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GOING ONLINE WITH TELEMEDICINE: WHAT BARRIERS EXIST AND HOW MIGHT THEY BE RESOLVED?

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With the advancement of telecommunications, telemedicine has been pushed to the forefront of medical practices by the federal government as a solution to the United States health care system's historical issues of limited access to health care and spiraling health care delivery costs.[1] Telemedicine is defined by the World Health Organization as "the delivery of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries."[2] It is a tool being used by a broad spectrum of medical fields, acting as versatile solution for various health disparities facing today's global populations. In practice, telemedicine can take a variety of forms. Most commonly, patients will seek care at a clinic, meeting with a nurse, physicians' assistant, or trained technician, and then that provider will call or engage in a video chat with a licensed physician who considers the information gathered by the provider and who issues an order for care. In 2010, a study of industrialized nations concluded that the U.S. ranked lowest in "quality, efficiency, access to care, equity, and

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[1] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119; Sharon Klein & Jee-Young Kim, *Telemedicine and Mobile Health Innovations Amid Increasing Regulatory Oversight*, WESTLAW J. HEALTH CARE FRAUD, Sept. 24, 2014, 20 No. 3 Westlaw Journal Health Care Fraud 9.

[2] WORLD HEALTH ORG., TELEMEDICINE: OPPORTUNITIES AND DEVELOPMENTS IN MEMBER STATES: REPORT ON THE SECOND GLOBAL SURVEY ON EHEALTH 9 (2009), *available at* http://whqlibdoc.who.int/publications/2010/9789241564144_eng.pdf?ua=1.

the ability to lead long, healthy, productive lives," marking that while the nation may be a global leader in most contexts, the U.S. is greatly behind when it comes to the health of our nation.[3] This trifecta of issues – limited access, high cost, and poor quality – can be attributed to the complex environment of medical care in the United States, in which insurance companies, state medical boards, physicians and consumers each have differing priorities and perceptions of how health care delivery should work. By maximizing the ability of telemedicine to deliver care over geographic distances and maximizing the efficiency of health providers' offices, telemedicine acts a potential solution to issues of access, efficiency, and cost for health care in the United States.

This timely solution, however, does not come without its fair share of obstacles. With questions of interstate licensing, medical malpractice, consumer privacy, and others, telemedicine receives push back from a number of stakeholders. State medical boards resist interstate telemedicine use, as it threatens their authority to regulate medical practices and infringes on their potential pool of patients.[4] Consumers also have concerns over the privacy of their medical records in a time when breaches in technology are far too common.[5] Additionally,

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[3] Mary Mahon & Bethanne Fox, *U.S. Ranks Last Among Seven Countries on Health System Performance Based on Measures of Quality, Efficiency, Access, Equity, and Healthy Lives*, COMMONWEALTH FUND (June 16, 2014), http://www.commonwealthfund.org/publications/press-releases/2014/jun/us-health-system-ranks-last.

[4] LATOYA THOMAS & GARY CAPISTRANT, AM. TELEMEDICINE ASS'N, 50 STATE TELEMEDICINE GAPS ANALYSIS: PHYSICIAN PRACTICE STANDARDS & LICENSURE (2015), *available at* http://www.americantelemed.org/docs/default-source/policy/50-state-telemedicine-gaps-analysis--physician-practice-standards-licensure.pdf?sfvrsn=6 (noting every state has imposed a policy that makes practicing medicine across state lines difficult; D.C., Maryland, New York, and Virginia are the only states that allow licensure reciprocity from bordering states, and ten other states extend a conditional or telemedicine license to out-of-state physicians).

[5] Don Detmer et al., *Integrated Personal Health Records: Transformative Tools for Consumer-Centric Care*, BMC MEDICAL INFORMATICS & DECISION MAKING (Oct. 6, 2008), http://www.biomedcentral.com/content/pdf/1472-6947-8-45.pdf (noting that real and perceived concerns with electronic records of personal information is privacy and security breaches).

doctors and consumers alike have concerns related to medical malpractice – for instance, in rem jurisdiction for negligence suits when the physician practicing is out-of-state or criminal liability for a provider when the provider's home state and practicing state have different medical practice laws. The federal government has a high stake in the success of telemedicine, due to the benefits in cost, access and efficiency, and it is working to develop solutions to resolve the many barriers and promote national support for the technology.

In Part I, this analysis will describe how state medical boards restrict use of both interstate and intrastate telemedicine through legislatively-delegated authority to regulate the licensure and practice of state medical practitioners. Part II will examine how the federal government encourages national use of telemedicine and will provide suggestions about how the federal government could further this support. And lastly, Part III will examine how a national mandate for arbitration of telemedicine claims may act as a potential solution to health care providers', consumers' and insurance companies' hesitance to use telemedicine services.

I. State Medical Board Authority

Telemedicine is accompanied by a long list of barriers for its implementation and widespread use, including the prominent barrier of overbearing state medical boards. Many states guard their statutory right to regulate medical practice standards by prohibiting physicians from practicing interstate telemedicine and by limiting intrastate telemedicine use.[6] As with any

[6] AM. TELEMEDICINE ASS'N, STATE POLICY TOOLKIT: IMPROVING ACCESS TO COVERED SERVICES FOR TELEMEDICINE (n.d.), *available at* http://www.americantelemed.org/docs/default-source/policy/ata-state-telemedicine-toolkit---coverage-and-reimbursement.pdf?sfvrsn=4 (noting forty-six states have some coverage of telemedicine health); AM. TELEMEDICINE ASS'N, MEDICAL LICENSURE AND PRACTICE REQUIREMENTS (June 2011), *available at* http://www.americantelemed.org/docs/default-source/policy/ata-policy-on-state-medical-licensure-and-practice-requirements.pdf (noting that in the past few years fourteen states have strengthened telemedicine licensing requirements and very few have worked to develop interstate licensing laws for neighboring states).

major shift in the health care system, new implementations face new obstacles and tensions between stakeholders. However, as legislators propose policies to resolve licensing and reimbursement issues, the issue of state medical boards' authority to regulate medical practice standards is often underestimated.

State legislatures delegate to their medical boards the authority to regulate medical licensure and practice, which includes the use of telemedicine by physicians.[7] With the delegation of such broad authority to these state boards, the legislature also vests these boards with adjudicative and rulemaking powers, thereby making the profession self-regulated and autonomous.[8] For telemedicine, this authority means state medical boards may have an unrestricted power to determine how and if telemedicine services are practiced. This analysis will explore the effect that state medical boards' authority may have on the growth of telemedicine, and how their broad discretion is often politics-based instead of science-based.

A. Delegation of Medical Board Authority

To better understand how state medical board authority has grown to be overbearing, consideration must be given to its necessity when first created. The Supreme Court first upheld the independent actions of a state medical board in 1889, holding that every state has an interest

[7] Hawker v. New York, 170 U.S. 189, 191 (1898) (noting that "within the acknowledged reach of the police power, a State may prescribe the qualifications of one engaged in any business so directly affecting the lives and health of the people as the practice of medicine.").

