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The Future Cannot Come Soon Enough: How Federal Regulation of Telepsychiatry Is Necessary to Create Greater Access to Mental Health Services During a Time When Psychiatrists Are in Short Supply

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**THE FUTURE CANNOT COME SOON ENOUGH: HOW FEDERAL
REGULATION OF TELEPSYCHIATRY IS NECESSARY TO CREATE
GREATER ACCESS TO MENTAL HEALTH SERVICES DURING A
TIME WHEN PSYCHIATRISTS ARE IN SHORT SUPPLY**

*Lisa V. Parciak**

I.	INTRODUCTION.....	478
II.	BACKGROUND.....	480
	A. <i>The Prevalence of Mental Illness in the U.S.</i>	480
	B. <i>Barriers to Treatment and the Shortage of Psychiatrists in the U.S.</i>	482
	C. <i>Telemedicine and Psychiatry</i>	484
III.	BARRIERS TO THE EXPANSION OF TELEPSYCHIATRY AND SOLUTIONS.....	487
	A. <i>State Regulation Is a Barrier to the Expansion of Telepsychiatry</i>	488
	1. Physician Licensure.....	488
	2. State Telemedicine Laws.....	490
	3. Malpractice Uncertainty, Variability, and Liability Insurance.....	491
	4. Solution: National Licensure and Federal Regulation of Telepsychiatry.....	492
	B. <i>Reimbursement Policies as a Barrier to the Expansion of Telepsychiatry</i>	499
	1. Medicare.....	500
	2. Medicaid.....	501
	3. Private Insurance Companies.....	502
	4. Solution: Expand Medicare, Medicaid, and Private Insurance Reimbursement.....	503
	C. <i>Privacy Concerns Are a Barrier to the Expansion of Telepsychiatry</i>	503
	1. The Current Regulatory Framework for Protecting Patients' Privacy.....	504
	2. HIPAA and Its Progeny Are Insufficient	

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	to Protect Patients' Privacy.....	507
	3. Solution: Amend HIPAA Privacy and Security Rules.....	508
IV.	CONCLUSION	510

I. INTRODUCTION

According to a 2016 study prepared for the U.S. Department of Health and Human Services (“HHS”), 44.7 million adults in the U.S. experienced some type of mental illness in the previous year.¹ Of those 44.7 million people, 10.4 million people experienced a mental illness in the previous year that was so serious that it interfered with one or more major life activities.² Examples of serious mental illness include schizophrenia and bipolar disorder.³ Mental illness is treatable, and there are a variety of treatments available, including psychotherapy and medication.⁴ While there are many types of mental health professionals,⁵ the focus of this Article is on psychiatrists. Psychiatrists, unlike other types of mental healthcare professionals, are physicians and, therefore, are able to prescribe medications to treat their patients’ mental illnesses.⁶

Despite mental illness being treatable, it is believed that only half of the people with mental illness actually receive treatment.⁷ While there are several barriers to treatment,⁸ one significant barrier to treatment is limited access to care.⁹ The U.S. is currently experiencing a severe shortage of mental health professionals.¹⁰ Not only are there not enough mental health professionals practicing in the U.S., but the ones that are practicing are not

¹ SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., KEY SUBSTANCE USE AND MENTAL HEALTH INDICATORS IN THE UNITED STATES: RESULTS FROM THE 2016 NATIONAL SURVEY ON DRUG USE AND HEALTH 2 (2017), <https://store.samhsa.gov/system/files/sma17-5044.pdf>.

² *Id.*

³ *See Mental Health Conditions*, NAT’L ALLIANCE ON MENTAL ILLNESS, <https://www.nami.org/Learn-More/Mental-Health-Conditions> (last visited Sept. 30, 2019).

⁴ *Id.*

⁵ *Types of Mental Health Professionals*, NAT’L ALLIANCE ON MENTAL ILLNESS, <https://www.nami.org/Learn-More/Treatment/Types-of-Mental-Health-Professionals> (last visited Sept. 30, 2019).

⁶ *Id.*

⁷ *Mental Health Information: Statistics*, NAT’L INST. MENTAL HEALTH, <https://www.nimh.nih.gov/health/statistics/index.shtml> (last visited Sept. 30, 2019).

⁸ Stacie Deslich et al., *Telepsychiatry in the 21st Century: Transforming Healthcare with Technology*, 10 PERSP. HEALTH INFO. MGMT. 1, 3 (2013).

⁹ NAT’L COUNCIL MED. DIR. INST., THE PSYCHIATRIC SHORTAGE: CAUSES AND SOLUTIONS 1, 6 (2017).

¹⁰ Susie M. Adams et al., *Telemental Health: Standards, Reimbursement, and Interstate Practice*, J. AM. PSYCHIATRIC NURSES ASS’N 1, 2 (2018).

evenly distributed throughout the U.S.¹¹ Mental health professionals are predominately located in large urban areas.¹² Furthermore, people living in the southern part of the U.S. have less access to mental healthcare than people living in other parts of the country.¹³

All hope, however, is not lost because telepsychiatry has the potential to create greater access to quality mental healthcare for those most in need.¹⁴ Telepsychiatry is the provision of mental healthcare services through the use of telemedicine.¹⁵ Telemedicine is the use of telecommunication technologies to diagnose and treat patients when patients and providers are separated by distance.¹⁶ Because the practice of psychiatry requires a high degree of patient-provider interaction, telepsychiatry typically involves interactive videoconferencing systems over high-bandwidth networks.¹⁷ Telepsychiatry creates greater access to mental healthcare by eliminating geographic barriers to care¹⁸ and by providing psychiatric treatment in a non-stigmatizing environment.¹⁹ Telepsychiatry is an effective way to deliver psychiatric services and is comparable to traditional in-person care.²⁰

Although telepsychiatry has the potential to create greater access to quality mental healthcare for those most in need,²¹ many psychiatrists have yet to incorporate telepsychiatry into their private practices.²² While telepsychiatry is finding success in certain settings, such as veteran hospitals,²³ its potential to create greater access to mental healthcare services is being stifled by several

¹¹ *Id.* at 2.

¹² *Id.*

¹³ See Allison N. Winnike et al., *Rewiring Mental Health: Legal and Regulatory Solutions for the Effective Implementation of Telepsychiatry and Telemental Health Care*, 17 HOUS. J. HEALTH L. & POL'Y 21, 31 (2017).

¹⁴ *Id.* at 23.

¹⁵ *Id.* at 43.

¹⁶ *Id.* at 44.

¹⁷ Deslich et al., *supra* note 8, at 4.

¹⁸ Winnike et al., *supra* note 13, at 23.

¹⁹ DAVID D. LUXTON ET AL., A PRACTITIONER'S GUIDE TO TELEMENTAL HEALTH: HOW TO CONDUCT LEGAL, ETHICAL, AND EVIDENCE-BASED TELEPRACTICE 111 (2016).

²⁰ See Donald M. Hilty et al., *The Effectiveness of Telemental Health: A 2013 Review*, 19 TELEMEDICINE J. & E-HEALTH 444, 451 (2013).

²¹ Winnike et al., *supra* note 13, at 23.

²² Kathleen Myers, *Telepsychiatry: Time to Connect*, 52 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 217, 217 (2013).

²³ See, e.g., Robert A. Petzel, *Telemental Health in VA: A New Source of Support for Veterans*, U.S. MED. (Feb. 9, 2013), <http://www.usmedicine.com/agencies/departments-of-veterans-affairs/telemental-health-in-va-a-new-source-of-support-for-veterans>.

barriers. Barriers to the expansion of telepsychiatry include (1) state licensure laws,²⁴ (2) restrictive reimbursement, (3) state telemedicine laws,²⁵ (4) malpractice uncertainty,²⁶ and (5) privacy and security concerns.²⁷

In order to create greater access to mental healthcare services to those most in need during a time in which there is a national shortage of psychiatrists, the federal government should create a national license to practice telepsychiatry and adopt preemptive legislation regulating its practice. Furthermore, to encourage psychiatrists to incorporate telepsychiatry into their practices, this Article proposes (1) reforming Medicare, Medicaid, and private insurance telemedicine reimbursement and (2) requiring liability insurance companies to cover interstate telepsychiatry in parity with traditional psychiatry. Lastly, to address patients' concerns regarding their privacy, this Article suggests amending federal privacy and security rules to include greater protections for the data created via telepsychiatry.

Part II provides background information on mental illness, the barriers to mental healthcare, and the benefits of telepsychiatry. Finally, Part III addresses the barriers to the expansion of telepsychiatry and the legislation that should be adopted in order to make the expansion of telepsychiatry a reality.

II. BACKGROUND

A. *The Prevalence of Mental Illness in the U.S.*

Mental illness is a general term used to describe a variety of mental, behavioral, and emotional disorders ranging in severity from mild to severe.²⁸ While each mental illness has its own particular symptoms, common signs of mental illness include, but are not limited to, the following: (1) excessive sadness, (2) excessive worry and/or fear, (3) extreme mood swings, (4) confused thinking, (5) delusional thinking, (6) hallucinations, (7) thoughts of suicide, (8) substance abuse, and (9) difficulty understanding or relating to

²⁴ Diane Hoffman & Virginia Rowthorn, *Legal Impediments to the Diffusion of Telemedicine*, 14 J. HEALTH CARE L. & POL'Y 1, 10 (2011) (noting that telemedicine practitioners who seek to practice across states find strict licensure laws burdensome).

²⁵ Adam D. Romney & Sean R. Baird, *Skype Sessions: Emerging Legal Issues in Tele-Mental Health Services*, 28 HEALTH L. 32, 32–33 (2015).

²⁶ Hoffmann & Rowthorn, *supra* note 24, at 32.

²⁷ Josh Sherman, Note, *Double Secret Protection: Bridging Federal and State Law to Protect Privacy Rights for Telemental and Mobile Health Users*, 67 DUKE L.J. 1115, 1120 (2018).

