

Telehealth in the Pandemic and Beyond: The Policies That Made It Possible, and the Policies That Can Expand Its Potential

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KEY TAKEAWAYS

Lawmakers have helped patients to access medical care more easily by temporarily lifting regulations on telehealth, leading to rapid growth in its adoption.

Telehealth gives patients who have few local providers more health care options and allows them to avoid waiting rooms and other contact while receiving care.

Policymakers should make the initial regulatory relief permanent and offer more reforms to encourage continued use and innovation.

The COVID-19 outbreak has ushered in an unprecedented acceleration in the use of telehealth services. Multiple health care systems and private telehealth companies have reported increases in use ranging from 100 percent to more than 4,300 percent since the pandemic began.¹ This was facilitated by policy changes when Congress, the Trump Administration, and individual states rapidly took several steps² to expand access to telehealth services by temporarily removing barriers to its adoption as part of the initial response to the pandemic. With this temporary regulatory relief, combined with strong consumer demand for remote health care services, the amount, and use of, telehealth services has grown rapidly as a result. Widespread patient satisfaction with telehealth during the pandemic³ suggests that many physician practices will continue to offer telehealth services

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beyond the pandemic. Continued reforms can build on this successful telehealth model and expand its potential for enhancing health care options through sustained innovation.

Telehealth is adjusting the focus of health care delivery in the U.S. to be more patient-centered, allowing patients to talk to doctors where and when they want to—supplemented by medical devices from home. Telehealth allows patients to get care from medical professionals remotely by phone or video, and to use medical tools at home, such as personal electrocardiogram (EKG) devices that connect to mobile phones.⁴ Telehealth helps patients to avoid crowded waiting rooms, where they may be needlessly exposed to other sick people. These features have made it an essential aspect of health care provision in the midst of the COVID-19 outbreak. Beyond the pandemic, telehealth can offer patients benefits over traditional care delivery methods: It allows patients to avoid taking the time to travel to and wait in a physical office; increases access to health care (especially helpful in locations with a shortage of physicians or specialists); and facilitates more routine monitoring of chronic health conditions.

Policymakers should build on these initial successes with further action to remove additional barriers to the adoption of telehealth services and continued innovation. Such actions should focus on freeing physicians to deliver care, and freeing patients to seek care remotely—with flexibility to use the most innovative technologies as they evolve, when clinically appropriate. Specifically, federal and state policymakers should foster continued adoption and lay the conditions for continued innovation in telehealth by:

- Making regulatory relief provided during COVID-19 permanent;⁵
- Updating payment reimbursement policies to emphasize flexibility over parity with traditionally delivered care;
- Encouraging both adoption and future innovation of telehealth by defining it in ways that emphasize medical-provider flexibility and discretion;
- Enabling patients to use telehealth easily by removing state and federal barriers that limit where patients can receive care; and
- Examining whether there is a need to update patient-data-privacy protections.⁶

Telehealth on the Rise before COVID-19

Prior to COVID-19, telehealth use and interest had been growing for several years. Use in non-hospital settings has surged in popularity, increasing by 1,393 percent from 2014 to 2018.⁷ The demand for care on the patient's terms, particularly outside of hospitals with a reduced risk of exposure to harmful bacteria and viruses, is strong.

This growth is tied to benefits for both patients and doctors. According to the 9th Annual Vitals Wait Time Report, over half of patients reporting limited access to medical care responded that they have left a doctor's office due to long wait times, a phenomenon that leads to lower patient-satisfaction with providers.⁸ Telehealth can address this problem by reducing the time that patients spend traveling to, and waiting in, a doctor's office while reducing the time that providers spend collecting patient records⁹ and preparing rooms between patient visits. According to a survey by Penn Medicine of almost 800 gastroenterology and hepatology patients, 67 percent of patients felt that their telemedicine appointment was "good/better" than traditional visits, with 96 percent saying they were "satisfied/very satisfied with medical care."¹⁰

In response to this demand, providers and insurers are adapting. As of 2019, over 90 percent of mid-size to large-size employers intend to offer, by the end of 2020, telemedicine in their employee health plans.¹¹ Seventy-six percent of hospitals are already offering at least one type of telehealth service.¹² With growing interest in the remote delivery of health care services, it is no surprise that 69 percent of physicians surveyed in the *Telehealth Index: 2019 Physician Survey* reported a willingness to use telehealth.¹³

The growth in use of telemedicine also was facilitated by policymakers who removed regulatory barriers to its adoption. In 2019, for example, 35 states finalized 54 regulations and passed 113 bills.¹⁴ Twenty-three states¹⁵ took the critical step of addressing medical-licensing regulations that limited patients to seeing only those doctors who were licensed to practice medicine in the state in which the patient is located¹⁶ (a clear relic of the pre-Internet era, made obsolete by technology that allows patients to meet with doctors remotely, regardless of location).

