Telehealth after the Federal COVID-19 Public Health Emergency: Implications and Future Directions

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Abstract: May 11, 2023, marked the end of the federal COVID-19 Public Health Emergency (PHE). During the PHE, regulatory flexibilities allowed telehealth to more effectively connect physicians providing care and patients seeking it. This paper discusses the implications of the end of the PHE on telehealth coverage, payment, reimbursement, and licensure, and exposes inconsistencies and inequities in extant state regulations.

May 11, 2023, officially marked the end of the federal COVID-19 public health emergency (PHE) implemented in January 2020 and extended 13 times, pursuant to Section 319 of the Public Health Service Act.[1] The PHE furnished significant regulatory flexibilities in telehealth access and delivery. In particular, the PHE allowed for greater flexibility in licensing requirements for providers who practice across state lines via telehealth, patient privacy regulations, and payment/coverage of telehealth services.[2] With the PHE expired, most pandemic-related flexibilities on both the federal and state levels have also ended, despite sustained demand for telehealth services.[3]

In this paper, we review key telehealth policy and regulatory changes that the end of the COVID-19 PHE brought, assess the implications for providers and patients, and delineate possible policy interventions to sustain telehealth as a viable modality of care in the long run. The end of the PHE represents more than merely a symbolic shift away from pandemic-induced telehealth regulatory flexibilities. The end of the federal PHE has constrained patients' access to, and physicians' ability to provide, vital telehealth services. And the substantial authority states wield in this domain means much of telehealth law and regulation exists as a state-by-state patchwork. To sustain broad access to telehealth beyond the pandemic, it is crucial — though admittedly challenging — to ensure greater inter-state coordination in telehealth law and policy.

Coverage and Payment

The end of the PHE eliminated many federal-level flexibilities for telehealth coverage, payment, and reimbursement (summarized in Table 1). On the private insurance side, this included numerous regulatory changes for group and non-group health plans introduced by the Departments of Health and Human Services, Labor, and the Treasury.[4] Perhaps most significantly, the end of the PHE discontinued telehealth's status as an excepted benefit.[5] Generally,

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plans, funds, or programs established by employers to furnish medical care coverage including telehealth services are classified as group health plans and must satisfy a number of federal requirements pursuant to the Employee Retirement Income Security Act.[6] June 2020 guidance from the Departments of Health and Human Services, Labor, and the Treasury, however, loosened such requirements for group health plans that "solely provide[] benefits for telehealth or other remote care services[,]" effectively classifying telehealth services as an excepted benefit similar to dental or vision.[7] The resulting regulatory changes permitted employers to extend telehealth coverage benefits to employees who are ineligible for full-fledged health care plans — namely, part-time workers, which March 2023 estimates from the U.S. Bureau of Labor Statistics suggest amount to over 26 million Americans.[8] Expiration of such coverage flexibility at the end of the PHE placed telehealth benefits already extended to potentially millions of part-time workers in limbo and barred employers from covering telehealth for newly hired part-time employees. Encouragingly, this development has inspired bipartisan legislation to amend title XXVII of the Public Health Service Act, the Employee Retirement Income and Security Act of 1974, and the Internal Revenue Code of 1986 to reclassify benefits for telehealth services offered during a group health plan or group health insurance coverage as excepted benefits. If passed, the bill would allow employers to offer stand-alone telehealth benefits to all employees, but this narrow legislation has seemingly stalled in the House. [9]

The end of the federal government's period of emergency also concluded flexibilities for "catastrophic plans" available on the individual market to people with relatively lower health risks and/or for whom other plans are unaffordable.[10] Under the Patient Protection and Affordable Care Act (ACA) such "catastrophic plans" are available for individuals under 30 years of age or over 30 years of age but who meet certain affordability or hardship exemption criteria under Section 5000A of the Internal Revenue Code of 1986.[11] Historically, such plans have covered only essential health benefits including pre-deductible coverage of at least three primary care visits and certain preventive services. During the federal PHE, however, the Centers for Medicare & Medicaid Services (CMS) implemented a moratorium on penalties for insurers who expanded catastrophic plans to include pre-deductible coverage of telehealth services, even those

Table 1

Selected Changes to Federal Telehealth Policy after the end of the Federal COVID-19 Public Health Emergency (PHE), Summarized.

