REMARKS OF
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Thank you, Jonathan Linkous, for that kind introduction. Thank you also to the American Telemedicine Association for inviting me to participate in today's Federal Policy Summit.

Now with this audience of health care experts, I feel duty bound to begin by offering my credentials. I come from a family teeming with physicians. Count my father, father-in-law, brother-in-law, and sister-in-law among them. I am the lowly lawyer in the bunch. Over holidays when the table turns to talk of hospitals and HIPAA, I listen politely. But I admit that it is not my realm. Because I know in their mind, somewhere I took a wrong turn, headed for the legal life, and wound up in Washington.

But as good fortune would have it, I wound up at the Federal Communications Commission. That means day-in and day-out I have the privilege of a front row seat at the digital revolution. The opportunity to see the networks that are remaking our civic life and commercial life. The opportunity to see the connectivity that is changing the ways we reach out around the corner and across the world. It is also provides a prime vantage point to witness the ways that telemedicine can revolutionize healthcare.

So let me start by telling you what I have seen.

In California, I saw how pediatric urologist Dr. William Kennedy and his team at Packard Children's Hospital share their special expertise via video with patients many, many miles away.

In Alaska, under the leadership of Dr. Stewart Ferguson, I saw how village clinics well beyond the last road mile, so remote they can only be accessed by airplane—can nonetheless provide first-class care using a mix of broadband and store-and-forward technologies.

And back in here in Washington, at the Children's National Medical Center, Dr. Craig Sable and his team showed me how pediatric specialists in their hospital can treat and diagnose cardiac patients with broadband-enabled video links that reach across the country and in some cases, around the world.

Now California, Alaska, and the District of Columbia are very different places. The institutions I visited look different, feel different, and treat different populations. But they had something in common: sheer optimism about the power of telemedicine.

I share their optimism. Even better, the numbers clearly show that lots of others do, too. More than 10 million Americans directly benefited from telemedicine services last year. This is double what it was only three years ago. More than 5 million Americans had their medical images read remotely last year and 1 million Americans currently benefit from remote cardiac

monitoring for implantable devices. In hospitals, a full 10 percent of all intensive care mobile unit beds now use telemedicine in some form. More than half of the states have telestroke programs to help identify and administer time-sensitive treatment to stroke patients living in rural areas. Add to these numbers the tens of thousands of mobile health applications available on smartphones—and you quickly get the picture. Technology is changing the nature of medicine and the way it is practiced in communities in urban areas, rural areas, and everything in between.

With the cost of healthcare in the United States projected to be nearly $3 trillion this year, we should seize solutions that can reduce costs while also improving medical outcomes and patient care. Telemedicine is one of those solutions.

Data from across the country make this clear. Telemedicine programs in Virginia have reduced transport by 1.4 million miles per year. Staying home with remote monitoring devices means avoiding longer hospital stays and reducing costs. In New Mexico, the Hospital at Home program reduced costs by as much as 19 percent. But cost reduction, of course, is only part of the equation. Improved patient care is essential. So we should take note when the University of Virginia's High Risk Obstetrics Telehealth program reduced the incidence of preterm births by 25 percent. At the same time, this translates into real savings, considering the cost of an extreme preterm birth is typically more than $40,000 a week.

All of this is impressive. But the best is yet to come. Imagine telemedicine aggregating patients with rare diseases and linking them to specialists for treatment and participation in clinical trials. Imagine how it can help keep local bonds strong in rural communities by fostering aging in place. Imagine how it can facilitate the connection of patients to doctors that can meet specialized language or cultural needs. These things are within reach.

With all this promise, then, the question becomes what can we do to expand upon the current successes of telemedicine?

To answer this question, let me start with three things the FCC is doing. Then I want to veer a little further afield and talk about telemedicine beyond the FCC.

First, let's start with the obvious. Telemedicine solutions require access to high-capacity broadband networks. That's where the FCC comes in. This idea is not new or novel. In fact, Congress charged the FCC with assisting with deployment to rural health care providers back in the Telecommunications Act of 1996. Let's credit Congress with being ahead of the curve. Seventeen years ago, big broadband was in its infancy. Dial-up was our online destiny. You and I probably called the Internet the information superhighway. But Congress saw clearly that better networks can mean better care.

So in the years following passage of this law, the FCC had a rural health care support system in place. It provided remote hospitals and clinics with funds for advanced communications. The program was used modestly, and demand for support was well, weak. So over time we revised our policies at the margins, tweaked our paperwork. But demand did not budge. We knew telemedicine was powerful—and Congress had given us a job to do. Back to

the drawing board. So a few years ago we tested some big changes in a pilot program—and this past December we put a better version of them in place and made them permanent.