²⁸ *Mental Illness*, NAT'L INST. MENTAL HEALTH, <https://www.nimh.nih.gov/health/statistics/mental-illness.shtml> (last visited Oct. 2, 2019).

other people.²⁹ Mental illness can be broken down into two categories: (1) Any Mental Illness (“AMI”) and (2) Serious Mental Illness (“SMI”).³⁰ The AMI category includes mental, behavioral, and emotional disorders that range from no impairment to severe impairment.³¹ The SMI category is a sub-set of AMI and includes mental, behavioral, and emotional disorders that cause serious functional impairments, which substantially interfere with or limit one or more major life activities.³² Examples of serious mental illnesses include major depressive disorder, schizophrenia, and bipolar disorder.³³ Signs of mental illness usually manifest early in a person’s life; for instance, 75% of all mental health conditions occur by the time a person turns 24 years old.³⁴ As stated previously, mental illness is a common affliction in the United States.³⁵ Tens of millions of U.S. adults experience some form of mental illness each year.³⁶ However, only half of those individuals with mental illness receive some form of mental health treatment.³⁷

Mental illness does not just impact individuals with mental illness and the people who love them; mental illness also has a large impact on society.³⁸ For instance, untreated mental illness increases a person’s risk of being homeless.³⁹ An estimated one-third of all homeless people are mentally ill.⁴⁰ Moreover, people with mental illness are eight times more likely to be incarcerated than non-mentally ill people.⁴¹ The U.S. spends an estimated \$15

²⁹ *Know the Warning Signs*, NAT’L ALLIANCE ON MENTAL ILLNESS, <https://www.nami.org/Learn-More/Know-the-Warning-Signs> (last visited Sept. 30, 2019).

³⁰ *Mental Illness*, *supra* note 28.

³¹ *Id.*

³² *Id.*

³³ *What Is Mental Illness?*, AM. PSYCHIATRIC ASS’N, <https://www.psychiatry.org/patients-families/what-is-mental-illness> (last visited Sept. 30, 2019).

³⁴ Emily Bazar, *Typical Kid Behavior or a Mental-Health Problem? It Can Be Hard to Decide.*, CHI. TRIB. (Aug. 14, 2018, 8:57 AM), <https://www.chicagotribune.com/lifestyles/health/ct-kid-behavior-mental-health-20180814-story.html>.

³⁵ *Mental Health Information: Statistics*, *supra* note 7.

³⁶ *Id.*

³⁷ *Id.*

³⁸ *Mental Health by the Numbers*, NAT’L. ALLIANCE ON MENTAL ILLNESS, <https://www.nami.org/learn-more/mental-health-by-the-numbers> (last visited Oct. 2, 2019).

³⁹ Winnike et al., *supra* note 13, at 31.

⁴⁰ *Id.*

⁴¹ *Id.* at 30.

billion per year incarcerating individuals with mental illness.⁴² Furthermore, between government spending on mental healthcare and the lost earnings of those with serious mental illnesses, the U.S. loses approximately \$1 trillion per year.⁴³

B. Barriers to Treatment and the Shortage of Psychiatrists in the U.S.

Fortunately, mental illness is treatable, and there are a variety of treatments available, including, but not limited to, therapy and medication.⁴⁴ Despite being treatable, it is estimated that only 50% of individuals with mental illness receive some type of mental health treatment.⁴⁵ Barriers to treatment include lack of proximity to care, treatment costs, transportation difficulties, time restraints,⁴⁶ and social stigma.⁴⁷ The shortage of psychiatrists practicing in the U.S. is another barrier to treatment.⁴⁸ As of June 2018, there are 5,119 designated mental healthcare Health Professional Shortage Areas (“HPSA”) in the U.S.⁴⁹ To be considered a mental health care HPSA, an area’s population-to-psychiatrist ratio must be, at a minimum, 30,000 to 1.⁵⁰ Over 126 million people live in mental healthcare HPSAs.⁵¹

Children and adolescents with mental illness experience even greater difficulty in accessing mental healthcare, with 55% of the states in the U.S. experiencing a serious shortage of child and adolescent psychiatrists.⁵² Other populations that experience greater barriers to accessing treatment include individuals with disabilities, individuals with limited English proficiency, and

⁴² *Id.* at 28.

⁴³ *Id.*

⁴⁴ See *Mental Health Treatment & Services*, NAT’L ALLIANCE ON MENTAL ILLNESS, <https://www.nami.org/Learn-More/Treatment> (last visited Oct. 2, 2019).

⁴⁵ *Mental Health Information: Statistics*, *supra* note 7.

⁴⁶ Deslich et al., *supra* note 8, at 3.

⁴⁷ Winnike et al., *supra* note 13, at 32.

⁴⁸ NAT’L COUNCIL MED. DIR. INST., *supra* note 9, at 6.

⁴⁹ *Help Wanted: HRSA Presents a Virtual Job Fair for Professional Counselors*, AM. COUNSELING ASS’N (Sept. 14, 2018), <https://www.counseling.org/news/aca-blogs/aca-government-affairs-blog/aca-government-affairs-blog/2018/09/14/help-wanted-hrsa-presents-a-virtual-job-fair-for-professional-counselors> [hereinafter *Help Wanted*].

⁵⁰ *Mental Health Care Health Professional Shortage Areas (HPSAs)*, KAISER FAM. FOUND., <https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited Oct. 2, 2019).

⁵¹ *Help Wanted*, *supra* note 49.

⁵² NAT’L COUNCIL MED. DIR. INST., *supra* note 9, at 6.

individuals located in low-income urban areas.⁵³ The shortage of psychiatrists in the U.S. is so great that many emergency rooms do not have psychiatrists on staff even though one in eight emergency room visits involves a mental illness or substance abuse issue.⁵⁴

The shortage of psychiatrists is only expected to get worse.⁵⁵ One recent study predicted that by 2025, an additional 6,090 psychiatrists will be needed to meet the service demand.⁵⁶ Another study projected the demand by 2025 to be much higher, finding that by 2025, 15,600 more psychiatrists will be needed to meet the demand for services.⁵⁷ Reasons for the shortage of psychiatrists include an aging workforce, burnout, low reimbursement rates, and burdensome record-keeping.⁵⁸

Moreover, the psychiatrists that are practicing in the U.S. are not evenly distributed throughout the country.⁵⁹ The majority of mental health care HPSAs are located in rural and partially rural areas.⁶⁰ Furthermore, states located in the southeast region of the U.S. (Alabama, Florida, Georgia, Kentucky, Mississippi, South Carolina, North Carolina, and Tennessee) have greater shortages, with only 28.51% of their needs being met, than those states located in the northeast region of the U.S. (Connecticut, Massachusetts, Maine, New Hampshire, Rhode Island, and Vermont), with 41.59% of their needs being met.⁶¹

Areas with sufficient patient-psychiatrist ratios are experiencing a different kind of shortage—a shortage of psychiatrists accepting insurance as a source of payment.⁶² Currently, 40% of the psychiatrists in the U.S. do not accept insurance as a form of payment.⁶³ The insurance acceptance rate for psychiatrists is significantly lower than the insurance acceptance rate for other

⁵³ Winnike et al., *supra* note 13, at 34–39.

⁵⁴ *What Is Telepsychiatry?*, AM. PSYCHIATRIC ASS'N, <https://www.psychiatry.org/patients-families/what-is-telepsychiatry> (last visited Oct. 2, 2019).

⁵⁵ NAT'L COUNCIL MED. DIR. INST., *supra* note 9, at 15.

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.* at 6.

⁵⁹ See Adams et al., *supra* note 10, at 2.

⁶⁰ See *Mental Health Care Professional Shortage Areas*, *supra* note 50.

⁶¹ *Id.*

⁶² Janet R. Cummings, *Rates of Psychiatrists' Participation in Health Insurance Networks*, 313 JAMA 190, 190 (2015).

⁶³ Tara F. Bishop et al., *Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care*, 71 JAMA 176, 179 (2014).

medical specialists.⁶⁴ Low insurance reimbursement rates for psychiatric services may explain the rise in cash-only practices.⁶⁵ It has also been suggested that perhaps psychiatrists do not need to accept insurance anymore to attract patients because their services are in such high demand.⁶⁶

C. Telemedicine and Psychiatry

Telemedicine is the delivery of clinical care by a licensed healthcare provider in one location (commonly referred to as the “distant site”) to a patient in another location (commonly referred to as the “originating site”) by way of telecommunication technologies.⁶⁷ The telemedicine industry has seen exponential growth in the past few years.⁶⁸ In fact, the market will generate \$1.9 billion this year—which is a 50% increase from 2013.⁶⁹ Telemedicine is also a hot topic for the government, with telehealth legislation being regularly proposed at the state and federal levels.⁷⁰

Telemedicine can be practiced on an interstate or an intrastate basis.⁷¹ Intrastate telemedicine occurs when the patient and the provider are located in the same state, while interstate telemedicine occurs when the patient and the provider are located in different states.⁷² When physicians practice intrastate telemedicine, they must only concern themselves with the laws and regulations of one state.⁷³ As this Article will discuss at length, matters become much more complicated when providers branch out into interstate telemedicine.⁷⁴

While there are many telecommunication technologies available, such as telephone, facsimile, electronic mail, and still imaging, most psychiatrists who use telemedicine use live videoconferencing to treat their patients.⁷⁵

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ *Id.* at 180.

⁶⁷ Steve Kreitner, *Telehealth Services Networks: A Promise Not Fully Delivered*, 39 MONT. LAW. 24, 24 (2014).

⁶⁸ Caroline M. Poma, *Telemedicine: A Therapeutic Prescription for Our Healthcare System Contaminated by Old Economy Rules and Regulations*, 17 N.C. J.L. & TECH. 74, 79 (2016).

⁶⁹ *Id.*

⁷⁰ See *Legislation and Regulation Tracking*, CTR. FOR CONNECTED HEALTH POL’Y, <https://www.cchpca.org/telehealth-policy/legislation-and-regulation-tracking> (last visited Oct. 2, 2019).

⁷¹ J. Craig Busey & Pam Michael, *Telehealth—Opportunities and Pitfalls*, 108 J. AM. DIETETIC ASS’N 1296, 1298 (2008).

⁷² *Id.*

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ Hilty et al., *supra* note 20, at 444.

Videoconferencing allows providers and patients who are separated by distance to see and hear each other in real time.⁷⁶ Telepsychiatry videoconferencing systems typically include a video camera, a microphone, speakers, and one or two video monitors at each location site.⁷⁷ Most laptops and mobile devices already have the necessary videoconferencing hardware built in.⁷⁸ Telepsychiatry via videoconferencing also requires a reliable and secure internet connection and Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) compliant videoconferencing software.⁷⁹ Videoconferencing works well for psychiatry because the practice of psychiatry involves observation and verbal interaction.⁸⁰ The term “telepsychiatry” in this Article only refers to the use of live videoconferencing to treat patients.

