

## NOTE

### REGULATORY TENSIONS IN TELEMEDICINE AND THE REALITIES OF VIRTUAL CARE POST PANDEMIC

Jean Yesudas

This is a correction to the original Article. For information about the changes made, please see the erratum

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# NOTE

## REGULATORY TENSIONS IN TELEMEDICINE AND THE REALITIES OF VIRTUAL CARE POST PANDEMIC

Jean Yesudas\*

### INTRODUCTION

Healthcare in the United States is expensive, disjointed, inequitable, and ineffective. Without a uniform health system, high costs paired with the lack of insurance coverage are causing social and economic discrimination in healthcare services. Average annual premiums for family coverage have increased, outpacing inflation and workers' earnings.<sup>1</sup> Medical expenditures are becoming increasingly unaffordable for marginalized communities, and many are forced to rely on emergency departments for primary healthcare services, treatment for chronic diseases, and preventative care.<sup>2</sup> “[T]he lack of health insurance in the U.S. costs

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\* J.D., 2022, University of Pittsburgh School of Law. I would like to thank my brother, James Manimala, for showing me unending support, and Alexander Dettwyler, for changing my life and always seeing the best in me.

<sup>1</sup> Sarah O'Brien, *Average Family Premiums for Employer-Based Health Insurance Have Jumped 47% in the Last Decade, Outpacing Wage Growth and Inflation*, CNBC (Nov. 11, 2021, 3:27 PM), <https://www.cnbc.com/2021/11/11/premiums-for-employer-health-insurance-have-jumped-47percent-in-10-years.html> [<https://perma.cc/WPZ9-6H3L>].

<sup>2</sup> Johonniuss Chemweno, *The U.S. Healthcare System Is Broken: A National Perspective*, MANAGED HEALTHCARE EXEC. (July 27, 2021), <https://www.managedhealthcareexecutive.com/view/the-u-s-healthcare-system-is-broken-a-national-perspective> [<https://perma.cc/HY55-B8F5>].

society between \$124 billion and \$248 billion per year” and is associated with “30-90 thousand deaths per year.”<sup>3</sup>

Another major driver of healthcare costs in the U.S. is chronic illness. It is also the leading cause of death and disability.<sup>4</sup> Seventy-five percent of aggregate healthcare spending in the U.S. go toward treating chronic illness.<sup>5</sup> Ninety-four percent of Medicare expenditures are represented by beneficiaries with two or more chronic conditions.<sup>6</sup> The country’s inability to effectively manage chronic conditions creates health disparities within minority, rural, and elder communities.<sup>7</sup> Minorities “are up to two times more likely than white people to have major long-term conditions.”<sup>8</sup> And rural Americans—who make up about fifteen percent of the U.S. population—have a significantly higher risk of dying than their urban counterparts due to the long travel distances required for specialty and emergency care.<sup>9</sup> The uninsured do not have as much incentive to schedule preventative care checkups, and inconsistent visits increase the chances for these conditions to develop into advanced diseases.<sup>10</sup> The complications then associated with the advanced progression of chronic illness often require repeat hospital visits and end-of-life treatment—which is more expensive than preventative care.<sup>11</sup>

In theory, an increase in telemedicine services increases access to healthcare services—which should solve the issues patients face in disadvantaged communities

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<sup>3</sup> *Id.*

<sup>4</sup> Wullianallur Raghupathi & Viju Raghupathi, *An Empirical Study of Chronic Diseases in the United States: A Visual Analytics Approach to Public Health*, 15 INT’L J. ENV’T RSCH. PUB. HEALTH 431, 431 (2018).

<sup>5</sup> *Id.*

<sup>6</sup> Stephanie Carlton et al., *Supplemental Benefit Changes in Medicare Advantage Increase Options for Those with Chronic Conditions*, MCKINSEY & CO. (Aug. 10, 2020), <https://www.mckinsey.com/industries/healthcare/our-insights/supplemental-benefit-changes-in-medicare-advantage-increase-options-for-those-with-chronic-conditions> [<https://perma.cc/GHX7-DGZM>].

<sup>7</sup> *Id.*

<sup>8</sup> Rachel Reiff Ellis, *Minorities and Chronic Disease: Obstacles to Care*, WEBMD (Oct. 7, 2020), <https://www.webmd.com/diabetes/features/minority-chronic-condition-burden> [<https://perma.cc/8GLV-AUF5>].

<sup>9</sup> *About Rural Health*, CDC (Aug. 2, 2017), <https://www.cdc.gov/ruralhealth/about.html> [<https://perma.cc/W9S2-MPHU>].

<sup>10</sup> Ellis, *supra* note 8.

<sup>11</sup> *Id.*

in the United States. Telemedicine services can offer care while simultaneously decreasing travel distance, individual costs, and possible appointment delays to care.<sup>12</sup> These services can ensure access to specialty, primary, and behavioral health care regardless of the patient's location. Telemedicine can help expand access to medical services for vulnerable groups such as incarcerated persons,<sup>13</sup> the elderly in nursing homes,<sup>14</sup> and children in foster care.<sup>15</sup> However, the COVID-19 pandemic has shown that telemedicine has not been and may not be the ultimate solution to many of the systemic issues of American healthcare.

As telemedicine services and remote monitoring technology expanded, so did the telemedicine market, and there was an influx of new digital health systems.<sup>16</sup> Currently, telemedicine companies are driven primarily by the free market where antitrust principles that resist regulation and promote vigorous competition are applied.<sup>17</sup> These values sometimes conflict as they relate to medicine, a highly regulated field.<sup>18</sup>

Professor Theodosia Stavroulaki, a leading scholar in healthcare antitrust, argues that in order for telemedicine services to provide quality care, antitrust principles in this field should account for a more balanced analysis between health policy objectives, consumer safety, and consumer choice.<sup>19</sup> She asserts that "antitrust enforcers should adopt a broader definition of healthcare quality,"<sup>20</sup> and that failing

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<sup>12</sup> Theodosia Stavroulaki, *Mind the Gap: Antitrust, Health Disparities and Telemedicine*, 45 AM. J.L. & MED. 171, 174 (2019).

<sup>13</sup> *Id.*

<sup>14</sup> Kat Jercich, *Rapid Telehealth Rollout was Beneficial for Nursing Homes, but Had Downsides Too*, HEALTHCARE IT NEWS (Nov. 10, 2021, 9:53 AM), <https://www.healthcareitnews.com/news/rapid-telehealth-rollout-was-beneficial-nursing-homes-had-downsides-too> [<https://perma.cc/6U2G-MGUL>].

<sup>15</sup> Jeanmarie Evely, *Pandemic Expansion of Telehealth Has Improved Access for Kids in Child Welfare System: Report*, CITY LIMITS (Jan. 27, 2021), <https://citylimits.org/2021/01/27/pandemic-expansion-of-telehealth-has-improved-access-for-kids-in-child-welfare-system-report/> [<https://perma.cc/DQU2-TZ9W>].

<sup>16</sup> Oleg Bestseny et al., *Telehealth: A Quarter-Trillion-Dollar Post-COVID-19 Reality?*, MCKINSEY & CO. (July 9, 2021), <https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality#skipToMain> [<https://perma.cc/5ZMX-GH2Z>].

<sup>17</sup> Stavroulaki, *supra* note 12, at 185.

<sup>18</sup> *Id.* at 186.

<sup>19</sup> *Id.* at 173.

<sup>20</sup> *Id.*

to do so may be “indirectly contribut[ing] to the existing health disparities in the United States.”<sup>21</sup> This Note expands on Professor Stavroulaki’s legal analysis to offer a critique of how her theory applies considering the increase in telemedicine usage due to the COVID-19 pandemic.