Flexibility During PHE	Implementing Agenc(ies)	Status Post-PHE
Telehealth temporarily classified as an excepted benefit.	Departments of Health and Human Services, Labor, and the Treasury	After May 11, 2023, telehealth is no longer considered an excepted benefit.
Moratorium on penalties for insurers who expanded catastrophic plans to include pre-deductible coverage of telehealth services, even those unrelated to COVID-19 treatment.	Centers for Medicare & Medicaid Services	After May 11, 2023, penalties resumed.
Waiver on geographic location restrictions for the originating site of telehealth services post-PHE.	Centers for Medicare & Medicaid Services	Because this change is tied to the Consolidated Appropriations Act of 2023 Section 4113(a), this flexibility will remain intact until at least December 31, 2024.
Extension of qualified telehealth provider status to a broader list of practitioners including physical therapists, occupational therapists, speech-language pathologists, and audiologists.	Centers for Medicare & Medicaid Services	Because this change is tied to the Consolidated Appropriations Act of 2023 Section 4113(b), this flexibility will remain intact until at least December 31, 2024.
CMS reimbursement of audio-only telehealth services for certain forms of care.	Centers for Medicare & Medicaid Services	Because this change is tied to the Consolidated Appropriations Act of 2023 Section 4113(e), this flexibility will remain intact until at least December 31, 2024.

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unrelated to COVID-19 treatment.[12] At the end of the PHE, however, CMS resumed its enforcement of such penalties, potentially restricting access to telehealth for tens of thousands of young, indigent Americans.[13] More symbolically, a return to pre-pandemic catastrophic plan coverage requirements casts telehealth services as non-essential — despite the integral role it can play in connecting low-income, rural individuals to necessary care.[14]

On the public insurance side, more encouragingly, a host of expansions to telehealth coverage and access for Medicare beneficiaries introduced early in the COVID-19 pandemic have endured beyond the PHE's end. Namely, numerous expansions to coverage tied to the Consolidated Appropriations Act of 2023 remain intact post-PHE — but this fact does not ensure their long-term viability. For instance, Section 4113(a) of the Act extends the waiver on geographic location restrictions for the originating site of telehealth services post-PHE, maintaining a wider set of potential providers of telehealth services and allowing Medicare beneficiaries to remain in-home to receive such services.[15] Relatedly, Section 4113(b) permits, temporarily, the extension of qualified telehealth provider status to a broader list of practitioners including physical therapists, occupational therapists, speech-language pathologists, and audiologists.[16] Section 4113(e) allows continued CMS reimbursement of audio-only telehealth services for certain forms of care. Crucially, however, all these foregoing provisions are currently slated to expire on December 31, 2024, teeing up future political conflict and drawing into question the extent to which Medicare beneficiaries — many of whom, particularly those with age-related and other physical disabilities, find it challenging to access ambulatory care — can rely on telehealth services for necessary medical care.[17]

Substantial changes to payment have also occurred on the *state* level which are not necessarily tied directly to the federal PHE. With regard to private insurance, states amended coverage, reimbursement, and payment parity laws to facilitate access to telehealth services during their respective public health emergencies — though inconsistently.[18] For instance, according to a 2021 analysis by The Commonwealth Fund, 36 states required that insurers cover telemedicine services pre-pandemic.[19] Four states — Utah, Illinois, West Virginia, and Massachusetts — added such requirements as a result of COVID-19.[20] In addition to coverage parity, only four states eliminated cost-sharing for telehealth services as a result of the COVID-19 pandemic, while three others inaugurated requirements that cost-sharing be identical to in-person services — bringing the total number of states with some form of cost-sharing requirement for telehealth services to 30.[21] With many of the foregoing regulatory changes being temporary and tied to state-defined public health emergencies, however, many of these expansions ended inconsistently — even long before the end of the federal PHE.