Telepsychiatry has the ability to create greater access to mental healthcare to those most in need because it eliminates the issue of geography⁸¹ and offers treatment in a non-stigmatizing environment.⁸² Moreover, telepsychiatry enables patients, primary care physicians, and emergency room physicians to have direct access to psychiatrists.⁸³ Psychiatrists can provide a variety of services via telepsychiatry, such as consultations, diagnostic evaluations, individual therapy, family therapy, group therapy, patient education, and medication management.⁸⁴

In addition to creating greater access to care, telepsychiatry leads to positive clinical outcomes and patient satisfaction.⁸⁵ Telepsychiatry is an effective modality of care for a variety of mental illnesses, including panic disorders, depression, and post-traumatic stress disorder.⁸⁶ Telepsychiatry has also been found to be an effective modality of treatment across a variety of populations, including children, college students, immigrants, veterans,

⁷⁶ Kreitner, *supra* note 67, at 24.

⁷⁷ Deslich et al., *supra* note 8, at 4.

⁷⁸ Luxton et al., *supra* note 19, at 19.

⁷⁹ *Platform and Software Requirements*, AM. PSYCHIATRIC ASS'N, <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/platform-software-requirements> (last visited Oct. 2, 2019).

⁸⁰ Myers, *supra* note 22, at 217.

⁸¹ See Winnike et al., *supra* note 13, at 23.

⁸² Luxton et al., *supra* note 19, at 111.

⁸³ *What Is Telepsychiatry?*, *supra* note 54.

⁸⁴ *Id.*

⁸⁵ Carolyn Lauckner & Pamela Whitten, *The State and Sustainability of Telepsychiatry*, 43 J. BEHAV. HEALTH SERV. & RES. 305, 306 (2016).

⁸⁶ *Id.*

inmates, and rural residents.⁸⁷ Patients report being satisfied with telepsychiatry and feeling as though they can share the same information via videoconferencing as they can in person.⁸⁸ Diagnostic reliability appears to be the same for videoconferencing as it is for traditional in-person care.⁸⁹ Moreover, telepsychiatry is a cost-effective way to deliver mental health services when compared to in-person treatment and video consultations.⁹⁰ According to the American Psychiatric Association, “[t]here is substantial evidence of the effectiveness of telepsychiatry and research has found satisfaction to be high among patients, psychiatrists and other professionals. Telepsychiatry is equivalent to in-person care in diagnostic accuracy, treatment effectiveness, quality of care and patient satisfaction. Patient privacy and confidentiality are equivalent to in-person care.”⁹¹

Telepsychiatry can be implemented in a variety of settings, including, but not limited to, clinics, emergency rooms, nursing homes, group homes, schools, and patients’ homes.⁹² Psychiatrists can offer telepsychiatry services directly to patients by implementing telemedicine videoconferencing software, or they can contract with virtual group practice companies.⁹³ Virtual group practice companies provide psychiatrists with a client base, reimbursement, and necessary infrastructure.⁹⁴

Telemedicine and telepsychiatry have already found success in a variety of settings. The Veteran Health Administration (“VHA”) of the Department of Veteran Affairs (“VA”) has already found great success in delivering mental health services to veterans via telemedicine and is considered to be a national leader in the delivery of telemental-health services.⁹⁵ The VHA currently uses telemedicine to treat a variety of mental health illnesses, including mood disorders, anxiety disorders, post-traumatic stress disorder, psychotic disorders, and substance-use disorders.⁹⁶ Since 2003, VHA has

⁸⁷ Deslich et al., *supra* note 8, at 3.

⁸⁸ Lauckner & Whitten, *supra* note 85, at 306.

⁸⁹ AM. PSYCHIATRIC ASS’N, RESOURCE DOCUMENT ON TELEMEDICINE: SYNCHRONOUS VIDEO-CONFERENCING IN PSYCHIATRY I (2017), <https://www.psychiatry.org/psychiatrists/search-directories-databases/library-and-archive/resource-documents>.

⁹⁰ Winnike et al., *supra* note 13, at 44.

⁹¹ *What Is Telepsychiatry?*, *supra* note 54.

⁹² Hilty et al., *supra* note 20, at 451.

⁹³ Myers, *supra* note 22, at 217.

⁹⁴ *Id.*

⁹⁵ Petzel, *supra* note 23.

⁹⁶ *Id.*

provided more than two million telemental health encounters.⁹⁷ The U.S. Department of Defense (“DoD”) recently gave telehealth vendor GlobalMed the authority to deploy its virtual health applications, hardware, and software directly onto DoD networks, thereby making its telehealth services available to 57 military hospitals, 400 military clinics, and numerous military bases around the world.⁹⁸ Telepsychiatry has also been successfully employed in the correctional setting.⁹⁹ In fact, 25 correctional systems located in the U.S. use some form of telemedicine, and 80% of those correctional systems use telepsychiatry.¹⁰⁰ However, despite being implemented successfully in certain settings, telepsychiatry is not being used to its full potential. Many psychiatrists have yet to incorporate telepsychiatry into their private practices.¹⁰¹

III. BARRIERS TO THE EXPANSION OF TELEPSYCHIATRY AND SOLUTIONS

The legal framework currently regulating the practice of telemedicine in the U.S. hinders telemedicine’s widespread adoption and growth.¹⁰² In particular, the current regulatory framework places unreasonable administrative burdens upon practitioners who desire to practice interstate telemedicine.¹⁰³ Because telepsychiatry is a form of telemedicine, the barriers that restrain the expansion of telemedicine also restrain the expansion of telepsychiatry. These barriers include, but are not limited to, (1) state physician licensure laws, (2) state telemedicine laws,¹⁰⁴ (3) malpractice uncertainty,¹⁰⁵ (4) restrictive

⁹⁷ U.S. DEP’T OF VETERANS AFFAIRS, FACTS ABOUT VETERAN SUICIDE: JUNE 2018 (2018), https://www.mentalhealth.va.gov/docs/OMHSP_Suicide_Prevention_Fact_Sheet_Updated_June_2018_508.pdf.

⁹⁸ Mike Miliard, *DoD Gives GlobalMed Authority to Run Telehealth Services on Federal Networks*, HEALTHCARE IT NEWS (Jan. 11, 2018, 3:29 PM), <https://www.healthcareitnews.com/news/dod-gives-globalmed-authority-run-telehealth-services-federal-networks>.

⁹⁹ Deslich et al., *supra* note 8, at 7.

¹⁰⁰ *Id.* at 8.

¹⁰¹ Myers, *supra* note 22, at 217.

¹⁰² Hoffman & Rowthorn, *supra* note 24, at 5.

¹⁰³ Amy E. Zilis, Note, *The Doctor Will Skype You Now: How Changing Physician Licensure Requirements Would Clear the Way for Telemedicine to Achieve the Goals of the Affordable Care Act*, 2012 U. ILL. J.L. TECH. & POL’Y 193, 213 (2012).

¹⁰⁴ Romney & Baird, *supra* note 25, at 32.

¹⁰⁵ Hoffman & Rowthorn, *supra* note 24, at 32.

reimbursement, and (5) privacy concerns.¹⁰⁶ For the purposes of this Article, these barriers have been grouped into the following three categories: (1) state regulation, (2) reimbursement, and (3) privacy and security concerns.

A. *State Regulation Is a Barrier to the Expansion of Telepsychiatry*

1. Physician Licensure

The state licensure system in the U.S. stifles the expansion of telepsychiatry because it prevents psychiatrists from treating patients that live in states in which the psychiatrist is not licensed.¹⁰⁷ Currently, every state in the union has a medical practice act that regulates the practice of medicine and licensure within its borders.¹⁰⁸ Through the licensure process, state medical boards make sure that the physicians practicing in their state have the necessary academic and clinical competencies to practice general medicine.¹⁰⁹ State medical practice acts, however, are not all the same.¹¹⁰ Medical practice acts can vary in how they define the practice of medicine and in what they require for physician licensure.¹¹¹

The states have a long history of regulating the practice of medicine within their own borders.¹¹² Shortly after the U.S. became a nation, individual states began regulating the practice of medicine pursuant to the police powers granted to them by the U.S. Constitution's Tenth Amendment.¹¹³ The Tenth Amendment gives each state the authority to regulate activities that impact the health, safety, and welfare of the people located within its borders.¹¹⁴ In 1889, the U.S. Supreme Court held that a state's authority to protect its citizenry included the ability to regulate medical licensure.¹¹⁵ Most physician licensure

¹⁰⁶ Amar Gupta & Deth Sao, *The Constitutionality of Current Legal Barriers to Telemedicine in the United States: Analysis and Future Directions of its Relationship to National and International Health Care Reform*, 21 HEALTH MATRIX 385, 393 (2011).

¹⁰⁷ See Jennifer M. Little, *Into the Future: The Statutory Implications of North Carolina's Telepsychiatry Program*, 93 N.C. L. REV. 863, 884–85 (2015).

¹⁰⁸ Gupta & Sao, *supra* note 106, at 393.

¹⁰⁹ Peter Critikos III, Comment, *License to Screen: A Review of the Medical Licensure Scheme Impacting Telehealth Proliferation in the United States, the European Union, and Australia*, 32 EMORY INT'L L. REV. 317, 329 (2018).

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² *Id.* at 328.

¹¹³ *Id.*

¹¹⁴ Zilis, *supra* note 103, at 201.