Part I of this Note provides a background of antitrust jurisprudence as it applies to telemedicine and the 2015 *Teladoc* decision. Part II describes the boom in telehealth services due to the pandemic. Part III explains the importance of targeted regulation to decrease health disparities currently exacerbated by increased use of telemedicine.

## I. ANTITRUST IN TELEMEDICINE: BACKGROUND

The Federal Trade Commission (“FTC”) has consistently advocated for states to avoid unnecessary regulations restricting service providers on the idea that an open marketplace provides consumers with “lower prices, higher quality services, greater access to services, and increased innovation.”<sup>22</sup> The FTC has also advised state legislatures to only restrict competition when preventing health and safety risks to consumers.<sup>23</sup>

Previously, states avoided implicating antitrust concerns in regulated fields by creating occupational regulatory boards.<sup>24</sup> Such boards included members that had either no financial interest in the particular field or that had a financial interest in the particular field and served in an advisory capacity.<sup>25</sup> However, active health care providers often dominated the licensing boards of their respective industries.<sup>26</sup> In 2015, the United States Supreme Court—agreeing with the FTC’s determination that the North Carolina State Board for Dental Examiners violated federal antitrust laws when they prevented unlicensed dentists from providing teeth-whitening services—held “that a state board on which a controlling number of decisionmakers are active market participants in the occupation the board regulates must satisfy *Midcal*’s<sup>27</sup>

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<sup>21</sup> *Id.* at 187.

<sup>22</sup> FED. TRADE COMM’N, FTC STAFF GUIDANCE ON ACTIVE SUPERVISION OF STATE REGULATORY BOARDS CONTROLLED BY MARKET PARTICIPANTS 2 (2015).

<sup>23</sup> *Id.*

<sup>24</sup> *Id.*

<sup>25</sup> *Id.*

<sup>26</sup> *Id.*

<sup>27</sup> *Cal. Retail Liquor Dealers Ass’n v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980).

active supervision requirement in order to invoke state-action antitrust immunity.”<sup>28</sup> This immunity is referred to as the “state action exemption,” and it shields state agencies from liability under federal antitrust laws.<sup>29</sup> The Supreme Court, however, rejected the use of the exemption in this case.<sup>30</sup> The Court concluded that because a controlling number of the occupational regulatory board members were active market participants, they were also considered private actors and must show active state supervision to be immune under the exemption.<sup>31</sup>

Within months of this ruling, a game-changing dispute for telemedicine was brought by Teladoc against the Texas Medical Board over a rule the Board implemented prohibiting physicians from filling a “prescription of any ‘dangerous drug or controlled substance’ without first establishing a ‘defined physician-patient relationship’ . . . .”<sup>32</sup> Establishing a physician-patient relationship required an in-person physical examination, which meant that Teladoc’s providers would not have been able to prescribe controlled substances exclusively through telemedicine.<sup>33</sup>

Beyond the issue introduced in this case, establishing a physician-patient relationship is legally consequential to physicians. It is a legal contract that forms when physicians examine, diagnose, and treat a patient.<sup>34</sup> Further, it allows physicians to access patient electronic medical records and prescribe medications. This relationship is also important for the patient. Once there is an established physician-patient relationship, physicians have a duty to affirmatively provide care and maintain confidentiality.<sup>35</sup> Physicians also then have an affirmative duty to provide quality care on the same standards as in-person visits.<sup>36</sup>

In this case, Teladoc claimed that requiring a face-to-face physical examination to establish a physician-patient relationship would completely deprive physicians of

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<sup>28</sup> N.C. State. Bd. of Dental Exam’rs v. FTC, 135 S. Ct. 1101, 1114 (2015).

<sup>29</sup> FED. TRADE COMM’N, *supra* note 22.

<sup>30</sup> *Id.*

<sup>31</sup> N.C. State. Bd. of Dental Exam’rs, 135 S. Ct. at 1114.

<sup>32</sup> Teladoc, Inc. v. Tex. Med. Bd., 112 F. Supp. 3d 529, 534 (W.D. Tex. 2015).

<sup>33</sup> *Id.*

<sup>34</sup> Valarie Blake, *When Is a Patient Physician Relationship Established?*, AMA J. ETHICS (May 2012), <https://journalofethics.ama-assn.org/article/when-patient-physician-relationship-established/2012-05> [<https://perma.cc/D88K-URZM>].

<sup>35</sup> *Id.*

<sup>36</sup> *Teladoc*, 112 F. Supp. 3d at 538.

the ability to provide health care via only telephone consultation.<sup>37</sup> Teladoc also argued that implementing this requirement would essentially destroy its business model—by increasing prices and reducing access to their services—and would no longer allow them to provide any services in Texas.<sup>38</sup> On the other side, the Texas Medical Board asserted that the face-to-face requirement protects patients from gaining access to dangerous or addictive drugs and is a critical safeguard against the “deficiencies in telephone-only diagnosis.”<sup>39</sup>

The court found that Teladoc successfully presented evidence that safe and quality care was provided and that “Teladoc’s business model led to increased supply of physician services and lower healthcare costs.”<sup>40</sup> It dismissed the Board’s concerns as “anecdotal”<sup>41</sup> and concluded that “no imminent peril to public health, safety or welfare” existed to justify implementing a rule requiring face-to-face physical examinations before prescribing controlled substances.<sup>42</sup> The Board appealed the result and was supported by both the American Medical Association and the Texas Medical Association with briefs supporting the appeal—explaining why “public safety would be harmed if telemedicine use was left to market forces.”<sup>43</sup> Ultimately, however, the Texas Medical Board dropped the case after the FTC, the Department of Justice, the “Cato Institute, fifty-five antitrust law professors, and the . . . Texas Association of Business” filed in Teladoc’s favor.<sup>44</sup>

As Professor Stavroulaki explains, the medical associations argued that telemedicine “is inappropriate for certain medical conditions and carries risks”—not that increasing access to healthcare services would harm patient welfare.<sup>45</sup> They argued that physicians could have difficulty treating patients remotely and that

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<sup>37</sup> *Id.* at 541.

<sup>38</sup> *Id.*

<sup>39</sup> *Id.* at 538.

<sup>40</sup> Stavroulaki, *supra* note 12, at 173.

<sup>41</sup> *Teladoc*, 112 F. Supp. 3d at 538.

<sup>42</sup> *Id.* at 544.

<sup>43</sup> Stavroulaki, *supra* note 12, at 182.

<sup>44</sup> Edgar Walters, *Federal Regulators Take Teladoc’s Side in Medical Board Suit*, TEX. TRIB. (Sept. 10, 2016), <https://www.texastribune.org/2016/09/10/federal-regulators-take-teladocs-side-medical-board/> [<https://perma.cc/98CG-SG2U>].

<sup>45</sup> *Id.*

telehealth could increase the opportunity for fraud and abuse.<sup>46</sup> The associations also submitted evidence that physicians tend to overprescribe unnecessary medication due to the limited information they are provided.<sup>47</sup> However, using the traditional antitrust analysis, the FTC found that “a public safety defense [was] extraneous to an analysis of competitive effects.”<sup>48</sup> That competition from the free market naturally protects the quality concerns addressed in this case.<sup>49</sup>

## II. TELEHEALTH BOOM

At the time of the *Teladoc* case, telemedicine was not a popular mode of delivery and was not yet fully integrated into the healthcare system.<sup>50</sup> Although the FTC determined that establishing a physician-patient relationship no longer required an in-person physical examination, other regulations limited the opportunity for patients to practically use virtual care services.<sup>51</sup> These regulations were particularly complicated with respect to insurance coverage and privacy.<sup>52</sup> Most insured patients were not reimbursed unless they lived in rural areas—with a few exceptions for select disorders.<sup>53</sup> And some privacy regulations required providers to use specific technology during appointments to secure patient health information.<sup>54</sup> There were also additional hurdles due to provider licensing restrictions.<sup>55</sup> Accordingly, there was limited ability to collect empirical data about the quality and effectiveness of telehealth services, which made it challenging to understand whether telemedicine needed to be regulated and, if so, to what extent.