With regard to public insurance, some states have permanently amended state Medicaid reimbursement policies to augment access to telehealth services — though, again, the approach has varied widely state by state. A 2022 analysis of non-COVID-19-related telehealth policy by the Center for Connected Health Policy (CCHP) found that, though all 50 states had laws providing some form of Medicaid reimbursement for telehealth services permanently, only 17 states reimbursed all four common modalities of telehealth care — live video, store-and-forward, remote patient monitoring, and audio-only.[22] CCHP identified the audio-only telehealth modality as having the largest increase in incidence of reimbursement, but even so, only 34 states and the District of Columbia extended Medicaid reimbursement to this form of care.[23] 50 state, district or territorial Medicaid programs reimbursed live video, 25 reimbursed store-and-forward, and 34 reimbursed remote patient monitoring services.[24] Tellingly, the timeline of these policy changes has been uncoordinated, with some states making such policy changes permanent while others only extended such expansions for multiple years.[25]

Ensuring adequate provider reimbursement for a broader set of telehealth services is understandably critical to facilitating patients' access to these services. Indeed, initial evidence suggests that reimbursement parity weighs significantly on patients' decision to seek telehealth care. Reimbursement parity also matters to health equity — which we define, at the highest level, as the ability for those who most acutely need telehealth and virtual care services due to physical disabilities, old age, or other reasons to access these services. For instance, Ellison and colleagues, in 2022, found that telehealth visits relating to contraception increased 25% among parity states versus non-parity states after adjusting for potential confounding factors.[26] Moreover, recent work from Kleinman and Sanches suggests the burden of elimination of reimbursement of audio-only telehealth services would fall disproportionately on Hispanic and non-Hispanic Black populations, with these groups being estimated to see the largest decreases in in-home telehealth access in the absence of audio-only coverage.[27] Likewise, given that some estimates suggest nearly 43.5% of audio-only telehealth users are aged 65 or

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older, a move away from audio-only telehealth reimbursement would likely restrict senior citizens' access to this form of care.[28] Because providers often choose to offer telehealth services on the basis of Medicare reimbursement, continued reimbursement for audio-only and other forms of telehealth care frequently used by senior citizens will allow this population to receive continued virtual care to manage chronic conditions and support aging in place. Altogether, the lack of coordinated efforts to extend consistent and permanent expansions to telehealth reimbursement across all U.S. states and territories has not only likely restricted access to telehealth services more broadly but also served to widen extant socioeconomic inequities in access to health care nationwide.

When we examine the landscape of state action on telehealth coverage on both the private and public fronts, a convoluted patchwork of permanent and temporary changes to telehealth law and policy emerges. Indeed, the dearth of interstate coordination in telehealth coverage law and policy is particularly problematic for patients and providers at state borders, whose billing may not be approved across state lines due to divergent billing practices and regulations across states.[29] As a whole, this dynamic suggests that the federal government still has an important role to play in coordinating the extant patchwork of state law and policy.

Given the state-level changes described above, it appears the end of the *federal* PHE matters less to the accessibility of telehealth services moving forward than changes to state law and policy. To be sure, the termination of telehealth's status as an excepted benefit, along with the end of telehealth services' inclusion in catastrophic health plans, will appreciably reduce the accessibility of telehealth services for many Americans. But the substantial leeway states have in setting private coverage law and Medicaid coverage requirements within their own jurisdictions in the American system of federalism suggests that states — not the federal government — can and should take the lead in facilitating patient access to and provider compensation for telehealth care. But states' leadership opportunity raises questions of geographic inequalities and inconsistencies. When we examine the landscape of state action on telehealth coverage on both the private and public fronts, a convoluted patchwork of permanent and temporary changes to telehealth law and policy emerges. Indeed, the dearth of interstate coordination in telehealth coverage law and policy is particularly problematic for patients and providers at state borders, whose billing may not be approved across state lines due to divergent billing practices and regulations across states.[29] As a whole, this dynamic suggests that the federal government still has an important role to play in coordinating the extant patchwork of state law and policy.