Telehealth and the COVID-19 Pandemic

The value of telehealth services during a pandemic is clear. They enable patients to seek care and use clinical-grade tools at home, such as remote EKGs or diabetes monitors, facilitating social distancing and avoiding

unnecessary visits by tracking and treating symptoms remotely—all of which reduce the risk of viral transmission for patients and medical staff and conserve masks and other personal protective equipment.

Patient use of telehealth services has grown rapidly during the pandemic at a wide range of facilities, with further growth expected. The number of Medicare beneficiaries using telehealth services during the pandemic increased 11,718 percent in just a month and a half.¹⁷ The *Harvard Business Review* reported that Boston Children’s Hospital “was doing more telemedicine visits during any given day in late March than it had during the entire previous year.”¹⁸ From March 25 to April 20, the Cancer Treatment Centers of America found an 80-fold increase in telehealth visits, and scheduled over 7,000 telehealth visits into June.¹⁹ Some providers and patients, especially in rural areas, do not have reliable Internet access, so they consult primarily by phone, without video. Use of remote glucose-monitoring devices saw significant growth, with analysts expecting market growth for the devices alone to reach mid-double-digits this year,²⁰ with the telehealth market as a whole expected to grow over 80 percent year over year.²¹

While many doctors are hearing positive feedback from patients,²² others are still adjusting to the new surge in demand. Providers are limited by the technology that they or their patients have available for use. Some patients do not have access to video calls, so some providers are conducting consultations primarily by phone.²³

Given this variation, policymakers would be wise to ensure that regulations provide medical providers maximum flexibility to use tools the provider thinks will serve their patients.

Policy Changes Enabling Telehealth Adoption as Part of the COVID-19 Response

As part of the response to the pandemic, policymakers moved to “clear out as many regulatory barriers standing in the way of access to telemedicine as possible.”²⁴ Key issues addressed include allowing patients to see doctors across state lines and from their homes, removing barriers to paying or reimbursing medical professionals who practice telehealth, and making it easier to access telehealth tools, such as those to monitor glucose levels remotely.²⁵

Making It Easier for Patients to See Doctors from Home and Across State Lines. Both federal and state policymakers took steps to remove regulatory barriers that made it harder for patients to see their doctors of choice from their homes. Congress allowed²⁶ the Centers for

Medicare and Medicaid Services (CMS) to temporarily lift the restriction that limits the delivery of telehealth to Medicare patients residing in rural communities, allowing Medicare patients across the country to receive telehealth services at home during the pandemic.²⁷ The CMS waived Medicare rules that prevented physicians who are licensed in one state from practicing telemedicine in another.²⁸ The agency lifted location requirements for telehealth reimbursement that required that the patient reside in a rural area and receive care at a specific health care facility. The CMS also encouraged states to reimburse medical professionals for telehealth services in their Medicaid programs, and noted the changes that states can make without obtaining federal approval.²⁹

All 50 states and the District of Columbia expanded access to telehealth services for either, or both, Medicaid and privately insured patients for the duration of the emergency, implementing changes to facilitate the ability of insurers to implement more widespread use of telehealth services among privately insured patients.³⁰ In one example, Minnesota’s legislature passed an emergency bill amending the state’s definition of telemedicine to categorize a patient’s home as an authorized “originating site” through February 1, 2021.³¹ Kansas, Florida, Missouri, Tennessee, and Vermont permitted physicians who are licensed out of state to offer remote services for Medicaid patients,³² while New Jersey expedited licensing for out-of-state providers.³³

Removing Barriers to Payment. Both private companies and policymakers made it easier to access telemedicine via private coverage, Medicare, and Medicaid.