¹¹⁵ Critikos, *supra* note 109, at 328.

laws were adopted in the early 1900s, a time when the practice of medicine was solely local in nature.¹¹⁶

Most medical boards require physicians to be licensed in the states where their patients are located before they make diagnoses or recommend treatments.¹¹⁷ This holds true when the physician and the patient see each other face-to-face or communicate with the assistance of telemedicine.¹¹⁸ Therefore, unless a state creates a licensure exception for telemedicine, a physician must be licensed in the state where the patient is located to legally treat the patient using telemedicine.¹¹⁹ Physicians who use telemedicine to treat out-of-state patients risk liability for the unauthorized practice of medicine if they are unlicensed in a patient's state.¹²⁰ Performing the unauthorized practice of medicine can result in civil damages, criminal penalties, and disciplinary sanctions.¹²¹

However, obtaining a license to practice medicine in every state in which a physician would like to treat patients is not practical.¹²² Obtaining a license to practice medicine is an expensive and time-consuming endeavor.¹²³ The process of becoming licensed to practice medicine is an arduous process that requires full disclosure.¹²⁴ Moreover, although states have many of the same basic standards for medical licensure, each state has its own unique filing and administrative requirements, which make maintaining multiple state licenses burdensome.¹²⁵ For instance, states vary in how they approach continuing medical education requirements, finger printing, and background checks, among other things.¹²⁶ Moreover, state licensing fees, which are an

¹¹⁶ Hoffman & Rowthorn, *supra* note 24, at 9.

¹¹⁷ See Tara E. Kepler & Charlene L. McGinty, *Telemedicine: How to Assess Your Risks and Develop a Program that Works*, AM. HEALTH LAW. ASS'N SEMINAR PAPERS, Feb. 9, 2009, at 1, 10.

¹¹⁸ *Id.*

¹¹⁹ *Id.*

¹²⁰ Joy Elizabeth Matak, Note, *Telemedicine: Medical Treatment Via Telecommunications Will Save Lives, But Can Congress Answer the Call?: Federal Preemption of State Licensure Requirements Under Congressional Commerce Clause Authority & Spending Power*, 22 VT. L. REV. 231, 240–41 (1997).

¹²¹ *Id.*

¹²² Kepler & McGinty, *supra* note 117, at 10.

¹²³ *Id.*

¹²⁴ Zilis, *supra* note 103, at 202.

¹²⁵ Amy Schumacher, Note, *Telehealth: Current Barriers, Potential Progress*, 76 OHIO ST. L.J. 409, 421 (2015).

¹²⁶ *Id.* at 422.

important source of state revenue,¹²⁷ must be paid and can range anywhere from \$200 to \$1,000.¹²⁸ Licenses must also be renewed and, in some states, licensing fees must be paid on an annual basis.¹²⁹ Because of the costly and painstaking nature of the licensure process, many physicians maintain only one license for the state in which their practice is physically located.¹³⁰ In fact, only 22% of active and licensed physicians maintain licenses in more than one state.¹³¹

2. State Telemedicine Laws

The ability of each state to regulate telemedicine as it deems appropriate has resulted in great variation amongst the states.¹³² Some of the adopted legislation encourages the use of telemedicine by providing clarity regarding its practice. For example, some states have adopted legislation that says the standard of care for telemedicine is the same as the standard of care for traditional in-person care.¹³³ Several states have legislation that says that a physician-patient relationship is created when services are provided via telemedicine.¹³⁴ Moreover, as of 2017, 20 states and Washington D.C. have statutes requiring informed consent for telemedicine services.¹³⁵

While some states have legislation that facilitates and encourages the use of telemedicine across state lines, other states have restrictive legislation.¹³⁶ Some attempts to provide clarity for telemedicine have resulted in more stringent or heightened standards of care.¹³⁷ For example, Texas and Georgia require an in-person visit after the use of most telemedicine services.¹³⁸ Furthermore, several states have adopted specific policies regarding the

¹²⁷ Paul Spradley, *Telemedicine: The Law Is the Limit*, 14 TUL. J. TECH. & INTELL. PROP. 307, 319 (2011).

¹²⁸ Zilis, *supra* note 103, at 202.

¹²⁹ Schumacher, *supra* note 125, at 422.

¹³⁰ Zilis, *supra* note 103, at 202.

¹³¹ *Id.*

¹³² Schumacher, *supra* note 125, at 420.

¹³³ LATOYA THOMAS & GARY CAPISTRANT, STATE TELEMEDICINE GAPS ANALYSIS: PHYSICIAN PRACTICE STANDARDS AND LICENSURE 1 (2017), <https://utn.org/resources/downloads/50-state-telemedicine-gaps-analysis-physician-practice-standards-licensure.pdf>.

¹³⁴ *Id.*

¹³⁵ *Id.* at 9.

¹³⁶ Schumacher, *supra* note 125, at 422.

¹³⁷ THOMAS & CAPISTRANT, *supra* note 133, at 6.

¹³⁸ *Id.* at 8.

prescription of medicine through telemedicine.¹³⁹ Although the federal government regulates remote online prescribing via the Ryan Haight Online Pharmacy Consumer Protection Act of 2008 (“Ryan Haight Act”), state laws providing greater restrictions for online prescribing are not preempted by the federal law.¹⁴⁰

State regulation of telemedicine has resulted in a patchwork quilt of regulations across the nation.¹⁴¹ Physicians interested in practicing telemedicine in more than one state bear the heavy burden of complying with various and, in some situations, incongruent state laws.¹⁴²

3. Malpractice Uncertainty, Variability, and Liability Insurance

In the event a state does not have telemedicine specific legislation, existing state malpractice case law, tort law, and civil procedure will apply to telemedicine malpractice cases.¹⁴³ State malpractice laws can vary in regards to standards of care, statutes of limitation, informed consent requirements, arbitration requirements, and damage caps, among other things.¹⁴⁴ State law variances limit the predictability of loss allocation and the effectiveness of risk management.¹⁴⁵ Additionally, because few telemedicine malpractice cases have been litigated, there is very little case law from which to draw guidance.¹⁴⁶ There is also little guidance at both the federal and state level regarding jurisdiction and choice of law when the provider and patient live in different

¹³⁹ Romney & Baird, *supra* note 25, at 33.

¹⁴⁰ Alexis S. Gilroy & Nathaniel M. Lacktman, *Hot Topics in Telemedicine 2016: Payment Policy, Prescribing, and Practice Standards*, AM. HEALTH LAW. ASS’N SEMINAR PAPERS, June 27, 2016, at 10.

¹⁴¹ Carl F. Ameringer, *State-Based Licensure of Telemedicine: The Need for Uniformity but Not a National Scheme*, 14 J. HEALTH CARE L. & POL’Y 55, 69 (2011); Wynter K. Miller, Note, *Trust and Anti-Trust: State-Based Restrictions in Telemedicine*, 50 U.C. DAVIS L. REV. 1807, 1829 (2017).

¹⁴² Laura Wibberley, *Telemedicine in Illinois: Untangling the Complex Legal Threads*, 50 J. MARSHALL L. REV. 885, 889 (2017).

¹⁴³ Kepler & McGinty, *supra* note 117, at 17.

¹⁴⁴ *Id.* at 21.

¹⁴⁵ *Id.*

¹⁴⁶ Bradley J. Kasper, Note, *Legislating for a New Age in Medicine: Defining the Telemedicine Standard of Care to Improve Healthcare in Iowa*, 99 IOWA L. REV. 839, 849 (2014).

states.¹⁴⁷ Uncertainty regarding malpractice liability causes many physicians to fear utilizing telemedicine to its full potential.¹⁴⁸

The availability of malpractice insurance is another barrier to the expansion of telemedicine. Not all medical malpractice insurance plans cover telemedicine services.¹⁴⁹ Furthermore, most insurance companies do not offer multi-state medical malpractice coverage.¹⁵⁰ Therefore, physicians who want to practice interstate telemedicine may have to purchase multiple malpractice insurance policies to ensure coverage for the use of telemedicine.¹⁵¹

Further complicating matters is the fact that each state has its own insurance code with specific laws and procedures regarding medical liability insurance coverage.¹⁵² Many states have statutes barring medical malpractice insurers from selling insurance across state lines without a license to sell insurance or some other permission.¹⁵³ Moreover, in states where “government administered funds have been set up for basic or excess professional liability,” coverage is often limited to services rendered in the state and frequently do not cover telemedicine services.¹⁵⁴

4. Solution: National Licensure and Federal Regulation of Telepsychiatry

The current regulatory framework stifles the expansion of interstate telemedicine by placing unreasonable administrative burdens upon practitioners who desire to practice telemedicine in more than one state.¹⁵⁵ In order for telemedicine to grow, the current state-based regulatory framework should be replaced by a uniform and centralized system run by the federal government.¹⁵⁶

The current laws and regulations governing the practice of medicine are reflections of the time in which they were drafted—a time when patients and physicians lived and worked within the same state.¹⁵⁷ When the practice of medicine was only a local activity, it made practical sense for the states to

¹⁴⁷ *Id.* at 848–49.

¹⁴⁸ *Id.* at 849.

¹⁴⁹ Kepler & McGinty, *supra* note 117, at 20.

¹⁵⁰ *Id.*

¹⁵¹ *Id.*

¹⁵² Gupta & Sao, *supra* note 106, at 397.

¹⁵³ *Id.*

¹⁵⁴ Kepler & McGinty, *supra* note 117, at 20.

¹⁵⁵ Zilis, *supra* note 103, at 213.

¹⁵⁶ Bill Marino et al., *A Case for Federal Regulation of Telemedicine in the Wake of the Affordable Care Act*, 16 COLUM. SCI. & TECH. L. REV. 274, 282 (2015).

¹⁵⁷ Hoffman & Rowthorn, *supra* note 24, at 5.

regulate it.¹⁵⁸ However, advances in medical knowledge and technology have changed the practice of medicine so that it is no longer a local activity restricted to a state's borders.¹⁵⁹ Health care is now a "global commercial activity."¹⁶⁰ For instance, because of technological advancements, not only can physicians treat patients remotely, patients can also travel across state and national borders to obtain medical treatment.¹⁶¹ Moreover, many health care providers work for or with national hospital chains or multi-state managed care companies.¹⁶² Because our health care system is no longer local in nature,¹⁶³ the current state-by-state regulatory framework is unable to handle the challenges of the modern health care industry.¹⁶⁴

While the practice of intrastate telemedicine does help create greater access to mental health care services, interstate telemedicine is what is really needed to improve the health care situation in the U.S.¹⁶⁵ In order for telepsychiatry to create greater access to psychiatric services to those most in need, psychiatrists must be able to practice across state lines without having to obtain licensure in every state in which they wish to practice.¹⁶⁶ To achieve this end, federal regulation and national licensure for the practice of telepsychiatry are needed.

