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Socially Distant Health Care

Allyson E. Gold,[*] Alicia Gilbert,[†]
and Benjamin J. McMichael[‡]

The COVID-19 pandemic has elucidated many problems within the American health care system, chief among them the continuing access-to-care issue. Though the Affordable Care Act increased access to health insurance, the current pandemic has demonstrated that health insurance alone is not enough. Communities need access to health care providers. Indeed, many fully insured Americans across the country are experiencing what many have faced on a daily basis: the inability to access a health care provider. Rural areas and communities of color regularly battle an inability to obtain care from health care professionals and have done so for many years.

Much of the care demanded during the pandemic related to COVID-19 itself, but the pandemic also created access-to-care problems due to quarantines and shut-downs instituted to slow its spread. These measures have prevented millions from receiving necessary care for chronic diseases, simple injuries, and mental health needs, among others. Despite the tragic consequences of the COVID-19 pandemic, one of the bright spots has been state and federal responses designed to increase access to health care providers. One of the most important mechanisms that governments have employed to increase access to care has been telehealth. Though telehealth has been possible for decades, the federal government and many state governments maintain salient legal barriers to its use.

Congress recently considered the Protecting Access to Post-COVID-19 Telehealth Act of 2021, which seeks to remove some barriers to accessing telehealth. Against this backdrop of political hunger for continued improvement in telehealth access, this Article explores the policy experimentation catalyzed by the COVID-19 pandemic to make specific policy prescriptions aimed at alleviating both acute and chronic access-to-care issues. It argues that, following the pandemic, federal agencies and states should continue to dismantle barriers to telehealth as an important tool for increasing access to health care providers among residents of rural areas and communities of color that have historically lacked reliable access to providers. Importantly, governments at both levels should make permanent many of the temporary policies they have instituted to improve access to telehealth and, therefore, health care more generally.

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I. INTRODUCTION

Before 2020, few patients or doctors would have considered surgery prior to an in-person consultation. But for Fred Thomas and his doctor, meeting "for the first time a few minutes before he operated" felt comfortable following several video and phone appointments.[1] These telehealth appointments allowed Mr. Thomas to meet with an orthopedic specialist to discuss his neck and arm pain, culminating in a diagnosis and recommendation for surgical treatment.[2] In addition to successfully treating his underlying health issues, the use of telehealth eliminated the need for Mr. Thomas to make multiple day-long trips to

1. Sarah Gantz, *Coronavirus Has Forced Doctors, Insurers to Embrace Telemedicine Like Never Before*, PHILA. INQUIRER (July 2, 2020) (internal quotations omitted), https://www.inquirer.com/health/coronavirus/coronavirus-telemedicine-embraced-doctors-insurers-future-health-care-20200702.html [https://perma.cc/56M4-ZVLG].
2. *Id.*

see a specialist, saving him time and transportation costs, while also reducing the risk of exposure to COVID-19.[3]

Mr. Thomas is not an anomaly.[4] As the pandemic forced hospitals and health care providers to suspend services and discontinue in-person treatment, many fully insured patients across the country were unable to access regular care for the first time. Suddenly, those who previously had readily available access to care had to do without. Responding to these challenges has spurred exponential growth in telehealth. In February 2020, before the World Health Organization declared COVID-19 a pandemic,[5] less than 1% of Medicare primary care visits were provided using telehealth; by April 2020, nearly half of such visits were conducted virtually.[6] As one health care analyst noted, "[i]t's fair to say that tele[health] was in its infancy before the pandemic, but it's come of age."[7] The drastic increase in telehealth usage is the result of amendments to federal and state laws governing the practice.

At the federal level, three major changes facilitated the expansion of telehealth. First, the Department of Health and Human Services (HHS) and Office of Civil Rights (OCR) relaxed the rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA),[8] affecting which health care delivery modalities could be used to provide care. Whereas before the pandemic, complying with HIPAA forced health care providers to use complicated health care-specific

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3. *Id.*

4. *See, e.g.*, Shari Rudavsky, *The Doctor May Be In, But the Patient is at Home: COVID-19 Spurs Telemedicine*, INDIANAPOLIS STAR (Dec. 29, 2020, 5:00 AM), https://www.indystar.com/story/news/health/2020/12/29/telemedicine-indiana-covid-19-spurs-virtual-doctor-visits/3932227001/ [https://perma.cc/M85Z-RNMD] (describing Tom Watson, a patient who utilized telehealth to meet with his endocrinologist).

5. Tedros Adhanom Ghebreyesus, Director-General, World Health Org., WHO Director-General's Opening Remarks at the Media Briefing on COVID-19 (March 11, 2020), https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at|-the-media-briefing-on-covid-19---11-march-2020 [https://perma.cc/VH7R-NVPW].

6. Assistant Secretary for Planning and Evaluation, *Medicare Beneficiary Use of Telehealth Visits: Early Data from the Start of the COVID-19 Pandemic*, U.S. DEP'T OF HEALTH & HUM. SERVS. (July 28, 2020), https://www.aspe.hhs.gov/sites/default/files/migrated_legacy_files//198331/hp-issue-brief-medicare-telehealth.pdf [https://perma.cc/JM77-BHGZ].

7. Associated Press, *Fad or Future? Telehealth Expansion Eyed Beyond Pandemic*, L.A. TIMES (Aug. 30, 2020, 4:36 AM), https://www.latimes.com/world-nation/story/2020-08-30/fad-or-future-telehealth-expansion-eyed-beyond-pandemic [https://perma.cc/GW69-BRBB].

8. U.S. Off. for C.R., *Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency*, U.S. DEP'T OF HEALTH & HUM. SERVS. (Jan. 20, 2021), https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html [https://perma.cc/Y9B8-TVP7].

applications, the HHS and OCR changes permitted the use of familiar, easily accessible programs like Apple FaceTime, Skype, and Zoom. Second, the Centers for Medicare & Medicaid Services (CMS) amended their regulations to pay for telehealth services that were previously excluded from reimbursement.[9] Third, the Department of Drug Enforcement Administration (DEA) relaxed a statutory requirement that previously mandated that patients meet with a health care provider in-person for a medical examination prior to receiving a scheduled prescription drug.[10] Following the lead of the federal government, many states issued temporary relaxations to telehealth requirements through gubernatorial executive orders.[11]

These pandemic-induced changes to federal and state law created a mechanism for continuity of care while mitigating the risk of exposure to COVID-19, but the pandemic need not limit the role of telehealth. In some instances, telehealth offers a benefit to health care providers that a traditional patient exam room cannot match: the ability to "assess a patient's living conditions and determine how they help or hinder the patient's health problem."[12]

Moreover, virtual health care delivery can overcome barriers that have historically contributed to health disparities in rural areas and among patient populations of color. For these communities, barriers to health care neither began with the pandemic, nor will end when it has run its course. Access to care has been a persistent challenge for rural areas and populations of color, fueling disparities in health care and health outcomes. Among rural populations, this is the result of lower

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9. Press Release, U.S. Ctrs. for Medicare & Medicaid Servs., Trump Administration Issues Second Round of Sweeping Changes to Support U.S. Healthcare System During COVID-19 Pandemic (Apr. 30, 2020), https://www.cms.gov/newsroom/press-releases/trump-administration-issues-second-round-sweeping-changes-support-us-healthcare-system-during-covid.

10. *See* 21 U.S.C. § 829(e) (2018); Press Release, U.S. Drug Enf't Admin., DEA's Response to COVID-19 (Mar. 20, 2020), https://www.dea.gov/press-releases/2020/03/20/deas-response-covid-19.

11. *See, e.g.*, Ariz. Exec. Order No. 2020-15 (Mar. 25, 2020), https://azgovernor.gov/executive-orders (requiring insurers to cover telehealth versions of services at the same rate that would have been covered if provided in-person during the state of emergency) (now rescinded); Ariz. Exec. Order No. 2020-29 (Apr. 14, 2020), https://azgovernor/gov/executive-orders (requiring workers' compensation insurers to cover healthcare services provided through telehealth as they would be covered if provided in person) (now rescinded).

12. Jane E. Brody, *A Pandemic Benefit: The Expansion of Telemedicine*, N.Y. TIMES (May 11, 2020), https://www.nytimes.com/2020/05/11/well/live/coronavirus-telemedicine-telehealth.html (discussing the benefit of a doctor seeing whether there are, for example, obstacles that may cause an injury to the patient).

population densities, lack of accessible hospitals, and a dearth of providers. Likewise, disparities in health insurance coverage, bias in the health care system, and health care deserts contribute to disproportionately adverse health outcomes among nonwhite patients.

The pandemic itself underscores the severity of these health care disparities: the rate of hospitalization of Black COVID-19 patients is more than triple the rate of white patients, while the death rate of Black patients is more than double.[13] Among Hispanic patients, the hospitalization rate is four times higher than white patients, and the death rate is more than double.[14] Compounding this, once COVID-19 patients are hospitalized, biases within the health care system may result in scarce medical resources being disproportionately directed to white patients.[15] "[O]ne of the biggest societal advantages" that telehealth offers is closing the access-to-care gaps that affect rural areas and low-income communities.[16] Accomplishing this will require addressing existing regulatory roadblocks to ensure that using telehealth to increase access to health care is possible beyond the current health crisis.

This Article examines the growth of telehealth in response to access-to-care challenges posed by COVID-19 and analyzes the steps federal agencies and states can take to overcome persistent barriers to health care, even after the pandemic ends. In developing these points, this Article proceeds in three parts. Part II defines health care disparities

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13. Leo Lopez III et al., *Racial and Ethnic Health Disparities Related to COVID-19*, 325 JAMA 719, 719 (2021).

14. *Id.* Additionally, Indigenous Americans have been disproportionately affected by COVID-19. Press Release, U.S. Ctrs. for Disease Control and Prevention, CDC Data Show Disproportionate COVID-19 Impact in American Indian/Alaska Native Populations (Aug. 19, 2020), https://www.cdc.gov/media/releases/2020/p0819-covid-19-impact-american-indian-alaska-native.html [https://perma.cc/H8UR-S4ZR].

15. Natalie M. Chin et al., *Examining How Crisis Standards of Care May Lead to Intersectional Medical Discrimination Against COVID-19 Patients* (Feb. 2021), http://thearc.org/wp-content/uploads/2021/02/Intersectional-Guide-to-Crisis-Care_FINAL.pdf [https://perma.cc/W68R-H2V9] (discussing how "[p]eople of color may also be disparately impacted by discriminatory crisis standards of care").

16. Ryan Blethen & Megan Burbank, *Even as Washington Reopens, Telemedicine May Be the New Normal in a Post-Coronavirus World. Here's How it Works in Six Common Specialties*, SEATTLE TIMES (June 14, 2020, 10:37 AM), https://www.seattletimes.com/seattle-news/health/even-as-washington-reopens-telemedicine-may-be-the-new-normal-in-a-post-coronavirus-world-heres-how-it-works-in-six-common-specialties/ ("'One of the biggest advantages to telehealth that will hopefully only get better is trying to close some of the disparities in health care,' [Dr. Sue] Moreni said, citing telehealth visits as a useful option for rural or low-income patients who might face unique challenges to accessing a traditional appointment.").

and discusses access-to-care barriers experienced by rural areas and populations of color prior to the pandemic. In doing so, Part II notes how the pandemic exacerbated these pre-existing inequalities as well as interrupted health care delivery for populations who had previously enjoyed regular access to care. Part III engages with pandemic-induced changes to federal and state law in response to these access-to-care barriers. It details the steps taken by various levels of government to explore changes in the regulatory landscape in the wake of the pandemic. Part IV details structural and regulatory challenges to expanding telehealth beyond the pandemic and address health disparities.

Recognizing the benefits of continued use of telehealth, Part V proposes two mechanisms that will increase access to care even after the pandemic has abated. This Part first provides specific recommendations concerning the bipartisan Protecting Access to Post-COVID-19 Telehealth Act, currently before the House of Representatives.[17] Second, this Part recommends that all jurisdictions implement a state compact or uniform law approach under which states adopt standardized statutory language to promote conformity in telehealth regulations across the United States.

II. HEALTH CARE DISPARITIES

Health disparities refer to:

> A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.[18]

17. Protecting Access to Post-COVID-19 Telehealth Act of 2020, H.R. 7663, 116th Cong. (2020); *see also* Matthew M. Shatzkes & Kimberly Rai, *Re-Introducing the Protecting Access to Post-COVID-19 Telehealth Act*, NAT'L L. REV. (Jan. 28, 2021), https://www.natlawreview.com/article/re-introducing-protecting-access-to-post-covid-19-telehealth-act (detailing the provisions of the Protecting Access to Post-Covid-19 Telehealth Act of 2020).