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<sup>46</sup> *Id.*

<sup>47</sup> *Id.*

<sup>48</sup> *Id.* at 184.

<sup>49</sup> N.C. Bd. of Dental Exam'rs, FTC Docket No. 934, at 25 (Dec. 7, 2011).

<sup>50</sup> Julia Shaver, *The State of Telehealth Before and After the COVID-19 Pandemic*, PRIMARY CARE: CLINICS OFF. PRAC. (Apr. 2022), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9035352/> [<https://perma.cc/J9TX-3PUA>].

<sup>51</sup> *Id.*

<sup>52</sup> *Id.*

<sup>53</sup> *New HHS Study Shows 63-Fold Increase in Medicare Telehealth Utilization During the Pandemic*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Dec. 3, 2021), <https://www.cms.gov/newsroom/press-releases/new-hhs-study-shows-63-fold-increase-medicare-telehealth-utilization-during-pandemic> [<https://perma.cc/RWX5-MH7D>].

<sup>54</sup> Shaver, *supra* note 50.

<sup>55</sup> *Id.*

The COVID-19 pandemic, however, accelerated the growth of the telemedicine industry, and many of these restrictions consequently fell away.<sup>56</sup> The Centers for Medicare and Medicaid Services (“CMS”) and federal policymakers enacted thirty-one changes through emergency orders, which waived certain statutory limitations.<sup>57</sup> The two primary changes that increased access and coverage for telehealth visits were: the relaxation of geographic restrictions, which allowed physicians to be reimbursed for telehealth appointments regardless of where the patient was located, and the expansion of Medicare- and Medicaid-reimbursable telehealth services.<sup>58</sup> This expansion allowed telehealth visits for Medicare beneficiaries to go from “hundreds of thousands [pre-pandemic] to tens of millions.”<sup>59</sup>

Prior to the pandemic, telehealth visits were less than one percent of outpatient care.<sup>60</sup> This percentage skyrocketed to thirteen percent in the first six months of the pandemic, peaking in April 2020—with a seventy-eight-fold increase from February 2020 alone.<sup>61</sup>

Additionally, it was not only existing hospitals and health systems that adopted telehealth strategies to provide their patients with care. The number of telemedicine companies and the increase in venture capital financing in virtual care also soared.<sup>62</sup> In 2021, \$7.67 billion was invested in telemedicine startups.<sup>63</sup> There are currently

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<sup>56</sup> *History of Telemedicine*, EVISIT, <https://evisit.com/resources/history-of-telemedicine/> [https://perma.cc/2EAQ-97Y2] (last visited Apr. 15, 2022).

<sup>57</sup> Kat Jercich, *Senate HELP Committee Weighs the Future of Telehealth*, HEALTHCARE IT NEWS (June 17, 2020), <https://www.healthcareitnews.com/news/senate-help-committee-weighs-future-telehealth> [https://perma.cc/4GKL-GRQV].

<sup>58</sup> *Id.*; CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 53.

<sup>59</sup> CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 53.

<sup>60</sup> Justin Lo et al., *Outpatient Telehealth Use Soared Early in the COVID-19 Pandemic but Has Since Receded*, PETERSON-KFF (Feb. 10, 2022), <https://www.healthsystemtracker.org/brief/outpatient-telehealth-use-soared-early-in-the-covid-19-pandemic-but-has-since-receded/> [https://perma.cc/8WY7-2KVS].

<sup>61</sup> Bestsenny et al., *supra* note 16.

<sup>62</sup> *Telemedicine Will Remain Even as the COVID-19 Crisis Recedes; But the Policies That Enabled Great Advances in Telemedicine Should Become Permanent*, NAT'L L. REV. (Nov. 29, 2021), <https://www.natlawreview.com/article/telemedicine-will-remain-even-covid-19-crisis-recedes-policies-enabled-great> [https://perma.cc/A8WG-4M7E].

<sup>63</sup> *Id.*

more than 280 telehealth companies offering on-demand healthcare in the United States.<sup>64</sup>

This increase in digital health access and usage provides the perfect opportunity to identify the potential gaps in quality of care and determine what regulations may be necessary to decrease health disparities and protect consumer health and safety.

#### A. *Direct-To-Consumer Models of Telemedicine*

Telemedicine companies that provide services with a direct-to-consumer (“DTC”) model are the most popular and well-known form of telemedicine, as their services were around long before the pandemic. DTC telemedicine companies, such as Teladoc, American Well, and Doctor on Demand, provide care through digital services and affordable subscription plans without requiring reimbursement or insurance.<sup>65</sup> They often claim to cater towards the public mission of providing health care services to underinsured populations and advertise their potential to improve access to healthcare.<sup>66</sup> Within this model, patients simply select their clinical issue, submit a medical intake form online, and wait for a clinician to review the form and provide the patient with the necessary prescription.<sup>67</sup>

However, despite their alleged public mission, this mode of delivery predominately provides services to patients in urban areas that are in the top quartile in household income and that already have insurance.<sup>68</sup> As the COVID-19 pandemic progressed, more employers and health plans started to partner with telemedicine companies to provide their employees with a telehealth option.<sup>69</sup>

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<sup>64</sup> Anna Felvey & Brendan Talian, *280+ Telehealth Companies to Know / 2023*, BECKER’S HOSP. REV. (July 24, 2023), <https://www.beckershospitalreview.com/lists/280-telehealth-companies-to-know-2023.html>.

<sup>65</sup> See, e.g., *What We Do*, TELADOC HEALTH, <https://teladochealth.com/what-we-do/> [<https://perma.cc/97PR-ZY5B>] (last visited Sept. 1, 2022).

<sup>66</sup> *Id.*

<sup>67</sup> Tara Jain & Ateev Mehrotra, *Comparison of Direct-to-Consumer Telemedicine Visits with Primary Care Visits*, JAMA NETWORK (Dec. 8, 2020), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2773813> [<https://perma.cc/GBM7-842J>]; see also Suanne G. Bollmeier et al., *Direct to Consumer Telemedicine: Is Healthcare from Home Best?*, 117 J. MO. STATE MED. ASS’N, 303 (2020), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7431063/> [<https://perma.cc/6U5B-222Q>].

<sup>68</sup> Jain & Mehrotra, *supra* note 67.

<sup>69</sup> *2021 Employer Health Benefits Survey*, KFF (Nov. 10, 2021), <https://www.kff.org/report-section/ehbs-2021-section-13-employer-practices-telehealth-and-employer-responses-to-the-pandemic/> [<https://perma.cc/42WN-QFA7>].

It is possible that telemedicine services are being used excessively. “Research shows that up to 90% of patients say they wouldn’t have sought care if telehealth wasn’t available,” and that their utilization of it was a supplement to in-person care, not a substitute.<sup>70</sup> Before the pandemic, telehealth services were reimbursed at lower rates than in-office visits.<sup>71</sup> But in an effort to provide a more uniform use and regulation of telehealth reimbursement—a handful of states implemented payment parity laws that mandated providers to charge the same rate for telehealth services that they charged for in-person care.<sup>72</sup> Therefore, when high-income patients used telemedicine services and in-person visits—health care costs doubled.

