

## PROPOSED LEGISLATION INCREASES OPENNESS IN AND ACCESS TO HEALTHCARE IN MAINE

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Good morning, Chairs Sanborn and Tepler and members of the committee.<sup>1</sup> I am delighted to testify on Maine’s proposed healthcare legislation—LD 1194 and LD 1007.<sup>2</sup> My name is Robert Graboyes, and I am a senior research fellow at the Mercatus Center at George Mason University, where my work focuses on how America can make healthcare as innovative in the next 30 years as information technology was in the past 30 years.<sup>3</sup>

In commenting on these two bills (and others), I offer the following takeaways:

1. LD 1194 and LD 1007 open multiple pathways for saving lives and improving health.
2. Reimbursement methodologies will be a significant challenge for policymakers going forward.
3. Increased options will reduce costs, but that doesn’t guarantee lower spending on healthcare.
4. How patients and providers will respond to innovations is unknowable in advance.

### LD 1194 AND LD 1007 OPEN MULTIPLE PATHWAYS FOR SAVING LIVES AND IMPROVING HEALTH

A technological revolution is sweeping across healthcare, offering opportunities to bring better health to more people at lower cost. The COVID-19 pandemic forced the healthcare system to test some new ideas, and the results have been heartening,<sup>4</sup> but this is only the beginning. The bills I will address today

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1. Portions of this testimony are adapted from recent testimonies delivered to the Arizona and Colorado legislatures. Robert F. Graboyes, “Proposed Telehealth Legislation Is a Positive Step” (Testimony before the Arizona House of Representatives, Committee on Health and Human Services, Mercatus Center at George Mason University, Arlington, VA, February 1, 2021); Robert F. Graboyes, “Telehealth Is Evolving Rapidly; Legal Definition and Reimbursement Methods Need to Evolve with It” (Testimony before the Colorado General Assembly, Senate Health and Human Services Committee, Mercatus Center at George Mason University, Arlington, VA, April 12, 2021).

2. Legis. Doc. 1194, 130th Leg., 1st Reg. Sess. (Me. 2021); Legis. Doc. 1007, 130th Leg. 1st Reg. Sess. (Me. 2021).

3. Some of my ideas on the issue are explained in Robert F. Graboyes, “Fortress and Frontier in American Health Care” (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, 2014).

4. Adam Thierer, “Reconsidering Technology during the COVID-19 Crisis,” *Discourse*, March 24, 2020.

are impressive in their breadth and put Maine in a good position to take advantage of new technologies as they appear.

LD 1194 (a) permanently welcomes out-of-state and recently retired physicians, physician assistants, and nurses (including osteopathic physicians and physician assistants) to care for Maine residents; (b) includes audio-only telehealth within the definition of telehealth; (c) allows advanced practice registered nurses to practice without supervision or collaboration; and (d) allows nurses to provide care via telehealth. LD 1007 (a) expands who may practice telehealth and how they may do so, (b) assures that the services provided by those practitioners will be reimbursable, and (c) explicitly includes asynchronous care within the definition of telehealth. All of these actions will expand Mainers' access to timely care.

Other bills are in play in the Maine legislature: LD 323, LD 333, LD 849, and LD 1361 also validate the use of audio-only telehealth.<sup>5</sup> LD 333 puts telehealth prescribing and in-person prescribing on relatively equal terms. LD 863 facilitates telepsychology across state lines.<sup>6</sup> LD 649 and LD 1361 enable out-of-state providers to offer their services to Mainers.<sup>7</sup>

Since 2016, two coauthors and I have produced the Mercatus Center's Healthcare Openness and Access Project (HOAP), which provides comparative data on each state's openness to telehealth and other aspects of healthcare.<sup>8</sup> Using early-2020 data, the project ranks Maine as having a relatively open and accessible healthcare system—18th out of the 50 states and the District of Columbia.<sup>9</sup> At the time that the ranking was performed, the state earned some of the top scores in the country in the areas touched by these bills—telehealth, professional licensure, and scope of practice. Maine has offered broad reimbursement for telehealth providers and relative freedom from telepresenter requirements. The state joined the Interstate Medical Licensure Compact in 2017. It has offered nurse practitioners, opticians, behavioral health providers, and pharmacists broad scope of practice. Executive actions undertaken during the emergency enhanced this openness. And these bills seek to make this enhanced openness permanent. (My coauthors and I have not updated our data or rankings since the pandemic began because of the constant COVID-19-related policy changes.)