Private Coverage. Private insurers expanded telemedicine services and provider networks for their beneficiaries, by waiving cost-sharing for visits conducted using specific telemedicine platforms. Congress, too, helped by amending the Internal Revenue Code to permit a “high-deductible health plan (HDHP) with a health savings account (HSA) to cover telehealth services prior to a patient reaching the deductible.”³⁴ Under current law, an individual can only make tax-free contributions to an HSA if he or she is: (1) covered by a qualified HDHP and (2) does not have other insurance that pays for expenses below the HDHP’s deductible. The CARES Act clarifies that those restrictions do not apply to instances where the HDHP, or other coverage, reimburses telehealth services before the enrollee reaches the HDHP’s deductible.³⁵

Medicare. The CMS issued several temporary reforms to expand telehealth access in Medicare, including by temporarily reducing or waiving cost-sharing for telehealth visits paid by federal health care programs. First, the CMS repeatedly updated the definitions of providers and services³⁶ that can offer telehealth services,³⁷ and announced that it is “changing its process [for adding

new services to the telehealth Medicare service list] during the emergency, and will add new telehealth services on a sub-regulatory basis, considering requests by practitioners now learning to use telehealth as broadly as possible.”³⁸

Second, the U.S. Department of Health and Human Services (HHS) changed its policies. Key steps here include authorizing Medicare to reimburse telehealth visits in lieu of in-person office, hospital, and other types of visits with a wide range of providers.³⁹ The CMS also decided to reimburse telehealth “at the same rate as regular, in-person visits,”⁴⁰ bundle payment for telemedicine services into pre-existing Medicare CPT codes for over 80 different medical services,⁴¹ and—based on reports from multiple medical organizations explaining that “[m]any patients, especially seniors, have access to phones but not video-enabled telehealth apps”—increased reimbursement rates for audio-only visits. Finally, the CMS stated that, for services performed during the pandemic, it will not audit reimbursement claims to ensure that a prior relationship existed between the provider and patient, a requirement during non-pandemic times.

Further, the HHS said that it will exercise its enforcement discretion and waive potential penalties for violations of federal patient privacy laws against health care providers that service patients through “widely available communications apps, such as FaceTime or Skype, when used in good faith for any telehealth treatment or diagnostic purpose, regardless of whether the telehealth service is directly related to COVID-19”⁴²—which allows providers to treat patients remotely using generally available software.

Medicaid. All 50 states and the District of Columbia issued temporary policy updates related to telehealth for Medicaid patients.⁴³ As of May 7, 2020, 48 states and the District of Columbia “issued guidance related to the expansion or reimbursement of telehealth services in Medicaid” while 38 states and the District of Columbia included guidance for audio-only Medicaid telehealth services.⁴⁴ Also as of May 7, 38 states and the District of Columbia are mandating payment parity for Medicaid telehealth services.⁴⁵ Washington State purchased a limited number of Zoom software licenses to allow physicians to help Medicaid patients access telehealth visits.⁴⁶

Other states took a narrower approach to temporary relief. For example, Indiana limits telemedicine for Medicaid patients to live video-only communication.⁴⁷ Maine requires that services be conducted in real time, and allows use of phone calls only when a video call is not possible.⁴⁸ Arkansas permits only live video and phone calls, and requires that physicians have access to a Medicaid patient’s personal health record.⁴⁹ These narrower approaches can limit a patient’s ability to see doctors in ways that work for both the patient and the doctor.

Enabling More Use of Remote Monitoring Devices. The U.S. Food and Drug Administration (FDA) issued guidance to manufacturers suspending the requirement that they obtain prior approval for hardware or software modifications that enhance the remote-monitoring capabilities of various non-invasive patient-monitoring devices. The guidance also allows manufacturers to market for home use some monitoring devices previously approved only for use in hospitals or other health care facilities. This guidance applies to types of devices and types of modifications that do not entail patient safety concerns, and for the duration of the current public health emergency.⁵⁰

What Policymakers Can Do Next to Remove Barriers to Long-Adoption and to Support Innovation

Telehealth is adjusting the focus of health care delivery in the U.S. to be more patient-centered, allowing patients to visit doctors where and when they want to—supplemented by medical devices at home. Its impact can improve the delivery of health care in the U.S. after the pandemic passes—if policymakers can get the regulatory conditions right. Absent action, temporary regulatory relief provided during the pandemic will revert to prior law, and patients will have to forego much of the increased telehealth flexibility they experienced during the pandemic. Moreover, the regulatory relief provided to date—while helpful—leaves some barriers in place that also should be removed as soon as possible in order to (1) help with the pandemic response, and (2) facilitate a permanent, clinically reasonable adoption of remote health care delivery.

