

Breaking Barriers for the Baby Boomer Burden: How Removing Interstate Provider Licensure for Telemedicine Can Alleviate Impending Health Care Costs

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In March 2018, the United States Census Bureau projected¹ that by 2030, all baby boomers will be over the age of 65. This shift in the population will mark the first time in U.S. history where there will be more people over the age of 65 than people under the age of 18.² With this aging population, the Census Bureau projects that the ratio of older adults to working adults will rise.³ In the health care industry, this results in a shortage of providers and a surplus of patients.⁴ This article examines the impact of the aging baby boomer population on health care costs and suggests that, by reducing the licensing barriers for providers practicing telemedicine, cost savings can be realized.

Baby Boomers and Health Care Costs

According to research conducted by the Association of American Medical Colleges (AAMC), the United States could see a shortage of up to 120,000 physicians by 2030.⁵ The impact will be felt on primary and specialty care physicians, alike, with projections estimating a shortage of between 14,800 and 49,300 primary care physicians and 33,800 and 72,700 specialty care physicians by 2030.⁶

And then, at the heart of this issue, is the fact that Americans are living longer than ever before.⁷ Over the last two decades, life expectancies have increased.⁸ In 1996, life expectancy in the United States was 79.1 years for females and 73.1 years for men.⁹ In 2016, life expectancy in the United States was 81.1 years for females and 76.1 for males.¹⁰ Many are living their lives while maintaining care of chronic diseases.¹¹ According to the National Council on Aging, approximately 80% of older adults have at least one chronic disease, and 77% have at least two.¹²

Chronic diseases have a significant impact on health costs in the United States.¹³ In 2010, approximately 86% of the nation's \$2.7 trillion in annual health care expenditures was used for patients with one or more chronic conditions.¹⁴ Notably, in the United States, people with five or more chronic conditions make up only 12% of the population but, on average, spend 14 times more on health services than those with less chronic conditions—as a result, people with five or more chronic conditions account for 41% of total health care spending.¹⁵

In July, Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma evaluated the health care spending forecast, noting that “the cost of [health] care in the United

States has accelerated at an alarming pace. Healthcare costs are growing faster than the U.S. GDP, making it more difficult with each passing year for CMS to ensure healthcare for generations to come.”¹⁶ Verma explained that, by continuing on this path, by 2026 the United States “will be spending one in every five dollars on healthcare,” meaning that less funding will be available to support other government priorities, which will ultimately drive up the out-of-pocket health care costs incurred by the consumer.¹⁷

Fortunately, health care technology has advanced in ways that will hopefully assist providers in preventing and monitoring chronic illness, even at a distance. The effective adoption and implementation of telemedicine promises to reduce health care costs by making health care available, even as the number of health care providers declines.

What is “Telemedicine”?

The American Telemedicine Association describes telemedicine as “the natural evolution of healthcare in the digital world.”¹⁸ Used synonymously with the term “telehealth,” the American Telemedicine Association defines telemedicine as “the remote delivery of health care services and clinical information using telecommunications technology.”¹⁹ With such a broad definition, telemedicine is best defined by the services that the health care industry considers “telemedicine services.” For primary care and specialist providers, telemedicine may be used by a primary care provider to engage with a specialist through a live interactive video for diagnosis assistance. In the area of remote patient monitoring, telemedicine services can be used to monitor patients with chronic diagnoses. Such services include the use technological devices to remotely collect data and send that data to the appropriate recipients.²⁰ Data collected through telemedicine services can include blood glucose, heart ECG, or other vital signs.²¹

The adoption of telemedicine has been fast. A study reviewing telehealth between 2011 and 2016 found that in that time period, the number of individual telehealth procedures listed on insurance claims increased 643% nationally.²²

Why “Telemedicine”?

In the health care industry, notorious for a culture of apprenticeship and “age-old” traditions, the question becomes: why the rapid adoption of new technology? The American Telemedicine Association lists four fundamental benefits of telemedicine: (1) improved access, (2) patient demand, (3) improved quality, and (4) cost efficiencies.