Ease of licensure and greater autonomy for advanced practice registered nurses will enable localities to expand access to care. But my remarks here will focus on telehealth, which is especially valuable for those who have traditionally had difficulty receiving timely care. These include patients in rural communities, patients in inner-city communities, foreign-language speakers, people with limited mobility, those with busy schedules, those with childcare responsibilities, and anyone who has a health issue after hours or on weekends.<sup>10</sup> Even when in-person encounters are feasible, telehealth offers advantages, including reduced exposure to pathogens in waiting rooms and examining rooms, reduced no-shows for appointments, and greater patient compliance for treatment regimens (particularly with respect to psychological health).<sup>11</sup> For patients, telehealth dispenses with the time and stress of transit.

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5. Legis. Doc. 323, 130th Leg., 1st Reg. Sess. (Me. 2021); Legis. Doc. 333, 130th Leg., 1st Reg. Sess. (Me. 2021); Legis. Doc. 849, 130th Leg., 1st Reg. Sess. (Me. 2021); Legis. Doc. 1361, 130th Leg., 1st Reg. Sess. (Me. 2021).

6. Legis. Doc. 863, 130th Leg., 1st Reg. Sess. (Me. 2021).

7. Legis. Doc. 649, 130th Leg., 1st Reg. Sess. (Me. 2021); Legis. Doc. 1361, 130th Leg., 1st Reg. Sess. (Me. 2021).

8. Jared M. Rhoads, Darcy N. Bryan, and Robert F. Graboyes, "Healthcare Openness and Access Project 2020: Full Release," Mercatus Center at George Mason University, December 22, 2020, <http://www.mercatus.org/HOAP>.

9. Jared M. Rhoads, Darcy N. Bryan, and Robert F. Graboyes, "18 | Maine," Mercatus Center at George Mason University, December 22, 2020, <https://www.mercatus.org/publications/healthcare/18-maine>.

10. Robert F. Graboyes, "Telemedicine as Lifesaver — Ian Tong and Doctor on Demand," *InsideSources*, October 5, 2016.

11. Robert F. Graboyes, "Telepsychiatry — Serving the Underserved," *InsideSources*, October 9, 2018.

The following personal anecdote illustrates well the value of telehealth: In early 2021, I incorrectly thought I might be suffering a heart attack and took my first-ever ambulance ride. It proved to be a false alarm, but I spent a month experiencing intermittent symptoms and repeated blood-pressure spikes. I had just changed primary care physicians, the pandemic was still raging, and I didn't wish to expose myself to a doctor's waiting room. My new doctor was able to diagnose me remotely and change my medications—which immediately fixed the problem. This was all accomplished through telehealth consults and exchanges of texts. Though we have now established a warm relationship, my doctor and I have still never met in person.<sup>12</sup>

## REIMBURSEMENT METHODOLOGIES WILL BE A SIGNIFICANT CHALLENGE FOR POLICYMAKERS GOING FORWARD

As more providers and patients participate in telehealth, questions regarding reimbursement will arise. One of the daunting questions will be whether rigid parity undermines one of the great virtues of telehealth—the capacity to reduce unit costs of medical care. Telehealth doctors presumably have lower brick-and-mortar costs than in-office practices. And telehealth physicians with national range can ease localized shortages (during, say, a regional flu outbreak), effectively allowing communities across the country to share resources that are needed only during local peak-load-demand situations. (This was the justification for dropping barriers to interstate telehealth consults during the pandemic.)

I saw a reimbursement issue firsthand during my earlier-mentioned health crisis in January 2021. When helping me navigate my transitory health problem, my new primary care physician was reimbursed for two virtual visits lasting perhaps 15 minutes apiece. But she spent far more time over a four-week period on my case, communicating with me frequently via text message and doing administrative work. Whereas an attorney or accountant could bill for such uses of time, my doctor received no compensation for anything outside of the two virtual visits. When I asked her about it, she told me, “Under our current system, the only thing that generates income are in-person visits, virtual visits (some insurances aren't covering them) and some telephone visits. . . . I have to learn two mutually exclusive ways to understand my patient's conditions—one to help them and one to get paid.”<sup>13</sup>

As providers devise innovative means of communicating with patients, state governments and the federal government will be challenged to set payment methods that compensate for the time and effort of healthcare providers in ways that help patients get well.