[8] *See* Douglas v. Noble, 261 U.S. 165, 170 (1923) (holding that the delegation professional regulatory powers to an administrative board is consistent with the U.S. Constitution). *E.g.* MINN. STAT. ANN. § 147.01 (2005) (describing the Board of Medical Practice); N.Y. EDUC. LAW § 6523 (McKinney 2001) (describing the State Board for Medicine). *See generally* FED'N OF STATE MED. BDS., ELEMENTS OF A MODERN STATE MEDICAL AND OSTEOPATHIC BOARD § III (2012), *available at* http://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/GRPOL_Elements_Modern_Medical_Board.pdf.

in protecting its citizens through the regulation of medical licensure.[9] The Court emphasized the importance of locality with regard to medical professionals and stated that "few professions require more careful preparation by one who seeks to enter it than that of medicine" and those individuals must be judged "by an authority competent to judge . . . that he possesses the requisite qualifications."[10] This case centered on a Fourteenth Amendment claim regarding the right to practice one's chosen profession. The Court found that the Fourteenth Amendment does provide that individual right, however the chosen profession may be subject to regulation.[11]

Since 1889, the role of state medical boards has expanded from its early regulation of restricting the supply of physicians to those graduates of approved medical schools to a more complex participation in the consumer-driven health care market focused on physician performance, consumer-expectation and government involvement.[12] Today, medical boards work with a number of entities overseeing and monitoring the practices of many health care providers. Additionally, their role extends into the realm of practice, as they now issue guidelines instructing doctors for proper pain management, controlled substance abuse, sexual misconduct, Internet prescription, alternative medicine and outpatient surgery.[13]

Over the short history of telemedicine, state medical board issued rules have accumulated, limiting the use of telemedicine, both in scope of services that may be offered, as well as the

[9] Dent v. West Virginia, 129 U.S. 114 (1889).
[10] *Id.* at 122-23.
[11] *Id.* at 123.
[12] Carl F. Ameringer, *State Medical Boards and the Politics of Public Protection*, 15 ISSUES L. & MED. 235 (1999)
[13] FED'N OF STATE MED. BDS., FSMB POLICIES (June 2014), *available at* http://www.fsmb.org/policy/advocacy-policy/policy-documents (follow "2004: Model Policy for the Use of Controlled Substances in the Treatment of Pain" hyperlink; also "2006: Addressing Sexual Boundaries: Guidelines for State Medical Boards" hyperlink; also "2004: Model Guidelines for the Appropriate Use of the Internet in Medical Practice" hyperlink; also "2004: Report of the Special Committee on Outpatient (Office-Based) Surgery" hyperlink).

scope of cross-jurisdictional use. The core functions of medical boards in protecting patients from incompetent physicians and protecting physicians from out-of-state competition are at odds with a rapidly developing technology that crosses jurisdictional lines to deliver health care.[14] To the extent that concerns over professional territory override the objective of protecting the welfare of the public, state medical boards lose sight of their original purpose and risk interference with health care delivery.

B. Politically Driven

With the recent implementation of the Affordable Care Act ("ACA"),[15] Americans have a broader opportunity of access to care. This expansion is expected to put a strain on the number of physicians available to provide care – effectively limiting access to care for both those newly insured and previously insured.[16] The use of telemedicine is expected to mitigate the shortage in two ways: (1) improve health care provider efficiency and (2) increase the geographic area that physicians can serve. By providing the same care through a different medium, telemedicine will be consistent with the ACA focus on increasing access to health care for Americans.

While interstate telemedicine implicates difficult licensing issues for states, it can still act as a useful health care medium through intrastate use by reaching those rural and otherwise difficult to reach citizens. A state medical board issues licenses to physicians certifying that they are qualified and approved to provide care to patients within that state – an approval that is not

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[14] *Physician Licensure: An Update of Trends*, AM. MED. ASS'N (Sept. 11, 2010), http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/young-physicians-section/advocacy-resources/physician-licensure-an-update-trends.shtml; Carl F. Ameringer, *State-Based Licensure of Telemedicine: The Need for Uniformity but Not a National Scheme*, 14 J. HEALTH CARE L. & POL'Y 55 (2011).

[15] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119

[16] *See* John D. Goodson, *Patient Protection and Affordable Care Act: Promise and Peril for Primary Care*, 152 ANNALS INTERNAL MED. 742, 742 (2010) (discussing the "urgent need" to expand primary care capacity since "a projected 32 million people will gain access to health care" as a result of the Patient Protection and Affordable Care Act).

specialty specific and presumably includes various forms of delivery.[17] As the AMA notes, "whether a patient is seeing his or her physician in person or via telemedicine, the same standards of care must be maintained."[18] However, instead of translating state regulated medical standards to telemedicine, state medical boards can use their authority instead to prohibit uses of telemedicine.[19]

By extending their authority past that of licensing, state medical boards use their authority to regulate medical practices to ensure that the medical environment of their state remains consistent with the medical board's vision. For instance, the board may require additional precautions for particular treatment after considering the FDA's recommendations (this use of authority is beneficial to the welfare of that state's public and is within the original spirit of the authority delegated to the boards). Additionally, state medical boards have expanded their authority to physician disciplinary actions for violating state standards of medical practice. Again, this function ensures public protection from wayward physicians. Where board authority fringes on reasonable limits, however, are instances where the board considers the opinions of leaders from religious groups and implements rules based on those opinions. By allowing religious or political views to meddle with scientific and medical expertise, state medical boards illustrate a stretch of properly delegated power. An example of such an instance, is that of the Iowa Board of Medicine, where the board favored the opinions of community and religious

[17] *State-specific Requirements for Initial Medical Licensure*, FED'N OF STATE MED. BDS., http://web.archive.org/web/20160313101145/http://fsmb.org/policy/public-resources/state_specific (last visited Apr. 11, 2016).
[18] *AMA Press Releases and Statements: AMA Adopts Telemedicine Policy to Improve Access to Care for Patients*, AM. MED. ASS'N (June 11, 2014), http://www.ama-assn.org/ama/pub/news/news/2014/2014-06-11-policy-coverage-reimbursement-for-telemedicine.page.
[19] *See supra* note 13.

leaders rather than scientific medical studies to decide upon the political charged issue of abortion.

C. *Planned Parenthood of the Healthland, Inc. v. Iowa Bd. Of Med.*, Iowa Dist. Ct.

In August 2014, the Iowa District Court for Polk County found for the Iowa Board of Medicine, upholding a rule requiring physicians to be present and to perform a physical examination before certain drugs are dispensed. The facts involved Planned Parenthood of the Heartland, Inc. ("PPH") physicians using telemedicine to order RU-486 for the termination of pregnancies beyond the fiftieth day of gestation.[20]

In 2008, PPH incorporated telemedicine into the standard procedures for the distribution of RU-486. The patient-physician interaction was unaltered, except for the fact that the physician spoke with the patient via a real-time, two-way video conferencing system, as opposed to physically being in the exam room. The physician, while interacting with the patient, had access to her ultrasound, blood lab work and physical exam details, which were performed by technicians who were at the clinic with the patient. Once the physician had sufficiently evaluated the patient and determined that it was appropriate for RU-486 to be administered, the physician would electronically release a drawer in the patient's room containing the drug, and the patient would then take the drug in front of the doctor, by video, and the PPH staff in the room.[21] PHH implemented this use of telemedicine to increase the number of clinics available

[20] Planned Parenthood of the Heartland, Inc. v. Iowa Bd. Of Med., No. CVCV 046429, Iowa Dist. Ct. for Polk County, (filed Aug. 18, 2014) *available at* http://www.adfmedia.org/files/IowaBOMruling.pdf.
[21] *Id*. at 4.

for women seeking to terminate their pregnancies, expanding access to women in rural communities in particular.[22]

In June of 2013, the Iowa State Medical Board received a petition from fourteen individuals, only five of which were physicians, urging for the adoption of a policy requiring the physical presence of a physician at the time of the distribution of RU-486.[23] PPH filed a petition for judicial review and motion for stay of agency action, basing their constitutional claims on both violations of agency due process and undue burden on a woman's right to abortion access.[24]

While this case centers on the historically and universally controversial topic of abortion, the court's reasoning was unambiguous and the chance of success on appeal is minimal.[25] The court held for the medical board, noting that there is "no question that the board has the power to establish standards of practice for the medical profession."[26] The opinion provided the procedural steps taken by the medical board to adopt the rule, and the court found appropriate delegation of rulemaking authority and no arbitrary or capricious abuse of power.[27]

The court additionally analyzed whether requiring a physician to physically be in the presence of a woman seeking an abortion through RU-486 would be an undue burden on abortion access.[28] The landmark holding of *Roe v. Wade* established that women may choose to have an abortion before viability, with the Court adding a condition in *Planned Parenthood of*

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[22] *Id.* at 2 (noting that there are eleven abortion providers in Iowa, with services being offered in nine of Iowa's ninety-nine counties).
[23] *Id.* at 6.
[24] *Id.*
[25] *Supreme Court of Iowa Oral Arguments, Oral Argument Schedule*, IOWA JUDICIAL BRANCH, http://www.iowacourts.gov/About_the_Courts/Supreme_Court/Oral_Argument_Schedule/ (last visited Apr. 11, 2016) (at the date of writing this article, the Supreme Court of Iowa has heard oral argument for the appeal of this case but has not yet issued an opinion).
[26] *Planned Parenthood of the Heartland, Inc.*, No. CVCV 046429, at 13.
[27] *Id.* at 16 (citing Doe v. Iowa Bd. of Med. Exam'rs, 733 N.W.2d 705, 707 (Iowa 2007).
[28] *Id.* at 31-35 (citing Planned Parenthood of Se. Penn. v. Casey, 505 U.S. 833 (1992)).