18. *Disparities*, HEALTHYPEOPLE.GOV (quoting U.S. DEP'T OF HEALTH & HUM. SERVS., THE SECRETARY'S ADVISORY COMMITTEE ON NATIONAL HEALTH PROMOTION AND DISEASE PREVENTION OBJECTIVES FOR 2020. PHASE I REPORT: RECOMMENDATIONS FOR THE FRAMEWORK AND FORMAT OF HEALTHY PEOPLE 2020 (2008), https://www.healthypeople.gov/sites/default/files/PhaseI_0.pdf [https://perma.cc/A85Q-NTXA]), https://www.healthy

Disparities permeate all aspects of health and health care. This includes access to the health care system, quality of the health care system, utilization of health care, and health outcomes for individual patients and communities.[19] The existence of health disparities denotes a higher prevalence of negative health outcomes (e.g., illness, injury, or mortality) experienced by one group compared to another.[20] Health care disparities also signify differences in health insurance coverage, access to the health care system, use of the health care system, and quality of care received between different groups.[21] For both health and health care disparities, the differences between groups stem from broader inequities, as the differences are "closely linked with social, economic, and/or environmental disadvantage."[22] Moreover, as the landmark 2003 Institute of Medicine report noted, even when vulnerable populations have access to insurance, health disparities persist.[23]

Social context, local circumstances, and systemic conditions help to explain health and health care disparities among different populations. Social determinants of health (SDH) are the "conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life,"[24] which are "shaped by the distribution of money, power, and resources at global,

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people.gov/2020/about/foundation-health-measures/Disparities [https://perma.cc/W4S5-3NGG] (last visited Feb. 9, 2022).

19. *About Health Disparities*, U.S. DEP'T HEALTH & HUM. SERVS., NAT'L HEART, LUNG, & BLOOD INST. (June 2014), https://www.nhlbi.nih.gov/health/educational/healthdisp/about-health-disparities.htm [https://perma.cc/3RXL-QNA3].

20. Nambi Ndugga & Samantha Artiga, *Disparities in Health and Health Care: 5 Key Questions and Answers*, KAISER FAM. FOUND. (May 11, 2021), https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/ [https://perma.cc/J8QC-6G4P].

21. *Id.*

22. *Id.* ("The terms 'health inequality' and 'inequity' are also used to refer to disparities.").

23. INST. OF MED., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 1 (Brian D. Smedley et al. eds., 2003).

24. *Social Determinants of Health*, WORLD HEALTH ORG., https://www.who.int/social_determinants/en/ [https://perma.cc/69Q5-PDK3] (last visited Feb. 9, 2022) ("These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems."); *see also* NAT'L ACADS. SCIS., ENG'G, & MED., COMMUNITIES IN ACTION: PATHWAYS TO HEALTH EQUITY 38 (James N. Weinstein et al. eds., 2017) ("[Social determinants of health] are the conditions in which one lives, learns, works, plays, worships, and ages, and these conditions are shaped by historical and contemporary policies, law, governance, investments, culture, and norms.").

national, and local levels."[25] SDH affect individual and population health (e.g., safe and affordable housing and access to healthy foods),[26] as well as access to health care (e.g., individual and community financial resources).[27] Several factors affect disparities in access to care, including differences in rates of health insurance coverage, utilization of health care services, and availability of health care services. Taken together, these factors cause health and health care disparities between rural and suburban/urban individuals as well as between communities of color and white patients.

As COVID-19 ravaged the country, many people found themselves unable to access care for the first time in their lives. While uninsured and/or under-insured individuals routinely struggle to gain access to health care, even wealthy and well-insured individuals could not access routine care during the pandemic. With hospitals discontinuing elective surgeries and emergency departments encouraging non-COVID-19 patients to avoid their waiting rooms, people who typically have ready access to these avenues of care suddenly had to do without. For people with insurance and means, a return to a post-COVID world will mean a return to readily accessible health care. However, for many communities of color and individuals living in rural areas, the lack of access to care—and attendant disparities—neither began with the COVID-19 pandemic nor will end when the pandemic does. This subpart addresses the health and health care disparities relevant to rural areas and communities of color in turn.

A. Rural Health Care Disparities

Rural areas of the country lack access not only to health insurance but also to more basic needs such as health care providers and health care facilities. The expansion of telehealth has the potential to address these important needs, but to understand the impact telehealth may have, it is useful to first understand the problem that must be solved. This subpart details the various problems rural communities must regularly confront.

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25. *About Social Determinants of Health*, U.S. CTRS. FOR DISEASE CONTROL AND PREVENTION (Mar. 10, 2021), https://www.cdc.gov/socialdeterminants/about.html [https://perma.cc/2PCC-WDWX].

26. *Id.*

27. Ernest Moy & William Freeman, *Federal Investments to Eliminate Racial/Ethnic Health-Care Disparities*, 129 PUB. HEALTH REPS. 62, 63 (2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863704/?report=printable#B5 [https://perma.cc/4G6F-CZXM].

1. Rural Demographics

Rural counties look much different than their urban counterparts[28] and the disparities between the two have only grown recently. For example, the Pew Research Center explains that the growth rate in urban counties roughly tracks that of the nation overall and the growth rate in suburban counties generally outpaces the national rate.[29] However, "[r]ural counties have lagged, and half of them have fewer residents now than they did in 2000."[30] Indeed, "the total rural population has grown less than it did in the 1990s," and "a somewhat smaller share of Americans now live in rural counties."[31]

Even as fewer individuals choose to call rural America home, those that do tend to share traits that make accessing health care more difficult. The Association of American Medical Colleges recently observed that "rural health disparities are deeply rooted in economic, social, racial, ethnic, geographic, and health workforce factors."[32] Rural counties have lower median incomes[33] and higher poverty levels than other types of counties, with over 30% of rural counties having concentrated poverty.[34] And there is little to indicate that these trends will soon reverse. "Rural communities lag in the share of the population with a college degree," with fewer than one in five residents having completed a bachelor's degree or higher.[35]

At the same time, those best able to reverse the economic fortunes of rural areas are leaving. The number of prime working-age adults increased in urban and suburban areas but declined in rural areas.[36] Among prime working-age adults in rural counties, fewer were

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28. Robin Warshaw, *Health Disparities Affect Millions in Rural U.S. Communities*, ASS'N. AM. MED. COLLS. (Oct. 31, 2017), https://www.aamc.org/news-insights/health-disparities-affect-millions-rural-us-communities [https://perma.cc/675C-TD54].

29. Kim Parker et al., *What Unites and Divides Urban, Suburban and Rural Communities*, PEW RSCH. CTR. 1, 16 (May 22, 2018), https://www.pewsocialtrends.org/2018/05/22/demographic-and-economic-trends-in-urban-suburban-and-rural-communities/#:~:text=Suburbs%20growing%20more%20rapidly%20than,8%25%20growth%20in%20the%201990s (comparing national growth rate with that of rural, suburban, and urban communities from 2000 and 2012-2016).

30. *Id.*

31. *Id.*

32. Warshaw, *supra* note 28.

33. *Id.*

34. Parker et al., *supra* note 29, at 26 (noting that concentrated poverty exists in counties where at least one-fifth of the population is poor).

35. *Id.*

36. *Id.* at 27 (defining prime-age workers as those people between twenty-five- and fifty-four-years-old who are employed).

employed relative to the same group of workers in urban and suburban counties.[37] Unsurprisingly, this has left rural counties with older populations on average—i.e., populations that require more health care and have less ability to access it.[38]

These demographic trends only serve to compound the existing problems of providing care in rural communities. Population density has always been lower in rural areas,[39] and this presents unique problems when delivering care. "Rural residents who live on farms, ranches, reservations, and frontiers often must travel long distances to reach a health care provider," which often leads to delays and intermittent care.[40] For example, the director of the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences commented that "[a]ccess to providers, even family physicians, is a problem. If you want to go to an OB/GYN, depending on where you live in the country, you may have to go 200 miles."[41]

Even once rural residents are able to see a health care provider, they often lack the ability to pay for that encounter. Rural patients have less access to health insurance than their more urban counterparts. Even among those that have some form of coverage, they often cannot access in-network providers close by.[42] These factors have led to Medicaid playing an outsized role in rural health care. "Medicaid is the primary source of health insurance coverage for low-income Americans,"[43] and because "rural populations on average have lower incomes than their urban counterparts," these "populations may particularly benefit from Medicaid expansion."[44] However, several states with rural populations

37. *Id.*

38. *Id.* at 22.

39. *See What is Rural?*, U.S. DEP'T AGRIC. ECON. RSCH. CTR. (Oct. 23, 2019), https://www.ers.usda.gov/topics/rural-economy-population/rural-classifications/what-is-rural/#:~:text=The%20same%20computerized%20procedures%20and,but%20less%20than%2050%2C000%20persons.&text=According%20to%20this%20system%2C%20rural,with%20fewer%20than%202%2C500%20people [https://perma.cc/FK4Q-7FCU] (discussing differences in population density between rural and urban areas in the United States).

40. Warshaw, *supra* note 28.

41. *Id.*

42. *Id.*

43. Richard C. Lindrooth et al., *Understanding the Relationship Between Medicaid Expansions and Hospital Closures*, 37 HEALTH AFFS. 111, 111 (2018).

44. Aparna Soni et al., *Medicaid Expansion Under the Affordable Care Act and Insurance Coverage in Rural and Urban Areas*, 33 J. RURAL HEALTH 217, 218 (2017).

that could most benefit from this expansion have declined to expand their Medicaid programs.[45]

Collectively, these factors make accessing health care in rural America difficult. Just as important as the direct effect of these factors on the ability of individuals to access care, however, is the impact of these factors on the ability of providers to operate in rural areas. The same factors that inhibit the ability of a rural resident to obtain care inhibits the ability of providers to operate in rural communities. The next subparts explicitly address how providers struggle to deliver care to rural populations.

2. Rural Hospitals

The demographic and economic challenges faced by rural communities translate directly into challenges faced by rural hospitals. A recent study explained that "[many] rural hospitals were originally built in the post-World War II era to provide a level and volume of care that is no longer needed."[46] This has created challenges for rural hospitals that struggle to find patients and provide profitable services. A recent report from the U.S. Government Accountability Office (GAO) noted that "[t]he years 2010 through 2016 marked the first recorded period of [national] rural population decline" and that "population decline in rural areas was likely associated with the recent decline in rural residents seeking inpatient services."[47] This trend does not bode well for rural hospitals, as "[h]ospitals with higher outpatient, surgery and obstetric volumes are more likely to be profitable and remain open."[48]

As rural hospitals struggle to get patients in the door, they are less able to keep pace with recent technological advances and fall farther behind their urban counterparts. As "changes in health care technology have expanded the provision of outpatient surgical procedures," rural

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45. *See* Adam Searing, *More Rural Hospitals Closing in States Refusing Medicaid Coverage Expansion*, GEO. UNIV. HEALTH POL'Y INST. (Oct. 29, 2018), https://ccf.georgetown.edu/2018/10/29/more-rural-hospitals-closing-in-states-refusing-medicaid-coverage-expansion/ [https://perma.cc/A7KH-PAAT].

46. David Mosley & Daniel DeBehnke, *Rural Hospital Sustainability: New Analysis Shows Worsening Situation for Rural Hospitals, Residents*, GUIDEHOUSE (Feb. 22, 2019), https://guidehouse.com/insights/healthcare/2019/rural-hospital-sustainability [https://perma.cc/Q7NS-KAVC].

47. U.S. GOV'T ACCOUNTABILITY OFF., RURAL HOSPITAL CLOSURES: NUMBER AND CHARACTERISTICS OF AFFECTED HOSPITALS AND CONTRIBUTING FACTORS 24-25 (2018).

48. Brystana G. Kaufman et al., *The Rising Rate of Rural Hospital Closures*, 32 J. RURAL HEALTH 35, 41 (2016).

hospitals have been unable to attract the same number of patients as in the past.[49] Instead of seeking care at their local hospitals, "[r]ural residents may choose to obtain services from . . . newer hospital systems outside of the area."[50]

Compounding these problems are the shifts in rural demographics described above. A recent study explained that "[c]ompared to urban hospitals, rural hospitals serve older, poorer, and sicker communities where higher percentages of patients are covered through public insurance programs if they are covered at all."[51] Two separate studies in the *Journal of Rural Health* explored the effects these challenges can pose for rural hospitals. The first study concluded that the "[o]dds of unprofitability increase with proportion of residents over age 65, [and] proportion of households in poverty."[52] The second study concluded that "an increase in the proportion of households in poverty in the service area increased the odds of [financial] distress."[53]

The increased likelihood of unprofitability and financial distress have translated into many rural hospitals closing over the last decade. The Cecil G. Sheps Center for Health Services Research at the University of North Carolina has identified 181 rural hospital closures since 2005 with 138 of those occurring since 2010 alone.[54] With fewer hospitals available, rural communities must either forego needed care or travel long distances to suburban and urban hospitals. One might expect that networks of individual providers may absorb some of the increased demand for care following the closure of a rural hospital. However, as described in the next subpart, these providers often choose not to practice in rural areas.

3. Rural Providers

The Association of American Medical Colleges has estimated that "[t]he United States will see a shortage of up to nearly 122,000

49. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 47, at 24.

50. *Id.*

51. Sharita R. Thomas et al., *2012-14 Profitability of Urban and Rural Hospitals by Medicare Payment Classification*, N.C. RURAL HEALTH RSCH. PROGRAM (Mar. 2016), https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2016/03/Profitability-of-Rural-Hospitals.pdf.

52. Kaufman et al., *supra* note 48, at 40.

53. George M. Holmes et al., *Predicting Financial Distress and Closure in Rural Hospitals*, 33 J. RURAL HEALTH 239, 244 (2017).