Telemedicine has demonstrated success in improving access to health care, particularly in rural areas. Although about 20% of Americans live in rural areas, only 9% of physicians practice there.²³ Even over the last decade, telehealth has had a significant impact in access to care in rural areas. The same survey that found telemedicine claims increased 643% nationally over a 5-year period also determined that, in the same period, the number of individual procedures listed on insurance claims for telemedicine services increased by 960% in rural areas as compared with a 629% increase in urban areas.²⁴

And while millennials are touted to be the “technologically-obsessed” generation, the baby boomers have also revealed interest in using telemedicine, driving up the popularity, demand, and adoption of such services. A 2016 study of 2,065 adults produced surprising data regarding baby boomers’ use of telemedicine.²⁵ The study revealed that 57% of the baby boomers surveyed were open to virtual care treatment as an alternative to in-office visits for non-urgent matters and that 51% of those baby boomers surveyed would choose a primary care physician that offered a patient app over one that did not.²⁶ Surprisingly, the study revealed that 74% of the baby boomers surveyed felt that virtual care was more convenient than in-office visits.²⁷

Even if patients are willing to use the technology, technological advances in health care are relatively worthless if the use of such technology does not at least maintain, if not increase, the quality of health care provided. Although the metrics for improved quality are difficult to capture at this stage, particularly when looking at populations struggling with chronic illness, some short-term studies have yielded positive results. In 2016, researchers found that telehealth, and specifically the use of a 4G

wireless tablet to collect vital signs via wireless peripherals, was associated with a 73% relative reduction in 30-day readmission rates over a three-year period.²⁸ A 2015 study conducted by the TRECS Institute, a nonprofit corporation aiming to identify new technologies to meet the needs of the long term care industry yielded similar results.²⁹ The telemedicine study reviewed patients in a 365-bed skilled nursing facility (SNF) and examined the impact of the facility’s use of after-hours telemedicine services.³⁰ The services used by the SNF allowed a physician to virtually evaluate patients and differentiate between those patients who could be treated inside the facility and those who needed to be transferred to a hospital.³¹ The study found that the use of the after-hours telemedicine physician coverage services averted 91 hospitalizations.³² Not only did the patients receive improved, appropriate care (not to mention that those 91 SNF patients avoided unnecessary exposure to hospital-acquired infections), but the use of the after-hours telemedicine services saved insurers more than \$1.55 million.³³

In making telemedicine services the “norm,” providers, patients, and payers stand to benefit financially. By using telemedicine, patients, particularly those living in rural areas or living far distances from their providers and specialists, are, at minimum, able to save the financial costs associated with traveling to receive care.³⁴ In the early 1990s, the Veterans Health Administration (VHA) recognized the possibility of telehealth cost savings and “pioneered” the use of such services in the United States.³⁵ Based on studies conducted in 2012 the VHA estimated an average annual savings of \$6,500 for each patient that utilized the VHA telehealth program, with cumulative savings of over \$1 billion throughout the VHA in 2012.³⁶ The VHA also recognized the





financial benefits inured to patients in the form of travel avoided and fewer lost work days.³⁷ Vulnerable patients also avoided the risk of health care facility-acquired diseases, which would result in additional costs to the patient and payer alike.

Telemedicine and Licensure

The majority of the veteran population was born between 1927 and 1964, meaning that the total veteran population is expected to decline from 20.0 million in 2017 to 13.6 million in 2037.³⁸ Based on such data, it makes sense that agencies supporting veterans have been such active proponents of the adoption of telemedicine. In May 2018, the United States Department of Veterans Affairs (VA) issued a final rule permitting VA health care providers to provide telemedicine services nationally, waiving the state-specific provider licensure requirements.³⁹ The Authority of Health Care Providers to Practice Telehealth Rule addressed an issue impacting health care providers, patients, and insurers, alike: licensure of medical providers utilizing telemedicine. In issuing that rule, the VA echoed the sentiments of the American Telemedicine Association finding that “[j]ust as it is critical to ensure there are qualified health care providers on-site at all VA medical facilities, VA must ensure that all beneficiaries, specifically including beneficiaries in remote, rural, or medically underserved areas, have the greatest possible access to mental health care, specialty care, and general clinical care.”⁴⁰

In the United States, health care providers wishing to practice medicine are subject to the stringent requirements imposed by both state and federal government. A health care provider must be licensed in each state in which their current or potential patients are, or may be, located.⁴¹ State statutes establish the standards and requirements for licensing and disciplining medical professionals and also define the tasks that medical professionals may perform.⁴² State licensing boards are tasked with checking the credentials⁴³ of medical professionals, disciplining errant practitioners, and reporting their activities to the public.⁴⁴ The state boards not only establish health care providers’ education and training criteria but also manage the fingerprinting, criminal background check verifications, and background checks required of these health care professionals.⁴⁵ Notably, the credential verification and background checks conducted by these state boards “account for a sizable share of state medical board spending.”⁴⁶

