OKLAHOMA CITY UNIVERSITY
LAW REVIEW

VOLUME 46 WINTER 2021 NUMBER 1

ARTICLE

HIPAA, TELEHEALTH, AND THE TREATMENT OF MENTAL ILLNESS IN A POST-COVID WORLD

J. Michael E. Gray*

The COVID-19 pandemic created an unprecedented test of the United States healthcare system's ability to provide telehealth services and the legality of doing so. It also presented new questions about the applicability of the HIPAA Privacy Rule. Access to and utilization of telehealth technology was already growing prior to March of 2020, but an almost overnight desire of both healthcare practitioners and patients to avoid in-person services triggered responses from the federal government and state governments to overcome legal and financial obstacles to providing remote services. This Article examines those governmental responses[1] and

* J. Michael E. Gray is Legislative & Policy Counsel at the Treatment Advocacy Center. He holds a J.D. from the Brandeis School of Law at the University of Louisville and has taught political science at Simmons College of Kentucky. This article is partially based on his presentation at the 2021 Zarrow Mental Health Symposium, hosted by the Mental Health Association of Oklahoma (MHAO). The author thanks JoBeth Hamon and the staff of MHAO. Lisa Dailey provided invaluable feedback on the first draft. The author also thanks Elizabeth Sinclair Hancq, Sabah Muhammad, Amy Lukes, and Kathy Day for their support and their general wealth of knowledge on the law and policy discussed in this article, as well as his family, for their infinite patience and support.

analyzes the likelihood of pandemic-era changes remaining in place once the crisis is over,[2] while also discussing the impact of HIPAA[3] and telehealth on a vulnerable population—people living with severe mental illness (SMI).

I. HIPAA AND THE PRIVACY RULE

In order to fully explain the effect of HIPAA on the treatment of SMI, as well as the interplay of the HIPAA Privacy Rule and telehealth during the COVID-19 pandemic, this section provides necessary background on the origins of the legislation, its intent, and its real-world implications. The Privacy Rule is the most impactful, but ironically least contemplated at its inception, piece of the Health Insurance Portability and Accountability Act (HIPAA). The intent behind the landmark legislation had little to do with privacy and more to do with the actual components of its acronym—portability and accountability of health insurance.[4]

By 1996, Congress believed that over 20 million Americans were in what it called "job lock"; they were trapped in a job because they would lose their health insurance if they changed employers.[5] In some cases employees were at risk of losing coverage altogether and in others they were unable to gain coverage under a new employer's plan because of a preexisting condition that either the employee or their immediate family member had contracted since their previous coverage began.[6] The portability of insurance coverage was therefore a priority for the legislators

1. *See infra* Part II.A (discussing a pandemic-era response to enforcement of the HIPAA Privacy Rule); *See infra* Part III (discussing federal and state changes to telehealth regulations and statutes in response to the pandemic).

2. *See infra* Part IV (assessing whether or not the changes discussed in earlier sections will continue after the national emergency has passed).

3. *See infra* Part II (providing background on the HIPAA Privacy Rule and its impact on mental healthcare).

4. Congressional floor debates over HIPAA's final passage were dominated by talk of portability and MSAs. *See* 142 CONG. REC. 21,220-21,237 (1996) (House debate); 142 CONG. REC. 21,481-21,510 (1996) (Senate debate).

5. 142 CONG. REC. 21,222 (1996) (statement of Rep. Roberts).

6. HIPAA did not fully address the problem of coverage for preexisting conditions. This was still a major point of debate in the buildup to passage of the Affordable Care Act in 2010. *See generally* Nathalie Huguet et al., *Prevalence of Pre-existing Conditions Among Community Health Center Patients Before and After the Affordable Care Act,* 32 J. OF THE AM. BOARD OF FAM. MED. 883 (Nov. – Dec. 2019) (noting the increase in covered patients with preexisting conditions after the Affordable Care Act).

who shepherded HIPAA through Congress.[7] In addition to portability, Congress also attempted to hold private health plans more accountable to their members by allowing small businesses to utilize group plans and creating a mechanism for establishing medical savings accounts (MSAs).[8]

HIPAA was bipartisan and became law[9] in the context of a politically tense period of United States history. Democratic President Bill Clinton was up for reelection and his eventual opponent in the general election, Senator Bob Dole of Kansas, was in a series of competitive state primaries while HIPAA was moving through Congress.[10] Dole was the Senate Majority Leader for all but the last two months of the lengthy negotiations for HIPAA's final language.[11] As Majority Leader, he had the ability to control the flow of legislation in the Senate, the authority to decide which

---

7. The principal legislators behind HIPAA were Sens. Nancy Kassebaum and Edward Kennedy. Brian K. Atchinson & Daniel M. Fox, *The Politics of the Health Insurance Portability and Accountability Act*, 16 HEALTH AFFS. 146 (1997). Rep. William Archer, then chair of the House Ways & Means Committee, was the actual sponsor and was the public face of the bill in the House. 142 CONG. REC. 21,220-21,221 (1996).