Southeastern Penn. v. Casey, that states may regulate these procedures so long as the regulations are without "undue interference from the State."[29] The Iowa court analyzed the facts of this case using both the rational basis standards as dictated by *Gonzalez v. Carhart*, as well as the strict scrutiny test as suggested by the Fifth Circuit case, *Planned Parenthood of Greater Texas v. Abbott.*[30] The *Abbott* court found that while the statutory changes would to increase travel to obtain an abortion by up to 150 miles to obtain an abortion, the law did not place an undue burden on a woman's choice to seek an abortion.[31] Similarly, the Iowa court here found that the medical board's ban created no undue hardship.[32] Using rational basis, the court found for the board as it "is authorized to adopt a standard of practice, and it did so in this instance on rational grounds."

Highlighting the breadth of the board's authority is where the court addresses that the board failed to consider "its own past policy" concerning the PPH telemedicine program. During trial, PPH presented evidence that the board had adopted a policy in 2010 that the telemedicine program was in fact safe and did not warrant disciplinary action.[33] PPH also introduced evidence of a study by Dr. Daniel Grossman, vice president of research for Ibis Reproductive Health, which concluded there was no statistically significant difference in the complication rates of medical abortion patients who saw a doctor in person versus by video conferencing.[34] However, less than three (3) years after the board approved PPH's specific use of telemedicine for the RU-486, the board retracted that approval and issued the rule at contention in this case.

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[29] Roe v. Wade, 410 U.S. 113 (1973); *Casey*, 505 U.S. at 846.
[30] Gonzalez v. Carhart, 550 U.S. 124, 158 (2007); Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott, 748 F.3d 583, 590 (5th Cir. 2014).
[31] *Id.*
[32] *Planned Parenthood of the Heartland, Inc.*, No. CVCV 046429, at 32-33.
[33] *Id.* at 19.
[34] *Id.* at 5.

And deferring to the board's decision making, the court responded that the board was authorized to make rules regardless of past treatment of medical practices by the board.

While at trial, the board cited numerous reasons for passing the restrictive rule. The top three (3) reasons included: (1) in-person examinations were important to the health and safety of the public, (2) ultrasound quality issues could be resolved with an in-person exam and (3) a desire to strengthen the patient-physician relationships through an in-person exam.[35] While there is merit in the board's reasoning, there is a question of how it weighs against the evidence brought by PPH – a question that the court sidestepped, giving deference to the board. In response to PPH's argument that their medical procedure did in fact protect the health and welfare of the public, the court respectfully deferred to the board noting, "[I]t is not for the court to review medical studies and determine which is the most persuasive . . . the board's reasoning is not unreasonable and must be granted deference by the court."[36] This deference is consistent with agency authority precedent, following that where decision-making authority is conferred upon an agency, it is not the court's job to make the same conclusions, only to determine that the decisions were reasonable.[37] The conclusion by the Iowa court is consistent with both abortion precedent and delegation of authority case law – however, it highlights the breadth of the medical board's authority. If the board wishes to limit the use of telemedicine, they have the power to do so.

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[35] *Id.* at 22-23.
[36] *Id.* at 24.
[37] *See* Whitman v. American Trucking Ass'n, Inc., 531 U.S. 457 (2001) (holding when decision making authority delegated to an agency, Congress must give an intelligible principle to which the agency must conform); *see also* Chevron v. Natural Resource Defense Council, Inc., 467 U.S. 837 (1984) (holding that where Congress has not given clear guidance, it is up to the agency to do so with their knowledge and expertise).

D. Other Explanations for Telemedicine Limitations

An alternate reasoning for the rule passed by the Iowa Board of Medicine is that abortion procedures are controversial with the public. Because of this added level of public scrutiny, medical boards may be cautious in expanding delivery to telemedicine not because of the technology of telemedicine, but rather the nature of the service being offered.

Looking to other state medical boards and banned uses of the telemedicine, there is a consistent theme of banning certain telemedicine uses associated with risky health behaviors. The Nevada Board of Medical Examiners prohibits prescribing Viagra without personally conducting a physical examination of the patient.[38] In North Carolina, the medical board ruled that prescribing drugs to an individual that the prescriber has not personally examined is usually inappropriate.[39] While it is rational to require a physical examination for the prescription of drugs to ensure a certain standard of care, there is little evidence that any consideration of the quality of telemedicine care is being considered. Where the role of the medical board is to protect the public from unsafe medical care, and the medical boards are ruling out a method of care before considering its quality, it would seem on the surface that either their core function has shifted or their decision-making authority is too broad.

Rooted within the original purpose and traditional role of a state medical board is the idea of professional disciplinary minimalism. That is, the goal of professional licensure and

[38] *Board's Position on the Prescribing of Viagra*, NEWSLETTER (Nev. Bd. Of Med. Examiners), Oct. 1998, *available at* http://epubs.nsla.nv.gov/statepubs/epubs/213935-1998-10.pdf.
[39] *Position Statements: Contact with Patients Before Prescribing*, N.C. MED. BD. (Nov. 1, 1999, updated June 2015), http://www.ncmedboard.org/resources-information/professional-resources/laws-rules-position-statements/position-statements/contact_with_patients_before_prescribing.

discipline guarantees the public a minimal level of competence in their physicians.[40] Ensuring that a professional is licensed is simply assuring the public that the physician possesses the knowledge necessary to practice medicine – it does not go further to ensure that the physician is using that knowledge appropriately. Rather, the second main function of medical boards – discipline – is the safeguard put in place to check the actions of licensed physicians. By interjecting a rule making process in the middle of these two functions, medical boards are overstepping their purpose and self-appointing themselves as a legislative body. While their decisions may be grounded in rational basis and motives of implementing inspirational standards of practice, medical board rulemaking poses a threat to innovative physicians seeking to advance more efficient and affordable means of health care delivery.

E. State Medical Board Authority Going Forward

The history of medical advances in the United States is marked by innovation, technological advances, and a working goal of providing the best possible care to the most people possible. The history of state medical boards is marked by a gradual expansion of authority, allowing the boards to delegate to themselves a more invasive role into physicians' practice within their jurisdictional boundaries. These two histories are at tension with one another, and courts' deference to the boards' rule-making authority suggests that the authority of medical boards surpass the momentum of medically technological advances. However, while state medical boards hold a powerful position with regard to the advancement of telemedicine, it is the states that possess the ultimate police power to ensure the health and welfare of the

[40] Nadia N. Sawicki, *Character, Competence, and the Principles of Medical Discipline,* 13 J. HEALTH CARE L. & POL'Y 285, 296 (2010).

public.[41] Considering Congress's emphasis in the ACA to expand access to care in the most cost-efficient way, it is up to state legislatures to embrace the potential of telemedicine as a solution to health care disparities and to enact legislation promoting the use of intrastate telemedicine, and cooperation in interstate telemedicine. Given the interstate jurisdictional issues and the impact on commerce between states, a national standardization of telemedicine standards by federal law is the only other solution to widespread use of this method of health care delivery.

