STATEMENT OF
COMMISSIONER MICHAEL O'RIELLY

Re: *Promoting Telehealth in Rural America,* WC Docket No. 17-310.

I welcome this proceeding to update the Rural Health Care program. I have seen firsthand the role that the program can play in promoting the health and safety of Americans in some of the most remote parts of the country. One of my first trips as a new Commissioner was to Alaska, a telemedicine pioneer and hot spot by necessity. As I traveled to isolated villages accessible only by air, I saw health aides use what I've called "technology triage" to assess patients and forward relevant health information to larger facilities in regional cities and Anchorage. Through this connectivity, many patients can be montiored and treated remotely. At other times, the information is used to determine whether a patient needs to be air lifted for treatment as far away as Seattle, which can come at great cost and health risk to the patient. This is how I envisioned the program working, but it was powerful to experience it in person and I wish more of our good staff could have the same opportunity. For this reason, I remain cautious when suggestions are made to take funding from a portion of the U.S. that is unlike any other in our Union.

While that experience helped illustrate the benefits of the program, I have also had a chance to witness its shortcomings. For years, regulators and recipients complained that the program was underutilized, meaning it didn't spend every last dollar allowed under a set budget cap. Therefore, a prior Commission expanded the program to include broadband and marketed the heck out of it. Pushing dollars out the door quickly took precedence over cost-effectiveness and, not surprisingly, spending increased rapidly. To be sure, most of this funding has been used for the intended purposes – to provide discounted connectity to rural health care providers, improving access for more consumers. However, in some cases, it has been used to buy more capacity than what's actually needed, overbuild other rural providers, and connect sites that were not originally intended to be part of the program.

I implored the last Chairman to put a plan in place to address the spending increases, but my requests were ignored. Now, demand exceeds the cap and we are left playing catch up. However, that cannot be an excuse to spend more and reform later.

Fortunately, the Notice seeks comment on ways to root out inefficiencies and target support where it is needed most. Indeed, I am pleased to see cost-saving ideas from other programs included in this Notice. In particular, the item seeks comment on excluding certain expenses outright, examining whether services are "used and useful," and capping or limiting support that exceeds a specified threshold or reasonable comparability benchmark – issues I've spent a great deal of time on in the high-cost program. In fact, I think we are getting real close to announcing new limitations on the extraneous uses of ratepayer funding by rate-of-return providers. The item also seeks comment on prioritizing certain areas, including based on economic need, which sounds a lot like the means-testing concept that Commissioner Clyburn and I have urged the Commission to at least seek comment on in the high-cost program.

At the same time, the Notice does ask about increasing the spending cap above the current $400 million. I have several concerns with such an approach. As a threshold matter, it is my hope that improving program efficiency and targeting of the funds will obviate or at least decrease the need for more of it.

In addition, there seems to be an underlying assumption by some that the budget should be set based soley on health care demand. That's simply not the right approach. We are not a health care agency and we really aren't even part of that realm. What we do through the Rural Health Care program can help provide savings on the health care side, but we do not have insight into that nor do we recoup any of the savings to help offet our costs. Our job, according to the statute, is to provide a *discount* to

help make *already available service* more afforable. Funding new networks that potentially overlap and undermine existing infrastructure is expensive and can be wasteful.

We have to keep in mind that the federal universal service program is already authorized to spend approximately *$11 billion* per year. And, there is no shortage of requests for additional funding as recipients from each of the four programs have requested even more. Instead of looking holistically and finding the necessary offsets, the Commission has tended to increase funding at the expense of consumers.

It is time for the Commission to decide how much we reasonably and justifiably should take from ratepayers then set an overall budget for USF and individual program budgets accordingly. Just recently, some suggested that a separate Commission action was akin to a tax on consumers, but this actually is one, if not officially labeled as such. Hard working Americans and businesses are charged extra fees on their phone bills in order to fund these programs. There must be a limit on how much we are willing to take from them – no matter how meritorious the spending could be. So, let me be clear: I will be extremely reluctant to increase the budget of the Rural Health Care program in any final item without corresponding spending reductions elsewhere.

I thank the Chairman and staff for working with me to include additional questions on the impact of funding increases on consumers. I am also pleased that the Order makes clear that any price reductions undertaken by service providers to help address the current shortfall will be completely voluntary. I vote to approve.