Physician Licensure

In addition to coverage and payment for telehealth services, physician licensure has seen greater flexibility during the PHE. But as is the case in our foregoing analysis of telehealth coverage, physician licensure has undergone the most significant change on the state, not federal, level. Prior to the pandemic, federal law already granted significant leeway to clinicians providing care within federal health networks. For example, the Veteran Affairs MISSION Act of 2018 eliminated all geographic licensing barriers for physicians but only within the Veterans Health Administration system.[30] Relatedly, during the COVID-19 PHE, the Consolidated Appropriations Act of 2023 removed geographic requirements and expanded originating sites for telehealth services under Medicare through at least December 31, 2024.[31] Numerous other bills calling for an extension of telehealth licensure flexibilities beyond even the post-PHE grace period have emerged, but virtually none of these gained significant political traction. The Ensuring Telehealth Expansion Act of 2021, for example, would make telehealth flexibilities during the federal PHE, such as rural health clinics serving as the distant site for telehealth services under Medicare, permanent — but such legislation has seemingly stalled in Congress.[32]

States, by contrast, have at times leveraged their authority over licensing reciprocity agreements to reduce barriers to telehealth practice, but generally

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with little interest in extending these regulatory initiatives beyond the pandemic. Prior to the pandemic, the Interstate Medical Licensure Compact (IMLC) was the most notable avenue for states to facilitate multi-state practices for physicians, including telehealth practices. The IMLC expedites the process by which physicians obtain additional secondary state licensures in 40 participating states, the District of Columbia, and the Territory of Guam, although interested physicians still must endure significant expense, effort, and paperwork.[33] During the PHE, to increase care supply, all 50 states and the District of Columbia waived some aspect of licensing requirements, per the Alliance for Connected Care.[34] For example, in March 2020, during the peak of New York State's COVID-19 infection surge, Executive Order 202.10 eliminated any "restrictions on approved ambulance services or providers operating outside of the primary territory," essentially allowing ant out-of-state providers to practice in the state.[35] Since then, despite the potential realized benefits of recognizing out-of-state providers, New York State has yet to join the IMLC, with the relevant bill introduced only earlier this year.[36]

Other interstate attempts to establish more porous state licensure boundaries have also fallen short. The Medical Excellence Zone Compact, advocated by legislators in D.C., Maryland, and Virginia, would allow healthcare providers to practice across state lines within the zone via telehealth, while being held accountable to the Medical Board guidelines and discipline of their specific state.[37] A key distinction from the IMLC is that, under this model, practitioners would not be required to go through additional states' licensing processes — rather, they would be able to assume the benefits of a kind of "mutual recognition of licensure."[38] While conceptually appealing, this proposal likely faces an uphill battle, given that it would potentially diminish the disciplinary authority of state medical licensing boards.[39]

The Uniform Telehealth Act has recently emerged as a potential way to expand interstate telehealth care. The Act, according to a final draft authored by the National Conference of Commissioners on Uniform State Laws, would allow a practitioner to provide telehealth services to a patient located in another state that has adopted the Act, so long as the care provided is consistent with "the practitioner's scope of practice in [the enacting] state, applicable professional practice standards in [the] state, and requirements and limitations of federal law and law of [the] state."[40] The Act, however, requires the out-of-state physician to pay a registration fee in the desired state of practice — an economic burden that may further stymie physicians' ability to practice across state lines.[41] To date, the Act has only been introduced in four states and adopted in none.[42]

To address the extant patchwork of laws and policies surrounding telehealth licensure and coverage, greater interstate coordination is critical. Through legislation compelling currently non-participating states to join compacts that recognize license reciprocity, Congress could expand the scope of the IMLC.[43] To ensure fluid cross-state telehealth care, it may also be prudent to redefine licensing requirements such that physicians need only be licensed in the state in which they are located *physically*. Section 713 of the 2012 National Defense Authorization Act applied this model of licensure to physicians furnishing care under the TriCare military health plan. Under this Act, providers who are "member[s] of the armed forces" and any "other health-care professional credentialed and privileged at a federal health care institution" could render "regardless of where such health-care professional or the patient are located."[44] In 2021, legislation introduced by Senators Ted Cruz and Marsha Blackburn proposed extending this more flexible definition of licensure to all telehealth services nationwide for at least as long as the PHE.[45] Other policymakers have even suggested that the U.S. adopt a federal licensure model, though such a proposal has been met again with opposition from those who fear this would too greatly undermine state medical licensing boards' disciplinary power.[46]