8. 142 CONG. REC. 21,484 (1996) (statement of Sen. Kennedy); 142 CONG. REC. 21,222 (1996) (statement of Rep. Roberts). MSAs generally are similar to health savings plans (HSAs), accounts into which individuals contribute and may withdraw funds to cover out of pocket healthcare expenses, usually with tax benefits. *See generally* Sherry A. Glied & Dahlia K. Remler, *The Effect of Health Savings Accounts on Health Insurance Coverage*, THE COMMONWEALTH FUND (Apr. 2005) (defining HSAs and discussing their impact on health insurance coverage and commenting on the short-lived MSA option created by HIPAA). During the legislative process that eventually passed HIPAA, Republicans argued that MSAs were a necessary aspect of expanding coverage and Democrats argued they were a "poison pill" (lobbying jargon for a legislative provision designed to eliminate a bill's chance of passage) intended to turn congressional Democrats and the White House against the bill. 142 CONG. REC. 21,214 (1996) (statement of Rep. Pallone); 142 CONG. REC. 21,484 (1996) (statement of Sen. Kennedy).

9. HIPAA passed the Senate by a vote of 98-0. 142 CONG. REC. 21,510 (1996). It passed the House by a vote of 421-2. 142 CONG. REC. 21,237 (1996).

10. The 1996 Republican primary races were somewhat closer than anticipated. Dole easily dispatched with competition from fellow United States Senators in the Iowa caucuses, but lost the New Hampshire primary to Pat Buchanan. Steve Forbes also remained in the primaries long enough to win two states before dropping out. *See* Marc Humbert, *Dole Dubs Himself 'Presumptive Nominee;' Buchanan, Forbes Dig In*, ASSOCIATED PRESS (March 8, 1996),
https://apnews.com/article/e25a397b985c04967269a940f7d583bf; Deborah Zabarenko, *Forbes Pulls Out But Not Defiant Buchanan,* IRISH TIMES (March 15, 1996).

11. Dole resigned his seat and thereby his leadership role in June of 1996 to focus entirely on his presidential campaign. Francis Clines, *Citizen Dole Bids Farewell to the Senate*, N.Y. TIMES (June 12, 1996), https://www.nytimes.com/1996/06/12/us/citizen-dole-bids-farewell-to-the-senate.html.

bills came to a vote, and the timing of those votes. Dole may have used HIPAA to sway primary voters, strategically moving it forward or stalling different committee votes to delay its passage.[12] Meanwhile, elected officials in both parties spent resources to make HIPAA appear as either a victory for underprivileged and uncovered individuals (Democrats) or a fiscally innovative way to solve a humanitarian problem (Republicans).[13] As with most politicized legislation, the truth was somewhere in between those two messages. To add more layers of political context, the Republican Party had taken control of Congress in the 1994 midterm elections and had defeated healthcare reform legislation—a priority of the Democratic White House—that was much more ambitious and had different overall aims than HIPAA.[14] Both parties needed a political victory in the form of an impactful healthcare law. Although the partisan trappings of the mid-1990s may pale in comparison to contemporary divisions on Capitol Hill, it was still noteworthy that any piece of truly bipartisan landmark legislation passed in 1996.[15]

Title II of HIPAA enabled the Department of Health and Human Services (HHS) to promulgate, *inter alia*, the Privacy Rule.[16] Its inclusion was likely a last-minute addition by Senator Christopher "Kit" Bond of Missouri, then-chair of the Senate Small Business Committee.[17] Despite

12. *See* 142 CONG. REC. 21,484 (statement of Sen. Kennedy) (alleging that Dole stalled the bill to gain favor with private insurers then agreed to move it for political reasons during the New Hampshire primary); Atchinson & Fox, *supra* note 7, at 148 (noting that Dole may have believed that killing the bill would improve his chances in the primaries).

13. *See* Judith Havemann, *President Signs Insurance Portability Bill Into Law*, WASH. POST (Aug. 22, 1996), https://www.washingtonpost.com/archive/politics/1996/08/22/president-signs-insurance-portability-bill-into-law/46ea70fe-50ee-4c17-8209-3f99045b123e/.