Until 1997, most third-party payers did not have policies that covered payment for telemedicine services. The Balanced Budget Act of 1997 allowed for telemedicine providers to be reimbursed for providing telemedicine services under Medicare, effective in 1999. Although slow, insurers began adopting policies that allowed health care providers to obtain reimbursement for telemedicine services.⁴⁷ While telemedicine allowed health care providers to provide services to far-away patients and payers were more willing to cover medicine services, licensing nevertheless created a barrier to entry. In order to provide telemedicine

services to patients across state lines, health care professionals were required to go through the often-laborious process of obtaining a license to practice medicine in each state the provider “saw” patients. Licensing challenges forced providers to limit their potential telemedicine practice areas to a few states, further advancing the barriers that limit or restrict access to health care for millions of Americans.⁴⁸ For example, through two-way video conferencing, a specialist based out of Pennsylvania could easily evaluate and diagnose, and be reimbursed for a virtual visit a patient in California, but the Pennsylvania-based provider would have to be licensed in California to provide care to that patient. As a result of such challenges, initiatives to reduce the barriers to telemedicine began to develop at both the state and federal levels.

As provider licensure falls under the authority of the states, breaking down the provider-licensing telemedicine barrier required the support of state provider licensing bodies. State action initiatives have taken multiple forms. Some states have created telehealth-specific medical licenses.⁴⁹ For example, Texas offers the Out-of-State Telemedicine license, which is a “limited license that allows a physician to practice medicine across state lines.”⁵⁰ With the Out-of-State Telemedicine License, the holder “is not authorized to practice medicine in the state of Texas.”⁵¹ The license holder’s practice of medicine in Texas is limited exclusively to: (1) the interpretation of diagnostic testing and reporting of results to a Texas fully licensed physician practicing fully in Texas, or (2) for the follow-up of patients where the majority of the patient care was rendered in another state.⁵² Such parameters are particularly helpful to the use of emergency provider telemedicine services and specialist telemedicine services.

Other states have opted for reciprocity and endorsement.⁵³ Pennsylvania and Tennessee have reciprocity agreements with other states that permit those states to grant licenses to out-of-state physicians that reciprocally accept their physicians’ home state licenses.⁵⁴ So far, Connecticut is the only state that has adopted endorsement, which allows an out-of-state physician to obtain an in-state license based on the home-state’s practitioner standards.⁵⁵

Other states have joined into interstate compacts.⁵⁶ In 2017, the Interstate Medical Licensing Compact (IMLC) was launched. The IMLC was an agreement between 24 states,⁵⁷ one territory, and 31 Medical and Osteopathic boards allowing licensed physicians to qualify to practice medicine across state lines within the ILMC if the physicians met certain eligibility requirements.⁵⁸ The IMLC requires states that want to join to pass a bill authorizing

the state to join the compact, with language identical to the other IMLC member-states. Once the state’s governor signs the bill into law, physicians from that state may begin applying for an IMLC license.⁵⁹ The IMLC Application leverages the physician’s existing information as submitted in the state of principal licensure. Once the state of principal licensure verifies the physician’s information and conducts an updated background check, the qualified physician may practice in any of the IMLC states.⁶⁰

Federally, outside of the VA, there have been far fewer telemedicine licensure initiatives. The Health Resources and Services Administration has provided grants that support various state professional licensing boards in both developing and implementing policies aimed at reducing the barriers to access to health care through telehealth services.⁶¹ The Federal Trade Commission (FTC) has also taken steps to support removing barriers to telemedicine, particularly in rural areas. In March 2016, the FTC sent comments in support of an Alaska bill that would allow Alaska-licensed physicians located out-of-state to provide telehealth services “in the same manner as Alaska licensed in-state providers and allow[] certain Alaska licensed behavioral health professionals to provide services remotely.”⁶² As telemedicine becomes more widely accessible, and as the federal government begins to feel the financial impact of the aging baby boomers, it is likely that more federal agencies will be weighing-in on the provider licensure issues inhibiting telemedicine adoption.

Conclusion

As the baby boomer generation grows older, millions of baby boomers will face barriers in access to health care. Revising the traditional health care provider licensure system is one approach to tackling this problem. By making it easier for providers to obtain interstate licensure to administer telemedicine, providers, patients, and payers will benefit. Patients will benefit from the financial savings of reduced transportation costs and earlier detection. Providers will be able to utilize new technology to monitor, record, and maintain care of their chronically-ill patients, even those traveling and living far distances from their offices. Payers will benefit from the increased number of services that providers will be able to complete and bill for. While telemedicine is not the magic wand that will take away the impending health care crisis resulting from aging baby boomers, it provides an effective and efficient method of increasing health care access and reducing health care costs.