As policymakers consider next steps, they should make temporary relief permanent, while looking ahead to the future with additional reforms. Policymakers should use flexible regulatory approaches to allow providers and patients to continue to use today's technologies and adopt new ones as innovators create them and doctors and patients find them to add value. Such an approach would be rooted in the recognition that America's medical professionals are among the world's best trained and America's medical device approval process is the world's gold standard. This approach would also facilitate continued innovation in telehealth, allowing greater adoption of existing tools that supplement a remote clinical visit by allowing patients who need chronic care to use devices at home to supplement remote visits. One can imagine, for example, a mother who fits a camera device to her phone to allow a doctor to see inside her child's ear remotely to check on an ear infection. The potential uses are wide ranging and will emerge over

time as patients and doctors work together to deliver care via telemedicine. No one can enumerate all of the possible uses at this time, and it is wise for policymakers to build flexibility into regulatory definitions of telehealth to allow health care providers to adopt new technologies as they become available and, in the case of devices, the FDA approves their use.

To advance these principles, federal and state policymakers should:

Update Reimbursement Policies and Allow Reimbursement-Rate Flexibility for Telehealth. Since telehealth is a rapidly evolving field with constant innovation in the development of new and better software, devices, processes, and clinical applications, the economics of telehealth will also be shifting at a rapid pace, and in ways that are currently unknowable for the foreseeable future. Consequently, policymakers need to ensure that providers and payers have sufficient flexibility to continually revise and update payment arrangements in response.

During the pandemic, the CMS has temporarily instituted reimbursement for telehealth “at the same rate as regular, in-person visits.”⁵¹ Multiple states have temporarily required equal reimbursement rates for telehealth services rendered to Medicaid and privately insured patients.

While payment parity for telehealth certainly incentivizes wider and quicker adoption, going forward, policymakers should take a more flexible approach to revising and updating reimbursement rates for telehealth services. Such an approach would take a middle ground between two approaches to this question, one which emphasizes paying less for care delivered via telehealth (on the theory that costs should be less because, for example, a doctor does not have to come into an office) and those that emphasize paying the same for care delivered via telehealth (on the theory that this will promote faster adoption).⁵² Policymakers’ goal beyond this immediate pandemic response should be to allow the space for health care providers and private payers to sort through these questions over time.

To advance this goal, policymakers could look to a model policy in Utah, which permits certain providers to request reimbursement from health plans covering public employees for “medically appropriate telemedicine services at a commercially reasonable rate.”⁵³ This reimbursement strategy is flexible and allows providers and payers to negotiate specific reimbursement amounts for different telehealth services to best serve individual patients.

Encourage Adoption of Existing Telehealth Tools and Future Innovation of New Telehealth Tools by Updating Definitions of “Telehealth.” Policymakers should pay particular attention to statutory and regulatory definitions, as the approach taken here will have significant ramifications for adoption and innovation, now and in the future.

Definitions continue to vary across states and the federal government, with some using more restrictive or flexible approaches. For example, while the CMS recognizes the form of telemedicine that includes automated diagnostic and management tools, known as asynchronous telemedicine, as an eligible form of care, not every state does—thereby preventing patients and doctors from easily adopting new technology as it emerges.⁵⁴

One such tool, Zipnosis, which includes an asynchronous form of telemedicine in its platform known as an “adaptive interview” that adjusts its diagnostic questions to patient responses in real time, saw a 3,600 percent increase in visits during the first 11 days of the pandemic in the United States. Of these visits, 88.2 percent were asynchronous and required only 1.5 minutes of clinical work per patient.⁵⁵ Usage could very well have been higher—with more patients benefitting—if regulations had allowed more people to engage. Other emerging tools that can improve treatment and save money are similarly caught in this regulatory catch-22.⁵⁶

The varied types of available telehealth services demonstrate that there is no one-size-fits-all solution for every patient or every disease. For instance, a virtual check-in consisting of a phone call may not be clinically appropriate or necessary for a certain patient, but a telehealth visit with real-time video and audio might be. Further, not every patient will need, or be suited for using, any given telehealth tool, but those who are should be able to work with their medical care provider to choose appropriate telehealth care treatments.

Rather than requiring that specific types of telehealth be reimbursed, state and federal policymakers should update definitions to be flexible and broad enough to allow physicians to choose options, as the technologies evolve, that will benefit an individual patient over the course of his disease diagnosis, treatment, and management. Such an approach would balance the need to adopt existing tools, while encouraging room for future innovation. Definitions should reinforce the patient–physician relationship to ensure that patients receive appropriate care. Building flexibility into definitions of telehealth would reduce the time that providers and patients have to wait in order to benefit from market-based innovation and competition that delivers the newest technologies with low-cost and high-value potential. Patients and providers should not have to wait for telehealth definitions to be updated, for example, before private and public insurance plans pay for the use of new devices that have obtained FDA approval.