14. Clinton campaigned on healthcare reform in the 1992 general election and his administration prioritized the "Health Security Act" during the first two years of his first term. *See generally* Health Security Act, H.R. 3600, 103rd Cong. (1994). The Clinton plan would have mandated that most people living in the United States obtain health coverage and that no individual with coverage could be denied care. It was a nonstarter with Republicans and died in the House shortly before the midterm elections in November of 1994. *See* Christopher M. Johnson, *Who Broke Health Care? Inside Bill Clinton's Ill-fated Reform Plan*, WNYC NEWS (Dec. 14, 2017), https://www.wnyc.org/story/who-broke-healthcare-inside-bill-clintons-ill-fated-reform-plan/.

15. 142 CONG. REC. 21,510 (1996); 142 CONG. REC. 21,237 (1996).

16. *See* Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936; *See* the Privacy Rule, 45 C.F.R. § 160 (2021); §§ 164.102-.106 (2021); 164.500-.534 (2021).

17. *See* 142 CONG. REC. 21,502 (1996) (statement of Sen. Chafee); 142 CONG. REC. 21,485 (1996) (statement of Sen. Roth).

the main congressional focus on portability of health insurance, there was at least some concern among members that the growing capabilities of technology for data storage and transfer endangered the confidentiality of medical records.[18] The Office for Civil Rights (OCR) within HHS promulgated the rule with an effective date of April 14, 2003.[19]

A. Privacy Rule

The Privacy Rule prohibits the disclosure of an individual's protected healthcare information (PHI) by a "covered entity" without permission from the individual.[20] PHI is any information created, stored, or transmitted as part of providing healthcare to an individual[21] and covered entities include healthcare providers, health insurance plans, and healthcare clearinghouses.[22] OCR has the authority to levy fines against offenders.[23] However, there are significant and underutilized exceptions to the Privacy Rule's prohibitions and the punitive powers of OCR are, as enforced, relatively weak.

There are several exceptions to the Privacy Rule, but this Article will highlight and analyze two that directly impact the treatment of mental illness and other conditions. First, the Privacy Rule allows practitioners to disclose PHI in the case of an emergency situation if, "in the exercise of professional judgment," it is "in [a patient's] best interest" to do so.[24] This exception is highly underutilized in mental healthcare settings.[25] A typical

---

18. *See e.g.*, 142 CONG. REC. 21,504-21,506 (statement of Sen. Leahy).
19. *See* the Privacy Rule, 45 C.F.R. §§ 164.102-.106 (2021); §§ 164.500-.534 (2021).
20. 45 C.F.R. § 164.502 (1996). ("A covered entity or business associate may not use or disclose protected health information, except as permitted or required [by exceptions in this chapter.]").
21. 45 C.F.R. § 160.103 (1996).
22. *See id.*
23. *See* 45 C.F.R. §§ 160.400-.426. (2021).
24. 45 C.F.R. § 164.510(a)(3)(i)(B) (2021).
25. Months after promulgation of the Privacy Rule, a study found that 54 percent of practitioners were unclear as to what constitutes PHI and 95 percent apply privacy laws "conservatively." Tina Marshall & Phyllis Solomon, *Professionals' Responsibilities in Releasing Information to Families of Adults With Mental Illness*, 54 PSYCHIATRIC SERVS., no. 12, Dec. 2003, at 1622 (2003). Nearly two decades later, the experience of family members implies that practitioners have made little progress in correctly interpreting and applying the rule. *See e.g.,* Theresa Defino, *Families Detail Years of Anguish, Pain As They Plead for Changes to Privacy Rule*, HEALTH CARE COMPLIANCE ASS'N (July 9, 2021), https://www.jdsupra.com/legalnews/families-detail-years-of-anguish-pain-3909989/ (giving examples of public comments on changes to the Privacy Rule from family members

scenario in the treatment of SMI occurs when a family-member caregiver of an adult with SMI experiencing a psychiatric emergency seeks two-way communication with healthcare providers. Unless the family member has guardianship over the adult patient or some other legal agreement in place to circumvent the Privacy Rule, practitioners typically do not share PHI relevant to emergency treatment and stabilization of the patient's condition.[26] That lack of communication is problematic because families often possess information about their loved one's history that is highly relevant in medical decision-making, while clinicians possess information on the person's current psychiatric condition. The patient's prospects for effective treatment often depend on the unrestricted flow of information between those parties.[27] Practitioners can bring down this barrier to communication by invoking the "exercise of professional judgment" exception. It is either a lack of awareness on behalf of healthcare providers or a lack of understanding the language of the exception that is currently barring communication, lessening the standard of psychiatric care, and endangering patient lives.[28]

Another exception to the Privacy Rule allows practitioners to disclose PHI when such disclosure is "necessary to prevent or lessen a serious and imminent threat to the health or safety of [the patient] or the public."[29] Such disclosures must be "to a person or persons reasonably able to prevent or lessen the threat."[30] This exception is applicable in many

---

who care for adults with SMI).