II. Raising the Stakes: How the Federal Government Can Continue To Incentivize Cross-Jurisdictional Telemedicine Use

While telemedicine has existed in the United States since the 1960s,[42] it has recently been embraced in the market-driven health industry by health care entities, consumers and technology companies. In looking for ways to save costs, health care entities seek out various ways to utilize technology. With the widespread use of hand-held devices and access to the Internet, health care consumers have become more adept and conformable with services offered online or through telecommunications. Furthermore, with devices and software programs becoming more advanced, technology companies are striving for more sophisticated medical devices for the market.[43] Behind the advances of each of these forces, however, is the stakeholder that launched it all – the federal government.

The federally-adopted ACA urges a shift in traditional notions of health care delivery – a shift that emphasizes cost-effective quality of care by expanding access to health care to all

[41] U.S. CONST. amend. X; *see* Jacobsen v. Massachusetts, 197 U.S. 11 (1905) (holding it is within a state's police power to protect the public health and safety of its citizens).
[42] Lisa Rannefield, *The Doctor Will E-Mail You Now: Physician's Use of Telemedicine to Treat Patients Over the Internet*, 19 J.L. & HEALTH 75, 78 (2005) (noting that NASA implemented the use of telemedicine in the 1960s to monitor the health of astronauts in space).
[43] Klein & Kim, *supra* note 1.

Americans, attempting to lower expensive emergency care costs, focusing on preventive health to lower health expenses, and doing so all while doctors are seeing more patients. In accordance with these ideals, in 2011, the U.S. Centers for Medicare and Medicaid Services issued a rule allowing a more flexible credentialing process for practitioners providing telemedicine services to beneficiaries, which would increase the efficiency of doctors serving Medicare and Medicaid patients while also expanding coverage for beneficiaries.[44] Within two years, federal and state legislation expanded types of reimbursable telemedicine services for Medicare and Medicaid patients.[45] Most recently, the trend has prompted the Federation of State Medical Boards to publish a model policy providing guidance for state medical boards in regulating the use of telemedicine technologies in the most efficient manner, suggesting what rules they should adopt regarding interstate use of telemedicine and solutions to potential licensing issues.[46]

While this federal and national support has been beneficial to the expansion of telemedicine, and therefore access to health care, the complex matrix of differing state and federal regulation still remains the major barrier to the standardization and widespread use of telemedicine.

A. Current Regulating Bodies

Today, a number of overlapping and sometimes conflicting government agencies regulate telemedicine, with each regulating different and coordinating aspects of telemedicine implementation and regulation. On the state level, individual state medical boards use their broad authority to hamper telemedicine practices in their state in any way the board sees fit –

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[44] *Id.* at 2.
[45] *Id.*
[46] STATE MEDICAL BOARDS' APPROPRIATE REGULATION OF TELEMEDICINE (SMART) WORKGROUP, FED'N OF STATE MED. BDS., MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE (Apr. 2014), *available at* https://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/FSMB_Telemedicine_Policy.pdf.

with each state coming to varying conclusions and resulting in a complex mosaic of telemedicine regulations from state to state.[47] On the federal level, federal agencies such as the Food and Drug Administration ("FDA"), the Federal Communications Commission ("FCC"), Federal Trade Commission ("FTC"), and the Office of the National Coordinator for Health Information Technology ("ONC") exist to regulate different aspects of cross-jurisdictional health care. These federal agencies collaborate to develop a risk-based regulatory framework for health information technology ("health IT") in order to avoid regulatory duplication and thereby simplify national telemedicine regulations.[48] Within this framework exists any number of possibilities of agencies, which Congress could consolidate, and delegate the authority to regulate telemedicine on a national scale, which in turn, would hopefully promulgate widespread, interstate use.

On the state level, medical boards are generally granted the power to regulate medical licensure and practice, including regulation of health care delivery through telemedicine.[49] This broad authority can be, and has been, used negatively by boards seeking to restrict the delivery of services through telemedicine, such as the Iowa Board of Medicine that recently limited the services Planned Parenthood could provide via telemedicine.[50] On the other hand, some state

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[47] *See* FED'N OF STATE MED. BDS., TELEMEDICINE POLICIES: BOARD BY BOARD OVERVIEW (n.d.), *available at* http://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/GRPOL_Telemedicine_Licensure.pdf. *See generally* Ameringer, *supra* note 12.

[48] Press Release, U.S. Dep't of Health & Human Servs., Proposed Health IT Strategy Aims to Promote Innovation, Protect Patients, and Avoid Regulatory Duplication (Apr. 3, 2014), *available at* http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm390988.htm; *see also* FED. COMMC'NS COMM'N & OFFICE OF NAT'L COORDINATOR FOR HEALTH INFO. TECH., U.S. FOOD & DRUG ADMIN., FDASIA HEALTH IT REPORT: PROPOSED STRATEGY AND RECOMMENDATIONS FOR A RISK-BASED FRAMEWORK (Apr. 2014), *available at* http://1.usa.gov/1oBNDZZ [hereinafter FDASIA HEALTH IT REPORT].

[49] Hawker v. New York, 170 U.S. 189, 191 (1898) ("[W]ithin the acknowledged reach of the police power, a State may prescribe the qualifications of one engaged in any business so directly affecting the lives and health of the people as the practice of medicine.")

[50] *See supra* note 20.

medical boards have supported the efforts of the Federation of State Medical Boards in developing an interstate compact to allow for expedited state licensing procedures in order to promote the use of telemedicine interstate.[51] Regardless of what type of support or barriers state medical boards implement for use of telemedicine, the breadth of their authority allows for local governance and oversight over telemedicine use from state-to-state.

On the national scale, the FDA, FCC, FTC, and ONC play different, and at times coordinating roles in telemedicine oversight. For decades, the FDA has played a major role in protecting the public health by national regulation of drugs and medical devices.[52] Congress first delegated power to the FDA in 1906, to regulate interstate sale of drugs.[53] Over time, this federal regulation extended to include food, drugs, and medical devices, holding the authority to ban devices entering interstate commerce, impose labeling requirements, and seize misbranded and fraudulent devices.[54] By the 1960s, Congress continued to broaden the scope of the FDA's authority, which emphasized Congress's concerns with health and safety. Under these amendments, the FDA made medical devices subject to the same pre-approval as drugs entering the market, and further, FDA's medical regulations would now pre-empt any conflicting state regulations.[55] This expansion of authority allows the FDA to efficiently regulate advancing

[51] Kendra Casey Plank, *Federation of State Medical Boards Release Final Interstate Licensure Compact Guidance*, BLOOMBERG BNA (Sept. 8, 2014), http://news.bna.com/hiln/display/alpha.adp?mode=topics&letter=T&frag_id=55877088&item=5166&prod=hiln

[52] Charles J. Walsh & Alissa Pyrich, *Rationalizing the Regulation of Prescription Drugs and Medical Devices: Perspectives on Private Certification and Tort Reform*, 48 RUTGERS L. REV. 883, 886 (1996).

[53] Pure Food and Drugs Act, ch. 3915, § 1, 34 Stat. 768, 768 (1906) (repealed by Federal Food, Drug, and Cosmetic Act of 1938, Pub. L. No. 75-717, 52 Stat. 1040).

[54] 21 U.S.C. §§ 301-395 (2012). The Food Drug and Cosmetic Act of 1938 repealed the Pure Food and Drugs Act and expanded how the FDA can regulate medical devices.

[55] Walsh & Pyrich, *supra* note 52, at 903.

medical technologies on a national scale, and acts a prime example of success for a national regulation scheme of health care delivery for telemedicine.