It is also not necessarily true that telehealth reduces expenses for providers. In a fee-for-service system, the payment rates for outpatient visits, as set by CMS, are based on the estimated costs of clinical effort, malpractice insurance, and practice expenses.<sup>73</sup> The expenses for malpractice insurance and clinical effort remain unchanged between telehealth and in-person visits.<sup>74</sup> Practice expenses, however, for telemedicine companies may be lower—but providers that perform both in-person and telehealth visits experience additional costs since they must also maintain the fixed expenses that are required in brick-and-mortar practices.<sup>75</sup>

For telehealth services adopted by brick-and-mortar practices and for telemedicine companies that attempt to coordinate care with health systems and labs, the costs for providing telehealth services increase. Additionally, as telehealth services become more robust and many companies aim to deliver national coverage, providing quality care on such a large scale becomes increasingly challenging. National telemedicine providers must hire and retain a large clinician staff to support patient needs. They are also forced to meet a wide range of unique regulations, as

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<sup>70</sup> Gary Call, *Telehealth Post-COVID: Going Digital to Reduce Costs?*, MED. ECON. (Jan. 28, 2022), <https://www.medicaleconomics.com/view/telehealth-post-covid-going-digital-to-reduce-costs-> [https://perma.cc/E5YF-7692].

<sup>71</sup> Jeff Lagasse, *Telehealth Reimbursement Parity Spurs Insurer Concerns of Overutilization*, HEALTHCARE FIN. (May 13, 2021), <https://www.healthcarefinancenews.com/news/telehealth-reimbursement-parity-spurs-insurer-concerns-overutilization-though-future-bright> [https://perma.cc/MCW8-MNX7].

<sup>72</sup> *Id.*

<sup>73</sup> Chad Ellimoottil, *Understanding the Case for Telehealth Payment Parity*, HEALTH AFFS. (May 10, 2021), <https://www.healthaffairs.org/doi/10.1377/forefront.20210503.625394/full/> [https://perma.cc/FWZ3-L58V].

<sup>74</sup> *Id.*

<sup>75</sup> *Id.*

healthcare regulations differ from state to state. Further, highly regulated fields, such as behavioral, reproductive, and adolescent health, are incredibly complicated and the governing laws and regulations can vary significantly depending on the jurisdiction. Nevertheless, many telemedicine companies have been working to incorporate these services. Depending on the services provided, each state will have different workflows that the clinicians licensed in multiple states will be forced to keep track of, such as differences in privacy requirements, recordkeeping and reporting requirements, record sharing requirements, and consent requirements.<sup>76</sup> The heavy lifting and legwork that is required of the legal and compliance teams at these organizations, as well as the clinicians learning and applying the differing regulations, make providing national care difficult without incurring huge costs and significant risks.<sup>77</sup> Thus, telemedicine institutions that lack the necessary funding or staff to maintain such services may be pushed out of the telemedicine industry or forced to limit their range of care—subsequently advertising a wide range of hard-hitting services but barely scratching the surface of meaningful care.<sup>78</sup>

A perfect example of this is Amazon Care. Amazon Care was Amazon's second attempt at delivering fast and convenient healthcare services since 2018.<sup>79</sup> Amazon Care was maintained within the Amazon App and included chat and video services with a clinician “24/7, 365 days a year.”<sup>80</sup> In addition to its virtual care features, Amazon Care also provided in-person services and arranged a system that would allow nurses (referred to as “mobile care nurses”) to “come directly to [the patient] for testing, immunizations, blood draws,” and other primary and urgent care services that most other telemedicine companies would have to refer out.<sup>81</sup> In less than a year of its opening, Amazon Care quickly expanded to provide telehealth services

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<sup>76</sup> See, e.g., Jonathan Linkous, *The Role of Telehealth in an Evolving Health Care Environment: Workshop Summary*, NAT'L LIBR. MED., <https://www.ncbi.nlm.nih.gov/books/NBK207146/> [<https://perma.cc/HE3E-8ZDR>] (last visited July 30, 2023) (“Licensing was a minor issue when the ATA was formed, because most telemedicine systems operated within a single state. Today there are multistate systems with multistate practices.”).

<sup>77</sup> See also *id.* (demonstrating that a lack of reimbursement makes sustaining telemedicine services difficult due to high costs).

<sup>78</sup> See *id.*

<sup>79</sup> Libby Watson, *Amazon Really Believed It Could Sell You a Health Care Fantasy*, N.Y. TIMES: OPINION (Sept. 2, 2022), <https://www.nytimes.com/2022/09/02/opinion/amazon-health-care.html> [<https://perma.cc/9JWA-2W8B>].

<sup>80</sup> *About: Healthcare Has Never Been More Convenient*, AMAZON CARE, <https://amazon.care/about> [<https://perma.cc/UBB4-UVAR>] (last visited Sept. 3, 2022).

<sup>81</sup> *Id.*

nationwide and in-person services in at least seven major cities.<sup>82</sup> They also signed large contracts with employers like Hilton, Silicon Labs, TrueBlue, Precor, and Whole Foods Market.<sup>83</sup>

Amazon Care launched as a pilot program in 2019—expanded its services amidst the pandemic—and announced in August 2022 that they would be shutting down at the end of the year.<sup>84</sup> The *New York Times* reported testimonies from former clinical employees that spoke out about how they “struggled with regulations and the logistics of caring for patients in many states” and were “unsure if they could prescribe antibiotics or where to refer patients for X-rays.”<sup>85</sup> Although patient satisfaction for Amazon Care services was high, “some health professionals who worked for the service said Amazon sometimes prioritized pleasing patients over providing the best standard of care.”<sup>86</sup> The company’s business-oriented efforts often clashed with the medical staffers, “who felt the company sometimes ignored their concerns about its approach to health care.”<sup>87</sup> One healthcare-consultant reported to the *Washington Post* about how she felt that Amazon may have underestimated some of the challenges that may occur in a tech and medical start-up—these “kinds of services require degrees of staffing and scaling that’s not easy in the health-care world.”<sup>88</sup>

The disconnect and clashes between experienced clinicians and business managers who are focused on efficient and affordable delivery is accurately illustrated during this period of expansion at Amazon Care. When Amazon Care was planning to broaden its in-person services to other cities, to avoid building a physical hub, “they asked if nurses could store and dispose of medical supplies at home and

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<sup>82</sup> *Id.*

<sup>83</sup> Heather Landi, *Amazon Expanding Healthcare Service to 20 More Cities, Lands Silicon Labs, Whole Foods Market as Customers*, FIERCE HEALTHCARE: HEALTH TECH. (Feb. 8, 2022, 9:50 AM), <https://www.fiercehealthcare.com/health-tech/amazon-expands-virtual-care-service-nationwide-lands-silicon-labs-whole-foods-market> [https://perma.cc/X3LZ-VQ7H].

<sup>84</sup> Watson, *supra* note 79.

<sup>85</sup> *Id.*; Caroline O’Donovan, *Amazon’s Health Ambitions Sometimes Clashed with Medical Best Practices, Nurses Say*, WASH. POST, <https://www.washingtonpost.com/technology/2022/08/19/amazon-care-patient-safety-concerns/> [https://perma.cc/UCK7-7MTK] (Aug. 19, 2022, 1:42 PM).

<sup>86</sup> Watson, *supra* note 79.

<sup>87</sup> O’Donovan, *supra* note 85.

<sup>88</sup> *See id.*

stabilize patient blood samples using centrifuges in their personal cars.”<sup>89</sup> Although there is no evidence that any employees at Amazon Care followed through with this request, the consideration itself is a medical and legal nightmare and not in line with best practices or standard of care.

