As 2015 winds down, I think it is safe to say that it has been a whirlwind year in telehealth. According to the National Conference of State Legislatures (NCSL), over 200 telehealth-related bills were introduced in 42 states. The Federation of State Medical Boards (FSMB) has launched an interstate physician licensure compact that creates a new pathway to expedite physician licensure in multiple states. Twelve states (with Wisconsin being the latest) have so far enacted the licensure compact. Many states such as Colorado, Iowa, and Louisiana released regulations or policies that in my view took a more progressive approach to telehealth regulation.

Activity has not just been limited to the states. Congress has introduced a number of telehealth-related bills such as the TELE-MED Act of 2015 which permits certain Medicare providers licensed in a state to provide telemedicine services to certain Medicare beneficiaries in a different state without having to be licensed in that state. In addition, a number of reports, surveys, and white papers have been published on all aspects of telehealth. After many false dawns, telehealth has truly arrived. But many issues remain to be addressed.

Now we look forward to a new year. What can we expect? In addition to a continuation of what has occurred in 2015, there are a few other issues and/or trends that bear watching. Here are a few:

The Rise of Compacts to Address Licensure Issues

The use of compacts to address licensure issues will continue to gain steam in 2016. I have already mentioned FSMB’s interstate physician licensure compact. As many of you know, nurses (RNs and LPNs/VNs) have long had a licensure compact in which a nurse who declares a compact state as his or her primary state of residence can practice (physically and remotely) in other compact states without having to obtain another license. There are 25 states that are members of the nurse compact.

Other providers are getting in on the act. Recently, the National Council of State Boards of Nursing, a non-profit association comprising 59 boards of nursing, released a draft compact for advanced practice registered nurses (e.g., nurse practitioners). The draft APRN compact essentially follows the framework of the nurse licensure compact allowing APRNs to practice in any participating state with just one license. One interesting change in the draft APRN compact not included in the nurse compact is the requirement that states “implement procedures for considering the criminal history records of applicants for initial APRN licensure.” I expect a number of states to enact the APRN compact in the coming years.

Note that psychologists, physical therapists, counselors, and EMS personnel are just a few of the provider groups that have considered or are considering compact models in some fashion.

Telehealth Accreditation

While there have been some accreditation programs that have touched on telehealth, I believe that 2016 will be
the year in which telehealth accreditation takes on new significance. Two recent examples highlight my point. About a year ago, the American Telemedicine Association launched an accreditation program for online consultations in which ATA accredits organizations that provide online, real-time health services complying with certain standards. Among the examples the ATA offers of what kind of the kind of organizations the program would accredit is an employer providing its employees with online, real-time telehealth services.

More recently, URAC, a longstanding accrediting organization, has launched its own telehealth accreditation program for providers involved in consultations with facilities, consumers, and other health care providers through televideo and other electronic methods. URAC’s accreditation standards were developed by an expert panel that included health systems, hospitals, health plans, telemedicine companies, and academic medical centers.

**The Voice of Large Employers**

I believe 2016 will be the year large employers will be heard loud and clear in the telehealth regulatory debates that are sure to take place. The fact is many Americans receive their health insurance through their employers. And, according to the National Business Group on Health, 74 percent of large employers are expected to offer telehealth in 2016 compared to 48 percent in 2015. Given the important role employers play in health care, and how telehealth is increasingly being used by employers, it is only logical that employers would ultimately play a significant role in our ongoing telehealth regulatory debate.

One group is leading the charge. The ERISA Industry Committee (ERIC), the only nonprofit national association advocating solely for the employee benefit and compensation interests of the country’s largest employers, earlier this year launched a telehealth initiative to promote policies that facilitate access to telehealth for employees to have expanded access to health care services. ERIC will be actively involved in the major telehealth discussions that occur next year both at the state and federal levels giving large employers a significant voice not usually heard from in telehealth regulatory circles.

**Wearable Market Poised for Breakout**

As I have written before in previous blog posts, the healthcare wearables market is projected to significantly increase in the next few years. Generally speaking, wearables are devices (which usually include microchips or sensors) that, among other functions, collect data and track fitness and wellness. Market research is bullish. For example, Soreon Research, a leading independent research firm, projects that the wearable healthcare market will reach $41 billion by 2020—with diabetes, obesity, sleep disorders, and cardiovascular disease as the largest growth segments in the market. From my perspective, a combination of the ability to collect data along with big data analytics capabilities will drive this market. And as the market booms and the technology becomes more sophisticated, legal and regulatory issues loom. Here are a few issues of which to be mindful:

- Data privacy and security (who has access to the data, who owns the data, how long the data will be used, etc.).
- Potential changes to malpractice liability (clinicians having access to more information regarding a particular patient, providers ability to review the voluminous data, etc.).
- Employer issues (wellness programs, ADA concerns, etc.)
- FDA.

I have only touched on a few issues. Other issues such as reimbursement (particularly Medicare), use of telehealth in ACOs and similar models, antitrust, use of diagnostics and peripherals, scope of practice, and privacy and security will be some of the frontline telehealth issues in 2016. We look forward to addressing all of those issues throughout next year.

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