This is exciting. We have a new Healthcare Connect Fund that is part of the $400 million the agency makes available annually to rural health care providers through its universal service program. Under the program, eligible health care providers can apply to receive funding to cover 65 percent of the cost of either broadband services or health care provider-owned networks. Consistent with the law, eligibility is impacted by whether or not the health care provider is located in a rural area. But both non-rural and rural health care providers can be eligible for support if they apply as part of a consortium that has a majority of rural health care providers. This makes good sense. Linking rural and urban providers means more access to specialists. It means lower cost broadband services through bulk buying. It means less administrative expense.

We are proud of this new program and believe it is the start of something good. Funding for existing pilot program participants begins a few days from now on July 1. Funding for new applicants begins on January 1 of next year. I encourage you to learn more and participate. Then tell us your stories. We want to always be on guard for ways to improve this program.

Second, the FCC is taking note of how spectrum can be put to totally novel health care uses. Last year, the agency allocated airwaves in the 2360-2400 MHz band for Medical Body Area Networks, or MBANs. It sounds like science fiction, but by using small, low-powered sensors on the body, we can capture a wide range of physiological data. Information about blood pressure, glucose, oxygen concentration in the blood, and other medical metrics then can be sent along wirelessly to health care providers. This reduces the cost of patient monitoring. It frees patients from being tethered to a messy jumble of wires and devices both in the hospital and at home. It makes it possible for medical care that is more accurate, more patient-centered, and more preventative. But MBANs are only one example. Going forward, we need to continue to look for new ways spectrum-enabled activities can help improve health care.

Third, coordination. That sounds simple, doesn't it? But by my count, some 16 federal agencies have a role in shaping telemedicine policy. That is a lot of seats at the table and a lot of people at the party.

For our part, we are forging ahead at the FCC. We are locking hands and building bridges with our federal colleagues. For instance, we have been part of a working group with the Food and Drug Administration and the Office of the National Coordinator for Health Information Technology. Together, we are producing a report on an appropriate, risk-based regulatory framework for health information technology and mobile medical applications. We want to promote innovation, protect patient safety, and avoid the time-worn problem of regulatory duplication.

We also have coordinated so that our new Healthcare Connect Fund works in tandem with other federal initiatives. For example, the Affordable Care Act and the Health Information Technology for Economic and Clinical Health Act both emphasize the use of electronic health records. As a result, our Healthcare Connect Fund includes support for broadband connections

to off-site administrative offices and data centers, which in turn will support cloud-based electronic health records.

So there you have it. Three things we are doing at the FCC: a new Healthcare Connect Fund, a new focus on opportunities for enhanced care with spectrum, and a renewed commitment to coordinate. Three things that I hope will foster even better telemedicine in the days ahead.

But now I want to veer off a bit and describe something outside my bailiwick at the FCC. But it comes up in every single visit I have made to a major telemedicine facility—including in California, Alaska, and Washington. So here it goes.

We can strive to do great things with telemedicine, but we will cut its promise short if it is fenced in by state borders and old rules premised on local paperwork. States have played a large role in the regulation of our health care system and physicians. Indeed, today, 69 jurisdictions are involved in licensing doctors in the United States. Before the advent of telemedicine, the diagnosis, treatment, and care of patients almost always happened face-to-face. But what if it doesn't? After all, with telemedicine patients may receive treatment across state borders. This means medical professionals typically must comply with different licensing requirements in multiple jurisdictions.

But licensing rules are only part of the story. State by state, insurance reimbursement through Medicaid and private insurance companies vary based on state requirements. Moreover, malpractice laws also vary, so malpractice insurance must be procured at the state level. The added cost of compliance with so many individual state requirements can hinder the development of relationships across state lines. This can cut patients off from multistate and regional networks that can be both valuable and cost-effective. It can mean that however good and smart our programs are at the FCC, they will never reach their full potential.

Add to all this that under federal law, reimbursement for telemedicine services for Medicare patients is restricted to very limited circumstances. That means a great number of patients that could otherwise benefit from telemedicine are missing out. And without the promise of reimbursement for such a large segment of the patient population, this may keep many health care providers from embracing telemedicine at all.

What can we do about it?

For starters, I think we should study the Servicemembers' Telemedicine and E-Health Portability Act. It has helped streamline rules and foster the use of telemedicine across the country by allowing all Department of Defense doctors to practice in any location in the United States. Similar legislation has been introduced that would do the same streamlining for physicians from the Department of Veterans Affairs. I hope as we move forward we keep these efforts in mind. Because we need new ways to streamline cross-border licensing and practice protocols for telemedicine. We should identify what works at the national level—and why. In the meantime, we should encourage states to streamline their own requirements or form reciprocity arrangements to help their residents reap the real benefits of telemedicine.

But even with these challenges ahead, I am an optimist. There are simply too many good things we can accomplish with telemedicine. I even think my many relatives in medicine would agree. Because digitization, cloud computing, broadband ubiquity, and new wireless services are combining in such a potent way. We can seize this mix and make telemedicine an integral part of modern medicine. And in the process, we can save lives, enhance patient care, improve outcomes, and lower costs. That is an effort worth the fight—and I want the FCC to be a part of it.

Thank you.