54. *181 Rural Hospital Closures Since January 2005*, UNIV. N.C. CECIL G. SHEPS CTR. HEALTH SERVS. RSCH., https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/ [https://perma.cc/2J2Q-2ZYE] (last visited Feb. 9, 2022).

physicians by 2032 as demand for physicians continues to grow faster than supply."[55] While this prediction certainly has implications for the country at large, shortages are likely to be more acute in rural areas. A recent article in the *New England Journal of Medicine* observed that "there is little disagreement that the uneven distribution of physicians presents serious access problems in many rural areas" with "[l]imited access to physicians [potentially] reduc[ing] access to preventive care and exacerbat[ing] unmet health needs."[56] There is little reason for optimism that current rural shortages will abate in the near future. The authors of the study explained that between 2000 and 2017 the number of young physicians practicing in rural areas declined such that "the number of physicians under 50 years of age living in rural areas decreased by 25%."[57] Other types of providers have stepped in to provide a larger proportion of care in rural areas. Nurse practitioners, for example, increasingly outnumber physicians in rural areas, and represent the primary source of care in many communities.[58]

Despite the increasing use of providers other than physicians to deliver care in rural communities, these areas continue to suffer from a lack of health care delivery capacity. To delve deeper into these problems, we examined data from the Area Health Resource Files (AHRFs).[59] This data comes from a variety of sources, and the Health Resources and Services Administration compiles the information into

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55. Press Release, Ass'n Am. Med. Colls., New Findings Confirm Predictions on Physician Shortage (Apr. 23, 2019), https://www.aamc.org/news-insights/press-releases/new-findings-confirm-predictions-physician-shortage.

56. Lucy Skinner et al., *Implications of an Aging Rural Physician Workforce*, 381 NEW ENG. J. MED. 299, 299 (2019).

57. *Id.* at 300.

58. *See* Ying Xue et al., *Research Letter: Primary Care Nurse Practitioners and Physicians in Low-Income and Rural Areas, 2010-2016*, 321 JAMA 102, 102-04 (2019); Hilary Barnes et al., *Rural and Nonrural Primary Care Physician Practices Increasingly Rely on Nurse Practitioners*, 37 HEALTH AFFS. 908, 908 (2018) ("We found increasing [nurse practitioner] presence in both rural and nonrural primary care practices in the period 2008-16."); *see also* Peter I. Buerhaus et al., *Practice Characteristics of Primary Care Nurse Practitioners and Physicians*, 63 NURSING OUTLOOK 144, 146 (2015) ("[Primary care nurse practitioners] are significantly more likely than [primary care physicians] to practice in urban and rural areas, whereas [primary care physicians] are more likely to practice in suburban locations."); Benjamin J. McMichael, *Beyond Physicians: The Effect of Licensing and Liability Lows on the Supply of Nurse Practitioners and Physician Assistants*, 15 J. EMPIRICAL LEGAL STUD. 732, 759-64 (2018) (finding that nurse practitioners are more likely to practice in health professional shortage areas following the relaxation of licensing and liability laws).

59. *Area Health Resources Files*, HEALTH RES. & SERVS. ADMIN., https://data.hrsa.gov/topics/health-workforce/ahrf (last visited Feb. 9, 2022).

a single dataset. Using this dataset, we analyzed shortages of both primary care and mental health providers.

Figure 1 provides a map of all counties in the United States. Counties in the lightest shade of blue had an adequate supply of primary care health professionals in 2020. Counties in the darkest and intermediate shade of blue have been designated by the HHS as including areas that have shortages of these health professionals. The HHS designates areas as Health Professional Shortage Areas (HPSAs) when several criteria demonstrating unmet primary care needs are satisfied.[60] Counties in the darkest shade were wholly designated as HPSAs by the HHS and thus represent areas with the least availability of primary care providers. At least some part of counties in the intermediate shade of blue were designated as lacking access to primary care providers in 2020. Only counties in the lightest shade of blue had not been designated as HPSAs.

Figure 2 mirrors Figure 1 but focuses on mental health professional shortage areas instead of primary care HPSAs. Counties in the lightest shade of blue had an adequate supply of mental health professionals in 2020. Counties in the intermediate shade were partially designated as mental health HPSAs by the HHS, and counties in the darkest shade were wholly designated as such in 2020. Figures 1 and 2 both demonstrate the lack of access to care in rural areas. Providers have increasingly chosen not to practice in these areas, leaving rural residents the choice of driving hours to obtain care or foregoing care altogether. Figure 2, however, demonstrates greater potential for improvement with telehealth. The delivery of mental health services is particularly well suited to telehealth, and providers across the country could begin to address the troubling reality elucidated by Figure 2 via telehealth. The figures that follow are produced vertically to avoid display distortion.

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60. 42 C.F.R. § 5.3 (2020); 42 C.F.R. § 5 app. A (2020) (providing the criteria for designating HPSAs).

Figure 1: Health Professional Shortage Areas for Primary Care

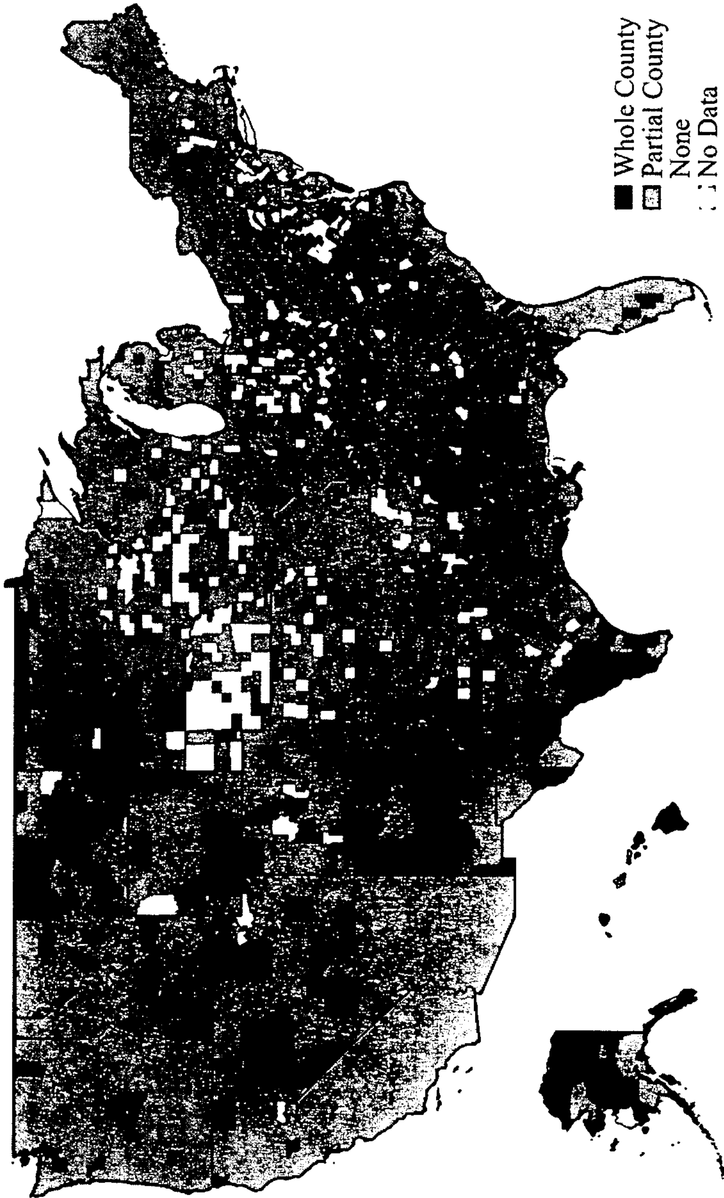
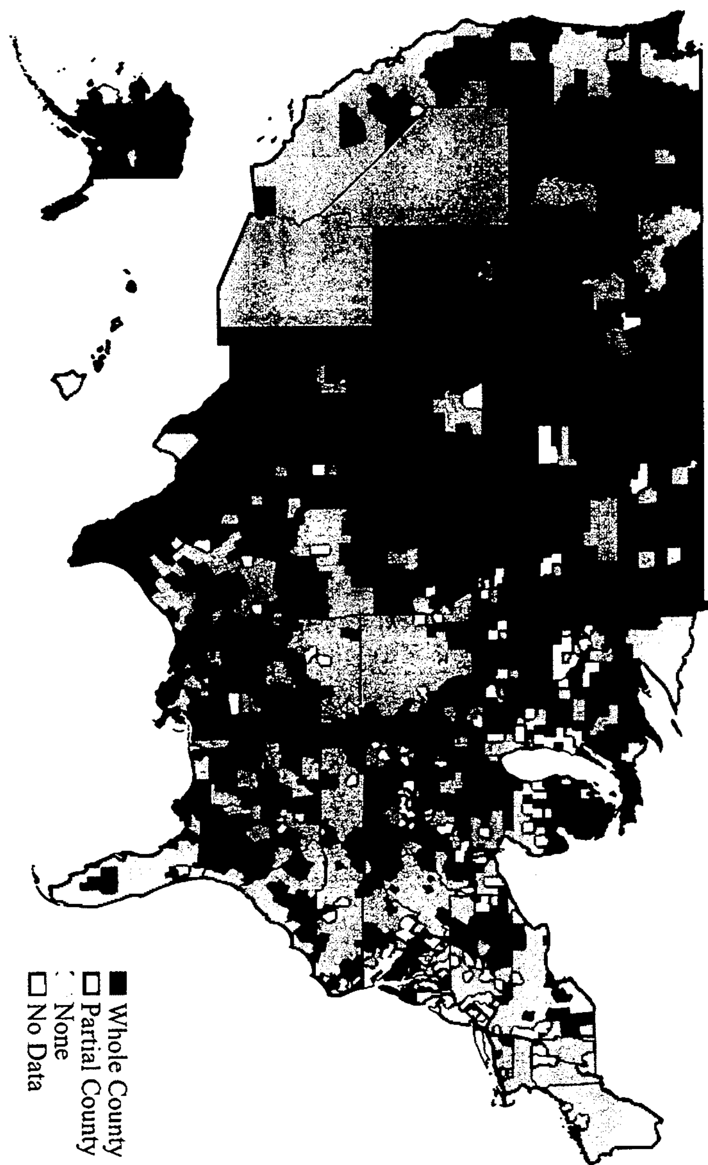


Figure 2: Health Professional Shortage Areas for Mental Health



B. Racial Disparities in Health Care

As in rural areas of the country, disparities in health care also negatively affect the health of individuals and communities of color. Disparities in health insurance coverage, bias in the health care system, and health care deserts all contribute to disproportionately adverse health outcomes among nonwhite patients.

1. Disparities in Health Insurance Coverage

Lack of health insurance causes significant negative health effects including "use of fewer preventive services, poorer health outcomes, higher mortality and disability rates, lower annual earnings because of sickness and disease" and worse health outcomes when ill.[61] These negative effects disproportionately impact individuals and families of color, who have lower rates of health insurance coverage than their white counterparts.[62] The 2010 passage of the Affordable Care Act (ACA) expanded access to health insurance to previously uncovered populations, which narrowed—but did not eliminate—the gap in rates of health insurance coverage.[63] Prior to the passage of the ACA, Black adults were 70% more likely to be uninsured, and Hispanic adults were three times as likely to be uninsured, than white adults.[64]

The ACA reduced racial and ethnic disparities in insurance coverage,[65] with health insurance rates increasing more for Black and

61. Wayne J. Riley, *Health Disparities: Gaps in Access, Quality and Affordability of Medical Care*, 123 TRANSACTIONS AM. CLINICAL & CLIMATOLOGICAL ASS'N 167, 171 (2012), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3540621/ [https://perma.cc/D3ZS-C46T].

62. *Id.* ("[T]he uninsured tend to be disproportionately poor, young, and from racial and/or ethnic minority groups.").

63. *See generally* COMM. ON HEALTH CARE UTILIZATION AND ADULTS WITH DISABILITIES, NAT'L ACADS. OF SCIS., ENG'R & MED., HEALTH-CARE UTILIZATION AS A PROXY IN DISABILITY DETERMINATION 38-56 (2018) (discussing the expansion of healthcare coverage through the ACA to uninsured populations).

64. Thomas C. Buchmueller & Helen G. Levy, *The ACA's Impact on Racial and Ethnic Disparities in Health Insurance Coverage and Access to Care*, 39 HEALTH AFFS. 395, 396-97 (Mar. 2020), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2019.01394 ("Before 2014 approximately 15 percent of white nonelderly adults were uninsured, compared with about 24 percent of [B]lack adults and more than 40 percent of Hispanic adults."); *see also Medicare Benefits*, SOC. SEC. ADMIN., https:www.ssa.gov/benefits/medicare/ (last visited Feb. 9, 2022) (noting that adults under age sixty-five are a focus when investigating the health insurance gap, as Medicare provides coverage for people ages sixty-five and older).