The role of the FCC in telemedicine is different from that of the FDA's as it relates solely to the platforms delivering telemedicine services. The FCC establishes regulations for interstate and international communications by airwaves, covering issues of wireless technology, connectivity, and regulations for transmitters and other equipment.[56] Regarding the transmitted information itself, the FTC develops regulations to safeguard the collection and use of consumer data and prevent breaches of consumer privacy that could lead to deceptive or fraudulent trade practices. As the FTC is currently focused on health care competition, this agency may be vital in resolving the barriers of interstate telemedicine.[57] And lastly, regarding the privacy and protection of patients' medical records, the ONC establishes regulations for certification criteria of health information technology.[58] Charged by an executive order, it is ONC's mission to "implement and use the most advanced health information technology and . . . electronic exchange of health information."[59] The role that each of these government entities plays in the technical aspects of telemedicine delivery and use, combined with FDA's extensive national regulatory role, sets up a prime network of federal entities for a national telemedicine regulatory scheme.

Further to this point, in 2012, the FDA, FCC, and ONC proposed a risk-based regulatory framework for health IT that would avoid regulatory duplication or inefficiencies. In April 2014, the Department of Health and Human Services ("DHHS") released the draft report, which stated

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[56] *See* Klein & Kim, *supra* note 1, at 5.
[57] *Id.*
[58] *Id.*
[59] *See generally About ONC*, HEALTHIT.GOV, http://www.healthit.gov/newsroom/about-onc (last updated Aug. 11, 2014).

that the FDA, FCC, and ONC recommended a risk-based framework with four key priority areas: "promote the use of quality management principles; identify, develop, and adopt standards and best practices; leverage conformity assessment tools; and create an environment of learning and continual improvement."[60] While a majority of the report focuses upon how to draw support from stakeholders to implement these four focuses, the report also calls for the creation of a Health IT Safety Center as a "public-private entity with broad stakeholder engagement" whose purpose would be the governance of a "sustainable, integrated health IT learning system that avoids regulatory duplication and leverages and complements existing and ongoing efforts."[61] This recommendation would be key to the smooth implementation of national telemedicine standardization. By centralizing the health IT implementation efforts to one entity, telemedicine use on a national scale would be better simplified, standardized, and ideally, easier for use. Congressional action is needed as the catalyst.

B. Proposed Enactments

With telemedicine on the rise and the federal government recognizing its cost-saving benefits, Congressional members have proposed three bills to promote telemedicine use within Medicare and Medicaid.[62] First, Representative Mike Thompson (D-CA) introduced the Medicare Telehealth Parity Act to broaden Medicare reimbursements of telemedicine services.[63] If passed into law, Medicare would extend coverage to beneficiaries receiving telemedicine services from originating sites that are Federally Qualified Health Centers and rural health clinics, and telemedicine providers would then include certified diabetes educators, licensed respiratory

[60] FDASIA HEALTH IT REPORT, *supra* note 48, at 14.
[61] *Id.*
[62] *See* H.R. 5380, 113th Cong. (2014); *see also* H.R. 3077, 113th Cong. (2013); S. 2662, 113th Cong. (2014).
[63] H.R. 5380, 113th Cong. (2014). The bill was not passed into law during the 113th congressional session and therefore died.

therapists, audiologists, occupational therapists, physical therapists, and speech language pathologists.[64] As of August 1, 2014, the bill was referred to the House Energy and Commerce Subcommittee on Health for committee consideration.

Also seeking to expand telemedicine services to Medicare beneficiaries, the TELEmedicine for MEDicare Act of 2013, or the TELE-MED Act, seeks to relax Medicaid provider licensing requirements for those offering services via telemedicine.[65] The legislation, proposed by Representative Devin Nunes (R-CA), would allow certain Medicare providers to surpass cross-jurisdictional licensing requirements when treating beneficiaries in other states. This bill has not left the House Energy and Commerce Subcommittee on Health since arriving there on September 2013.[66]

The final telemedicine enactment currently before Congress is the Telehealth Enhancement Act of 2014, introduced by Senator Thad Cochran (R-MS).[67] While this bill also focuses on telemedicine use within the Medicare framework, its focus is more directed towards telemedicine incentives. The proposed language calls for the Secretary of Health and Human Services to provide a positive incentive to certain hospitals to lower their readmission rates, authorizes expansion of telemedicine use by accountable care organizations ("ACOs"), and requires the FCC to relax their rules and disregard provider location. On July 24, 2014, the bill was read twice and referred to the Senate Committee on Finance for consideration.[68]

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[64] *Id.*
[65] H.R. 3077, 113th Cong. (2013). The bill was not passed into law during the 113th congressional session and therefore died.
[66] *Id.*
[67] S. 2662, 113th Cong. (2014).
[68] S*ummary: S. 2662*, CONGRESS.GOV, https://www.congress.gov/bill/113th-congress/senate-bill/2662. The bill was not passed into law during the 113th congressional session and therefore died.

While these three bills may not go far in the current political environment, the language and the ideas behind them are a good start. Providing incentives for telemedicine use, broadening the services included in telemedicine use, and most importantly, providing for a national licensing and standardization scheme would effectively minimize all major barriers national telemedicine use faces today. Effective legislation, paired with the regulatory functions of the FDA, FCC, FTC, ONC, and the possible creation of a Health IT Safety Center, would provide an effective infrastructure for national telemedicine implementation – a solution to health care costs and access to issues that may not be too far off.

C. Need for National Regulation

Although state medical boards have historically been the gatekeepers of medical practice regulation and oversight, the modern health care system, telemedicine in particular, calls for consideration of national standards and regulations for interstate transactions. The traditional notion supporting state medical board authority is that health and safety issues are "inherently local in nature," and thus the state is most qualified to handle them.[69] And while that notion has been true historically, the context of telemedicine provides that an individual's best access to health solutions is no longer necessarily within state boundaries. With health information technology, patients may access national and international health resources through various telecommunications platforms and providers can easily access patients' health records allowing

[69] *See* Jacobsen v. Massachusetts, 197 U.S. 11 (1905) (holding it is within a state's police power to protect the public health and safety of its citizens); *see also* Lars Noah, *Ambivalent Commitments to Federalism in Controlling the Practice of Medicine*, 53 U. KAN. L. REV. 149, 156-57 (2004).

for more complete treatment.[70] As modern health care delivery advances beyond state boundaries, so should the authority to establish standards and regulation.

With the growing demands for interstate use of telemedicine and the growth of the health care system on a national and international basis, state regulation is becoming less and less appropriate in light of the Federal Commerce Power. With the health care industry implicating a number of cross-jurisdictional transactions, interstate commerce is indisputably implicated and as such Congress has the sole authority to engage in the interstate regulation.[71] And further, the Dormant Commerce Clause, as interpreted by the Supreme Court, indicates that the federal government may invalidate state and local laws for placing an undue burden on interstate commerce.[72]

Without delving too deep into the intricacies of constitutional law, Congress can constitutionally regulate commerce among the states if the regulation passes the "Substantial Effect" test.[73] Under the test, the regulation is permissible so long as it fits into one of the following categories: regulation of use of channels of interstate commerce, regulation and protection of instrumentalities of interstate commerce, or regulation of activities having substantial effect on commerce.[74] Federal regulation of health care would concern use of the channels of interstate commerce, as telemedicine and other health care transactions frequently cross state borders. Likewise, federal regulation of health care concerns the protection of

[70] Amar Gupta, *Prescription for Change*, WALL ST. J., Oct. 20, 2008, http://online.wsj.com/articles/SB122426733527345133.
[71] U.S. CONST. art. I, § 8, cl. 3; *see* Gibbons v. Ogden, 22 U.S. (9 Wheat.) 1, 26-27 (1824).
[72] *E.g.*, Cooley v. Bd. of Wardens, 53 U.S. (12 How.) 299 (1851); Dean Milk Co. v. Madison, 340 U.S. 349 (1951).
[73] United States v. Lopez, 514 U.S. 549 (1995).
[74] *Id.*

instrumentalities of interstate commerce and activities having a substantial effect on interstate commerce, due to the impact of health care on interstate economic activity.