Under a national licensing scheme, psychiatrists who want to practice interstate telepsychiatry could do so provided they have a national license to practice telepsychiatry.¹⁶⁷ The national license would be an additional and secondary medical license limited to the practice of interstate telepsychiatry. Psychiatrists would have to be licensed in their home states in order to apply for the national license. To protect patients from incompetent psychiatrists, only psychiatrists who are certified by the American Board of Psychiatry and Neurology and in good standing would be able to obtain the national license. Moreover, when psychiatrists' state medical licenses are revoked, their national licenses to practice telepsychiatry will also be revoked.¹⁶⁸

¹⁵⁸ Gupta & Sao, *supra* note 106, at 406.

¹⁵⁹ *Id.*

¹⁶⁰ *Id.* at 417.

¹⁶¹ *Id.*

¹⁶² *Id.*

¹⁶³ *Id.* at 405.

¹⁶⁴ *Id.*

¹⁶⁵ See Zilis, *supra* note 103, at 203.

¹⁶⁶ *Id.* at 213–14.

¹⁶⁷ See Schumacher, *supra* note 125, at 432.

¹⁶⁸ *Id.* at 433.

To implement this proposed national licensure scheme, a national licensing board would be created and charged with determining licensure criteria, collecting licensure fees, and determining any disciplinary matters involving the use of telepsychiatry.¹⁶⁹ The national licensing board would also inform state medical boards of any disciplinary matters brought before it, and, in turn, each state would report any state disciplinary action to the national licensing board.¹⁷⁰ Any issues regarding the traditional practice of psychiatry would continue to be handled by the psychiatrist's home state's medical board.¹⁷¹ Under this proposed licensing scheme, states would not lose any of their medical licensure revenue, which is often cited as the reason states are hesitant to support national licensure programs,¹⁷² because psychiatrists would continue to need a state medical license to practice both traditional psychiatry and telepsychiatry.

For a national telepsychiatry licensing scheme to succeed, uniform guidance and clarity regarding the practice of telepsychiatry are necessary. Therefore, in addition to adopting a national licensing scheme, Congress should also adopt legislation that (1) regulates the practice of interstate telepsychiatry and (2) preempts conflicting state laws. Because state law variation and uncertainty stifle the expansion of telemedicine, having one set of clear expectations will lead to greater certainty and ease the administrative burdens of having to comply with multiple state laws. In particular, Congress should clearly state the appropriate standard of care for interstate telepsychiatry and whether informed consent for telepsychiatry is required. Furthermore, to remove any doubt, Congress should adopt legislation that says telepsychiatry creates a patient-doctor relationship. Congress should also adopt legislation that addresses choice of law and jurisdiction.¹⁷³ Moreover, any federal law regarding the practice of telepsychiatry should preempt any conflicting state law as it relates to telepsychiatry. For example, the Ryan Haight Act should preempt state laws regarding the prescription of medicine via telepsychiatry. Having uniform legislation regarding the practice of interstate telepsychiatry should encourage more psychiatrists to incorporate telepsychiatry into their private practices.

The national telepsychiatry licensing scheme suggested in this Article is a realistic and practical approach to help create greater access to mental health services to those most in need. The licensing scheme proposed in this Article should receive congressional support for several reasons. First, one of

¹⁶⁹ *Id.* at 432–33.

¹⁷⁰ *Id.* at 433.

¹⁷¹ *Id.*

¹⁷² *Id.* at 432.

¹⁷³ *See* Gupta & Sao, *supra* note 106, at 434.

the benefits of the proposed licensing scheme is that it is narrowly tailored to address a nationwide problem and only applies to a specific group of physicians.¹⁷⁴ Under the proposed national telepsychiatry licensing scheme, states will maintain their revenue stream and their ability to protect their citizens from incompetent physicians within their borders.¹⁷⁵ Second, Congress should support the licensing scheme proposed in this Article because Congress previously supported a similar licensing scheme for the purpose of creating greater access to telemedicine for U.S. veterans.¹⁷⁶ The licensing scheme proposed in this Article should also receive the current Administration's support because the VA recently passed a rule granting physicians and other health care providers the ability to render treatment to veterans using telemedicine, regardless of the location of the patient and provider.¹⁷⁷ The VA's new rule makes it clear that the federal government is exercising its powers of preemption to override conflicting state licensure and state telemedicine laws.¹⁷⁸

Congress can use either its commerce powers or its spending powers to create a national telepsychiatry license and to regulate telepsychiatry.¹⁷⁹ Article 1, Section 8, Clause 3 of the U.S. Constitution grants Congress the power to regulate "[c]ommerce with foreign Nations, and among the several States, and with the Indian Tribes."¹⁸⁰ The provision of medical services has already been determined to be a form of commerce.¹⁸¹

In *United States v. Lopez*,¹⁸² the U.S. Supreme Court set forth three types of activities Congress can regulate using its commerce power.¹⁸³ Pursuant

¹⁷⁴ *Id.*

¹⁷⁵ *Id.* at 435.

¹⁷⁶ Jessica Davis, *Senate Passes VETS Act, Would Enable VA Providers to Offer Telehealth Across State Lines*, HEALTHCARE IT NEWS (Jan. 4, 2018, 12:52 PM), <https://www.healthcareitnews.com/news/senate-passes-vets-act-would-enable-v-a-providers-offer-telehealth-across-state-lines> (Both the Senate and the House passed slightly different versions of the VETS Act, which allowed V.A. providers to treat veterans using telemedicine across state lines.); Jessica Davis, *VA Finalizes Telehealth Rule to Let Providers Practice Across State Lines*, HEALTHCARE IT NEWS (May 11, 2018, 11:52 AM), <https://www.healthcareitnews.com/news/va-finalizes-telehealth-rule-let-providers-practice-across-state-lines>.

¹⁷⁷ Press Release, U.S. Dep't of Veteran Affairs, *VA Expands Telehealth by Allowing Health Care Providers to Treat Patients Across State Lines* (May 11, 2018), <https://www.va.gov/opa/pressrel/includes/viewPDF.cfm?id=4054>.

¹⁷⁸ *Id.*

¹⁷⁹ See Schumacher, *supra* note 125, at 439.

¹⁸⁰ U.S. CONST. art. 1, § 8, cl. 3.

¹⁸¹ Poma, *supra* note 68, at 94–95.

¹⁸² 514 U.S. 549 (1995).

to *Lopez*, Congress may use its commerce power to regulate (1) the channels of interstate commerce; (2) the instrumentalities, persons, or things in interstate commerce; or (3) those activities that substantially affect interstate commerce.¹⁸⁴ While telemedicine need only fit into one of the three *Lopez* categories to be federally regulated, telemedicine likely fits into all three *Lopez* categories.¹⁸⁵ First, when physicians transmit and receive medical information across state lines using telemedicine, telemedicine networks serve as the channels of interstate commerce.¹⁸⁶ Second, physicians become instrumentalities of interstate commerce when they use telemedicine to provide services to patients across state lines.¹⁸⁷ Third, telemedicine is currently a billion dollar industry¹⁸⁸ and, therefore, has a substantial effect on interstate commerce.¹⁸⁹

The U.S. Supreme Court has interpreted the Commerce Clause to mean Congress has the exclusive authority to regulate interstate commerce.¹⁹⁰ The Dormant Commerce Clause, while not expressly put forth in the U.S. Constitution, has been recognized by the U.S. Supreme Court to mean Congress can invalidate state laws that impede upon interstate commerce, even when those state laws concern areas that Congress has not yet acted upon or where there is no explicit federal law preemption.¹⁹¹ The Commerce Clause, therefore, can be used by Congress to regulate telepsychiatry, to preempt state licensure regulation, and to create a national license for telepsychiatry.¹⁹²

In addition to the Constitution's Commerce Clause, the Constitution's Spending Clause can also be used to create a national license for telepsychiatry and to preempt state law regarding the regulation of same.¹⁹³ Article 1, Section 8, Clause 1 of the U.S. Constitution sets forth Congress's spending power, which states that "[t]he Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defense and general Welfare of the United States."¹⁹⁴ Over the years, the

¹⁸³ *Id.* at 558.

¹⁸⁴ *Id.* at 558–59.

¹⁸⁵ Gupta & Sao, *supra* note 106, at 429.

¹⁸⁶ Matak, *supra* note 120, at 247.

¹⁸⁷ *Id.*

¹⁸⁸ Poma, *supra* note 68, at 79.

¹⁸⁹ Schumacher, *supra* note 125, at 437.

¹⁹⁰ Gupta & Sao, *supra* note 106, at 417.

¹⁹¹ *Id.* at 418.

¹⁹² *See* Schumacher, *supra* note 125, at 438.

¹⁹³ *Id.* at 437.

¹⁹⁴ U.S. CONST. art. 1, § 8, cl. 1.

Spending Clause has been broadly interpreted.¹⁹⁵ Congress has the discretion to determine what is in the U.S.'s general welfare.¹⁹⁶ Furthermore, Congress has the right to determine the terms and conditions for dispensing federal funds to the states.¹⁹⁷ In order to pass constitutional muster, however, a regulation drafted pursuant to the Spending Clause must: (1) advance the general welfare, (2) bear some relation to the spending program, (3) be clearly expressed to recipient states, and (4) be voluntarily to the states.¹⁹⁸ Therefore, Congress could implement a national licensure scheme for telepsychiatry pursuant to the Spending Clause, provided it conditioned the receipt of federal funds upon a state's voluntary adoption and implementation of the national licensure scheme.¹⁹⁹

The national licensure of telemedicine is not without its critics. Both the American Medical Association and the Federation of State Medical Boards oppose it.²⁰⁰ Critics of national licensure believe that the states are better equipped to protect their citizens from unqualified physicians.²⁰¹ Critics argue that because "health and safety issues have 'local peculiarities,'" states are best suited to regulate them.²⁰² However, this argument ignores the fact that medicine is no longer a local activity because medical knowledge is now able to transcend state boundaries.²⁰³ This argument also ignores the fact that state medical licensure only enables physicians to practice general medicine.²⁰⁴ State medical licenses are not specialty specific.²⁰⁵ National private specialty boards govern specialty practice.²⁰⁶

Critics of national licensure also argue that the Tenth Amendment of the U.S. Constitution gives states the exclusive authority to regulate health care.²⁰⁷ While the Tenth Amendment has been interpreted to mean that states

¹⁹⁵ Gupta & Sao, *supra* note 106, at 429.