LD 1007 establishes reimbursement for telehealth at parity with in-office encounters—similar to what the Centers for Medicare and Medicaid Services adopted on an emergency basis in August 2020.<sup>14</sup> I recommend that some consideration be given to a more flexible reimbursement policy for telehealth encounters. In a recent release of the Healthcare Openness and Access Project,<sup>15</sup> my coauthors and I write the following: “We take it as beneficial that in some states Medicaid will pay for telehealth. But [payment] parity itself is problematic. One argument for telehealth is that it is less costly than traditional office visits. Therefore, if Medicaid pays the same amount for both, it may be depriving telehealth practices of the ability to compete on the price dimension to push costs downward.”<sup>16</sup>

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12. In fact, we may never meet, given that the US Army just transferred her husband to a base in Hawaii and that she will soon follow.

13. Web portal message from physician to author, February 18, 2021.

14. Susan Morse, “CMS Proposes Telehealth Changes under Trump Executive Order,” *Healthcare Finance*, August 4, 2020.

15. Web portal message from physician to author, February 18, 2021.

16. Jared M. Rhoads, Darcy N. Bryan, and Robert F. Graboyes, “Healthcare Openness and Access Project 2020: Full Release” (project overview, Mercatus Center at George Mason University, Arlington, VA, December 2020), 9.

It would be worthwhile to consider, in lieu of rigid parity (i.e., telephysicians being paid the same as in-person physicians), whether a more flexible version of parity might be in order. For example, telephysicians could be allowed to charge *up to the level of* parity but could, if costs of provision were lower, charge less in order to expand market share. Reference-based pricing and reward-based programs have the potential for introducing cost savings and price competition.<sup>17</sup> With reference-based pricing, payers agree to pay up to a certain price but possibly less. With reward-based programs, patients receive direct financial benefits for using lower-cost providers.

## INCREASED OPTIONS WILL REDUCE COSTS, BUT THAT DOESN'T GUARANTEE LOWER SPENDING ON HEALTHCARE

I am confident in predicting that more telehealth, broader scope of practice, and more welcoming licensure laws will reduce costs. A physician examining a patient from a laptop at home is not paying for the same level of office space as a physician examining a patient in an office. A 24-hour clock for telehealth services means that assets aren't idle for two-thirds of each day. Communities across America can share the cost of physicians who stand ready to absorb a sudden increase in demand that hits a particular community during, say, a flu epidemic or natural catastrophe. And the opportunity for earlier intervention will help stave off expensive situations.

But this doesn't mean America will spend less on healthcare. To understand why, one can think of information technology. In the 1950s, the computing power of an iPhone would in theory have cost trillions of dollars. In 1983, I purchased a Kaypro II portable computer whose internal memory was 64KB—not nearly enough memory to hold the PDF document containing this testimony. The Kaypro cost me around \$5,000 in today's dollars. The Windows Surface laptop on which I am composing this testimony cost me perhaps \$2,000, and its memory is roughly 250,000 times greater than the Kaypro's. And my Surface is vastly faster than the Kaypro was. The price of computing power has probably dropped further and faster than any other good in human history. And yet, Americans are not spending less in 2021 on electronic devices than they did in 1983. They just get unimaginably more bang for each buck they spend.

I'm confident that telehealth in 2046 will be as different from today's telehealth as an iPhone X is from a mid-90s flip phone. I just don't know how—and neither does anyone else. Perhaps Americans will be able to spend less on healthcare and more on other things. Alternatively, with quality improvements in healthcare, Americans may decide to spend even more on their health than they do today. No one knows—and no one can.