Enduring Challenges

The need for consistency across state coverage, payment, reimbursement, and licensure laws post-PHE notwithstanding, the U.S. Supreme Court's recent overturning of *Roe v. Wade* (1973) in *Dobbs v. Jackson Women's Health Organization* (2022) presents a unique barrier to inter-state coordination of telehealth law and policy.[47] In ruling that *Roe* and its progeny, *Planned Parenthood v. Casey* (1992), arrogated states' authority to regulate abortion law within their jurisdictions, *Dobbs* revitalized states' authority over the health policy domain.[48] Recent advancements in tele-abortion and tele-contraceptive care will likely only decrease states' willingness — particularly those with distinct political compositions — to coordinate telehealth law and policy.

For instance, with the in-person dispensing and administering requirement waived by the FDA in 2021, mifepristone can be prescribed and delivered to a patient's residence via telehealth. Missouri legislators have met this development with a proposal to regulate conduct outside of its borders, barring even

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abortions performed out-of-state if any aspect of "informed consent or pre- or post-abortion counseling ... occurs within [Missouri]," or "involves a resident of [Missouri]."[49] Abortion medication provision across state borders via telehealth would violate both stipulations. This legislation stands in stark contrast to California's recent large bill package furnishing greater access to abortion medication.[50] It is difficult to see these two states, with such seemingly irreconcilable conceptions of abortion law, allowing the free flow of medical care across their borders. Indeed, the struggle for telehealth coordination across states is further complicated by states' competing views of what healthcare should look like within their borders. So long as these broader debates remain unresolved, the national landscape of telehealth law and policy is likely to remain inconsistent and indefinite.

Critically, patient access to quality telehealth care will rely on adequate physician training on the virtual care modality. Currently, specific requirements for telehealth training and education are unstandardized, which could contribute to inconsistencies in quality of care for patients as well as physician reluctance to offer telehealth services.[51] While the Association of American Medical College (AAMC), Accreditation Council for Graduate Medical Education (ACGME), and the Veterans Healthcare Administration (VHA) offer educational modules, such pedagogical methods are often lacking in direct observation or feedback.[52] This inadequate patchwork of physician education for telehealth care delivery combined with the dearth of education on reproductive health and abortion could exacerbate limits to accessible reproductive healthcare post-PHE

Policymakers and physicians must also remain highly cognizant of how patients may make decisions about their care with the rise of nationwide retailers, such as Amazon, Walmart, and CVS entering the healthcare industry.[53] Key business decisions such as Amazon's acquisition of One Medical have the potential to impact thousands of patients, many of whom will undoubtedly reside in states with varying coverage and licensure policies.[54] These consumer-facing conglomerates often promise a more hassle-free, affordable, and convenient telehealth experience and begin to blend the roles of hospital patient and product consumer. But even in spite of these promises, the fractures existing in the regulatory landscape will continue to impact physicians and patients."

Conclusion

The end of the federal PHE presents policymakers and clinicians alike with an opportunity to advance the telehealth care modality beyond the COVID-19 emergency phase. The fragmented landscape of state telehealth law and regulation, primarily determined at the state level, has introduced inefficiencies and inequities that can likely only be ameliorated through greater inter-state coordination, underscoring the need for federal action. However, the recent reversal of *Roe v. Wade* (1973) poses an additional obstacle to this endeavor, transforming the debate over the future of telehealth into a more fundamental struggle over the nature of health care within state lines. These challenges notwithstanding, the sustained need for telehealth services post-PHE suggests it remains critical to foster coordination between states and find innovative policy solutions to ensure equitable access to telehealth care long-term.

Note

Minsoo Kwon and James René Jolin contributed equally to this manuscript.

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54. *See* Reed, *supra* note 53.

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