Remove Barriers That Make It Hard for Patients to Receive Care at their Home or Other Locations of their Choice. Policymakers should eliminate requirements that prevent patients from receiving telehealth

services from the doctor of their choice at home or another place of the patient's choosing. These reforms would increase access to primary and specialty care for patients in both urban and rural areas. Policymakers should start by making the steps taken in this direction during the initial response to the pandemic permanent. Congress should make permanent temporary waivers (by CMS) of location requirements mandating that a Medicare patient be at a designated facility or in a rural area to receive telehealth services, as well as requirements that an in-person physician-patient relationship be established before telemedicine can be practiced by the physician. States also should review their laws and health care programs and permanently address any similar barriers.

Remove Barriers That Make It Hard for Patients to See Licensed Providers of Their Choice Remotely Across State Lines. While some steps have been taken to allow patients to see out-of-state providers remotely, federal and state rules governing out-of-state telehealth licensure need to be reformed to improve access and care coordination across state lines. Such reforms have the potential to help patients in areas with a physician shortage access care.⁵⁷ Additionally, the National Academy of Medicine found that many community hospitals would benefit from expert telehealth consults to support care for patients during the COVID-19 pandemic.⁵⁸

To start, policymakers should make actions taken during the pandemic permanent. Congress should codify the actions taken by the CMS under emergency authority that permit out-of-state physicians to see Medicare patients remotely. So, too, should the states that waived in-state licensure requirements for out-of-state physicians to practice telehealth.

Beyond this, state policymakers should also permit out-of-state physicians to offer telehealth services to Medicaid patients as well as to all privately and self-insured patients. One example is Georgia's approach, which grants a license to out-of-state telehealth practitioners licensed in other states.⁵⁹ Alternatively, Congress might consider permitting federal health care programs to reimburse participating providers for telehealth services in cases where the enrollee does not reside in a state where the provider is licensed.⁶⁰

Examine Whether There Is a Need to Update Patient Data Privacy Protections. Every medical provider is covered by federal law, the Health Insurance Portability and Accounting Act (HIPAA), which grants privacy protections to patients in the use of their health data. Written largely before the Internet age began, HIPAA does not explicitly include specific provisions related to telehealth. For the duration of the pandemic, the HHS chose to waive potential penalties for violations of federal patient

privacy laws against health care providers who service patients via “widely available communications apps, such as FaceTime or Skype, when used in good faith for any telehealth treatment or diagnostic purpose, regardless of whether the telehealth service is directly related to COVID-19.”⁶¹ While these platforms have security features to protect privacy, news reports suggest that providers and Members of Congress question whether these protections are sufficient, raising concerns both over privacy protection and whether providers could face future legal risks using these tools once the pandemic passes.⁶² If these concerns continue and escalate, they could jeopardize future use and adoption of telehealth services. Congress and the HHS should consider whether existing patient privacy laws and regulations need to be updated in order to accommodate the growth of telemedicine.

Conclusion

Temporary policy reforms implemented during the COVID-19 public health emergency have accelerated the adoption of telehealth. Going forward, federal and state policymakers should approach regulatory and statutory reform surrounding telehealth with the goals of enabling physicians and patients to conduct medical visits remotely, and of doctors using new innovations when clinically appropriate for an individual patient. Such changes will continue to help the U.S. health care system move toward a patient-centered footing—long after the pandemic has ended.