If Maine is like Montana,<sup>18</sup> then Maine's local physicians may fear that out-of-state doctors will snatch away some patients and revenue. (An article in the *New England Journal of Medicine* notes that this incentive is common among state licensing boards in general.<sup>19</sup>) I think this worry is exactly backwards. Maine's physicians may be the ones snatching away others' revenue because Maine is a more cost-effective place to live. A doctor living in Maine can do telehealth visits in New York or San Francisco just as easily as a New York or San Francisco doctor can. In fact, the lower cost of living, calm environment, and scenic beauty of Maine could make it a magnet for doctors specializing in telehealth. The bills we are discussing would position Maine very well in this context.

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17. Caroline Hroncich, "A How-To Guide for Reference-Based Pricing," *Employee Benefit News*, October 22, 2019.

18. Matt Volz, "The Boom in Out-of-State Telehealth Threatens In-State Providers," *Kaiser Health News*, March 15, 2021.

19. Ateev Mehrotra, Alok Nimgaonkar, and Barak Richman, "Telemedicine and Medical Licensure — Potential Paths for Reform," *New England Journal of Medicine* 384, no. 8 (2021): 687–90.

## HOW PATIENTS AND PROVIDERS WILL RESPOND TO INNOVATIONS IS UNKNOWABLE IN ADVANCE

I'm often asked to predict the future of healthcare innovation. How will doctors use telehealth in 5 to 10 years? How many people will use telehealth? How much care will be delivered virtually as opposed to in person? How much will Americans spend on virtual health?

Here's the problem with asking such questions: Imagine going back to, say, 2005, and asking people, "Would you like an app that will summon a total stranger to your house to give you a ride? Or how about another app that will enable you to sleep in another complete stranger's house somewhere in the world?" For most people, those ideas might have been horrifying, and yet, within five years, Uber and Airbnb radically changed how people travel and where they sleep. In 2016, after experiencing a one-time episode of cardiac arrhythmia, I purchased an AliveCor Kardia device that enabled my cellphone to administer an electrocardiogram in 30 seconds and diagnose the condition of my heartbeat.<sup>20</sup> Dave Albert, the Oklahoma doctor who invented the device, came up with the idea in the 1990s, and engineers told him it was impossible. In 2007, he saw Steve Jobs introduce the iPhone and immediately thought that this new phone might make his idea feasible. Engineers told him the answer was still no, but he insisted that they try—and they succeeded. (My \$99 device has kept me out of the emergency room several times, thereby saving me and my insurer thousands of dollars.)

In December 2019, plenty of doctors and patients still swore that they would never do medical examinations through an iPad. The novel coronavirus changed all that so that, by midsummer 2020, doctors were seeing patients via telehealth 50 to 175 times as often as they were a mere six months before.<sup>21</sup> The McKinsey Report offering that datum suggests that in the future, "Approximately \$250 billion—or ~20%—of all Medicare, Medicaid, and Commercial OP, office, and home health spend, could potentially be virtualized." My hunch is that McKinsey's estimate grossly underestimates the potential of telehealth, particularly when one considers the addition of remote monitoring, artificial intelligence, and machine learning. In Rwanda, drones transport much of the country's blood supply—an approach that would work well with Maine's topography.<sup>22</sup>

Will people want more telehealth in the future? Apple CEO Tim Cook has said, "Our whole role in life is to give you something you didn't know you wanted. And then once you get it, you can't imagine your life without it."<sup>23</sup> The same will be true of telehealth if it is allowed to flourish—as Maine seems to be doing.

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20. AliveCor (website), accessed May 3, 2021, <http://www.alivecor.com>.

21. Oleg Bestsenyy et al., "Telehealth: A Quarter-Trillion-Dollar Post-COVID-19 Reality?," McKinsey & Company, May 29, 2020, <https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality>.

22. Robert F. Graboyes, Darcy Nikol Bryan, and John Coglianese, "Overcoming Technological and Policy Challenges to Medical Uses of Unmanned Aerial Vehicles" (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, January 2020); Robert F. Graboyes and Brent Skorup, "Medical Drones in the United States and a Survey of Technical and Policy Challenges" (Mercatus Policy Brief, Mercatus Center at George Mason University, Arlington, VA, February 2020).

23. Tim Cook, interview with Brian Williams, *Rock Center*, NBC, December 7, 2012, <https://www.youtube.com/watch?v=zz1GCpqqd-0A>.