Although Amazon Care has closed its doors, Amazon continues to innovate and already plans to launch another healthcare service<sup>90</sup> that will hopefully solve many of the quality and logistical concerns it struggled with in Amazon Care. Many of the issues Amazon Care faced were due to insufficient technology and staffing needs compared to the level and scale of services the Company was providing.<sup>91</sup> Regardless, patient satisfaction rates were among the highest of any other telehealth company—appointments were efficient and prescriptions were quickly delivered.<sup>92</sup> However, an important consideration to note is that there were concerns about the customer-first mentality and “tension between what would give you good ratings versus what is sound clinical care.”<sup>93</sup>

### B. Cost-Sharing Contracts

As competition in the industry increases, telemedicine companies have had to devise innovative incentives for their corporate partners to stay in business with them. For example, telemedicine companies are negotiating cost-sharing contracts that set up “payment systems that reward them for keeping patients’ costs low and penalize them for overspending”<sup>94</sup>—taking on significant financial risk. This is atypical. Traditionally, the arrangement for both brick-and-mortar practices and telehealth have been a fee-for-service system, which reimburses providers a set fee for appointments and procedures.<sup>95</sup> However, because telemedicine services are

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<sup>89</sup> *See id.*

<sup>90</sup> Watson, *supra* note 79.

<sup>91</sup> O’Donovan, *supra* note 85.

<sup>92</sup> *Id.*

<sup>93</sup> *See id.*

<sup>94</sup> Mohana Ravindranath, *Telehealth Companies Seek a Bigger Financial Stake in Patient Care*, BOS. GLOBE (Jan. 16, 2022, 4:35 PM), <https://www.bostonglobe.com/2022/01/16/business/telehealth-companies-seek-bigger-financial-stake-patient-care/> [https://perma.cc/XJY7-YUPH].

<sup>95</sup> *Id.*

often more continuous and ongoing than traditional brick-and-mortar practices, payments for every visit or every check-in with their provider is excessive.<sup>96</sup>

These new cost-savings contracts can potentially lower costs for preventative medicine and patients with chronic illness since such patients are easily virtually monitored. Preventative medicine and treatment for chronic illnesses are generally expensive because effective treatment requires a sustained level of care.<sup>97</sup> When patients manage their care appropriately, treatment is neither invasive nor extensive.<sup>98</sup>

These contracts also give telemedicine companies the incentive to prove that their interventions reduce aggregate healthcare costs. Although, in reality, specific evidence demonstrating a correlation between their interventions and aversion of expensive treatment might be challenging to find—especially since many insured patients are part of other healthcare programs (i.e., weight loss goals and smoking cessation) that incentivize good health outcomes with lower premiums.<sup>99</sup> Because these health programs have overlapping goals, and because it is difficult for patients to know which intervention truly made a difference in their health, overall patient satisfaction may be prioritized over reducing medical costs.<sup>100</sup> This is most likely so that employers are not compelled to cancel their contracts and move forward with a different telemedicine company that may offer more effective digital health benefits. Furthermore, due to the demographic for whom these services are primarily being provided, the focus will be on implementing care that is most convenient for working professionals and high-income earners—rather than independent subscribers who are not part of an employment plan or insured.

### III. TARGETED REGULATION

As Libby Watson writes in the *New York Times*:

Any company claiming its innovation will revolutionize American health care by itself is selling a fantasy. There is no technological miracle waiting around the corner that will solve problems caused by decades of neglectful policy decisions

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<sup>96</sup> *See id.*

<sup>97</sup> *See generally* Raghupathi & Raghupathi, *supra* note 4.

<sup>98</sup> *Id.*

<sup>99</sup> Ravindranath, *supra* note 94.

<sup>100</sup> *Id.*

and rampant fraud. And a fix aimed at just the upper crust of employer-sponsored health coverage has no hope of making health care more accessible to those who are truly being left behind.<sup>101</sup>

Although the lack of regulation has shown to be excellent for innovation within the field—and the COVID-19 pandemic proves that the increase in competition has forced telemedicine institutions to try and provide satisfactory care with a measurable impact on patient health—the reality is that currently, telehealth services are not increasing access to healthcare or reducing equity concerns as much as they would like to believe they are. And numerous issues need to be addressed through healthcare policy and regulations.

#### A. *Provider Shortage Crisis*

In addition to the systemic issues, there is also a significant shortage of health care providers in the United States. The U.S. healthcare system is underfunded and understaffed to meet patient needs—and virtual care is not necessarily a solution. A recent study by the Association of American Medical Colleges projected a “shortfall of up to 139,000 physicians by 2033,” and that more than two of five physicians will be at retirement age or older in the next ten years.<sup>102</sup> Currently, about 132 million U.S. citizens live in areas with mental health professional shortages.<sup>103</sup> In 2020, “[a]lmost 83 million people diagnosed with anxiety or depression were unable to access counseling services.”<sup>104</sup> To fill the gap, roughly 6,400 additional providers are required nationally.<sup>105</sup>

In *Teladoc*, the plaintiffs cited evidence that Teladoc increased opportunities for physicians to provide more appointments, helping alleviate the shortage of doctors, especially in rural areas.<sup>106</sup> However, as we saw with Amazon Care, due to the excessive use of telemedicine, there is a deficiency in providers available to

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<sup>101</sup> Watson, *supra* note 79.

<sup>102</sup> Chemweno, *supra* note 2.

<sup>103</sup> Mark Barna, *Mental Health Workforce Taxed During COVID-19 Pandemic: Worker Shortage Hinders Access*, APHA: THE NATION’S HEALTH (Jan. 2022), <https://www.thenationshealth.org/content/51/10/1.3> [<https://perma.cc/FD9B-UB94>].

<sup>104</sup> *Id.*

<sup>105</sup> *Id.*; Kaia Hubbard, *Many States Face Shortage of Mental Health Providers*, U.S. NEWS (June 10, 2021), <https://www.usnews.com/news/best-states/articles/2021-06-10/northeastern-states-have-fewest-mental-health-provider-shortages>.

<sup>106</sup> *Teladoc, Inc. v. Tex. Med. Bd.*, 112 F. Supp. 3d 529, 537 (W.D. Tex. 2015).

sustain these services.<sup>107</sup> Furthermore, the patients prioritized to receive care are usually employed, insured, and live in densely populated urban areas.<sup>108</sup> Patients suffering due to a lack of providers in rural areas are not at all the focus of such companies, and the influx of services brought about by telemedicine is only stretching our health care providers further. Virtual care may only increase access if there are physicians available to handle the increase in telehealth demand.

### B. Telefraud

The lack of regulation within the telemedicine industry and the increase of telemedicine companies also gave rise to healthcare fraud schemes. The Department of Justice criminally charged forty-two doctors and nurses, as well as almost a hundred other medical professionals for fraud schemes that cost \$1.1 billion in losses that arose out of the use of telehealth services.<sup>109</sup> Telemedicine fraud loss was more than three times the amount of other fraud loss and was largely perpetrated by providers ordering and billing unnecessary medical equipment and lab tests while treating homebound elderly and vulnerable patients.<sup>110</sup>

Additionally, the expansion of covered services allowed for the reimbursement of more virtual interactions; this included reimbursement and coding for “telemedicine visits, virtual check-ins, telephone visits, and e-visits.”<sup>111</sup> Although the new cost-sharing systems are attempting to forego those additional costs because of the continuous and ongoing nature of their services,<sup>112</sup> the slack in reimbursement regulations to increase access during the pandemic allowed for improper and excessive payment practices.

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<sup>107</sup> O’Donovan, *supra* note 85.

<sup>108</sup> *Id.*

<sup>109</sup> Heather Landi, *Feds Charge 138 Medical Professionals with 1.4B in Healthcare Fraud, Including Telehealth Schemes*, FIERCE HEALTHCARE: HEALTH TECH. (Sept. 20, 2021, 11:17 AM), <https://www.fiercehealthcare.com/tech/feds-charge-138-medical-professionals-including-doctors-1-4b-telehealth-fraud-case> [https://perma.cc/29M8-TXCP].