1 Press Release, United States Census Bureau, *Older People Projected to Outnumber Children for First Time in U.S. History* (Mar. 13, 2018) (Release Number CB18-41), available at <https://www.census.gov/newsroom/press-releases/2018/cb18-41-population-projections.html>.

2 *Id.*

3 *Id.*

4 *Id.*

5 Press Release, Association of American Medical Colleges, *New Research Shows Increasing Physician Shortages in Both Primary and Specialty Care* (Apr. 11, 2018), available at https://news.aamc.org/press-releases/article/workforce_report_shortage_04112018/.

6 *Id.*

7 Federal Interagency Forum on Aging-Related Statistics, *Older Americans 2016: Key Indicators of Well-Being*, Washington, DC: U.S. Government Printing Office (Aug. 2016).

8 *Id.*

9 Robert N. Anderson, *United States Abridged Life Tables, 1996*, National Vital Statistics Reports from the Centers for Disease Control and Prevention (Dec. 24, 1998), available at https://www.cdc.gov/nchs/data/nvsr/nvsr47/nvs47_13.pdf.

Health Care Liability & Litigation

- 10 Kenneth D. Kochanek, Sherry L. Murphy, Jiaquan Xu, & Elizabeth Arias, *Mortality in the United States, 2016*, National Center for Health Statistics from the Centers for Disease Control and Prevention (Dec. 2017), available at <https://www.cdc.gov/nchs/data/databriefs/db293.pdf>.
- 11 Federal Interagency Forum on Aging-Related Statistics, note 7 *supra*.
- 12 *Healthy Aging Facts*, National Council on Aging, <https://www.ncoa.org/about-ncoa/> (last visited Sept. 5, 2018).
- 13 *Health and Economic Costs of Chronic Diseases*, Centers for Disease Control and Prevention, available at <https://www.cdc.gov/chronicdisease/about/costs/index.htm> (last updated Aug. 7, 2018).
- 14 *Id.*; see also Gerteis J, Izrael D, Deitz D, LeRoy L, Ricciardi R, & Miller T, Basu J., *Multiple Chronic Conditions Chartbook: 2010 MEPS Data*.
- 15 Christine Buttorff, Teague Ruder & Melissa Bauman, *Multiple Chronic Conditions in the United States*, The RAND Corporation, 2017, available at https://www.rand.org/content/dam/rand/pubs/tools/TL200/TL221/RAND_TL221.pdf.
- 16 Seema Verma, CMS Administrator, Medicare Remarks at the Commonwealth Club of California (July 25, 2018), transcript available at <https://www.cms.gov/newsroom/press-releases/speech-medicare-remarks-cms-administrator-seema-verma-commonwealth-club-california>.
- 17 *Id.*
- 18 *About Telemedicine*, American Telemedicine Association, 2018, available at <http://www.americantelemed.org/main/about/telehealth-faqs->.
- 19 *Id.*
- 20 *Services Provided by Telemedicine*, American Telemedicine Association, 2018, available at <http://www.americantelemed.org/main/about/about-telemedicine/services-provided-by-telehealth>.
- 21 *Id.*
- 22 *FH Healthcare Indicators and FH Medical Price Index*, FairHealth, Mar. 2018, available at <https://s3.amazonaws.com/media2.fairhealth.org/whitepaper/asset/FH%20Medical%20Price%20Index%20and%20FH%20Healthcare%20Indicators--whitepaper.pdf>.
- 23 Greg Slabodkin, *Telehealth plays growing role for patient access to care in rural America*, HealthData Management (July 2, 2017), available at <https://www.healthdatamanagement.com/news/telehealth-plays-growing-role-for-patient-access-to-care-in-rural-america?regconf=1>.
- 24 See *supra*, note 22.
- 25 Connected Patient Report, Salesforce, 2016, available at <https://healthtechinsider.com/2016/08/25/2016-connected-patient-report/>.
- 26 *Id.*
- 27 *Id.*
- 28 <https://www.ncbi.nlm.nih.gov/pubmed/27437037>.