26. Any "personal representative" of a patient may receive PHI from a practitioner. 45 C.F.R. § 164.502(g) (2021).

27. *See generally* E. FULLER TORREY, SURVIVING SCHIZOPHRENIA: A FAMILY MANUAL 254-58 (7th ed. 2019).

28. *See id.*

29. 45 C.F.R. § 164.512(j)(1)(i)(A) (2021). OCR is, at the time of this Article's writing, considering changing this language from, "serious and imminent threat," to, "serious and reasonably foreseeable threat." Proposed Modifications to the HIPAA Privacy Rule to Support, and Remove Barriers to, Coordinated Care and Individual Engagement, 86 Fed. Reg. 6446, 6477-78 (Jan. 21, 2021). These changes would reduce a significant barrier to effective treatment of SMI, assuming practitioners fully understand and appropriately apply the language. See the public comments submitted by the Treatment Advocacy Center for a more detailed explanation of the impact of the proposed changes on families impacted by SMI. TREATMENT ADVOCACY CENTER, *Treatment Advocacy Center's Submitted Comments to HHS on Changes to HIPAA Privacy Rule* (Feb. 17, 2021), https://www.treatmentadvocacycenter.org/fixing-the-system/features-and-news/4375-treatment-advocacy-centers-submitted-comments-to-hhs-on-changes-to-hipaa-privacy-rule (last visited Nov. 21, 2021).

30. 45 C.F.R. § 164.512(j)(1)(i)(B) (2021).

scenarios, but an illustrative example is when a practitioner, falsely believing they are restricted by HIPAA, fails to inform an adult patient's family that the patient has made threats against the family's lives while in a psychotic state. The patient is discharged, goes home, and harms their family.[31] A patient might also harm themselves because of practitioners' failure to disclose PHI during a mental health emergency.[32]

In light of those exceptions, the Privacy Rule does not prohibit mental healthcare providers from disclosing PHI to family-member caregivers in times of psychiatric crises. What it does instead is force practitioners to be careful and thoughtful with such disclosures. Applying both common sense—i.e., a defensible and logical reason to violate a patient's privacy and disclose PHI—and basic medical ethics—i.e., only disclosing PHI when it is in the best interest of the patient to do so—will prevent practitioners from committing egregious HIPAA violations and running afoul of OCR. Even when OCR levies fines for violators, it is rare and usually for reprehensibly large amounts of digitized data that is not properly stored or transferred.[33] OCR is unlikely to visit a practice or a hospital because a mental healthcare provider shared relevant PHI with a family-member caregiver. Furthermore, HIPAA contains no private cause of action; a patient could not successfully sue a practitioner for breach of the Privacy Rule, even if there were no codified exceptions to the rule.[34]

---

31. *See* TORREY, *supra* note 27, at 254.

32. Healthcare providers must understand their flexibility under this Privacy Rule, but the current wording of exceptions to the Privacy Rule is problematic. *See* Proposed Modifications to the HIPAA Privacy Rule to Support, and Remove Barriers to, Coordinated Care and Individual Engagement, 86 Fed. Reg. 6,446, 6,477-78 (Jan. 21, 2021).

33. *See e.g.,* Press Release, U.S. Dep't. of Health and Hum. Servs., Press Office, University of California Settles HIPAA Privacy and Security Case Involving UCLA Health System Facilities (July 7, 2011), http://wayback.archive-it.org/3926/20140108162127/http://www.hhs.gov/news/press/2011pres/07/20110707a.html.