¹⁹⁶ *Id.* at 431.

¹⁹⁷ *Id.*

¹⁹⁸ *Id.* at 430.

¹⁹⁹ See Schumacher, *supra* note 125, at 438.

²⁰⁰ Zilis, *supra* note 103, at 214.

²⁰¹ *Id.*

²⁰² Gupta & Sao, *supra* note 106, at 406.

²⁰³ *Id.*

²⁰⁴ *United States Medical Licensure Requirements*, U.S. MED. LICENSING EXAMINATION, <https://www.usmle-courses.eu/united-states-medical-licensure-requirements> (last visited Sept. 25, 2019).

²⁰⁵ *Id.*

²⁰⁶ Ameringer, *supra* note 141, at 67.

²⁰⁷ Gupta & Sao, *supra* note 106, at 413.

have the authority to police activities affecting the health, safety, and welfare of their citizens, this authority is not exclusive to the states.²⁰⁸ Historically, the U.S. Supreme Court has affirmed federal involvement in areas traditionally viewed as being under the states' purview when Congress has the concurrent right to regulate under its enumerated constitutional powers.²⁰⁹

Furthermore, the argument that health care and licensure are matters that have been exclusively relegated to the states ignores the fact that the federal government has been involved in the regulation of health care for years.²¹⁰ For instance, the Food and Drug Administration is a federal agency that administers a national policing system tasked with regulating drugs and medical devices for the purpose of protecting the public's health.²¹¹ Other examples of the federal government regulating health care include the Affordable Care Act²¹² and Medicare.²¹³ Furthermore, national medical licensing systems already exist for physicians employed by the VA, the U.S. Military, and the Bureau of Indian Affairs.²¹⁴

Some states have recognized the limiting effects that state licensures have on telemedicine and have created expedited licensing options, such as reciprocity and endorsement schemes, for physicians already licensed in one state.²¹⁵ Another pathway to multi-state licensure is the Interstate Medical Licensure Compact ("IMLC").²¹⁶ At least 29 states, the District of Columbia, and the Territory of Guam have joined the IMLC.²¹⁷ A state that opts into the IMLC agrees to implement an expedited licensing process for physicians who maintain medical licenses in other IMLC states and meet certain eligibility requirements set by the IMLC.²¹⁸ The licensure process is expedited because states in the IMLC agree to rely upon the verification and approval processes of other IMLC states.²¹⁹ If a physician's state of principal license is in the IMLC, the physician may—with the requisite approval—practice in any of the IMLC

²⁰⁸ *Id.* at 413–14.

²⁰⁹ *Id.* at 414.

²¹⁰ Marino et al., *supra* note 156, at 299–300.

²¹¹ Gupta & Sao, *supra* note 106, at 409.

²¹² Marino et al., *supra* note 156, at 302.

²¹³ Matak, *supra* note 120, at 245.

²¹⁴ Pierron Tackes, *Going Online with Telemedicine: What Barriers Exist and How Might They Be Resolved?*, 11 OKLA. J.L. & TECH. 80 (2015).

²¹⁵ Kepler & McGinty, *supra* note 117, at 10.

²¹⁶ *The IMLC*, INTERSTATE MED. LICENSURE COMPACT, <https://imlcc.org> (last visited Oct. 1, 2019).

²¹⁷ *Id.*

²¹⁸ *Id.*

²¹⁹ *Id.*

states.²²⁰ Physicians, however, must still pay the licensing fees for all of the states in which they practice.²²¹

The IMLC is not an adequate solution to the licensure problem plaguing the expansion of telepsychiatry. First, the decision to join the IMLC is voluntary.²²² States do not have to join the IMLC if they do not want to, and many states have not joined the IMLC, including New York and California.²²³ Furthermore, expedited licensing schemes do not eliminate the costs or the burden of having to go through the licensure process.²²⁴ Physicians applying through the IMLC are required to complete an additional application, pay an application fee, and undergo a background check.²²⁵ Additionally, under the IMLC, physicians must pay the licensing fees of every state in which they desire to practice.²²⁶ Furthermore, even though certain licensure schemes, such as the IMLC, may expedite the licensure process, physicians are still subjecting themselves to multiple jurisdictions and multiple board regulations.²²⁷

If this nation is serious about creating greater access to psychiatric care, it needs to lessen the burdens of practicing telepsychiatry across state lines; this can only be accomplished through national licensure and federal regulation. Although some states will likely balk at the concept of national licensure and see it as an attempt to infringe on their state police powers, this position can be overcome by the Commerce Clause and the Spending Clause.²²⁸

B. Reimbursement Policies as a Barrier to the Expansion of Telepsychiatry

While state licensure laws stifle the expansion of interstate telemedicine, the reimbursement policies of private and public payors limit the expansion of both interstate and intrastate telemedicine²²⁹ and, therefore, telepsychiatry. Although Medicare, Medicaid, and private health insurance

²²⁰ *Id.*

²²¹ *What Does It Cost?*, INTERSTATE MED. LICENSURE COMPACT, <https://imlcc.org/what-does-it-cost> (last visited Oct. 1, 2019).

²²² *The IMLC*, *supra* note 216.

²²³ *Id.*

²²⁴ Kepler & McGinty, *supra* note 117, at 10.

²²⁵ *What Is the Process?*, INTERSTATE MED. LICENSURE COMPACT, <https://imlcc.org/what-is-the-process> (last visited Oct. 1, 2019).

²²⁶ *Id.*

²²⁷ Kepler & McGinty, *supra* note 117, at 10.

²²⁸ Schumacher, *supra* note 125, at 431.

²²⁹ *Id.* at 425.

companies, the three main healthcare insurers in the U.S.,²³⁰ have recently begun to provide reimbursement for telepsychiatry services, their reimbursement remains limited, as each insurer conditions its reimbursement upon certain circumstances being met.²³¹ When insurers fail to provide adequate reimbursement for telemedicine services, providers lack the necessary incentive to provide telemedicine services.²³²

1. Medicare

Medicare provides federally funded and federally regulated health insurance for individuals over 65 years of age and individuals under 65 years of age with certain qualifying disabilities.²³³ According to 2015 data, approximately 16% of all health insured individuals have Medicare.²³⁴ Medicare limits reimbursement for telepsychiatry services in several ways. First, Medicare only provides reimbursement for certain approved telemedicine services and only when the patient receives the telemedicine service in an approved originating site.²³⁵ Approved originating sites include provider offices, hospitals, rural health clinics, federally qualified health centers, skilled nursing facilities, community mental health centers, and hospital-based or critical access hospital-based renal dialysis centers.²³⁶ Under Medicare rules, a patient's home is not an approved originating site.²³⁷ Second, Medicare only provides reimbursement for telemedicine services when the originating site is located in a Health Professional Shortage Area ("HPSA") or in a county that is outside of a Metropolitan Statistical Area ("MSA") as defined by the U.S. Census Bureau.²³⁸

²³⁰ Gupta & Sao, *supra* note 106, at 403.

²³¹ Deslich et al., *supra* note 8, at 6.

²³² *Telehealth and Medicare*, CTR. FOR CONNECTED HEALTH POL'Y, <https://www.cchpca.org/telehealth-policy/telehealth-and-medicare> (last visited Oct. 2, 2019).

²³³ *Medicare Program – General Information*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Medicare/Medicare-General-Information/MedicareGenInfo/index.html> (last visited Oct. 1, 2019).

²³⁴ Jessica C. Barnett & Marina S. Vornovitsky, *Health Insurance Coverage in the United States: 2015*, U.S. CENSUS BUREAU (Sept. 13, 2016), <https://census.gov/content/dam/Census/library/publications/2016/demo/p60-257.pdf>.

²³⁵ *Telehealth and Medicare*, *supra* note 232.

²³⁶ *Id.*

²³⁷ Schumacher, *supra* note 125, at 429.

²³⁸ *Medicare Program – General Information*, *supra* note 233.

2. Medicaid

Medicaid provides health insurance for qualifying low-income individuals and people with eligible disabilities.²³⁹ According to 2015 data, approximately 19% of all health insured individuals have Medicaid.²⁴⁰ While Medicaid programs receive both state and federal funding, each state administers its own Medicaid program.²⁴¹ Because each state administers its own Medicaid program, each state decides whether to provide reimbursement for telemedicine services.²⁴² Therefore, every state is free to condition or limit reimbursement for telemedicine services.²⁴³

Although Medicaid programs in all 50 states and Washington D.C. provide reimbursement for some form of live video telehealth services, many Medicaid programs condition their reimbursement upon certain factors being met.²⁴⁴ For example, as of September 2019, 23 states maintain reimbursement policies that restrict the type of facility that can serve as an originating site.²⁴⁵ Many Medicaid programs exclude the patient's home from serving as an originating site.²⁴⁶ Furthermore, some states condition reimbursement for telemedicine services upon providers adhering to heightened standards regarding privacy, informed consent, and care.²⁴⁷ Because states are free to decide whether to provide reimbursement for telemedicine services and if so, to what extent, wide variation regarding telemedicine reimbursement exists between the states.²⁴⁸

²³⁹ *Medicaid*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/index.html> (last visited Oct. 1, 2019).

²⁴⁰ Barnett & Vornovitsky, *supra* note 234.

²⁴¹ *Medicaid*, *supra* note 239.

²⁴² *Telemedicine*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/benefits/telemed/index.html> (last visited Oct. 1, 2019).

²⁴³ *Id.*

²⁴⁴ *State Telehealth Laws and Reimbursement Policies: At a Glance*, CTR. FOR CONNECTED HEALTH POL'Y (2019), <https://www.cchpca.org/sites/default/files/2019-05/50-State%20Infograph%20Spring%202019%20FINAL.pdf>.

²⁴⁵ CTR. FOR CONNECTED HEALTH POLICY, *STATE TELEHEALTH LAWS AND REIMBURSEMENT POLICIES: A COMPREHENSIVE SCAN OF THE 50 STATES AND THE DISTRICT OF COLUMBIA 9* (2019).

²⁴⁶ *Id.* at 8.

²⁴⁷ Kepler & McGinty, *supra* note 117, at 17.