- 29 David Chess, John Whitman, Diane Croll, Richard Stefanacci, *Impact of After-Hours Telemedicine on Hospitalizations in a Skilled Nursing Facility*, *The American Journal of Managed Care*, Aug. 14, 2018, available at <https://www.ajmc.com/journals/issue/2018/2018-vol24-n8/impact-of-after-hours-telemedicine-on-hospitalizations-in-a-skilled-nursing-facility?p=2>.
- 30 *Filling the Care Gap Across the Post-acute Sector*, TripleCare, <http://triple.care/company/> (last visited Sept. 7, 2018).
- 31 See *supra*, note 29.
- 32 *Id.*
- 33 *Id.*
- 34 Press Release, UC Davis Health, *Telemedicine Saves Patients Time, Money*, (Mar. 21, 2017), available at <https://www.universityofcalifornia.edu/news/telemedicine-saves-patients-time-money>.
- 35 *Telehealth: Helping Hospitals Deliver Cost-Effective Care*, American Hospital Association, 2016, available at <https://www.aha.org/system/files/content/16/16telehealthissuebrief.pdf>.
- 36 *Id.*
- 37 *Id.*
- 38 *Veteran Population Projections 2016-2037*, U.S. Department of Veterans Affairs, 2016, available at https://www.va.gov/vetdata/docs/Demographics/New_Vetpop_Model/Vetpop_Infographic_Final31.pdf.
- 39 83 Fed. Reg. 21897.
- 40 *Id.*
- 41 Shirly Svorny, *Medical Licensing: An Obstacle to Affordable, Quality Healthcare*, PolicyAnalysis, Sept. 17, 2008, available at <https://object.cato.org/pubs/pas/pa-621.pdf>.
- 42 *Id.*
- 43 *Id.*
- 44 *Id.*
- 45 *Id.*
- 46 *Id.*
- 47 Michael Greiwe, *Telemedicine and Getting Paid: The history of payer support for telemedicine and where it's headed*, OrthoLive (May 6, 2018), available at <https://www.ortholive.com/blog/telemedicine-and-getting-paid-the-history-of-payer-support-for-telemedicine-and-where-its-headed>.
- 48 *Licensing of Physicians and Other Health Care Providers*, Center for Connected Health Policy, <http://www.cchpca.org/licensing-physicians-and-other-health-care-providers> (last accessed Sept. 9, 2018).
- 49 *Telemedicine*, American Academy of Family Physicians, https://www.aafp.org/dam/AAFP/documents/advocacy/health_it/telehealth/BKG-Telemedicine.pdf (last accessed Sept. 9, 2018).
- 50 *Out-of-State Telemedicine License*, Texas Medical Board, <http://www.tmb.state.tx.us/page/telemedicine-license> (last visited Sept. 9, 2018).
- 51 *Id.*
- 52 *Id.*
- 53 Kate Blackman, *Telehealth and Licensing Interstate Providers*, National Conference of State Legislatures, July 2016, available at <http://www.ncsl.org/research/health/telehealth-and-licensing-interstate-providers.aspx>.
- 54 *Id.*
- 55 *Id.*
- 56 *Id.*
- 57 IMLC Member States serving as SPL processing applications and issuing licenses: Alabama, Arizona, Colorado, Idaho, Illinois, Iowa, Kansas, Maine, Mississippi, Montana, Nebraska, Nevada, New Hampshire, South Dakota, West Virginia, Wisconsin, Wyoming. IMLC Member States non-SPL issuing licenses: Minnesota, Utah. IMLC Passed; Implementation Delayed States: Pennsylvania, Tennessee. Compact Legislation Introduction States: District of Columbia, Georgia, Kentucky, Maryland, Michigan, New York, South Carolina, Vermont, Guam. See *The IMLC*, Interstate Medical Licensure Compact, <https://imlcc.org> (last accessed Sept. 9, 2018); *Doctors: What to Know About the Interstate Medical Licensure Compact*, Nomad Health, <https://medium.com/nomad-health/doctors-what-to-know-about-the-interstate-medical-licensure-compact-imlc-9592f4524803> (last updated May 10, 2018).
- 58 *The IMLC*, Interstate Medical Licensure Compact, <https://imlcc.org> (last accessed Sept. 9, 2018).
- 59 FAQs, Interstate Medical Licensure Compact, <https://imlcc.org/faqs/> (last accessed Sept. 9, 2018).
- 60 See *supra*, note 58.
- 61 See *supra*, note 53.
- 62 The Federal Trade Commission and Professional Licensure Boards, Center for Connected Health Policy, <https://www.cchpca.org/> (last accessed Sept. 9, 2018).