training, knowledge and skills needed to take on relevant tasks. They review any sanctions and malpractice claims. It's called credentialing and privileging. Medical professional liability insurance companies consider the same information and deny problem physicians malpractice insurance or limit their practice. (Where physician liability has been stripped by federal regulations, with adverse impacts, as on an Indian Reservation, liability should be imposed.)

Action by Congress to define the location of the practice of medicine as that of the physician would give patients access to specialty care, as for a rare cancer, and access to care in underserved, often rural areas, without traveling long distances. Really, all patients and payors will benefit from increased access to care. And there is evidence that consolidation among providers has reduced competition. Interstate license portability could add needed competition in these markets, making providers more receptive to patient preferences.

The "father of telemedicine," Jay Sanders, got it right in 1994 when he testified, "perhaps the most logical way to deal with state licensure requirements is to determine that the patient is, in fact, being 'electronically transported' to the physician rather than the physician being transported to the patient." Congressional action to define the location of practice as that of the physician would achieve that end.

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