65. Ajay Chaudry et al., *Did the Affordable Care Act Reduce Racial and Ethnic Disparities in Health Insurance Coverage?*, COMMONWEALTH FUND (Aug. 21, 2019), https://www.commonwealthfund.org/publications/issue-briefs/2019/aug/did-ACA-reduce-racial-ethnic-disparities-coverage [https://perma.cc/5QFE-8JDC] ("[T]hese gains were especially

Hispanic adults, as compared to white adults.[66] In the years following the ACA's passage, the national coverage gap between Blacks and whites decreased by 45%, while the gap between Hispanics and whites decreased by 35%.[67] However, these gains were not evenly distributed across the country; the percentage of insured individuals increased more in states that elected to expand Medicaid.[68]

Increasing health insurance coverage has implications for health system usage. Health insurance allows individuals to cover the cost of care more easily, which increases the likelihood that an individual will seek out health care. Indeed, after the passage of the ACA and subsequent increase in insurance rates, the number of Black and Hispanic individuals who reported forgoing care—that is, not seeking out health care due to prohibitive cost—dropped by more than 3% nationally between 2013 and 2017.[69] Despite these gains, between 26 and 30 million people, or 8 to 10% of the national population, continue to lack health insurance,[70] with non-white racial and ethnic groups more likely than whites to be uninsured.[71] Differences in insurance rates—and insurance types—continue to drive differences in access to care and health outcomes.

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pronounced for minority groups and individuals with incomes below 139 percent of the federal poverty level.").

66. Buchmueller & Levy, *supra* note 64, at 395.

67. *Id.* at 398.

68. *Id.*; *see also* Lindsay F. Wiley, *Medicaid for All? State-Level Single-Payer Health Care*, 79 OHIO STATE L.J. 845, 848, 853 (2018) ("Medicaid provides publicly financed coverage for people living in low-income households who meet additional eligibility requirements." Under the ACA, states had the option to receive funding to expand Medicaid to "nonimmigrants living at or below 133% [of the federal poverty line]"); *Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAM. FOUND. (Aug. 10, 2021), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/ (stating that as of August 10, 2021, "[thirty-nine] states . . . have adopted the Medicaid expansion").

69. Buchmueller & Levy, *supra* note 64, at 395.

70. Katherine Keisler-Starkey & Lisa N. Bunch, *Health Insurance Coverage in the United States: 2019*, U.S. CENSUS BUREAU (Sept. 15, 2020), https://www.census.gov/library/publications/2020/demo/p60-271.html [https://perma.cc/3WK9-MV2L] ("8.0 percent of people [in the United States] did not have health insurance at any point during [2019]. [However, at the time of interview,] 9.2 percent of people, or 29.6 million, were not covered by health insurance.").

71. Buchmueller & Levy, *supra* note 64, at 395.

2. Bias in the Health Care System

Bias and lack of diversity within the medical profession cause disparate health outcomes.[72] As Dean Dayna Bowen Matthew documents in detail in her landmark book, "racial and ethnic discrimination against minority patient populations [is] an uncontrovertibly significant contributor to health inequality."[73] Evidence suggests that patients of color "receive lower quality care than nonminorities and that, patients of minority ethnicity experience greater morbidity and mortality from various chronic diseases than nonminorities."[74] This is partially attributed to implicit biases[75] among health care providers, which affect clinical judgment and behavior of physicians and nurses.[76] Moreover, the power and control that health care providers wield over a patient's health trajectory, magnifies the effect of the bias.[77] This can manifest in many ways, such as patients of color waiting longer for care, providers spending more time and collaborating more with white patients,[78] and patients of color receiving

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72. *See generally* Shantanu Agrawal & Adaeze Enekwechi, *It's Time to Address the Role of Implicit Bias Within Healthcare Delivery*, HEALTH AFFS. (Jan. 15, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200108.34515/full/ [https://perma.cc/JPE4-XBJR] ("Often missing from today's discourse [around health disparities, health equity, and SDH] is the fact that individuals and communities interacting with the healthcare system are subjected to disparate treatment at the hands of clinicians.").

73. DAYNA BOWEN MATTHEW, JUST MEDICINE: A CURE FOR RACIAL INEQUALITY IN AMERICAN HEALTH CARE 2 (2015).

74. Leonard E. Egede, *Race, Ethnicity, Culture, and Disparities in Health Care*, 21 J. GEN. INTERNAL MED. 667, 667 (2006); *see, e.g.*, Khiara M. Bridges, *Racial Disparities in Maternal Mortality*, 95 N.Y.U. L. REV. 1229, 1248-67, 1293-317 (2020) (analyzing maternal mortality rates of Black women and critiquing legal prescriptions intended to address this health disparity).

75. *See* William J. Hall et al., *Implicit Racial/Ethnic Bias Among Health Care Professionals and its Influence on Health Care Outcomes: A Systematic Review*, 105 AM. J. PUB. HEALTH 60, 60-61 (2015) ("Implicit attitudes are thoughts and feelings that often exist outside of conscious awareness, and thus are difficult to consciously acknowledge and control. These attitudes are often automatically activated and can influence human behavior without conscious volition.").

76. Chloë FitzGerald & Samia Hurst, *Implicit Bias in Healthcare Professionals: A Systematic Review*, 18 BMC MED. ETHICS, no. 1, Mar. 2017, at 1-2; Agrawal & Enekwechi, *supra* note 72 ("For many white patients, these kinds of experiences are inconceivable. But for [B]lack or Hispanic patients, maltreatment can be routine, almost ubiquitous . . . [m]inority patients know they are not being treated well but have few alternatives for other care."); *see also* Hall et al., *supra* note 75, at 60 (examining empirical research on provider bias and concluding that "[m]ost health care providers appear to have implicit bias in terms of positive attitudes toward [w]hites and negative attitudes toward people of color").

77. Agrawal & Enekwechi, *supra* note 72.

78. Hall et al., *supra* note 75, at 72.

poorer treatment.[79] For example, one study found that "physicians with more pro-white implicit bias were more ready to prescribe pain medication to white patients" than to Black patients.[80] In addition to creating health disparities through unequal treatment, patient knowledge of health care provider bias discourages communities of color from seeking health care services, contributing to disparate health outcomes.[81]

Lack of diversity among physicians contributes to racial bias among health care providers.[82] Despite the fact that Black Americans comprise an estimated 13.4%[83] of the population, only 5% of physicians identify as Black.[84] Similarly, only 5.8% of all active physicians identify as Hispanic,[85] compared to 18.5% of the U.S. population.[86] Sharing a racial or ethnic background can improve communication and trust between patient and provider,[87] which can lead to improved health outcomes.[88] Moreover, physicians of color are

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79. *See, e.g.*, Michelle van Ryn at al., *Physicians' Perceptions of Patient's Social and Behavioral Characteristics and Race Disparities in Treatment Recommendations for Men with Coronary Artery Disease*, 96 AM. J. PUB. HEALTH 351, 353 (2006) (finding that a patient's race—and gender—predicted whether a physician would recommend particular types of treatment, based on biases held by providers about their patients); Matthew, *supra* note 73, at 106-53.

80. Matthew, *supra* note 73, at 69.

81. Egede, *supra* note 74 ("In [one] study, [researchers] conducted a cross-sectional analysis of 54,968 respondents to the 2001 California Health Interview Survey to assess the relationship between perceptions of health care discrimination and use of health services. Approximately 5% of respondents reported experiencing some form of discrimination. Those that reported discrimination were less likely to receive some preventive care services.").

82. Nicole Torres, *Research: Having a Black Doctor Led Black Men to Receive More-Effective Care*, HARV. BUS. REV. (Aug. 10, 2018), https://hbr.org/2018/08/research-having-a-black-doctor-led-black-men-to-receive-more-effective-care [https://perma.cc/L2A8-T962].

83. *Quick Facts*, U.S. CENSUS BUREAU, https://www.census.gov/quickfacts/fact/table/US/PST045219 [https://perma.cc/838N-BEUP] (last visited Feb. 9, 2022).

84. *Diversity in Medicine: Facts and Figures 2019, Figure 18. Percentage of All Active Physicians by Race/Ethnicity, 2018*, ASS'N AM. MED. COLLS., (July 1, 2019) https://www.aamc.org/data-reports/workforce/interactive-data/figure-18-percentage-all-active-physicians-race/ethnicity-2018 [https://perma.cc/7XH2-3QZE].

85. *Id.*

86. U.S. CENSUS BUREAU, *supra* note 83.

87. Torres, *supra* note 82 (citing Damon Tweedy, *The Case For Black Doctors*, N.Y. TIMES (May 15, 2015), https://www.nytimes.com/2015/05/17/opinion/sunday/the-case-for-black-doctors.html.

88. *See generally* Marcella Alsan et al., *Does Diversity Matter for Health? Experimental Evidence from Oakland* 4 (Nat'l Bureau of Econ. Rsch., Working Paper No. 24787, 2018) (finding that Black men treated by Black physicians agreed to receive more services than Black men treated by nonblack doctors).

more likely to treat patients of color.[89] This suggests that models of care that increase access to diverse providers would, in turn, improve patient health outcomes.

3. Health Care Deserts

Patients of color are more likely than white patients to live in health care deserts, or "communities with limited healthcare resources."[90] Longitudinal research dating to the 1930s documented what local communities had experienced for decades: "[a]s the minority proportion of the neighborhood around the hospital increases, so does the proportion of hospitals closing or relocating . . ."[91] More recently, researchers from the University of Chicago Pritzker School of Medicine found that in the three largest cities in the United States,[92] Black majority census tracts are significantly more likely to lack access to emergency medical care.[93]

While rural hospital closures have accelerated over the last two decades, many inner-city hospitals are now "fac[ing] a similar fate."[94] For example, in 2020, Chicago's Mercy Hospital & Medical Center announced that it would shutter all services in early 2021. Notably, 55% of Chicagoans living in poverty and 62% of Black Chicagoans live in Mercy's service area.[95] However, a state regulatory board voted unanimously to reject Mercy's request to shutter, citing the negative effect its closure would have on access to health care on Chicago's South Side.[96] After a series of public hearings, state regulators instead

89. Ernest Moy & Barbara A. Bartman, *Physician Race and Care of Minority and Medically Indigent Patients*, 273 JAMA 1515, 1517 (1995).

90. Darrell J. Gaskin et al., *Residential Segregation and the Availability of Primary Care Physicians*, 47 HEALTH SERVS. RSCH. 2353, 2354-55 (2012). Medical deserts may also be referred to as health care deserts. *See id.*

91. Brietta R. Clark, *Hospital Flight from Minority Communities: How Our Existing Civil Rights Framework Fosters Racial Inequality in Healthcare*, 9 DEPAUL J. HEALTH CARE L. 1023, 1030 (2005) (citing *Problems Facing Financially Troubled Hospitals: Field Hearings Before the Subcomm. on Health of the H. Comm. On Ways & Means*, 96th Cong. 196 (1980) (statement of Professor Alan Sager, Brandeis Univ.)).

92. The cities are New York City, Chicago, and Los Angeles.

93. Elizabeth L. Tung et al., *Race/Ethnicity and Geographic Access to Urban Trauma Care*, 2 JAMA NETWORK OPEN, no. 3, Mar. 2019, at 1-2.

94. Jordan Rau & Emmarie Huetteman, *Urban Hospitals of Last Resort Cling to Life in Time of COVID*, KAISER HEALTH NEWS (Sept. 17, 2020), https://khn.org/news/urban-hospitals-of-last-resort-cling-to-life-in-time-of-covid/ [https://perma.cc/65N4-YRY6].

95. *Id.*

96. Monte Reel, *The Left-for-Dead Hospital That Got a Second Change for $1*, BLOOMBERG BUSINESSWEEK (Oct. 1, 2021 4:00 AM), https://www.bloomberg.com/news/

approved the sale of Mercy to Insight Chicago, which will continue to operate the medical center. Mercy's near-closure follows those of Michael Reese Hospital, located in the same Chicago zip code as Mercy, Hahnemann University Hospital in Philadelphia,[97] and Providence Hospital in Washington, D.C. United Medical Center, the District's sole public hospital located in the city's most low-income ward, is scheduled to close in 2023.[98] The pandemic may further accelerate hospital closures by exacerbating existing economic burdens.[99] These closures overwhelmingly affect patients of color, who are more likely to receive health care from safety-net hospitals.

As Professor Brietta R. Clark notes, "[a] common scenario is that services are relocated from a lower [socioeconomic status], predominantly minority community to a more affluent, primarily white community located a great distance away."[100] This relocation can create insurmountable transportation barriers. For many, added distance and travel time can make it "difficult or even impossible" to access services.[101] Unsurprisingly, increased distance negatively affects health outcomes among patients. Indeed, "increased distance to the closest hospital increases deaths from heart attacks and unintentional injuries."[102] With fewer immediate health care options, many patients of color forgo treatment altogether. Telehealth offers a chance to address the factors that contribute to health and health care disparities affecting communities of color and rural areas by facilitating the provision of care in these communities.

III. Pandemic-Induced Changes to Telehealth Laws

Before the COVID-19 pandemic, both state and federal laws created regulatory roadblocks to telehealth. Because patients, including

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features/2021-10-01/mercy-hospital-gets-second-chance-to-provide-health-care-to-chicago-s-poor.

97. Peter P. Reese et al., *Preparing for the Next COVID-19 Crisis: A Strategy to Save Safety-Net Hospitals*, HEALTH AFFS. (June 22, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200617.787349/full/ [https://perma.cc/Y7JN-R2T7].

98. Rau & Huetteman, *supra* note 94.

99. Jordan Rau & Emmarie Huetteman, *Some Urban Hospitals Face Closure or Cutbacks as the Pandemic Adds to Fiscal Woes*, NAT'L PUB. RADIO (Sept. 15, 2020), https://www.npr.org/sections/health-shots/2020/09/15/912866179/some-urban-hospitals-face-closure-or-cutbacks-as-the-pandemic-adds-to-fiscal-woe [https://perma.cc/7ZW6-FKWV].