Additionally, a state law is deemed to violate the Dormant Commerce clause if it regulates a national subject matter – a designation defined as "imperatively demand[s] diversity, which alone can meet the local necessities."[75] While there are circumstances that allow a state to violate the Commerce Clause on the basis of police powers – one of which has traditionally been medical licensure – that exception is unlikely to apply here.[76] The largest indicator that a police power exception argument would fail is the fact that national licensing alternatives are already successfully in place with federal entities including the Veterans Administration, the Bureau of Indian Affairs and the U.S. Military.[77]

With the added commercial value and market-based nature of modern health care, as well as meeting the threshold of the "Substantial Effect" test, it is likely that Congress could regulate telemedicine on a national scale without confronting issues of constitutionality. As such, today's need for telemedicine as a cost-saving measure, as well as a solution to health care access disparities, necessitates that Congress step in to regulate telemedicine, utilizing the federal entities that have already been playing an integral role in the health IT infrastructure.

III. Federal Government Going Forward

The numerous barriers posed on telemedicine within the United States act as a detriment not only to new health care delivery technologies, but also the efficiency of our entire health care system. With problems of access, resulting both from underserved rural areas as well as the

[75] *Cooley*, 53 U.S. (12 How.) at 319.
[76] *Id.* at 314.
[77] Alison M. Sulentic, *Crossing Borders: The Licensure of Interstate Telemedicine Practitioners*, 25 J. LEGIS. 1, 37 (1999) (noting that U.S. Military law allows any health professional who holds a state license to practice anywhere in the national as long as the care provided is directly affiliated with the Department of Defense).

recent influx of newly insured individuals resulting from the ACA, telemedicine works to provide a cost effective solution. Efficiency of telemedicine can be quantified by the increase in access to care for Americans, by the decrease in medical spending costs from providers and insurance companies and by the increase in the number of patients that providers can deliver care to in a single business day. While federal telemedicine support thus far has been slow and minimal, there is the looming potential for the right congressional enactment to cause all the pieces to fall into place, and a national scheme for telemedicine to be implemented. The regulatory bodies understand and are prepared for their roles in telemedicine oversight, Congress has begun to develop the language needed to implement telemedicine on a national scale, and most importantly, Congress possesses the constitutional power to act. National telemedicine oversight will expand access to telemedicine services for Americans, which leaves the last consideration: will patients and providers feel comfortable using telemedicine or will issues of liability and dispute resolution prevent its widespread use?

IV. Mandated Arbitration as a Means to Promulgate Interstate Use of Telemedicine

Just as the federal government supports this transformation in health care delivery,[78] insurance companies have moved to support telemedicine through reimbursement policies.[79] The trend is accompanied with a caveat, however. Most beneficiaries using telemedicine services must agree to use non-binding arbitration for malpractice issues. While arbitration often faces criticism of subjugating an individual's right to adjudication, arbitration clauses may act as the solution that telemedicine needs to become widespread.

[78] *See supra* note 43.
[79] Ann Nevers, *Medical Malpractice Arbitration in the New Millennium: Much Ado About Nothing?*, 1 PEPP. DISP. RESOL. L.J. 45 (2000).

A. Arbitration in the United States

In recent decades, arbitration has gained recognition as a legitimate method of medical malpractice alternative dispute resolution ("ADR"), as it is generally cheaper and quicker than formal litigation. Federal and state courts encourage arbitration by directing cases to these forums with the parties' consent, and even in some states, courts mandate arbitration for claims under a certain damage amount.[80] Additionally, parties may seek resolution through ADR without suggestion from the courts if they enter into a written contract with an arbitration clause. Where an arbitration clause exists, and one party seeks litigation, most courts will return the case to arbitration before hearing the case.[81] Arbitration is often beneficial for both parties, as the parties are able to select by whom and how their case is arbitrated and what rules or procedures will govern the claim.[82]

Arbitration in the United States was prompted by the passage of the Federal Arbitration Act ("FAA") by Congress, which regulates the use of private agreements to arbitrate disputes and emphasizes a contractual approach to private arbitration agreements.[83] Directly following the enactment of the FAA in 1925, courts largely rejected arbitration based on the reasoning that it denied individuals their constitutional right to adjudicate their claims before a judicial body. The FAA was largely unacknowledged until the "Rights Revolution" of the 1960s and 70s, when

[80] The limit varies from state to state. *See* Thomas V. Burch, *Regulating Mandatory Arbitration*, 2011 UTAH L. REV. 1309.
[81] Southland Corp. v. Keating, 465 U.S. 1 (1984) (holding "contracts to arbitrate are not to be avoided by allowing one party to ignore the contract and resort to the courts").
[82] Kenneth A. DeVille, *The Jury Is Out: Pre-Dispute Binding Arbitration Agreements for Medical Malpractice Claims*, 28 J. LEGAL MED. 333, 368 (2007).
[83] 9 U.S.C.A. § 1; *see* Prima Paint Corp. v. Flood & Cocklin Mfg. Co., 388 U.S. 395 (1967) (holding that the act was constitutional as it was enacted by Congress through power to regulate interstate commerce); *Keating,* 465 U.S. 1 (stating that the FAA preempts state law in all instances in which interstate commerce is affected, to the extent that state law is inconsistent with the FAA).

Congress passed more protectionist laws, which in turn increased private individuals filing claims for adjudication.[84] As court dockets became overcrowded, judicial bodies began to recognize the benefits of arbitration to stand in as an effective and efficient method for claimants seeking adjudication of their claim.[85] Throughout this shift, courts began to enforce and define the boundaries of the FAA, establishing that arbitration clauses must be enforced by courts, that the standards of the FAA preempt state law where interstate commerce is implicated, that state legislation treating arbitration clauses different than standard contract law violates the FAA, and most importantly, that settlement reached through arbitration is enforceable in a court of law.[86] Following these court decisions, arbitration became effective in two ways: first, there is front end enforcement of arbitration clauses from the FAA, and second, there is back end enforcement where judicial bodies approve and enforce the award coming out of arbitration. As a result, arbitration has become widely successful in the United States, playing a large role in many business sectors, including that of health care.[87]

B. Arbitration and Health Insurance Companies

Paralleling the growth of arbitration is the increased use of arbitration clauses by health insurance companies, indicating how arbitration has become increasingly a preferred method for dispute resolution between health care providers, payors, managed care plans, and other companies in the health care industry. The cost, duration, and unpredictability of trial, as well as

[84] LEONARD L. RISKIN & JAMES E. WESTBROOK, DISPUTE RESOLUTION AND LAWYERS 432-43 (5th ed. 2014).
[85] *See supra* note 83.
[86] Doctor's Associates v. Casarotto, 517 U.S. 681 (1996) (holding that state legislation treating arbitration clauses differently than other standard contract language is inconsistent with the FAA). *See supra* note 77.
[87] Katherine Benesch, *The Increasing Use of Arbitration and Mediation in Adjudicating Healthcare Cases*, N.J. LAW., Apr. 2007, at 25, 25 (noting that between 1996 and 2002, total arbitration filings reported by the American Arbitration Association (AAA) more than doubled).

the technicality of health care issues, are attributed to the rising popularity of arbitration in the health care sector.[88]

Kaiser Permanente ("Kaiser"), a California-based nonprofit health management organization ("HMO"), has mandated arbitration among its members since 1971.[89] Additionally, Kaiser pays for neutral arbitrators' fees and expenses where claims are greater than $200,000, which further encourages the speedy and efficient resolution of disputes via arbitration. As of 2009, Kaiser paid for these fees in eighty-five percent of cases, ninety-one percent of which were medical malpractice disputes. Kaiser reported an increase in this rate in 2013, noting that ninety-eight percent of claims were medical malpractice.[90] Following the ACA, where individual health insurance coverage is mandated, the inclusion of arbitration clauses in health plans is an effective way to require arbitration before formal adjudication in medical malpractice claims.