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Endnotes

1. Teladoc reported that visits more than doubled by April 15 from early March; Amwell reported a 158 percent increase in app usage nationwide and 650 percent increase in Washington state alone; 98Point6 reported a 200 percent increase in app usage since January, with one-third of all visits being COVID-19-related (according to the company); Zipnosis' telemedicine platform reported a 3,600 percent increase in use during the first 11 days of the outbreak in the U.S.; and NYU Langone reported an increase in urgent and non-urgent telemedicine care by 683 percent and 4,345 percent, respectively. See Heather Landi, "Teladoc Anticipates Q1 Revenue to Reach \$180M Boosted by Surge in Telehealth Visits," *FierceHealthcare*, April 15, 2020, <https://www.fiercehealthcare.com/tech/teladoc-anticipates-q1-revenue-to-reach-180m-boosted-by-surge-telehealth-visits> (accessed July 16, 2020); Alejandra O'Connell-Domenech, "Interest in Telemedicine in New York Grows During Coronavirus Outbreak," *amNY*, March 27, 2020, <https://www.amny.com/coronavirus/interest-in-telemedicine-in-new-york-grows-during-coronavirus-outbreak/> (accessed July 16, 2020); Kevin J. Ryan, "Telehealth Startups Rake in Money During the Pandemic," *Inc.*, April 17, 2020, <https://www.inc.com/kevin-j-ryan/telehealth-companies-venture-capital-funding-covid-19.html> (accessed July 16, 2020); Shaina Heberden, "COVID-19 Update: The Numbers Don't Lie," *Zipnosis Blog*, April 9, 2020, <https://www.zipnosis.com/blog/covid-19-the-numbers-dont-lie/> (accessed July 16, 2020); and NYU Langone Health, "Telemedicine Transforms Responses to COVID-19 Pandemic in Disease Epicenter," April 30, 2020 <https://nyulangone.org/news/telemedicine-transforms-response-covid-19-pandemic-disease-epicenter> (accessed July 15, 2020).
2. For example, the Coronavirus Preparedness and Response Supplemental Appropriations Act, enacted on March 6, 2020, allowed the Centers for Medicare and Medicaid Services (CMS) to temporarily lift the restriction that limits telehealth to Medicare patients residing in rural communities, allowing Medicare patients across the country to receive telemedicine using different tools at home during the pandemic. Through the Coronavirus Aid, Relief, and Economic Security (CARES) Act enacted on March 27, 2020, Congress temporarily allowed individuals with high-deductible health plans (HDHPs) to use health savings account (HSA) funds for telehealth services and other remote care services without first meeting the deductible. Additionally, all 50 states and the District of Columbia expanded access to telemedicine for either or both Medicaid and privately insured patients for the duration of the emergency, implementing similar changes in their Medicaid programs or modifying state laws that restricted the ability of insurers to implement more widespread use of telemedicine among privately insured patients. The Heritage Foundation's fall 2018 Graduate Fellow in Health Policy proposed many of these reforms in December 2018. See Stephanie J. Zawada, "Telemedicine: The Promise and the Performance," *Heritage Foundation Backgrounder* No. 3373, December 17, 2018, https://www.heritage.org/sites/default/files/2018-12/BG3373_0.pdf (accessed June 25, 2020), including updating telemedicine definitions, reimbursing telemedicine at the same rate as in-person visits, expanding licensing to allow out-of-state physicians to practice across state lines, bundling Common Procedural Technology (CPT) codes to include telemedicine, and allowing patients to use their HSAs for telemedicine before the high deductible is met.
3. Upon administering over 3.5 million telemedicine surveys during the pandemic, Press Ganey learned that "clinicians are successfully meeting patients' interpersonal communication needs in this new model." Press Ganey, "The Rapid Transition to Telemedicine: Insights and Early Trends," May 19, 2020, <https://www.pressganey.com/about/news/press-ganey-releases-landmark-telemedicine-report-revealing-new-consumer-insights-for-providers-to-meet-patients-evolving-needs> (accessed July 11, 2020).
4. "Telehealth" and "telemedicine" are technically different but often are used interchangeably. To the extent that differences are drawn, "telehealth" is generally a broader term that encompasses all forms of remotely delivered health care, including, for example, a patient using a medical device such as an EKG connected to his phone, or a doctor remotely monitoring a patient's health data. "Telemedicine" is a form of telehealth that refers to a visit with a health provider for the purpose of seeking health care using means, such as a phone call or video call. This *Backgrounder* uses the broader term "telehealth," consistent with recent U.S. congressional actions, while noting the importance of policymakers using definitions going forward that emphasize flexibility in interpretation rooted in an approach that trusts doctors and patients to work together to decide which treatments are clinically appropriate and desirable.
5. A group of 30 Senators from both parties recently asked Majority Leader Mitch McConnell (R-KY) and Minority Leader Chuck Schumer (D-NY) to do just this. See U.S. Senate, letter, June 15, 2020, https://www.schatz.senate.gov/imo/media/doc/Letter%20to%20leadership_CONNECT%20for%20Health%20Act_06.12.20.pdf (accessed June 28, 2020).
6. Telehealth tools can be accessed by phone or the Internet. Issues related to Americans' ability to access the Internet are outside the scope of this *Backgrounder*. For more on these issues, see Klon Kitchen, "Congress Must Act on 5G," *The Hill*, March 12, 2020, <https://www.heritage.org/technology/commentary/congress-must-act-5g> (accessed June 4, 2020).
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