100. Clark, *supra* note 91, at 1032.

101. *Id.*

102. Thomas C. Buchmueller et al., *How Far to the Hospital? The Effect of Hospital Closures on Access to Care*, 25 J. HEALTH ECON. 740, 740 (2005).

vulnerable populations, risk contracting COVID-19 during health care appointments but need to access health care services despite the pandemic—or because of the pandemic—state and local governments began temporarily relaxing regulatory hurdles to allow patients to receive these services via telehealth. For example, states expanded access to Medicaid services provided via telemedicine. At the federal level, then President Trump signed an executive order focusing on expanding access to telehealth services, especially in rural areas, during the pandemic.[103] The executive order also sought to expand the availability of some telehealth services permanently.[104] Regarding health care access in rural areas, the executive order noted that:

> Americans living in rural communities face unique challenges when seeking healthcare services, such as limited transportation opportunities, shortages of healthcare workers, and an inability to fully benefit from technological and care-delivery innovations . . . . [Rural Americans] are more likely to die from [leading causes of death], many of which are preventable, than their urban counterparts.[105]

Patient usage of telehealth increased dramatically following the declaration of a public health emergency. The Center of Medicare and Medicaid Services (CMS) measured a dramatic jump in virtual visits by beneficiaries—from 14,000 visits before the declaration of a public health emergency to almost 1.7 million virtual visits during the last week in April 2020.[106] Furthermore, 43.5% of Medicare fee-for-service primary care visits were provided via telehealth in April compared to 0.1% of telehealth visits in February.[107] Finally, CMS found that patients frequently continued to choose telehealth services even after in-person services resumed in May.[108] The relaxation of telehealth restrictions during the public health emergency have led to a broader realization that these regulatory changes expanded access to health care services generally, including to rural, older, or medically vulnerable populations.[109] As a result, federal agencies are considering relaxing regulatory hurdles to telehealth beyond the pandemic to ensure long-

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103. Improving Rural Health and Telehealth Access, Exec. Order No. 13941, 85 Fed. Reg. 47,881 (Aug. 3, 2020).
104. *Id.* at 47,882.
105. *Id.* at 47,881.
106. *Id.*
107. *Id.*
108. *Id.*
109. *See id.*

term access to health care among these vulnerable and disparate populations.[110]

This Part analyzes the ways in which these regulatory changes provide opportunities to increase telehealth access beyond the pandemic. This Part first discusses temporary changes that states implemented to increase access to telehealth services during the pandemic. It then details both existing federal regulatory hurdles to telemedicine and the recent regulatory relaxations at the federal level.

Since the federal public health emergency declaration, states have taken several steps to remove impediments to the provision of telehealth. Similarly, various agencies have had to relax existing restrictions on the provision of telehealth services. First, the HHS and OCR have relaxed their enforcement of the HIPAA Rules.[111] Second, among other changes, CMS has expanded its reimbursement for services and providers that were previously restricted to in-person only.[112] It also loosened its technology requirements for telehealth services.[113] Finally, the DEA has temporarily relaxed a statutory requirement that a patient receive an in-person medical examination before receiving a scheduled prescription drug.[114]

A. Changes to State Law

States vary in both the means they used to ease telehealth restrictions and the number of relaxations imposed. Most states issued temporary relaxations to telehealth restrictions via an executive order from the state's governor.[115] Commonly, these orders included relaxations to site, technology, consent, and physician-patient

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110. *See* Memorandum of Understanding for Planning a Rural Telehealth Initiative Among the U.S. Department of Health and Human Services and U.S. Department of Agriculture and the Federal Trade Communications Commission (Aug. 31, 2020), https://www.hhs.gov/sites/default/files/rural-telehealth-mou-hhs-usda-fcc.pdf [https://perma.cc/X4JM-SR8Y].

111. U.S. Off. for C.R., *supra* note 8.

112. U.S. Ctrs. for Medicare & Medicaid Servs., *supra* note 9.

113. *Id.*

114. 21 U.S.C. § 802(54); U.S. Drug Enf't Agency, *supra* note 10.

115. *See, e.g.*, Ariz. Exec. Order No. 2020-15 (Mar. 25, 2020), https://azgovernor.gov/executive-orders [https://perma.cc/A4EH-SCUM] (requiring insurers to cover telehealth versions of services at the same rate that would have been covered if provided in-person during the state of emergency); Ariz. Exec. Order No. 2020-29 (Apr. 14, 2020), https://azgovernor/gov/executive-orders [https://perma.cc/A48H-SCUM] (requiring workers' compensation insurers to cover healthcare services provided through telehealth as they would be covered if provided in person).

relationship requirements.[116] Additionally, some states required insurers to cover telehealth services at the same rates as in-person services.[117] Some states even temporarily allowed providers from other states to provide health care services for the duration of the state of emergency.[118]

Some states have also granted these types of relaxations via state agency actions,[119] including allowing out-of-state providers to practice

116. *See, e.g.*, Mo. Exec. Order No. 20-04 (Mar. 18, 2020), https://www.sos.mo.gov/library/reference/orders/2020/eo4 [https://perma.cc/PNG9-YP3D] (suspending certain provisions of state law related to telemedicine temporarily and authorizing other state officials to temporarily waive or suspend statutes or rules to facilitate an effective response to the pandemic); Memorandum from Mont. Gov. Steve Bullock on the Directive Implementing Exec. Orders 2-2020 and 3-2020 and Providing for Expanded Telehealth to Montanans and All Officers and Agencies of the State of Montana (Mar. 20, 2020), https://covid19.mt.gov/_docs/Directive%20on%20Telehealth%203%2023%2020.pdf [https://perma.cc/PQ9A-THVF] (relaxing licensure and telehealth modality requirements); Memorandum from Mont. Gov. Steve Bullock on the Directive Implementing Exec. Orders 2-2020 and 3-2020 and Providing for the Use, Delivery, and Reimbursement of Telemedicine and Telehealth Services to All Montanans, Commercial Health Insurers, Health Plan Sponsors, and Health Care Providers (Apr. 21, 2020), https://covid19.mt.gov/_docs/4-21-20_telehealth_2.pdf [https://perma.cc/F3CW-G38Q] (relaxing technology requirements and prior relationship requirements).

117. *See, e.g.*, Mich. Exec. Order No. 2020-86 (May 14, 2020), https://www.michigan.gov/whitmer/0,9309,7-387-90499_90705-529458--,00.html [https://perma.cc/28LD-NMPA] (authorizing and encouraging public and private insurers to provide reimbursement for telehealth services) (no longer in effect); N.H. Emergency Order # 8 Pursuant to Exec. Order 2020-04 (Mar. 18, 2020), https://www.governor.nh.gov/sites/g/files/ehbemt336/files/documents/emergency-order-8.pdf [https://perma.cc/S7D3-YZWG] (requiring regulated insurers to cover medical services provided via telehealth). *But see* Tenn. Exec. Order No. 15 (Mar. 19, 2020), https://publications.tnsosfiles.com/pub/execorders/exec-orders-lee15.pdf [https://perma.cc/SGE5-SQEY] (urging carriers to provide coverage for all providers regardless of network status) (no longer in effect).

118. *See, e.g.*, Haw. Exec. Order No. 20-02 (Mar. 29, 2020), https://governor.hawaii.gov/wp-content/uploads/2020/03/2003219-ATG_Executive-Order-No.-20-02-distribution-signed.pdf [https://perma.cc/WS4R-GA6Y] (enabling out-of-state physicians to practice in Hawaii subject to certain conditions); Haw. Exec. Order No. 20-04 (Apr. 16, 2020), https://governor.hawaii.gov/wp-content/uploads/2020/04/2004089-ATG_Executive-Order-No.-20-04-distribution-signed.pdf [https://perma.cc/AG54-C3HB] (suspending certain licensure requirements).

119. Memorandum from Sarah Ream, Acting General Counsel on All Plan Letter 20-009: Reimbursement for Telehealth Services to All Health Care Service Plans (Mar. 18, 2020), http://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL%2020-009%20(OPL)%20-%20Reimbursement%20for%20Telehealth%20Services%20(3_18_20).pdf?ver=2020-03-18-105612-547 [https://perma.cc/S8YH-MEHL]; Colo. Dep't of Regul. Agencies, Div. of Insurance, Emergency Reg. 20-E-05: Concerning Coverage and Reimbursement for Telehealth Services During the COVID-19 Disaster Emergency (Apr. 3, 2020), https://drive.google.com/file/d/1RPT0thkoQv5bRU9GWh0Wr1UcVvPVjQoo/view [https://perma.cc/J3GE-LJHG]. *But see* Bulletin 20-01 from Jeffrey P. Rude, Wyo. Ins. Comm'r, on Requirements for Cost Sharing and Coverage Related to Respiratory Illnesses including COVID-19 to All Insurers to Transact Health Insurance in the State of Wyoming and Other Interested Parties (Mar. 11, 2020), https://cdn.cchpca.org/files/2020-04/Wyoming%20COVID-19%20Bulletin.pdf [https://perma.

for the duration of the state of emergency.[120] Fewer states have increased access to telehealth services via legislative action. For example, Alaska enacted a bill requiring insurers to cover mental health services delivered via telehealth.[121]

Most states have allowed medically necessary services for Medicaid beneficiaries to be provided via telehealth during the emergency period.[122] Some states also relaxed site or existing physician-patient relationship requirements for Medicaid to increase telehealth services.[123] The relaxation of site requirements by states allowed patients to receive services at home and sometimes allowed providers to deliver services at a location other than a medical facility, such as from the provider's home.[124] Some states added services that

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cc/8YT9-RBS9] (encouraging insurers to "liberalize telehealth services" because "[c]onsumers should have access to telehealth benefits through their current provider[s]").

120. *See, e.g.*, *Out of State MDs and PAs and Retired WV MDs and PAs Can Register to Practice*, W. VA. BD. OF MED., https://wvbom.wv.gov/Outofstateandretired.asp [https://perma.cc/P52G-ZJUC] (last visited Feb. 9, 2022) (allowing physicians and physician assistants with out-of-state licenses to provide healthcare services in West Virginia).

121. H.B. 29, 31st Leg., 2d Reg. Sess. (Alaska 2020).

122. *See* Memorandum from the Ala. Medicaid Agency on Alabama Medicaid Extends Temporary Telemedicine Coverage (Mar. 18, 2020), https://medicaid.alabama.gov/documents/1.0_ALERTS/1.0_2020/1.0_ALERT_Medicaid_Extends_Temporary_Telemedicine_Coverage_3-18-20.pdf [https://perma.cc/94R5-XLCE] (extending telehealth to provide medically necessary services for Medicaid recipients); Memorandum from the Ala. Medicaid Agency on Alabama Medicaid Extends Additional Behavioral Health Procedures Code Coverage via Telemedicine (May 21, 2020), https://medicaid.alabama.gov/alert_detail.aspx?ID=13909 [https://perma.cc/MGX7-57XZ] (expanding the Medicaid services which may be billed through telemedicine to include psychiatric and psychological testing and evaluation); Memorandum from the Ala. Medicaid Agency on COVID-19 Emergency Expiration Date Extended to June 30 (May 22, 2020), https://medicaid.alabama.gov/alert_detail.aspx?ID=13912 [https://perma.cc/7XNE-T47F] (extending the expiration date of the COVID-19 emergency period in relation to the Alabama Medicaid Agency).

123. *See* Memorandum from the N.J. Dep't of Hum. Servs. Div. of Med. Assistance & Health Servs. on the NJ FamilyCare Requirements for the Provision of Telehealth Services Under New Legislation and Corresponding Waivers to All Providers and Health Maintenance Organizations (Mar. 21, 2020), https://nj.gov/humanservices/library/slides/Temporary%20Telehealth%20Medicaid%20Newsletter%20FINAL.pdf [https://perma.cc/J3VH-D34N] (waiving site requirements and noting that providers were no longer required to review a patient's medical history and records before an initial encounter with a patient). *But see* Provider Bulletin No. 20-06 from the Neb. Div. of Medicaid and Long-Term Care on Providing Medicaid During COVID-19 (Mar. 17, 2020), http://dhhs.ne.gov/Medicaid%20Provider%20Bulletins/Provider%20Bulletin%2020-06.pdf [https://perma.cc/52PW-67W4] (offering reimbursement for telephone evaluations for situations including patients experiencing COVID symptoms, needing routine follow-up care, and needing behavioral health assessment or management, only when the patients seeking care were patients already covered by Nebraska Medicaid).