Although members are mandated by Kaiser to go to arbitration, and thereby waive their right to formal adjudication, a majority of members are satisfied with the results. A 2013 report noted that sixty-seven percent of claimants felt that arbitration was better than a court system, and thirty-two percent said it was comparable to court.[91] In comparison to the four or five year average for payouts from litigation in the United States, the time frame for alternative dispute resolution averages twelve months. In 2013, Kaiser reported three quarters of cases closing by

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[88] *See supra* note 84.

[89] OFFICE OF THE INDEP. ADM'R, FIRST ANNUAL REPORT OF THE OFFICE OF THE INDEPENDENT ADMINISTRATOR OF THE KAISER FOUNDATION HEALTH PLAN, INC. MANDATORY ARBITRATION SYSTEM FOR DISPUTES WITH HEALTH PLAN MEMBERS: MARCH 29, 1999- MARCH 28, 2000 (2000), *available at* http://www.oia-kaiserarb.com/pdfs/annrptyr1.pdf.

[90] OFFICE OF THE INDEP. ADM'R, ANNUAL REPORT OF THE OFFICE OF THE INDEPENDENT ADMINISTRATOR OF THE KAISER FOUNDATION HEALTH PLAN, INC. MANDATORY ARBITRATION SYSTEM FOR DISPUTES WITH HEALTH PLAN MEMBERS: JANUARY 1, 2013-DECEMBER 31, 2013 (2013) [hereinafter 2013 KAISER REPORT], *available at* http://www.oia-kaiserarb.com/pdfs/2013-Annual-Report.pdf.

[91] *See supra* note 84.

parties' action and a quarter closing by decision of the neutral arbitrator.[92] Nearly half of the claimants received some compensation, either through settlement or arbitration hearing, with an average award of $449,027, within a range of compensation from $10,510 to $4,950,527.[93] In comparison, a 2006 National Practitioner Data Bank report calculated that the median award arising out of litigation was $175,000 per patient.[94]

Since the mid-1990s, health care disputes are increasingly being resolved through arbitration, or other types of alternative dispute resolution. Most health insurance companies require dispute resolution via arbitration, and many states have statutes that require arbitration for all disputes involving health care parties.[95] Its popularity has largely caught on due to the various benefits, including shorter duration and lower costs, the ability to choose expert arbitrators, the complexity of the issues, the flexibility of the process, limited discovery and the maintenance of privacy and confidentiality.[96]

C. Arbitration and Telemedicine

Just as arbitration is a practical solution for many health care claims, it acts a useful solution to telemedicine claims as well. From the complex technologies of telemedicine services, to the issues regarding privacy of parties and medical records, as well as the numerous issues regarding choice of law and jurisdiction for interstate practices, the flexible, informal, and private nature of arbitration would allow parties to follow their pre-established rules of procedure and use technical experts for consultation and evidence as needed to best adjudicate the claim.

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[92] *See* 2013 KAISER REPORT, *supra* note 90, at x (finding 44% of claims settled, 27% withdrew and abandoned, and 5% failed to pay the filing fee or get the fee waived).
[93] *Id.*
[94] Deth Sao, *Healthcare Disputes Across National Boundaries: The Potential for Arbitration*, 42 GEO. WASH. INT'L L. REV. 475 (2010).
[95] Katherine Benesch, *Why ADR and Not Litigation for Healthcare Disputes*, DISP. RESOL. J., Aug.-Oct. 2011, at 52, *available at* https://www.adr.org/aaa/ShowPDF?doc=ADRSTG_014003.
[96] *Id.*

The FAA would govern interstate telemedicine use, as cross-border health care transactions constitute interstate commerce, and state arbitration laws, on the other hand, would guide intrastate use of telemedicine, so long as state law is consistent with standard contract law.[97] This framework works well with the current health care system, as the federal government is pushing for more use of telemedicine at both inter- and intrastate levels, and the states are still protective of their citizens and jurisdictions.

Interstate use of telemedicine raises the majority of issues with regard to its use in the United States. With each state, through their state medical board, having the authority to regulate health professionals who practice within their state boundaries, the licensing and regulations can differ significantly from state to state. Due to the inconsistency, the differing procedural and substantive laws governing health care issues raise a number of civil procedure issues for interstate litigation.[98] Rigid jurisdictional and choice of law approaches are ill-equipped to resolve disputes arising from the cross-border movement of people and health services in the United States.[99] Arbitration, however, would provide the flexibility needed to handle the complexities of telemedicine disputes, as the parties predetermine choice of law and procedural framework for the arbitrator to follow.

The streamlined private adjudication process of arbitration provides a more efficient dispute resolution process that is more adaptive to changes in the health services industry than litigation and could open doors for telemedicine to expand. First, agreements coming out of

[97] *See supra* note 81.
[98] Amar Gupta & Deth Sao, *The Constitutionality of Current Legal Barriers to Telemedicine in the United States: Analysis and Future Directions of Its Relationship to National and International Health Care Reform*, 21 HEALTH MATRIX 385 (2011).
[99] *See supra* note 95.

arbitration are enforceable in all United States jurisdictions.[100] In other words, a decision involving parties in California and Nevada would be enforced by both states. Second, parties avoid jurisdictional and choice of law concerns, because they consent to a set of procedural and substantive rules to govern the process and the choice of an arbitrator before the arbitration begins. This would allow parties to decide which procedure would be followed beforehand, thereby sidestepping the cumbersome issues of choice of law confronted during litigation. Additionally, arbitrators are more appropriate decision-makers than juries in medically related cases due to the type of expertise needed to understand the case. Parties in medical malpractice cases typically select arbitrators from a list of qualified candidates, and all candidates are required to be neutral and independent decision-makers by national laws, institutional rules, and international arbitration treaties. The parties' role in the selection of decision-markers contributes to confidence in the process and outcome.

In addition to providing predictability in the decision-making process and a more neutral forum for aggrieved parties, arbitration offers a more efficient and more flexible approach. First, discovery time and procedural time are both limited. Second, given the arbitrator's expertise, the amount of explanation needed to present the case is shortened. Third, although the arbitrator has wide discretion, the parties determine the procedural and substantive rules of law. Finally, the grounds on which a party may appeal are much more limited than those provided to a trial court party and such limited appellate rights facilitate a faster and more certain resolution of the dispute. Should a party to arbitration successfully appeal their case, it will be reviewed by a

[100] U.S. CONST. art. IV, § 1. *See supra* note 83.

court of law, which often gives deference to the arbitration decision, so long as there is not clear error on the part of the arbitrator.[101]

Arbitration is already widely in use for telemedicine disputes, in part because it is a good alternative for technically complex disputes and in part because health insurance companies widely require arbitration for members. However, two (2) implementations must be made to further extend the benefits of arbitration and encourage the use of telemedicine. First, a national standardization of telemedicine licensing must be enacted to allow for interstate practice of telemedicine.[102] And second, to ease the use of telemedicine for physicians, consumers, and insurance companies, arbitration should be mandated for telemedicine disputes. If Congress enacted a national mandate, requiring insurance companies to require non-binding arbitration for telemedicine services used by members, and where Congress has already mandated American citizens are members of health insurance coverage, the resulting effect would be a mandate of arbitration for all individuals using telemedicine services nationally.

The FAA reflects the authority of Congress to support arbitration on a national level as a more efficient resolution process than litigation by rendering all arbitration agreements "valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for revocation of any contract." Additionally, this national support has been backed by the Supreme Court and is now recognized in all judicial districts in the United States. The act upholds arbitration agreements and awards involving interstate and foreign commerce, the latter of which is possible

[101] 9 U.S.C. §10 (2012) (stating that the an arbitration award may be vacated only if (1) the award was procured by corruption, fraud, or undue means; (2) where there was evidence partiality or corruption in one or more arbitrators; (3) the arbitrators were guilty of misconduct or any misbehavior by which the rights of any party have been prejudiced; or (4) the arbitrators exceeded their powers).