<sup>110</sup> Eva Gunasekera & René Brooker, *In Recent National Health Care Fraud Enforcement Action, Telemedicine Fraud Takes the Gold*, NAT’L L. REV. (Sept. 23, 2021), <https://www.natlawreview.com/article/recent-national-health-care-fraud-enforcement-action-telemedicine-fraud-takes-gold> [https://perma.cc/6EAP-RDN8].

<sup>111</sup> Miranda Hooker et al., *Fraud Emerges as Telehealth Surges*, ABA CRIM. JUST. SECTION’S WHITE COLLAR CRIME COMM. (2021), [https://www.americanbar.org/content/dam/aba/publications/criminaljustice/2021/telehealth\\_fraud.pdf](https://www.americanbar.org/content/dam/aba/publications/criminaljustice/2021/telehealth_fraud.pdf) [https://perma.cc/DT4P-YTSU].

<sup>112</sup> Ravindranath, *supra* note 94.

For example, there were instances where providers and telehealth companies took advantage of technological difficulties when the patient was charged for services they could not fully benefit from.<sup>113</sup> The Office of Inspector General found that in many fraudulent telemedicine arrangements, digital health companies rewarded practitioners “in exchange for ordering or prescribing items or services: (1) for purported patients with whom the Practitioners have limited, if any, interaction; and (2) without regard to medical necessity.”<sup>114</sup> Practitioners were told to bill for services without contacting the patient, or that they “only need to speak to the purported patient by telephone.”<sup>115</sup> Thus, even though waiving many of the reimbursement regulations increased access and finally allowed telemedicine companies to flourish—some regulation to decrease the possibility of fraudulent reimbursement schemes must be reintroduced.

### C. Advertising

With the surge of telemedicine—and the federal government waiving the in-person exam mandate for Schedule II and Schedule III-controlled substances—many telehealth companies are using advertising loopholes to improperly market medications such as ketamine, stimulants, antidepressants, and testosterone.<sup>116</sup> Digital ad spending by telehealth companies went from \$10 million in 2020 to more than \$100 million in 2021.<sup>117</sup> A majority of these direct-to-consumer advertisements are found on popular social media platforms such as Facebook, Instagram, and TikTok, and often feature influencers that appear as customers rather than paid actors—“tout[ing] benefits of drugs with no mention of side effects and promot[ing] medications for uses not approved by the FDA.”<sup>118</sup>

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<sup>113</sup> *Id.*

<sup>114</sup> *Special Fraud Alert: OIG Alerts Practitioners to Exercise Caution When Entering into Arrangements with Purported Telemedicine Companies*, DEP’T HEALTH AND HUM. SERVS., OFF. INSPECTOR GEN. (July 20, 2022), <https://oig.hhs.gov/documents/root/1045/sfa-telefraud.pdf>.

<sup>115</sup> *Id.*; see also *Telehealth: The Latest Front in Fraud, Waste, and Abuse*, LMI (Feb. 10, 2022), <https://www.lmi.org/blog/telehealth-latest-front-fraud-waste-and-abuse> [https://perma.cc/9ASR-U3KS].

<sup>116</sup> Khadeeja Safdar & Andrea Fuller, *Misleading Ads Fueled Rapid Growth of Online Mental Health Companies*, WALL ST. J. (Dec. 27, 2022, 12:14 PM), <https://www.wsj.com/articles/telehealth-cerebral-done-ads-mental-health-adhd-11672161087>.

<sup>117</sup> *Id.*

<sup>118</sup> *Id.*

By law, the FDA requires drug companies to enumerate the risks and potential side effects in advertisements.<sup>119</sup> They are also required to cite the benefits and uses of the prescription—as approved by the FDA.<sup>120</sup> Furthermore, drug companies must make it clear when using paid actors to avoid being considered deceptive by the FTC.<sup>121</sup> However, many of the telehealth companies stated that “they aren’t subject to FDA advertising rules because they aren’t drug manufacturers.”<sup>122</sup> And that their social-media advertising is used “to educate customers about treatments.”<sup>123</sup>

According to an analysis run by the *Wall Street Journal*:

In a four-week period spanning October and November, about 20 companies ran more than 2,100 ads on Facebook and Instagram that described benefits of prescription drugs without citing risks, promoted drugs for unapproved uses or featured testimonials without disclosing whether they came from actors or company employees. . . .<sup>124</sup>

Telehealth companies such as Cerebral Inc. and Done Global Inc.—that treat attention-deficit hyperactivity disorder and anxiety—aggressively market their services on social media and have gained “hundreds of thousands” of patients since their 2019 beginnings.<sup>125</sup> Specifically, “Cerebral spends millions of dollars a month for online ads on TikTok, Instagram, and Google.”<sup>126</sup>

It was reported that employees of Cerebral and Done felt pressure to prescribe stimulants.<sup>127</sup> For Done, clinical leadership was required to review every case in

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<sup>119</sup> *Id.*

<sup>120</sup> *Prescription Drug Advertising / Questions and Answers*, U.S. FOOD & DRUG ADMIN., <https://www.fda.gov/drugs/prescription-drug-advertising/prescription-drug-advertising-questions-and-answers> [https://perma.cc/M2VV-6CBA] (last visited Sept. 11, 2023).

<sup>121</sup> Safdar & Fuller, *supra* note 116.

<sup>122</sup> *Id.*

<sup>123</sup> *Id.*

<sup>124</sup> *Id.*

<sup>125</sup> *Id.*; see also Rolfe Winkler & Joseph Walker, *Startups Make It Easier to Get ADHD Drugs. That Made Some Workers Anxious*, WALL ST. J. (Mar. 26, 2022, 12:00 AM), [https://www.wsj.com/articles/startups-make-it-easier-to-get-adhd-drugs-that-made-some-workers-anxious-11648267205?mod=article\\_inline](https://www.wsj.com/articles/startups-make-it-easier-to-get-adhd-drugs-that-made-some-workers-anxious-11648267205?mod=article_inline).

<sup>126</sup> Winkler & Walker, *supra* note 125.

<sup>127</sup> *Id.*

which medication was denied, and providers were encouraged to “not really do follow-ups.”<sup>128</sup> This tension between medical practitioners and management was similar to that of Amazon Care employees. Cerebral is currently under investigation by the Justice Department, and the DEA recently alleged that the retail pharmacy connected to the startup “wrongfully filled thousands of prescriptions for stimulants used in the treatment of Attention Deficit/Hyperactivity Disorder.”<sup>129</sup>

Overall, stimulant prescriptions have increased by more than 10% from 2020 to 2021.<sup>130</sup> The eruption in ADHD prescriptions through telemedicine has also directly contributed to the national Adderall and stimulant shortage, affecting patients, pharmacies, and hospitals nationwide since October 2022.<sup>131</sup>

#### D. Exacerbating Health Disparities

The acceleration of telemedicine due to the COVID-19 pandemic also brought to light the realities of this mode of delivery. Trends related to equity and access have emerged, especially regarding disparities in race, age, and geography. The digital divide with increased use of telemedicine was primarily driven by a lack of access to the internet and digital literacy, medical or technological mistrust, and unintended safety concerns.

##### 1. Rural v. Urban

Although many providers are open to continuing using telemedicine in practice—many believe that “[t]argeted training and quality improvement strategies are needed to sustain an effective post-pandemic telemedicine program.”<sup>132</sup> Specifically, providers are concerned about “the reliability of internet connection, the quality of video, and the limitations of physical assessment following actual

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<sup>128</sup> *Id.*

<sup>129</sup> *DEA Serves Order to Show Cause on Truepill Pharmacy*, U.S. Drug Enf’t Admin. (Dec. 15, 2022), <https://www.dea.gov/press-releases/2022/12/15/dea-serves-order-show-cause-truepill-pharmacy-its-involvement-unlawful> [<https://perma.cc/JM9D-PNFF>].