124. *See* N.J. Dep't of Hum. Servs., *supra* note 123.

could be provided to Medicaid beneficiaries via telehealth.[125] For example, Florida added mental health services and medication-assisted treatment services.[126] Notably, Florida also allowed out-of-state providers to treat Medicaid recipients during the state of emergency as long as the providers went through the state's provisional enrollment process if they were not already enrolled in the Florida Medicaid program.[127] In addition to the relaxations of the HIPAA Rules related to technology requirements at the federal level,[128] many states have further relaxed technology rules to allow providers to use telephones (i.e., audio-only technology) to provide services to Medicaid beneficiaries during the emergency period.[129]

Of course, states have frequently limited this expansion to telehealth access to only the emergency period defined in the relevant executive order or other declaration. However, the increase in telehealth access during the pandemic could catalyze a long-term increase in health care access as both state and federal governments consider permanently removing unnecessary regulatory hurdles to care. Furthermore, the potential long-term changes that agencies are exploring at the federal level to increase telehealth access[130] may guide states to implement some of these relaxations at the state level beyond the pandemic. As the next subpart will detail, it is critical that states with additional health care data security measures—those that go beyond what HIPAA provides—consider relaxing technological safeguards in sync with federal regulatory relaxations so that practitioners can expand telehealth access.[131]

B. HHS and OCR Changes to HIPAA

HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH) provide baseline health data privacy

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125. *Florida Medicaid Health Care Alert: Medicaid Telemedicine Guidance for Medical and Behavioral Health Providers*, AGENCY FOR HEALTH CARE ADMIN. (Mar. 18, 2020), https://ahca.myflorida.com/Medicaid/pdffiles/provider_alerts/2020_03/Medicaid_Telemedicine_Guidance_20200318.pdf [https://perma.cc/U4PS-FNTY].

126. *Id.*

127. *Id.*

128. *See infra* subpart IV.B.

129. *See* Memorandum from the Ga. Dep't of Cmty. Health on Telehealth Guidance for Medicaid/PeachCare Kids-Fee-for-Service Providers, GEORGIA MEDICAID (Mar. 18, 2020), https://medicaid.georgia.gov/covid-19 [https://perma.cc/J72N-RMKR].

130. *See infra* Part IV.

131. *See infra* Part IV.

and security rules.[132] The HIPAA Privacy Rule, Security Rule, and Breach Notification Rule protect the privacy and security of certain individual health information from disclosure by covered entities—which include health care providers and their business associates—and provide data breach notification rules. Sanctions for HIPAA violations include civil and criminal penalties.

Under HITECH, the HHS applied provisions from the Privacy Rule to business associates directly.[133] HITECH, which amended and updated the HIPAA Security Rule, requires covered entities and their business associates to have administrative, physical, and technical safeguards to guard against the impermissible disclosure of protected health information.[134] This subpart focuses on the technical safeguards in the HIPAA Rules.[135] These technical safeguards require providers and business associates to create policies and procedures to ensure that health information is protected from improper alteration or destruction. Only those people and programs that have access rights may obtain protected health information.[136] Furthermore, the technological safeguards require that the applications used to provide services and store protected health information contain certain auditing and logging functions.[137] Finally, and most importantly for expanding the use of telehealth, the technological safeguards require specific security measures to prevent unauthorized access to protected health information as it is being transmitted over an electronic communications network, such as firewalls or encryption in transit and at rest in certain circumstances.[138]

The HHS tried to create flexible, "technology neutral" standards because of rapid technological developments when it amended the

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132. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of 42 U.S.C.); Health Information Technology for Economic and Clinical Health Act, Pub. L. No. 111-5, 123 Stat. 115, 226 (2009) (codified as amended in scattered sections of 42 U.S.C.).

133. Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act; Other Modifications to the HIPAA Rules; Final Rule, 78 Fed. Reg. 5,566, 5,689 (Jan. 25, 2013) (codified as amended in scattered sections of 42 U.S.C.).

134. 45 C.F.R. §§ 164.302-.312 (2018).

135. *See id.* § 164.312 (2018).

136. *Id.*

137. *Id.*

138. *Id.*

HIPAA Rules.[139] The HHS did not want the HIPAA Rules to prohibit specific applications out of fear that they would quickly become obsolete. This flexible approach in the HIPAA Rules also seeks to allow covered entities to choose technologies that meet their specific needs but still meet the HIPAA requirements.

During the COVID-19 national emergency, covered entities may provide any telehealth services through remote communication technologies, some of which may not fully comply with the HIPAA Rules' technical safeguards.[140] The HHS relaxed these standards to allow providers to use non-public facing remote communication applications to treat patients, excluding applications like Facebook Live, Twitch, and TikTok.[141] The OCR will not impose sanctions for HIPAA Rules noncompliance so long as the provider acted in good faith.[142] However, providers "are encouraged to notify [their] patients that these third-party applications potentially introduce privacy risks."[143] Providers "should enable all available encryption and privacy modes when using [these] applications."[144] Under this standard, providers may use applications like FaceTime, Facebook Messenger, Google Hangouts, Zoom, or Skype to provide telehealth services without fear of penalties for noncompliance with the HIPAA Rules.[145]

While application creators of Skype for Business, Microsoft Teams, Zoom for Healthcare, and other common applications offer HIPAA-compliant applications, this relaxation allowed covered entities that traditionally provide in-person services to respond to the changing conditions in the COVID-19 pandemic and provide care via telehealth without the need to invest resources into new technology and without fear of sanctions.[146] These applications are also more readily accessible and understood by consumers, many of whom are receiving telehealth care for the first time. While the HHS and OCR have indicated that they do not intend to keep these changes permanently,

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139. U.S. Off. for C.R., *Do the Standards of the Security Rule Require Use of Specific Technologies?*, U.S. DEP'T HEALTH & HUM. SERVS. (July 26, 2013), https://www.hhs.gov/hipaa/for-professionals/faq/2011/do-the-standards-of-the-security-rule-require-use-of-specific-technologies/index.html [https://perma.cc/Y5HS-CJPB] (from HHS's "FAQ" webpage for healthcare professionals).

140. U.S. Off. for C.R., *supra* note 8.

141. *Id.*

142. *Id.*

143. *Id.*

144. *Id.*

145. *Id.*

146. *See id.*

these relaxations have facilitated increased health care access. Data privacy should concern federal and state governments, but legislatures and agencies should also seek to minimize the regulations necessary to address these concerns to ensure that governments facilitate the growth of telehealth access.

C. *CMS Expansion of Telehealth*

President Trump's executive order to improve telehealth access provided the U.S. Secretary of HHS the authority to review temporary flexibilities put in place during the public health emergency and to propose a new regulation extending these measures permanently, including "additional telehealth services offered to Medicare beneficiaries" and "the services, reporting, staffing, and supervision flexibilities offered to Medicare providers in rural areas."[147] The CMS has more than doubled the allowed telehealth services during the public health emergency.[148] Among other added services, the CMS is considering permanently reimbursing or allowing telehealth home visits for the evaluation and management of a patient and certain telehealth visits for patients with cognitive impairments.[149]

Before the COVID-19 pandemic, doctors, nurse practitioners, and physician assistants were the only providers allowed to deliver telehealth services.[150] As a result of the public health emergency, the CMS first waived its limitations on which health care providers can furnish telehealth services.[151] The CMS extended this ability to other providers, including physical therapists, occupational therapists, and

147. Improving Rural Health and Telehealth Access, Exec. Order No. 13941, 85 Fed. Reg. 47,881 (Aug. 3, 2020).

148. *Fact Sheets: President Donald J. Trump Is Expanding Access to Telehealth Services and Ensuring Continued Access to Healthcare for Rural Americans*, WHITE HOUSE (Aug. 3, 2020), https://trumpwhitehouse.archives.gov/briefings-statements/president-donald-j-trump-expanding-access-telehealth-services-ensuring-continued-access-healthcare-rural-americans/ [https://perma.cc/V3JS-AQP5]. During the public health emergency, CMS has been circumventing a formal rulemaking process when adding services. *See* U.S. Ctrs. for Medicare & Medicaid Servs., *supra* note 9.

149. Press Release, U.S. Ctrs. for Medicare & Medicaid Servs., Trump Administration Proposes to Expand Telehealth Benefits Permanently for Medicare Beneficiaries Beyond the COVID-19 Public Health Emergency and Advance Access to Care in Rural Areas (Aug. 3, 2020), https://www.cms.gov/newsroom/press-releases/trump-administration-proposes-expand-telehealth-benefits-permanently-medicare-beneficiaries-beyond#:~:text=CMS%20is%20proposing%20to%20permanently,for%20patients%20with%20cognitive%20impairments [https://perma.cc/JK6D-M2N4].

150. U.S. Ctrs. for Medicare & Medicaid Servs., *supra* note 9.

151. *Id.*

speech-language pathologists.[152] Second, hospitals were permitted to bill for services that patients received from providers at their homes, whereas site limitations existed before the emergency.[153] Third, the CMS declined to enforce any requirements that the patient and practitioner have a prior relationship before receiving telehealth services.[154] Finally, related to the HIPAA relaxations for certain types of technologies, the CMS expanded this relaxation to the use of everyday technology by agreeing to reimburse services provided by *telephone only*, rather than just audio-visual, including behavioral health and patient education services.[155]

D. DEA Relaxations for Scheduled Prescription Drugs

Previously, prescribing practitioners were required to conduct an in-person medical evaluation before prescribing controlled substances.[156] The DEA relaxed its regulations to allow registered practitioners to issue prescriptions for controlled substances to patients even if providers did not conduct in-person medical evaluations so long as the following requirements were met: (1) "The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice," (2) "[t]he telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system," and (3) "[t]he practitioner is acting in accordance with applicable Federal and State law."[157]

The pandemic catalyzed a dramatic increase in the use of telehealth. Telehealth is a practical means of providing health care access to populations that regularly experience barriers to health. However, as providers consider offering their services via telehealth, state and federal government entities should minimize providers' regulatory hurdles. Patients' continued use of telehealth services despite the offerings of in-person care suggests that patients are

152. *Id.*

153. *Id.*

154. Press Release, U.S. Ctrs. for Medicare & Medicaid Servs., Medicare Telemedicine Health Care Provider Fact Sheet (Mar. 17, 2020), https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet [https://perma.cc/WEJ4-H484].

155. U.S. Ctrs. for Medicare & Medicaid Servs., *supra* note 9 ("Since some Medicare beneficiaries don't have access to interactive audio-video technology that is required for Medicare telehealth services, or choose not to use it even if offered by their practitioner, CMS is waiving the video requirement for certain telephone evaluation and management services.").

156. 21 U.S.C. § 802(54) (2018).

157. U.S. Drug Enf't Admin., *supra* note 10.

satisfied with the level of care they have received.[158] During the pandemic, providers have offered safe, satisfactory care despite the relaxation of restrictions at both the state and federal level. While government entities should continue to consider the rationales underpinning the former regulations restricting the use of telemedicine, such as protecting patients' health care data in the HIPAA Rules, they must balance these concerns with ensuring that Americans—especially rural populations and communities of color—have access to health care in general, even after the pandemic.

IV. BEYOND THE PANDEMIC: REMAINING CHALLENGES TO EXPAND TELEHEALTH AND REDUCE HEALTH CARE DISPARITIES

To ensure increased access to health care with telehealth, various structural and regulatory roadblocks need to be addressed. This requires state and federal governments to make permanent relaxations addressed during the pandemic as well as ensure that the necessary technology is widely available.[159] Yet, these changes signal a broader applicability beyond the current health crisis.

When the pandemic is over, low-income and rural populations will still have problems obtaining care and health care disparities will still negatively affect patients of color.[160] Some communities will still lack providers.[161] Modern technology provides a practical means of addressing the problem of access. A provider and patient do not have to be in the same community or even the same state for the patient to receive care via telehealth.

Regulatory roadblocks prevent widespread use of telehealth. The regulations, presumably designed to maintain a certain level of quality of health care, suggest a former lack of trust in utilizing technology to provide health care.[162] Before ensuring the delivery of high-quality

158. In a recent AARP survey, most Americans were interested in telehealth, and almost 75% of those interested would consider telehealth for a routine primary care visit. *Views on Telehealth*, AARP 1, 5 (June 2020), https://www.aarp.org/content/dam/aarp/research/surveys_statistics/health/2020/views-on-telehealth.doi.10.26419-2Fres.00388.001.pdf [https://perma.cc/GNP6-9XDB].

159. *See infra* subpart V.B.

160. *See supra* subpart III.B.

161. *See* Skinner et al., *supra* note 56.

162. *See, e.g.*, Securing Updated and Necessary Statutory Evaluations Timely, 85 Fed. Reg. 70096 (Nov. 4, 2020). HHS has issued a proposed rule that would require it to review regulations that are more than ten years old. Otherwise, the rule would act as a sundown provision and remove outdated or unnecessary regulations. It proposed this rule after

care, however, the government should first ensure that people have actual access to care. Furthermore, the pandemic showed that telehealth can help provide quality care, even with these temporary regulatory relaxations.[163] As such, policymakers must look beyond the current health care crisis to see the potential for telehealth to address health care access problems and health disparities.

This Part highlights existing regulatory roadblocks to the wider usage of telehealth, offering clear options for reform. The following subpart then takes this basket of reforms and explores specific legislative options to implement them across the country.

A. *Expanding Infrastructure*

For regulatory changes to successfully expand access to care, policymakers must ensure that all patients are equipped with the necessary technology and education to meaningfully participate in telehealth. Many patients do not possess the requisite technology to attend a telehealth appointment. While most Americans own a smartphone, ownership is concentrated among those under age sixty-five.[164] Among patients over age sixty-five, nearly 40% lack a smartphone.[165] For seniors, digital illiteracy—like lack of familiarity with applications like Zoom or Microsoft Teams—can impede the use of telehealth. Only "26% of [I]nternet users ages 65 and over say they feel very confident when using computers, smartphones or other electronic devices."[166]

Even if a patient has access to a device, there may be issues with connectivity that interrupt or prevent a telehealth appointment. Communities of color and low-income households are more likely to be smartphone-dependent Internet users, meaning they lack traditional in-home broadband Internet service.[167] Likewise, rural communities are less likely than urban or suburban areas to have in-home broadband

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discovering that more than 85% of its regulations created prior to the 1990s have not been amended. *Id.* at 70101-02.