[102] Gupta, *supra* note 70 (highlighting the potential for patients to access top national and international health resources via telemedicine, so long as jurisdictional barriers do not impede).

because the FAA also incorporates certain international arbitration agreements into domestic law. Most courts have interpreted activities in the health care industry to be interstate commerce and thus subject to the FAA. This interpretation means that arbitration contracts and awards involving medical malpractice disputes are easily enforced in the United States, as the FAA is charged with the duty of honoring these types of arbitration contracts. Since arbitration is widely used by insurance companies today, taking the next step to ensure it's use would further encourage the use of arbitration on a national, cross-jurisdictional scale.

D. Downside of Arbitration

Arbitration has been criticized over the years for a number of reasons, largely that lower costs and higher efficiency come at a price. Due to the private nature of arbitration, it lacks the public scrutiny that can often benefit litigation. Lacking the careful and criticizing eye of the public, with the added flexible nature of procedure, some argue that arbitration is a lawless form of dispute resolution. Where parties have an issue with the procedure or outcome of arbitration, their ability to appeal the decision is very limited. Courts, in recent decades, have been highly deferential to the decision of arbitrators due to the fact that parties select the neutral arbitrator before the proceedings begin.[103]

The privacy however, is often an added plus in medical malpractice claims. Through arbitration, the medical reports of patients and practices of doctors are kept private, keeping them from the public repercussions of public litigation. Additionally, in business-to-business disputes, arbitration removes the hostility of litigant allowing parties to continue working together in future business settings, a common result for insurance companies and providers that often involve set contracts for coverage or business practice.

[103] *See supra* note 98.

A particular criticism of arbitration of health care practices is how the Health Insurance Portability and Accountability Act of 1996 (HIPAA) acts as an obstacle. The argument for raising HIPAA as a defense to arbitration is that where patient records are part of the evidence, that use violates the confidentiality of the patient's individually identifiable health information protected by the Act.[104] However, this defense does not account for the nondisclosure exception during the course of litigation or administrative proceedings, which states that an entity covered by HIPAA may disclose protected health information in the course of any judicial or administrative proceeding in response to a court order or administrative tribunal order if "satisfactory assurance" or a "qualified protective order" is obtained by the party seeking the information.[105] Additionally, HIPAA provides an exception that a covered entity may use or disclose protected health information for payment purposes, meaning any time the issue at hand is related to payment, there is not a HIPAA issue at hand. Even in the unlikely event that the Department of Health and Human Services held that the litigation exception did not apply to arbitration, the privacy of arbitration and ability to redact patient records would make it so no individual identifying information emerged from the claim.[106]

E. Call for National Telemedicine Arbitration Mandate

With the rising popularity of arbitration in health care disputes, the adoption of arbitration for telemedicine disputes is a natural and logical response to questions of liability in this growing area of health care delivery. The success of arbitration is observed through its ability to help parties reach a practical and private solution to a significant and often complex problem. Applying this solution to telemedicine would not only resolve questions of liability in a more

[104] *See supra* note 95.
[105] *Id*; 45 C.F.R. 164.512(e).
[106] *See supra* note 95.

efficient and cost-effective manner, but it would also aid the growth of telemedicine use on a national scale by lessening concerns of liability held by health care providers and patients alike. The lack of a national, uniform arbitration scheme for telemedicine practices is a potential problem, as medical regulations and malpractice statutes vary significantly from state to state. With the implementation of a national mandate of arbitration for telemedicine services, the health care system would be one step closer to a national telemedicine scheme, which would improve the cost, access and efficiency of health care delivery in the United States.

V. Conclusion

When legislatures originally delegated the power to state medical boards to oversee the public health of their citizens, legislatures did so because medical practices were all local. But, over the past hundreds of years, changes in both medical practices and technology have progressed such that health care now extends beyond both state and national borders. As such, there is a need for Congress to enact national standards for telemedicine. Not only does Congress have the power to do so, but the federal government is also capable of this regulation and oversight. A national scheme to standardize telemedicine practices would expand access and increase efficiency in health care delivery. Combined with a national scheme to mandate arbitration of telemedicine claims for individuals, Americans would both have the ability to use cross-jurisdictional telemedicine services, as well as the assurance that claims arising from telemedicine disputes would be resolved efficiently and appropriately. While the barriers for telemedicine are many and complex, the solutions are within reach. As technology continues to develop, so should the practice of telemedicine on a national scale.

Addendum

Prior to the publication of this article, the Supreme Court of Iowa overturned the holding of the Iowa District Court for Polk County in the *Planned Parenthood of the Heartland, Inc. v Iowa Board of Medicine* case. As discussed above, the district court upheld a rule established by the Iowa Board of Medicine, which set certain standards for physicians administering abortion-inducing drugs, thereby banning the use of telemedicine in the administration of such drugs.[107] Planned Parenthood of the Heartland (PPH) appealed the decision to the Supreme Court of Iowa. On June 19, 2015, the court affirmed in part and reversed in part the holding of the district court, finding that the Board's rule violates the "undue burden" test established by the United States Supreme Court as the federal test for constitutionality.[108] The opinion of the Supreme Court of Iowa demonstrates that state medical boards may have varying scales of power to limit telemedicine abortions depending on the jurisdiction.[109]

While PPH challenged both the rule-making process and the constitutionality of the rule on appeal, the court found that the rule itself was properly enacted and it did not violate any procedural or rule-making provisions in the state code. As such, the court reviewed only the constitutional issues. Noting that Board did not violate any rule-making provisions of the Iowa Code Chapter 17A, the court draws attention to the fact that the Iowa medical board possesses the authority to properly enact restrictive rules so long as those rules do not violate the constitution. This distinction highlights the fact that state medical boards in other jurisdictions

[107] *See supra* note 20.
[108] Planned Parenthood of the Heartland, Inc. v. Iowa Bd. of Med., 865 N.W.2d 252 (Iowa 2015) (citing Planned Parenthood of Se. Penn. v. Casey, 505 U.S. 833 (1992)).
[109] *Id*. at 262.

do have the authority able to enact a rule as restrictive as the rule in this case if they reside in those jurisdictions in which constitutional tests are interpreted differently.[110]

The "undue burden" test established in the plurality opinion of *Planned Parenthood of Southeastern Pennsylvania v. Casey* follows that a state regulation which has "the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus" will be found to place an undue burden on a woman's right to terminate a pregnancy.[111] However, different jurisdictions apply the "undue burden" test differently. For example, the Fifth and Sixth Circuits do not weigh the burden of the state statute or regulation against the burden placed on the woman, so long as the state provides a justification for an abortion regulation sufficient to pass the rational basis test.[112] The Iowa Supreme Court, on the other hand – like the Seventh and Ninth Circuits – found that the test established in *Casey* requires consideration of the state's justification for a statute or regulation weighed against the burden placed on the woman seeking to terminate her pregnancy.[113] Here, the court overturned the rule for placing an undue burden on a woman's constitutional right to seek an abortion, finding the burden that this rule placed on Iowan women far exceeded any health benefits the state claimed to be promulgated by this rule.[114]

With Iowa being the first state to perform telemedicine abortions on a widespread scale,[115] *Planned Parenthood of the Heartland, Inc.* acts both as a beacon for telemedicine, as well as a cautionary tale. On one hand, the opinion acts as an example of how telemedicine, as a

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[110] *See* Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott, 748 F.3d 583 (5th Cir. 2014).
[111] 505, U.S. 833, 877 (1992).
[112] *See Abbott*, 748 F.3d at 593-99; *see also* Planned Parenthood Sw. Ohio Region v. DeWine, 696 F.3d 490, 513-18 (6th Cir. 2012).
[113] *Planned Parenthood of the Heartland, Inc.*, 865 N.W.2d at 262.
[114] *Id.* at 269.
[115] *Id.* at 255 n.1.

medium of health care delivery, can expand access to patients in need, while also maintaining the upmost quality of care. On the other hand, this opinion illustrates that state medical boards residing in other jurisdictions, namely the Fifth and Sixth Circuits, possess the power to substantially limit both telemedicine and healthcare due to political or other non-medical motivations.