<sup>130</sup> Melissa L. Danielson et al., *Trends in Stimulant Prescription Fills Among Commercially Insured Children and Adults—United States, 2016–2021*, CDC (Mar. 31, 2023), <https://www.cdc.gov/mmwr/volumes/72/wr/mm7213a1.htm#:~:text=Overall%2C%20the%20percentage%20of%20enrollees,10%25%20during%202020%E2%80%932021;see%20also%20Winkler%20&%20Walker,%20supra%20note%20125.>

<sup>131</sup> *Id.*

<sup>132</sup> Dana A. Schinasi et al., *Attitudes and Perceptions of Telemedicine in Response to the COVID-19 Pandemic: A Survey of Naïve Healthcare Providers*, FRONTIERS PEDIATRICS (2021), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8058348/> [<https://perma.cc/C3FV-XACP>].

patient care experiences.”<sup>133</sup> The pandemic exposed gaps in internet connectivity and digital literacy nationwide and demonstrated that not all Americans have equitable access to telemedicine.<sup>134</sup>

Rural areas have a higher proportion of elderly patients, a higher frequency of health disparities, less access to healthcare facilities, and poorer healthcare infrastructure when compared to urban areas.<sup>135</sup> Rural and diverse communities experienced higher rates of COVID-19 deaths than urban communities.<sup>136</sup> Diverse rural counties experienced 258 deaths per 100,000 residents; less diverse rural counties experienced 161 deaths per 100,000 residents; and diverse communities within urban counties experienced a 13% higher death rate per 100,000 residents than less diverse urban communities.<sup>137</sup> American Indian and Alaska Native populations experienced the country’s highest COVID-19 death rates at 336 deaths per 100,000 individuals, followed by 185 deaths per 100,000 individuals for Black Americans.<sup>138</sup>

A key reason for this was that, although telemedicine use expanded, the adoption of virtual care in rural areas lagged behind urban areas—especially since many of the urban residents were provided telemedicine offerings through their employers.<sup>139</sup> Emerging studies are finding that hospitals in rural areas face more barriers than those in urban areas regarding the adoption of telehealth services. Rural hospitals were less likely to adopt telehealth services and were simply unable to afford the required level of remote monitoring necessary to achieve quality care.<sup>140</sup>

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<sup>133</sup> *Id.*

<sup>134</sup> *Id.*

<sup>135</sup> Sydney Clark M.Jour., *Study Finds Rural-Urban Disparity in Telehealth Access*, MD. TODAY (Dec. 3, 2020), <https://today.umd.edu/study-finds-rural-urban-disparity-telehealth-access-dd5bfadf-3706-4f9e-8aca-934e8c05cbc8> [<https://perma.cc/9BS4-NEK7>].

<sup>136</sup> Jesse Bradford et al., *COVID-19 and Rural Communities: Protective Rural Lives and Health*, MCKINSEY & CO.: HEALTHCARE SYS. & SERVS. (Mar. 10, 2021), <https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/covid-19-and-rural-communities-protecting-rural-lives-and-health> [<https://perma.cc/GL4W-3HCV>].

<sup>137</sup> *Id.*

<sup>138</sup> *Id.*

<sup>139</sup> *Id.*

<sup>140</sup> M.Jour., *supra* note 135.

At least 26.6 million Americans reside in low-access counties without any telehealth services available.<sup>141</sup>

To effectively use telemedicine, patients must also have access to the proper health management equipment. For telemedicine visits that required a blood pressure reading, research found that virtual care visits were associated with poorer outcomes and inaccurate treatment.<sup>142</sup> Metro-area hospitals, however, were twice as likely to adopt remote surveillance for terminal patients, stroke care, and psychiatric and addiction treatment.<sup>143</sup> And hospitals offering advanced telehealth services were more often private, nonprofit institutions that were affiliated with a hospital system.<sup>144</sup> Metro-area hospitals in general were also three times more likely to adopt telehealth as a means for patient monitoring after discharge.<sup>145</sup>

Compared to urban residents, rural residents are eight times more likely to lack access to a broadband connection at home.<sup>146</sup> Studies found that “64% of rural residents prefer a non-web-based modality of communication with healthcare providers . . . .”<sup>147</sup> A lack of digital literacy is also apparent, increasing the divide for vulnerable populations to access telehealth.<sup>148</sup>

Other studies found that telehealth patients with lower levels of digital literacy are less engaged and receive fewer benefits from telemedicine visits.<sup>149</sup> To effectively use telemedicine, patients must understand the telemedicine platform and

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<sup>141</sup> David I. Shalowitz, *Pre-pandemic Geographic Access to Hospital-Based Telehealth for Cancer Care in the United States*, PLOS ONE (Jan. 2023), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9888704/> [<https://perma.cc/U5ZE-UHHD>].

<sup>142</sup> Siqin Ye et al., *The Impact of Telemedicine Visits on the Controlling High Blood Pressure Quality Measure During the COVID-19 Pandemic: Retrospective Cohort Study*, JMIR PUBL'N (Mar. 23, 2022), <https://formative.jmir.org/2022/3/e32403> [<https://perma.cc/P37J-6656>].

<sup>143</sup> M.Jour., *supra* note 135.

<sup>144</sup> Shalowitz, *supra* note 141.

<sup>145</sup> *Id.*

<sup>146</sup> Bradford et al., *supra* note 136.

<sup>147</sup> *Id.*

<sup>148</sup> See Kelly D. Edmiston & Jordan AIZuBi, *Trends in Telehealth and Its Implications for Health Disparities*, NAIC CTR. FOR INS. POL'Y RSCH. (Mar. 2022), <https://content.naic.org/sites/default/files/Telehealth%20and%20Health%20Disparities.pdf> [<https://perma.cc/HT74-B48J>].

<sup>149</sup> *Id.*

offer providers accurate information.<sup>150</sup> Also, rural hospitals were less likely to offer telehealth systems that included patients' capability to view their online health records or transmit their medical information to third parties electronically.<sup>151</sup>

## 2. Discrimination

Healthcare disparities in minority populations often boil down to racial bias within the healthcare community,<sup>152</sup> and it is unclear whether telemedicine would alleviate or worsen this issue. Although one of the original goals for expanding telemedicine was to increase access to health care services for vulnerable populations—telemedicine expansion is largely due to consumer demand for convenience.<sup>153</sup> The evolving market-driven landscape of telemedicine puts marginalized groups more at risk for discrimination and could magnify the distrust in doctor-patient relationships.

Innovation within the telemedicine industry includes using predictive medical algorithms to provide faster care and support clinical practice.<sup>154</sup> These algorithms run autonomously in the background and send alerts to clinicians for findings of pre-

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<sup>150</sup> *Id.*

<sup>151</sup> *Barriers to Telehealth in Rural Areas*, RURAL HEALTH INFO. HUB, <https://www.ruralhealthinfo.org/toolkits/telehealth/1/barriers> [https://perma.cc/CMG4-6F3H] (last visited July 29, 2023) (“Interoperability, which includes the exchange of electronic health information, remains a challenge for many rural healthcare providers.”).