163. *See infra* subpart V.B.

164. *See Mobile Fact Sheet*, PEW RSCH. CTR. (Apr. 7, 2021), https://www.pewresearch.org/internet/fact-sheet/mobile/ [https://perma.cc/BH6E-JNYY] ("97% [of Americans] own a cellphone of some kind.").

165. *Id.* (finding only 61% of Americans sixty-five or older own a smartphone).

166. Monica Anderson & Andrew Perrin, *Tech Adoption Climbs Among Older Adults*, PEW RSCH. CTR. 1,10 (May 17, 2017), https://www.pewresearch.org/internet/2017/05/17/barriers-to-adoption-and-attitudes-towards-technology/ [https://perma.cc/A7V6-TKR4].

167. PEW RSCH. CTR., *supra* note 164.

Internet.[168] Wired Internet connections are often stronger than cellular data, which is also subject to monthly data limits. For smartphone dependent households, there may simply not be enough data to sustain a telehealth appointment. If telehealth expansion fails to address these barriers, it will only serve to further entrench health care disparities.

B. *Restrictions on Technology*

For certain services, CMS regulations currently require video conferencing technology and exclude audio-only technology such as landlines.[169] For the duration of the COVID-19 emergency, the CMS waived this requirement, allowing patients to receive audio-only care for (1) telephone evaluation and management services, (2) behavioral health counseling, and (3) educational services.[170]

Furthermore, while the technological safeguards under HIPAA do not technically prohibit specific platforms or applications, such as Zoom, the technological safeguards do restrict providers from using certain popular and more readily available platforms.[171] Additionally, compliant technologies, such as Zoom for Healthcare, may require a substantial investment by the provider. Thus, it is possible that the costs of compliant technology may be prohibitive, especially for rural providers or providers in low-income communities who receive reimbursement from public insurers as their primary means of reimbursement.[172] For the duration of the pandemic, covered entities have been allowed to provide telehealth services using non-public facing technologies that may not fully comply with the HIPAA technical safeguards without fear of sanctions, so long as those entities acted in good faith.[173]

While policymakers should continue to be concerned with protecting people's health information and data, they should reevaluate the current restrictions to determine if they could address these concerns in a way that is potentially less costly to providers. Policymakers should address these excess restrictions on technology sources at both the federal level by relaxing the HIPAA technological

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168. Andrew Perrin, Pew Rsch. Ctr., *Digital Gap Between Rural and Nonrural America Persists*, MEDIUM (May 31, 2019), https://medium.com/@pewresearch/digital-gap-between-rural-and-nonrural-america-persists-53bec5ebc6de [https://perma.cc/757Z-DP6H].

169. *See* 42 C.F.R. § 410.78(a)(3) (2020).

170. U.S. Ctrs. for Medicare & Medicaid Servs., *supra* note 9.

171. *Id.*

172. *See supra* subpart III.A.

173. U.S. Off. for C.R., *supra* note 8.

safeguards and at the state level to prevent additional, unnecessary technological restrictions. A new framework should ensure that common technologies are not overly restricted and that the required safeguards are not prohibitively expensive for providers in rural and low-income areas.

Furthermore, this framework should include audio-only technology, such as landlines, as a permitted technology so that patients who lack access to smart phones or Wi-Fi may still choose telehealth as a means of accessing health care. If audio-visual technology provides a meaningful improvement in the delivery of care, it could be required unless the patient does not have access to that technology, in which case audio-only technology would be permissible. In this way, providers may employ the best technology available when providing services but have access to lower-level technology when patients cannot access certain platforms.

The inclusion of audio-only technology as a permissible means of providing telehealth services is especially important for patients who live in rural areas without reliable Internet or cell service and patients who cannot afford computers, smart phones, or tablets that support more advanced applications. While audio-only technology obviously precludes a practitioner from performing a visual examination, telehealth care over a home phone line may also be the only consistent way in which some populations are able to access care. Therefore, policymakers need to be mindful of this reality and prioritize access to care.

C. Billing

Policymakers should address at least three broad categories of regulations related to billing at both the federal and state levels to increase access to telemedicine. First, regulations should not require providers to meet their patients in person to establish a relationship prior to the provision of telehealth unless an in-person meeting is medically necessary. Second, policymakers should remove site restrictions. Finally, pay parity should ensure that providers who care for patients in-person and those who provide care via telehealth receive the same reimbursement.

First, some states have restrictions on how a physician-patient relationship can be established, such as restricting the location in which a patient must receive care or the modality by which the patient

receives care.[174] Many states have relaxed these restrictions during the COVID-19 pandemic.[175] Patients living long distances from a provider or those who do not have access to reliable sources of transportation and who need routine check-ups that do not require a visual examination should be able to access initial care via telehealth. Eliminating requirements that providers and patients must establish a care relationship in person prior to the provision of telehealth (absent medical necessity to do so) will balance important competing concerns. On one hand, requiring an in-person consultation when a physician believes that this is necessary will promote the provision of high-quality care. When this consultation is not medically necessary, however, eliminating the requirement that it take place will not overly restrict the ability of patients to access care.

Second, the CMS has historically restricted Medicare reimbursement, based on both the originating site—the patient's location when a service is provided—and the distant site—the physician's location when the service is delivered.[176] Likewise, states may impose site restrictions for Medicaid reimbursement.[177] Addressing the COVID-19 pandemic under the CARES Act, the CMS relaxed some of the more restrictive site-based restrictions. For example, it allowed rural health clinics and federally qualified health centers to serve as distant sites, whereas previously they could not be reimbursed for the provision telehealth services since they were not distant sites.[178] Both state governments and the federal government

174. *See, e.g.*, Memorandum from the N.J. Dep't of Hum. Servs. Div. of Med. Assistance & Health Servs. on the NJFC Coverage and Reimbursement for Telemedicine and Telehealth Services to All NJ FamilyCare (NJFC) Providers and Health Maintenance Orgs. (Sept. 2018), https://www.matrc.org/wp-content/uploads/2019/08/NJ-Medicaid.pdf [https://perma.cc/2JML-KGXC] (declaring when an entity is an independent clinic, the service may only be billed if it is provided while the patient is located at the clinic); MONT. CODE ANN. § 33-22-138(6)(d) (2019) (noting that telemedicine does not include use of audio-only telephone, email, or facsimile transmissions); MONT. ADMIN. R. §24-156-813 (2018) (stating that a physician-patient relationship can be established in one of three ways, including through telemedicine, but only if the standard of care does not require an in-person exam).

175. *See* sources cited *supra* notes 116, 123.

176. 42 U.S.C. § 1395m(m) (2018).

177. *See, e.g.*, ANDREW M. CUOMO ET AL., FREQUENTLY ASKED QUESTIONS REGARDING USE OF TELEHEALTH INCLUDING TELEPHONIC SERVICES DURING THE COVID-19 STATE OF EMERGENCY 6 (2020) (noting that distant sites, specifically for the duration of the COVID-19 state of emergency, may be any site within the United States or its territories, including providers' homes and Federally Qualified Health Centers).

178. Press Release, Medicare Learning Network, Ctrs. for Medicare & Medicaid Servs., New & Expanded Flexibilities for RHCs & FQHCs During the COVID-19 PHE (Feb. 23, 2021) https://www.cms.gov/files/document/se20016.pdf [https://perma.cc/679M-BQKP]

have likewise allowed a physician's home to serve as a distant site during the national emergency.[179] They have removed originating site restrictions, such as restrictions on telehealth services for patients outside of rural areas.[180] Thus, patients can receive telehealth services in their home, and their providers can be reimbursed for providing those services from their own homes.

Maintaining these relaxed site-based restrictions must continue for telehealth to reach its full potential to expand access to care. This Article has established that rural populations struggle with obtaining care and that patients in urban areas often struggle to access reliable means of transportation, creating similar access issues and exacerbating health disparities.[181] Telehealth has the potential to improve access to care among both rural and urban populations. But originating site restrictions overly burden the ability of patients to access telehealth by forcing them to receive their care in specific locations. Absent medical necessity for a different site, patients' homes (whether located in a rural or urban area) should be permissible originating sites, and telehealth providers should be able to seek reimbursement for services provided to a patient who is at home. Similarly, providers' homes should, absent some medical necessity, qualify as distant sites.

Third, during the pandemic, the CMS and states have required reimbursement parity between services provided in-person and telehealth services, which increases incentives for providers to offer telehealth services.[182] By incentivizing providers to deliver care via telehealth, governments have removed meaningful roadblocks to the ability of patients to access care. Ensuring buy-in from providers will be key to expanding access in the long term. Even if all the

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(allowing rural health clinics and federally qualified health centers to provide distant site telehealth services during the pandemic); CARAVAN HEALTH, TELEHEALTH BEFORE AND AFTER COVID-19 (J. Findley & A. Loengard eds., 2020) (stating that after the pandemic, rural health clinics and federally qualified health centers could serve as distant sites).

179. Press Release, *supra* note 178; CARAVAN HEALTH, *supra* note 178; CUOMO ET AL., *supra* note 177.

180. *See supra* subpart IV.A; *see also* 42 U.S.C. § 1395m(m) (2018) (stating the previous originating site restrictions).

181. *See supra* subpart III.A.

182. Press Release, U.S. Ctrs. for Medicare & Medicaid Servs., Trump Administration Makes Sweeping Regulatory Changes to Help U.S. Healthcare System Address COVID-19 Patient Surge (Mar. 30, 2020), https://www.cms.gov/newsroom/press-releases/trump-administration-makes-sweeping-regulatory-changes-help-us-healthcare-system-address-covid-19 [https://perma.cc/752T-N6C6].

impediments to accessing care discussed above and below are eliminated, patients will only be able to access telehealth services if providers are willing to deliver those services. Accordingly, pay parity and the incentives it creates is a necessary component of the continued expansion of telehealth.

D. *Restrictions on Prescription Drugs*

Throughout the pandemic, the DEA has worked alongside the HHS to relax restrictions on prescriptions. It has allowed practitioners to issue prescriptions for controlled substances to patients during the pandemic, even if those providers have not conducted a prior in-person medical evaluation.[183] This relaxation, however, still requires a consultation using audio-video technology.[184]

Continued access to care following the pandemic requires that this temporary relaxation become permanent. Patients must be able to obtain the prescriptions needed for their treatment to have meaningful access to care. As discussed above, policymakers should also re-examine whether audio-visual technology is a necessary requirement. On one hand, the added visual technology may provide additional safeguards, such as an additional means of identification, preventing the issuance of inappropriate or harmful prescriptions. On the other hand, patients may not have access to audio-visual technology, so this requirement could preclude them from obtaining the medication that they need for meaningful care.[185]

E. *Health Care Provider Licensing and Liability*

An obvious prerequisite to delivering telehealth services is a health care provider willing, and more importantly, able to provide those services. This can present an important problem because, often, the states most in need of telehealth services—like those with large rural populations—have the most acute shortages of health care providers. Indeed, a recent study in the *New England Journal of Medicine* found that physician shortages affect all areas of the country but have the largest impacts on rural areas.[186] With such shortages affecting states with rural populations to a greater extent, simply

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183. *See supra* subpart IV.D.
184. *See supra* subpart V.B.
185. *See supra* subpart V.B.
186. Skinner et al., *supra* note 56, at 300.

expanding access to telehealth may not effectively extend health care access to all individuals who currently lack it.

Allowing health care providers to practice across state lines offers a mechanism to alleviate location-based provider shortages. For example, Massachusetts has the highest number of physicians per capita among all states and Mississippi has the lowest.[187] Expanding access to telehealth in Mississippi may ease the burden on Mississippi physicians in reaching patients in isolated areas, but that may not be sufficient to facilitate access to all those who need care. Allowing Massachusetts physicians (and physicians from other states) to treat patients in Mississippi could alleviate existing location-based provider shortages and further expand access to the states who suffer most from provider shortages. Such a mechanism could allow states with excess physician capacity to address shortages in states that lack sufficient capacity.

Typically, a fully-licensed physician in Massachusetts cannot provide care to a patient located in Mississippi without first obtaining a Mississippi medical license. The place of service refers to the location where services are received, meaning that providers need to acquire licenses for all states where they plan to provide telehealth services.[188] States have already taken limited steps to address these cross-border problems. For example, the nursing license compact allows registered nurses with a license in one compact-member state to practice in another compact-member state without obtaining a separate license.[189] By joining the compact, states offer an important mobility benefit to their own licensees and gain access to a larger supply of nurses who can immediately practice in the state. States have also entered into the interstate medical licensure compact.[190] This compact offers fewer

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187. AM. ASS'N MED. COLL., 2019 STATE PHYSICIAN WORKFORCE DATA REPORT, 7 (2019), https://store.aamc.org/downloadable/download/sample/sample_id/305/ [https://perma.cc/KV5Q-E9K7].

188. *See Place of Service Code Set*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS. (Sept. 2021), https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set [https://perma.cc/MM6M-MEEM].

189. Kathleen Gaines, *Compact Nursing States List 2021*, NURSE.ORG (July 7, 2021), https://nurse.org/articles/enhanced-compact-multi-state-license-eNLC/ [https://perma.cc/8RF7-C48Z] ("The Nursing Licensure Compact (NLC) is an agreement between states that allows nurses to have one license but the ability to practice in other states that are part of the agreement.").