²⁴⁸ *Id.*

3. Private Insurance Companies

According to 2015 data, approximately 67% of individuals with health insurance have private insurance policies.²⁴⁹ Only recently have private insurers begun to reimburse providers for telemedicine services.²⁵⁰ Private insurers that reimburse providers for telemedicine services either do so voluntarily or as a result of state legislation.²⁵¹ Currently, over half of the states in the U.S. have some type of private insurance telemedicine parity statute.²⁵² Full parity for telemedicine services is defined as reimbursement that is comparable to the reimbursement for traditional in-person services.²⁵³ However, many state parity statutes do not require full parity.²⁵⁴ Many state parity statutes often contain language that restricts and conditions reimbursement for telemedicine services.²⁵⁵ For example, some state telemedicine parity laws condition reimbursement on where the patient is located within the state.²⁵⁶ Other state parity statutes do not provide reimbursement for telemedicine services unless a patient-provider relationship existed prior to the telemedicine service.²⁵⁷ Although private insurance parity statutes are intended to create comparable coverage for telemedicine services, the reality is that they do not do so.²⁵⁸ Because the majority of individuals with health insurance are insured by private insurers, the lack of reimbursement parity by private insurers is a substantial barrier to the expansion of telemedicine²⁵⁹ and, therefore, telepsychiatry.

²⁴⁹ Barnett & Vornovitsky, *supra* note 234, at 1.

²⁵⁰ Carl Benjamin Lewis, Note, *Private Payer Parity in Telemedicine Reimbursement: How State-Mandated Coverage Can Be the Catalyst for Telemedicine Expansion*, 46 U. MEM. L. REV. 471, 481 (2015).

²⁵¹ *Id.*

²⁵² *State Policy Resource Center*, AM. TELEMEDICINE ASS'N, <http://www.americantelemed.org/main/policy-page/state-policy-resource-center#> (last visited Oct. 1, 2019).

²⁵³ Lewis, *supra* note 250, at 484.

²⁵⁴ *Id.*

²⁵⁵ *Id.*

²⁵⁶ *Id.* at 485.

²⁵⁷ *Id.* at 486–87.

²⁵⁸ *Id.* at 487 (citing Kirsten Rabe Smolensky, *Telemedicine Reimbursement: Raising the Iron Triangle to a New Plateau*, 13 HEALTH MATRIX 371, 382 (2003)).

²⁵⁹ *Id.* at 481–82.

4. Solution: Expand Medicare, Medicaid, and Private Insurance Reimbursement

In order to encourage more psychiatrists to offer telepsychiatry to their patients, Medicare, Medicaid, and third-party insurers need to cover traditional psychiatry and telepsychiatry in parity with one another.²⁶⁰ This means that telepsychiatry services should be reimbursed under the same conditions and at the same rate as traditional psychiatry services. Because state variation is a known barrier to the expansion of telemedicine, as previously discussed in this Article, it is essential that every state adopts the same telemedicine reimbursement policies.²⁶¹ Furthermore, because the majority of Americans are insured by private health insurance companies, it is imperative that all private health insurance companies provide reimbursement for telemedicine services.²⁶² Under the Tenth Amendment of the U.S. Constitution, each state has the ability to require private health insurance companies that do business in the state to provide reimbursement for telemedicine services.²⁶³

The current reimbursement policies regarding telemedicine deter both the provider and the patient from using it.²⁶⁴ Without proper reimbursement, provider-initiated telemedicine projects cannot grow or be sustainable for any length of time.²⁶⁵ Without proper financial motivation, psychiatrists are unlikely to stray from providing their services in the traditional face-to-face setting.²⁶⁶ Furthermore, patients are less likely to take advantage of telemedicine if doing so means paying for such services out of pocket.²⁶⁷

C. Privacy Concerns Are a Barrier to the Expansion of Telepsychiatry

Privacy concerns are another barrier to the proliferation of telemental health.²⁶⁸ Digital health breaches are on the rise.²⁶⁹ Computer files containing

²⁶⁰ Deslich et al., *supra* note 8, at 6.

²⁶¹ Lewis, *supra* note 250, at 473.

²⁶² *Id.* at 482.

²⁶³ *Id.* at 482–83.

²⁶⁴ Schumacher, *supra* note 125, at 425.

²⁶⁵ *Id.*

²⁶⁶ Michael A. Flaum, *When Will Telepsychiatry Reach Its “Tipping Point”?*, 68:12 PSYCHIATRIC SERVS. 1205, 1205 (2017).

²⁶⁷ Schumacher, *supra* note 125, at 425.

²⁶⁸ Sherman, *supra* note 27, at 1129–30.

²⁶⁹ Mark Lanterman, *Not What the Doctor Ordered: Security Concerns in Light of Evolving Health Technologies*, 17(4) J. HEALTH CARE COMPLIANCE 5, 8 (2015).

health information are particularly vulnerable to being breached or “hacked” because of the valuable information they contain, such as full names, dates of birth, and health histories.²⁷⁰ Hackers specifically target health information because it can be sold on the dark web and used to commit identity theft.²⁷¹ On the black market, medical information is believed to be ten times more valuable than a credit card number.²⁷²

Because patients are aware of the vulnerability of their health information, there has been a rise in “privacy protective behavior.”²⁷³ In an attempt to protect their privacy, patients give incorrect or incomplete health information or request that embarrassing information be omitted from their medical record.²⁷⁴ Because physicians require complete candor from their patients in order to render appropriate diagnosis and treatment, privacy protective behavior is very harmful.²⁷⁵

For telemedicine to reach its full potential, patients and providers must trust that the systems being used to deliver telemedicine services are protecting patient privacy and are being kept secure.²⁷⁶ The importance of patients feeling confident in the privacy and security of their personal information is all the more true for telepsychiatry because of the sensitive nature of the information that could be exposed by a data breach.²⁷⁷ Unfortunately, the current regulatory framework regarding the privacy and security of personal health information is ill-equipped to address telemedicine’s heightened security and privacy risks.²⁷⁸

1. The Current Regulatory Framework for Protecting Patients’ Privacy

The federal government has enacted several laws that were designed to protect the privacy and security of health information—specifically, HIPAA and the Health Information Technology for Economic Clinical Health Act of 2009 (“HITECH”).²⁷⁹ HIPAA provides general guidance regarding the privacy

²⁷⁰ *Id.* at 7–8.

²⁷¹ *Id.* at 8.

²⁷² Sherman, *supra* note 27, at 1130.

²⁷³ D’Arcy Guerin Gue & Steven J. Fox, *Growing Need for Data Standardization, Privacy Protection and Security*, GUIDE TO MED. PRIVACY & HIPAA 110, 112 (2015).

²⁷⁴ *Id.*

²⁷⁵ *Id.*

²⁷⁶ Joseph L. Hall & Deven McGraw, *For Telehealth to Succeed, Privacy and Security Risks Must Be Identified and Addressed*, 33 HEALTH AFF. 216, 216 (2014).

²⁷⁷ See Sherman, *supra* note 27, at 1118.

²⁷⁸ *Id.* at 1131.

²⁷⁹ Winnike et al., *supra* note 13, at 54–55.

and security of certain health information²⁸⁰ and instructs the Department of Health and Human Services (“HHS”) to create two comprehensive regulations, namely the Privacy Rule and the Security Rule.²⁸¹ In 2009, Congress passed HITECH in an effort to strengthen the privacy and security of patient information.²⁸² Most significantly, HITECH applied HIPAA’s privacy and security rules to the business associates of covered entities.²⁸³ HIPAA’s privacy and security protections preempt weaker state laws regarding the privacy and security of health information.²⁸⁴ States, however, are free to adopt laws that provide greater privacy and security protections.²⁸⁵ The Office for Civil Rights is tasked with enforcing the Privacy and Security Rules through voluntary compliance activities and civil money penalties.²⁸⁶

The Privacy Rule protects the privacy of all individually identifiable health information, in any form or media, that is held or transmitted by a covered entity or its business associate.²⁸⁷ The Privacy Rule sets forth how and when personal health information (“PHI”) can be used and disclosed.²⁸⁸ PHI is data that identifies the individual or provides a reasonable basis for identifying the individual and discloses (1) an individual’s past, present, or future mental or physical health; (2) an individual’s healthcare services; or (3) an individual’s past, present, or future payment for healthcare services.²⁸⁹ Individual identifiers include, but are not limited to, names, addresses, dates of birth, and social security numbers.²⁹⁰ Covered entities include, but are not limited to, health providers who transmit “health information in electronic form in connection with transactions for which the Secretary of HHS has adopted standards under HIPAA.”²⁹¹ Business associates are people or organizations that perform

²⁸⁰ *Id.* at 55.

²⁸¹ Sherman, *supra* note 27, at 1132.

²⁸² *Id.*

²⁸³ Winnike et al., *supra* note 13, at 57–58.

²⁸⁴ *Id.* at 58.

²⁸⁵ *Id.*

²⁸⁶ *Summary of the HIPAA Security Rule*, U.S. DEP’T HEALTH & HUM. SERVS., <https://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/index.html> (last reviewed by HHS on July 26, 2013).

²⁸⁷ *Id.*

²⁸⁸ *The HIPAA Privacy Rule*, U.S. DEP’T HEALTH & HUM. SERVS., <https://www.hhs.gov/hipaa/for-professionals/privacy/index.html> (last reviewed by HHS on Apr. 16, 2015).

²⁸⁹ *Summary of the HIPAA Security Rule*, *supra* note 286.