<sup>152</sup> See generally Martha Hostetter & Sarah Klein, *Understanding and Ameliorating Medical Mistrust Among Black Americans*, THE COMMONWEALTH FUND: ADVANCING HEALTH EQUITY (Jan. 14, 2021), <https://www.commonwealthfund.org/publications/newsletter-article/2021/jan/medical-mistrust-among-black-americans#:~:text=Trust%20in%20health%20care%20among,it's%20worse%20among%20Black%20Americans.&text=In%20an%20October%202020%20poll,prevent%20people%20from%20getting%20care> [https://perma.cc/VRT9-AK4].

<sup>153</sup> Matias Busso et al., *On the Demand for Telemedicine: Evidence from the COVID-19 Pandemic*, 31 HEALTH ECON. 1491 (2022) (“We also show that the increase in the use of telemedicine slightly decreased after mobility restrictions eased, but not enough to undo the [post-pandemic] increase in demand.”).

<sup>154</sup> Matthew Clair et al., *Unless It's Done Carefully, the Rise of Telehealth Could Widen Health Disparities*, STAT: FIRST OPINION (June 26, 2020), <https://www.statnews.com/2020/06/26/unless-its-done-carefully-the-rise-of-telehealth-could-widen-health-disparities/> [https://perma.cc/37CT-74CU].

set diagnoses.<sup>155</sup> However, these emerging technologies have been found to deepen social inequity with discriminatory designs encoded into the software.<sup>156</sup>

Providers may generally be less mindful of guarding against implicit bias in telehealth visits.<sup>157</sup> Predictive tools that average patterns across groups can never fully account for the complexity required with patient care, especially when assisting in identifying and treating disease.<sup>158</sup> Additionally, it is important to note that minority populations often distrust healthcare providers due to a history of mistreatment during in-person visits.<sup>159</sup> Researchers found that Black, Hispanic, and Asian patients were less likely to use telemedicine overall.<sup>160</sup> And that Black patients and those insured by Medicare or Medicaid were less likely to use video services during telehealth visits than White or commercially insured patients.<sup>161</sup>

### E. Safety & Privacy

Although virtual visits at the patients' homes can offer convenience—they can also open the door to privacy and safety concerns. Beyond telemedicine's cybersecurity and data security risks, bringing health care visits within the patients' homes compromises a different type of privacy. Video visits may allow physicians to openly view where the patient resides and how their home environment is maintained—potentially increasing bias. Patients may also find it challenging to find a private space within their home as other household members may be privy to their health care interactions.<sup>162</sup> As a result, patients may be reluctant to share pertinent

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<sup>155</sup> John Svirbely, *Can Medical Algorithms Help to Reduce Telemedicine Liability?*, MEDAL (Feb. 4, 2016), <https://blog.medicalalgorithms.com/telemedicine-liability/> [https://perma.cc/VZE3-TBGW].

<sup>156</sup> See generally RUHA BENJAMIN, *RACE AFTER TECHNOLOGY: ABOLITIONIST TOOLS FOR THE NEW JIM CODE* (2019) (ebook).

<sup>157</sup> *Id.*

<sup>158</sup> Clair et al., *supra* note 154.

<sup>159</sup> Hostetter & Klein, *supra* note 152.

<sup>160</sup> Connor Drake et al., *Understanding Telemedicine's "New Normal": Variations in Telemedicine Use by Specialty Line and Patient Demographics*, MARY ANN LIEBERT, INC. (Jan. 2022), <https://www.liebertpub.com/doi/pdfplus/10.1089/tmj.2021.0041> [https://perma.cc/X5PL-PUZC].

<sup>161</sup> *Id.*; see also Julia Shaver, *The State of Telehealth Before and After the COVID-19 Pandemic*, ELSEVIER (Apr. 25, 2022), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9035352/> [https://perma.cc/7X54-TL6V].

<sup>162</sup> *How to Protect Patient Privacy During Telemedicine Visits*, INST. FOR HEALTHCARE IMPROVEMENT (Apr. 28, 2022), <http://www.ihl.org/communities/blogs/how-to-protect-patient-privacy-during-telemedicine-visits> [https://perma.cc/ME9X-VRB6].

sensitive information—further limiting the provider’s access to information. These issues ultimately exacerbate inequities since they challenge patients who already have the fewest resources.<sup>163</sup>

Additionally, abusive partners often use isolation to prevent their partners from seeking assistance.<sup>164</sup> Social distancing, working from home, and stay-at-home orders only assisted controlling partners in keeping their victims isolated at home. Medical settings were often the only places domestic violence survivors could go to and the only place where they could privately speak with someone and ask for assistance.<sup>165</sup> Regulation requiring domestic violence screening during telehealth visits and advancing medical education on how physicians can screen for such abuse through telemedicine is imperative—and should be measured when assessing quality care and consumer safety.

### CONCLUSION

Currently, telemedicine companies are driven by the free market. The FTC determined that unless there was “imminent peril to public health, safety or welfare,” telemedicine companies should be allowed to provide care without unreasonable regulations on competition.<sup>166</sup> However, before the pandemic, there were still strict regulations limiting the use of telemedicine, and it was challenging to assess the benefits and limitations of its usage.

Many of these regulations fell away during the COVID-19 pandemic, and the increase in digital health access finally allowed us to recognize the potential gaps in the quality of care in telemedicine.

There are benefits to deregulating telemedicine—the increase in competition is forcing virtual care companies to find ways to lower patient medical costs, increase their range of services, and provide faster and more effective services in general. However, there were also unintended consequences to the populations that need the most care. An increase in access to telemedicine services and the surge of DTC

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<sup>163</sup> *Id.*

<sup>164</sup> *The Role of Isolation in Domestic Violence*, KUPFFERMAN & GOLDEN ATT’YS AT L.: DOMESTIC VIOLENCE, <https://www.kgfamilylaw.com/the-role-of-isolation-in-domestic-violence/> [<https://perma.cc/QZN7-3Z2R>] (last visited Mar. 25, 2022).

<sup>165</sup> *See, e.g.*, Tanya Albert Henry, *Tips to Help you ID Intimate Partner Violence via Telehealth*, AM. MED. ASS’N (Oct. 28, 2021), <https://www.ama-assn.org/delivering-care/public-health/tips-help-you-id-intimate-partner-violence-telehealth> [<https://perma.cc/6UGP-HXHW>].

<sup>166</sup> *Teladoc, Inc. v. Tex. Med. Bd.*, 112 F. Supp. 3d 529, 544 (W.D. Tex. 2015).

telemedicine companies have not solved the primary issues our healthcare system faces.

Professor Stavroulaki found that the FTC's focus on competition is improper when it comes to health care and medicine. And the physicians in *Teladoc* stressed that "[r]epercussions of poor care are felt from emergency rooms and inner-city clinics to schools and the workplace."<sup>167</sup> As such, telemedicine regulation must account for effectiveness, safety, responsiveness, accessibility, equity, and efficiency without implicating the competitive concerns of antitrust laws.<sup>168</sup>

Currently, the telemedicine infrastructure is inadequate. And as a result, both quality and continuity suffer. However, telemedicine is likely here to stay. On July 13, 2023, CMS released the Calendar Year 2024 Physician Fee Schedule Proposed Rule ("CY 2024 PFS Proposed Rule") which proposes increased coverage and access to telehealth services for Medicare beneficiaries.<sup>169</sup> For telemedicine to effectively reduce healthcare disparities, there needs to be system-level coordination between hospitals, communities, and public health agencies with specific goals that look beyond the increase of access and reduction of costs. Without mindful regulation and thoughtful safeguards to protect vulnerable populations, these social groups are left with limited care options when compared to urban populations that do not lack alternatives.

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<sup>167</sup> Stavroulaki, *supra* note 12, at 177.

<sup>168</sup> *Id.* at 186.

<sup>169</sup> Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program, 88 Fed. Reg. 52262 (Aug. 7, 2023) (to be codified at 42 C.F.R. points 405 *et seq.*).