190. *Physician Licensure*, INTERSTATE MED. LICENSURE COMPACT, https://www.imlcc.org/a-faster-pathway-to-physician-licensure/ [https://perma.cc/BH6L-C95L] (last visited Feb. 9, 2022) ("The Interstate Medical Licensure Compact is an agreement among participating

substantive benefits to physicians than the nursing license compact offers to nurses. Physicians with a license in compact-member state wishing to practice in another compact-member state must still obtain a new license in the second state. However, the requirements for doing so are significantly reduced relative to states that choose not to join the compact. The interstate medical licensure compact reduces burdens even further for physicians wishing to provide telehealth services.

Like the cross-border concerns around licensing health care providers who can deliver telehealth services, malpractice liability can vary substantially from state to state. Providing telehealth services across state lines may also implicate the liability systems of multiple states. When a Massachusetts physician provides care to a patient in Mississippi, which state's laws govern the physician's liability is an important question. Typically, the place of service is defined as the location where the patient receives treatment, consistent with the definition for the purposes of licensing providers.[191] While conflict of laws issues may complicate which state's laws apply to a greater extent than in the licensing context, the fact remains that malpractice liability creates substantial uncertainty around the provision of telehealth. A new framework for expanding access to care via telehealth must address this uncertainty. While implementing new tort reforms or removing the threat of liability altogether is almost certainly a step too far, providers could more easily provide services across state lines if they (and their malpractice insurers) know which state's malpractice liability scheme will apply.

Given the complicated state and federal challenges that must be overcome to pave the way for a health care system that embraces telehealth, and the expanded access to care that comes with it, a new regulatory scheme is needed. The next Part engages with different forms this scheme may take.

V. RETHINKING REGULATION FOR THE TELEHEALTH AGE

To address the remaining challenges to the expansion of telehealth, we argue that a new regulatory framework is required. In building this framework, a key threshold question is the relative involvement of the federal and state governments. Because many of the

U.S. states to work together to significantly streamline the licensing process for physicians who want to practice in multiple states.").

191. *See* U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 188.

existing impediments discussed above come from federal statutes and regulations, Congress must become involved. However, other roadblocks exist in the realm of state government, and an important question is the role of states in regulating telehealth going forward. States could take independent action or band together to take collective action to eliminate certain impediments, or Congress could simply preempt state law to address various problems itself. However, "the core of our federal system is the principle that the states should take the lead unless there is a need for [federal] action."[192] And "Congress has historically proven unwilling to repeal important areas of state regulation wholesale, especially in health care."[193]

Given these concerns, we operate under the assumption that, though Congress could take all the necessary actions to improve access to telehealth discussed below, doing so would not be politically feasible. Accordingly, we begin constructing a new telehealth framework by focusing on areas that Congress must address. We then move on to issues that are better suited to resolution at the state level.

A. Protecting Access to Post-COVID-19 Telehealth Act

Agency action can address many of the problems identified in the preceding section. While certainly important for some problems, that approach lacks the ability to move telehealth forward in a clear and centralized fashion. Instead, we advocate in favor of addressing these issues via legislation. Introduced in the 2021 session, the Protecting Access to Post-COVID-19 Telehealth Act is designed to remove certain regulatory roadblocks to the continued expansion of telehealth.[194] However, it does not offer complete solutions to all the problems outlined above, and we argue that further steps must be taken. For example, Congress could rewrite the relevant portions of HIPAA that impede rural patients' access to telehealth. In addition to removing roadblocks to the functioning of telehealth directly, the Act should direct relevant federal agencies to develop new rules to promote access to telehealth instead of impede it, which it has done in part in the current version of the bill allowing HHS to expand telehealth services during

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192. Nicholas Bagley, *Federalism and the End of Obamacare*, 127 YALE L.J.F. 1, 1-2 (2017).

193. Gabriel Scheffler, *Unlocking Access to Health Care: A Federalist Approach to Reforming Occupational Licensing*, 29 HEALTH MATRIX 293, 350 (2019).

194. *See supra* note 17 and accompanying text.

future emergencies.[195] Rewriting the entire Act is well beyond the scope of this Article, but any useful version of that Act would address and eliminate the impediments to accessing telehealth described in previous sections. Thus, this Article calls policymakers to address each of these areas in the Act.

At first blush, enacting a new federal law to address the issues around telehealth appears to be a drastic departure from Congress's involvement in health care in the past. However, a closer inspection reveals that this is not the case. Eliminating federal barriers to telehealth is well within Congress's power under the Commerce Clause, since that clause supported the enactment of the laws that have since become burdensome. Removing them and installing new laws in their place creates no constitutional problems.

On the other hand, addressing roadblocks created by state law (or that state law has failed to remove) may prove more difficult. Congress could attempt to address the problems associated with cross-state telehealth practices created by state-based licensing regimes or the issues created by state malpractice law. Given how tightly these two issues have become intertwined with the delivery of health care in the United States, addressing them almost certainly falls within Congress's commerce power. However, "the core of our federal system is the principle that the states should take the lead unless there is a need for [federal] action."[196] And "Congress has historically proven unwilling to repeal important areas of state regulation wholesale, especially in health care."[197]

Thus, even if Congress could confront cross-state licensing and malpractice liability problems, it likely would decline to do so. Accordingly, in addition to the Act, this Article recommends a new Telehealth Interstate Compact. The next subpart provides the details of this compact. Before doing so, it is worth noting that everything that this Compact could accomplish, the Act could similarly accomplish. The advantage of doing so via the Compact instead of the Act is that the existing balance of federalism with health care regulation continues. While this has important benefits it also makes achieving the goals detailed in this Article more politically feasible.

195. *See supra* note 17.
196. Bagley, *supra* note 192, at 2.
197. Scheffler, *supra* note 193, at 350-51.

B. Interstate Telehealth Compact

States cannot override federal law, but they can certainly work together to jointly combat problems created by their own laws. Of course, individual states could take steps to improve access to telehealth within their borders. Given the interstate nature of many of the problems detailed above, however, a joint effort would offer both standardization and a means to encourage more states to join.

To the extent state regulations, such as billing or restrictions on technology, mirror their federal counterparts, the first step in creating a successful Interstate Telehealth Compact would be to eliminate those regulations. By standardizing billing for telehealth via state statute across the country, providers can be confident that delivering telehealth services will provide them with adequate remuneration. Similarly, by standardizing technology requirements, a physician in Massachusetts who sees patients in Massachusetts, Mississippi, and Michigan need not worry about different technology regulations. If Massachusetts accepts the platform, the physician can be confident that Mississippi and Michigan do as well under a well-functioning compact.

Cross-state licensing and malpractice liability are thornier issues. However, the Interstate Telehealth Compact offers both a meaningful and feasible path to reform. Indeed, as discussed above, states have already entered into interstate compacts that address licensure problems in a limited fashion. Building on these existing initiatives would allow states to take advantage of current momentum. And Congress has already considered becoming involved to encourage states to take this path. Congress expressed interest in encouraging states to join the interstate medical licensure compact. For example, a bill introduced in late 2020 would have withheld funding from the Bureau of Health Workforce from states that refused to join the compact.[198] While congressional pressure could spur states to action, policymakers should focus on the content of the compact itself first. They could begin by expanding the language from the interstate medical licensure compact in a telehealth compact.

At minimum, any telehealth compact should adopt the approach of the nurse licensure interstate compact, which allows nurses with a license from one compact state to practice in any other compact state

198. Eric Wicklund, *New Telehealth Bill Would Penalize States Who Don't Join Licensure Compact*, MHEALTH INTEL. (Nov. 24, 2020), https://mhealthintelligence.com/news/new-telehealth-bill-would-penalize-states-who-dont-join-licensure-compact [https://perma.cc/5K5S-UFXF].

without obtaining a new license. Doing so would facilitate cross-border practices to a greater degree than simply curtailing fees or offering a streamlined licensing process. An even better approach would involve the elimination of licensing requirements at all. Accomplishing this goal would require relatively small changes to current law.

States could agree in the telehealth compact that the place of service is the location of the provider not the patient. Currently, providers who practice in (and are licensed by) Massachusetts cannot provide telehealth services to patients in Mississippi because those providers lack Mississippi licenses. They do, however, possess Massachusetts licenses. By redefining the place of service to Massachusetts (the location of the provider) from Mississippi (the location of the patient), those providers can easily care for Mississippi patients. And they can do so without any additional regulatory burdens, including the need to obtain a Mississippi license.

Such an approach may appear unnecessarily de-regulatory at first glance, but the requirements for obtaining a medical (or other type of health care) license in Massachusetts and Mississippi are remarkably similar. Both states rely on national certifying bodies to test the competency of physicians at all levels of practice from the first test medical students complete before encountering patients to the final requirements for board certification by national boards. While Mississippi may forgo a trivial amount of revenue by agreeing in a telehealth compact to not require re-licensure of Massachusetts physicians, the Mississippi legislature should have no compunction about ceding the responsibility of quality assurance in the health care workforce to the Massachusetts legislature.

Redefining the place of service to the location of the health care provider confers additional important benefits. Those providers need not learn a new regulatory system because their home state would continue to monitor their activities. The Mississippi legislature or various Mississippi agencies may have some concerns about allowing Massachusetts to regulate providers caring for Mississippi residents. However, Mississippi residents are already free to travel to Massachusetts to receive care if they wish, so allowing Massachusetts to maintain responsibility for provider quality at most eliminates the expenses incident to such travel.

Beyond eliminating unnecessary regulatory burdens, redefining the place of service to be the provider's location can streamline other, less obvious, aspects of health care provision, including malpractice

liability. More specifically, defining the place of service as the provider's location determines which state's malpractice laws will apply should the provider fail to satisfy the standard of care. As with the regulatory effects discussed above, defining the place of service as the provider's location will effectively cede control over malpractice liability to the state where the provider resides. And this may cause some states discomfort as their courts lose the ability to exercise a significant degree of control over providers caring for patients in their state. Overall, however, defining the place of service solves more problems than it causes in the context of malpractice liability.

First, and most importantly, surrendering some control over malpractice liability will result in broader access to health care for those who need it most. States have already demonstrated their willingness to immunize health care providers from medical liability in the wake of the COVID-19 pandemic. This immunization was justified for a variety of reasons,[199] but the willingness of states to essentially eliminate the threat of liability to address a health care crisis demonstrates that liability concerns can give way to broader concerns over people's health. COVID-19 has taken many lives, but so have diabetes, heart disease, and any number of chronic conditions that are manageable with the proper care. If states are willing to effectively give up all control over malpractice in the context of COVID-19, they should be willing to give up some lesser degree of control to combat other diseases.

Second, even if states worry about losing some control over malpractice liability, this liability may be less important in the telehealth context than care delivered via traditional methods. Many types of malpractice can occur only when a provider delivers care in person. For example, a provider will find it quite impossible to amputate the wrong limb or give the wrong injection when that provider is miles (potentially thousands of miles) away from the patient. Providers can certainly still commit malpractice via telehealth by, for example, misdiagnosing a patient, failing to refer the patient for specialty care, or writing an incorrect prescription. Malpractice liability remains a relevant concern because of the potential for these errors, but a large swath of medical errors simply cannot occur when providers deliver care remotely.

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199. Benjamin J. McMichael et al., *COVID-19 and State Medical Liability Immunity*, HEALTH AFFS. (May 14, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200508.8085890/full/ [https://perma.cc/WGF7-M26Q].

Overall, by solving both cross-state licensure and malpractice issues, an Interstate Telehealth Compact could pave the way for increased access to telehealth services. In doing so, it could maintain the existing state-federal balance in health care regulation, obviating any need for Congress to preempt large sections of state law. In other words, while an Interstate Telehealth Compact may prove more logistically difficult to implement because it requires the assent of more than fifty separate jurisdictions, it is more politically feasible by avoiding what would essentially be a federal coup in the health care arena.

VI. CONCLUSION

The COVID-19 pandemic highlighted a longstanding, but fundamental, problem in the American health care system. Many people lack access to care. By that, we do not mean an inability to pay for care. We refer to the more basic, and more troubling, problem of an inability to access care at all. Inability to access care disproportionately affects rural communities and populations of color. Over a decade ago, the Affordable Care Act took steps to alleviate the inability to pay problem. In the wake the pandemic, the time has come to alleviate the more fundamental access problem. And telehealth offers a meaningful avenue of doing so.

Expanding access to telehealth requires much less of policymakers than did the Affordable Care Act. With that Act, Congress had to marshal billions of dollars in support of various initiatives. The Act as proposed here can expand access primarily by eliminating existing regulatory barriers. Providers are already ready, willing, and able to provide care via telehealth. The Act need only remove impediments to their doing so. Of course, funding various initiatives offers a better chance of success, particularly if funding is required to equalize reimbursement for telehealth services or the construction of telecommunications infrastructure. But simply removing existing barriers can solve many of the current problems.

To maintain the current federal-state balance in health care regulation, an ideal policy package would include an Interstate Telehealth Compact alongside the Affordable Care Act. The combination of these two policies could meaningfully address the racial, geographic, and socioeconomic disparities in health care. In other words, expanding access to telehealth offers a real chance to address some of the fundamental inequity in the health care system.