²⁹⁰ *Id.*

²⁹¹ *Id.*

certain activities for covered entities, and such activities involve using or disclosing PHI.²⁹² Whenever a covered entity engages the services of a business associate, the covered entity and the business associate must enter into a written business associate agreement.²⁹³ A business associate agreement must contain language regarding the confidential nature of PHI, as well as language instructing the business associate to implement certain privacy and security measures.²⁹⁴

The Security Rule implements the Privacy Rule as it pertains to PHI that is held or transmitted in electronic form (“e-PHI”).²⁹⁵ The Security Rule does not apply to PHI that is transmitted orally or in writing.²⁹⁶ In general, the Security Rule requires covered entities and their business associates to (1) protect the confidentiality, integrity, and availability of the e-PHI that they create, receive, maintain, and transmit; (2) identify and protect against reasonably anticipated threats to the security and integrity of e-PHI; (3) protect against reasonably anticipated impermissible uses and disclosures; and (4) maintain a compliant workforce.²⁹⁷ The Security Rule requires covered entities to adopt and implement reasonable and appropriate administrative, technical, and physical safeguard standards.²⁹⁸ The Security Rule recognizes that covered entities vary in size and resources, and therefore it does not dictate any specific administrative, technical, or physical safeguard measures.²⁹⁹ Furthermore, simply having technology in place that claims to be HIPAA compliant does not protect a provider from liability in the event of a security or privacy breach.³⁰⁰

The Security Rule requires that covered entities perform risk analysis’ so that they can determine which security measures are reasonable and necessary under their circumstances.³⁰¹ Standards with implementation specifications are identified as either required or addressable.³⁰² While required implementation specifications are mandatory, the Security Rule gives covered entities the ability to determine for themselves whether an addressable

²⁹² *Id.*

²⁹³ *Id.*

²⁹⁴ *Id.*

²⁹⁵ *Id.*

²⁹⁶ *Id.*

²⁹⁷ *Id.*

²⁹⁸ *Id.*

²⁹⁹ *Id.*

³⁰⁰ See LUXTON ET AL., *supra* note 19, at 36.

³⁰¹ *Summary of the HIPAA Security Rule, supra* note 286.

³⁰² *Id.*

implementation specification is reasonable and appropriate.³⁰³ Under the Security Rule, should a covered entity find an addressable implementation to be unreasonable and inappropriate, the covered entity may adopt alternative measures in order to achieve the purpose of the standard.³⁰⁴

Under the Security Rule, the use of encryption is an addressable implementation specification.³⁰⁵ Encryption renders data files useless and indecipherable to everyone that does not have the necessary password to unlock or de-scramble the data.³⁰⁶ Encryption can be used to protect both stored data and data that is in-transit.³⁰⁷

2. HIPAA and Its Progeny Are Insufficient to Protect Patients' Privacy

HIPAA fails to protect the privacy of telepsychiatry patients. For instance, HIPAA does not provide mental health records any special or additional protection, with the exception of psychotherapy notes.³⁰⁸ Under HIPAA, in order for psychotherapy notes to be released, patient authorization is always required, even for treatment purposes.³⁰⁹ However, stored video-conferencing sessions are not considered psychotherapy notes.³¹⁰ While HIPAA does not treat mental health records differently than other health records, each state has statutes that specifically address the privacy and security of mental health records.³¹¹ Some states even have statutes that address the privacy and security of records created as a result of telemedicine.³¹² “Because state laws regarding privacy and security are typically more stringent than HIPAA, they are not preempted.”³¹³ As previously discussed in this Article, state variation stifles the expansion of telemedicine because of the administrative burdens that it creates. Having to comply with both federal and

³⁰³ *Id.*

³⁰⁴ *Id.*

³⁰⁵ *Is the Use of Encryption Mandatory in the Security Rule?*, U.S. DEP’T HEALTH & HUM. SERVS., <https://www.hhs.gov/hipaa/for-professionals/faq/2001/is-the-use-of-encryption-mandatory-in-the-security-rule/index.html> (last reviewed by HHS on July 26, 2013).

³⁰⁶ Lanterman, *supra* note 269, at 9.

³⁰⁷ SEAN P. MURPHY, HEALTHCARE INFORMATION SECURITY AND PRIVACY 210–11 (2015).

³⁰⁸ Sherman, *supra* note 27, at 1133.

³⁰⁹ *Id.* at 1149.

³¹⁰ *Id.* at 1143.

³¹¹ *Id.* at 1144.

³¹² *Id.* at 1145.

³¹³ *Id.* at 1144–45.

state privacy and security standards is expensive, difficult, and time-consuming.³¹⁴

Furthermore, HIPAA's Security Rule also fails to protect the privacy of telepsychiatry patients.³¹⁵ While the Privacy Rule protects all forms of PHI, the Security Rule only protects e-PHI.³¹⁶ According to the HHS website, e-PHI does not include video conferencing.³¹⁷ The HHS website says that video conferencing is not e-PHI because the information being exchanged during a videoconference does not exist in electronic form before its transmission.³¹⁸ The preamble to the Security Rule also states that videoconferencing is excluded from the Security Rule's scope.³¹⁹ Interestingly, the body of the Security Rule does not specifically exclude videoconferencing from its definition of electronic media.³²⁰ However, based on the Security Rule's preamble and the HHS website, it appears as though the Security Rule does not apply to live telepsychiatry sessions because the data transmitted during a live telepsychiatry session does not exist in electronic form prior to its transmission.³²¹

However, even if the Security Rule was modified to protect live videoconferencing, the Security Rule would still be insufficient to protect patients' privacy because the Security Rule does not require the encryption of telepsychiatry sessions.³²² Because encryption is merely addressable and not required under the Security Rule, providers can avoid encrypting their computers by merely documenting why encryption is not reasonable or appropriate under the circumstances.³²³

3. Solution: Amend HIPAA Privacy and Security Rules

For telepsychiatry to create greater access to mental healthcare, HIPAA's Privacy and Security Rules must be amended to address the privacy

³¹⁴ Gupta & Sao, *supra* note 106, at 403.

³¹⁵ Sherman, *supra* note 27, at 1137.

³¹⁶ *Summary of the HIPAA Security Rule*, *supra* note 286.

³¹⁷ Sherman, *supra* note 27, at 1137 (citing *Does the Security Rule Apply to Written and Oral Communications?*, U.S. DEP'T HEALTH & HUM. SERVS., <https://www.hhs.gov/hipaa/for-professionals/faq/2010/does-the-security-rule-apply-to-written-and-oral-communications/index.html> (last reviewed by HHS on July 26, 2013)).

³¹⁸ *Id.*

³¹⁹ *Id.* at 1138.

³²⁰ *Id.*

³²¹ *Id.*

³²² *Id.* at 1139.

³²³ *Id.*

and security of videoconferencing in the context of telepsychiatry. For instance, the Security Rule should be amended to protect live videoconferencing sessions.³²⁴ There is no valid reason to exclude live videoconferencing sessions from the Security Rule.³²⁵ Merely amending the Security Rule to include live video-conferencing sessions, however, is not enough to protect patients' privacy. The Security Rule should also be amended to require encryption for all live and stored telepsychiatry sessions.³²⁶

To further protect the privacy of telepsychiatry patients, the Privacy Rule should be amended to require informed consent to store videoconferencing sessions.³²⁷ Additionally, the Privacy Rule should also be amended to require patient authorization to disclose telepsychiatry sessions for any reason, just as it is required for psychotherapy notes.³²⁸ Furthermore, because state variation stifles interstate telemedicine due to the administrative burdens that it creates, psychiatrists who provide telepsychiatry services should only have to comply with one set of privacy and security laws.³²⁹ Therefore, HIPAA should be amended to preempt any and all state privacy and security laws as they relate to telepsychiatry.³³⁰

In addition to amending HIPAA, organizations can minimize security risks by creating and maintaining a "culture of security."³³¹ To create a "culture of security," organizations should implement strong policies regarding passwords, encryption, mobile devices, software updates, downloading, and non-work related internet-surfing, among other things.³³² Organizations can also maintain a "culture of security" by educating themselves and their staff on the importance of data security and being sure to never place more emphasis on convenience than security. In fact, providing regular employee education programming is considered to be the most cost-effective security control that an organization can implement.³³³ Because even the best education programs cannot prevent every employee from violating an organization's privacy and security policies, a fair and consistent sanction policy is necessary

³²⁴ *Id.* at 1147.

³²⁵ *Id.*

³²⁶ *Id.*

³²⁷ *Id.* at 1149.

³²⁸ *Id.*

³²⁹ *Id.* at 1151.

³³⁰ *Id.* at 1150.

³³¹ Lanterman, *supra* note 269, at 9.

³³² *Id.* at 9–10.

³³³ Murphy, *supra* note 307, at 211.

to maintain a compliant workforce.³³⁴ Moreover, in order to minimize security risks, third-party vendors should be carefully vetted during the hiring process.³³⁵ Providers should also insist that all third-party vendor contracts include the ability to audit the vendor's compliance with privacy and security laws.³³⁶

IV. CONCLUSION

Telepsychiatry has the potential to provide quality mental health services to those desperately in need during a time when mental health professionals are in short supply.³³⁷ Unfortunately, the following barriers prevent telepsychiatry from reaching its full potential: (1) state regulation of the practice of telemedicine,³³⁸ (2) lack of reimbursement for telemedicine,³³⁹ and (3) privacy and security concerns.³⁴⁰ To remove these barriers, the federal government should create a national license to practice telepsychiatry and adopt comprehensive preemptive legislation regarding the practice of telepsychiatry. To encourage more psychiatrists to incorporate telepsychiatry into their practices, steps must be taken to make reimbursement for telepsychiatry less restrictive. Finally, in order for telepsychiatry to expand, patients must trust the privacy and the security of the technology that is being used.³⁴¹ Because HIPAA fails to secure the privacy and security of both stored and transmitted videoconferencing, amendments to HIPAA must be made.³⁴² Because of the stigma that still plagues individuals with mental illnesses, HIPAA should be further amended to provide additional privacy and security protections for telepsychiatry sessions.³⁴³

Clearly, something must be done in order to address the mental health situation in this country. The solutions regarding regulation, reimbursement, and privacy suggested in this Article are reasonable and practical because they are narrowly tailored to address a nationwide problem and will not have a drastic impact on state governance or state revenue. Perhaps the success that telepsychiatry is currently experiencing with veterans and the VA will help to

³³⁴ *Id.* at 212.

³³⁵ Lanterman, *supra* note 269, at 9.

³³⁶ *Id.*

³³⁷ Winnike et al., *supra* note 13, at 40.

³³⁸ *See supra* Section III.A

³³⁹ Myers, *supra* note 22, at 217.

³⁴⁰ Sherman, *supra* note 27, at 1120.

³⁴¹ *See id.* at 1118–19.

³⁴² *Id.* at 1153.

³⁴³ *See id.*

2019]

FUTURE CANNOT COME SOON ENOUGH

511

persuade the federal government to offer similar telepsychiatry services to the public. However, in order to expand telepsychiatry to the public, the way in which telepsychiatry is regulated must change. For the millions of Americans who suffer from mental illness and lack access to quality mental healthcare, the future cannot come soon enough.