34. Practitioner fears of being sued over HIPAA Privacy Rule violations are unfounded. The law contains no private cause of action and a simple violation, particularly an inadvertent one, will not land a healthcare provider in court. The times that Privacy Rule violations have been relevant in litigation involve egregious behavior and bizarre fact patterns. *See e.g.,* Shepherd v. Costco Wholesale Corp., 482 P.3d 390 (Ariz. 2021) (finding that although HIPAA contains no private cause of action, the lower court properly allowed the Privacy Rule to inform the standard of care in a negligence claim. A pharmacist filled a prescription for erectile dysfunction medication despite the fact that the plaintiff asked him not to. The plaintiff was in the process of reconciling with his ex-wife, who picked up his prescriptions, saw the erectile dysfunction medication, broke off their relationship, and

II. TELEHEALTH, MENTAL HEALTHCARE, AND HIPAA IMPLICATIONS

Telehealth is the use of technology to provide healthcare services when the practitioner and the patient are not in the same physical space.[35] Telehealth, or "telemedicine," has been around since at least the 1920s. Communications technology and data transfer technology developed rapidly during the twentieth century and telehealth expanded accordingly.[36] Although telehealth had been in use for decades, state legislatures began formalizing its practice in the late twentieth century to ensure compliance with practitioner licensing laws.[37] Furthermore, the federal government gradually facilitated telehealth by allowing billing under Medicaid and Medicare.[38] The increasing availability of email and video communications during the 2000s and 2010s led to expanded capacity for healthcare providers to offer services through telehealth, including for patients living with mental illness.

The potential for telehealth in mental healthcare is vast, but it has limitations. Some of those limitations are surmountable and others may not be. Most people with mental health diagnoses do not require regular

---

told multiple people about the prescription); Walgreen Co. v. Hinchy, 21 N.E.3d 99 (Ind. Ct. App. 2014) (finding defendant breached a duty of privacy when a pharmacist accessed and shared PHI of her husband's former mistress, who allegedly had been diagnosed with a sexually transmitted disease and lied about taking birth control. The pharmacist's husband shared the information with multiple people). For a less sensational example of a court allowing HIPAA violations to inform the standard of care in a negligence action, see Byrne v. Avery Ctr. for Obstetrics & Gynecology, P.C., 102 A.3d 32, (Conn. 2014). Note that an ensuing Alabama case clarified *Byrne* by restating that a plaintiff may not "bring a lawsuit directly under HIPAA." Ruggieri v. City of Hoover, 2018 U.S. Dist. LEXIS 123377, 14-15 (N.D. Ala. July 24, 2018).

35. This concise definition is the author's. Technical legal definitions of telehealth are cumbersome, but are discussed as necessary below. *See infra* Part III.B.

36. Thomas S. Nesbitt, *The Evolution of Telehealth: Where Have We Been and Where Are We Going?*, *in* THE ROLE OF TELEHEALTH IN AN EVOLVING HEALTH CARE ENVIRONMENT: WORKSHOP SUMMARY, INST. OF MED. OF THE NAT'L ACADEMIES 11, 12-13 (The National Academies Press 2012).

37. For example, states are still clarifying the requirements for establishing patient-practitioner relationships remotely, a major hurdle to establishing telehealth within a state. Absent clear authority to establish the relationship using telehealth platforms, the existence of that relationship and all of the following responsibilities of the practitioner are at best vague and at worst non-existent. *See infra* Part III.B.

38. Medicare Part B specifically covers many telehealth services. *See* 42 C.F.R. § 410.78(B). Federal Medicaid regulations do not differentiate between telehealth and in-person services.

inpatient treatment or other forms of intensive services.[39] For people with those conditions—e.g., adjustment disorder, generalized anxiety disorder, or other illnesses that do not present with psychosis—most of the services necessary for treatment and maintenance of their illnesses could be provided remotely.[40] However, patients with SMI—schizophrenia, schizoaffective disorder, bipolar disorder, severe major depression, and other psychotic disorders—often need periodic inpatient psychiatric treatment.[41] Effective treatment of SMI requires physical brick-and-mortar institutions with a full array of hospital resources that can only be administered in-person. These facilities must be staffed with practitioners who have training and experience in treating SMI.[42] In other words, telehealth alone cannot offer the necessary continuum of care to treat SMI because inpatient psychiatric facilities are part of that continuum.[43] That is not to say that telehealth technology has no place in the treatment of SMI. Many individuals living with SMI live at home, in the community, and only require intermittent inpatient care.[44] Telehealth can be used to provide

39. In 2019, 51.5 million adults in the United States had "any mental illness," *i.e.,* "a mental, behavioral, or emotional disorder." Mental Illness Statistics, NAT'L INST. OF MENTAL HEALTH, https://www.nimh.nih.gov/health/statistics/mental-illness_(last visited Nov. 11, 2021). At the same time, 13.1 million adults had "serious mental illness," which the National Institute of Mental Health (NIMH) defines as, "a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities." *Id.* This article focuses on yet another subset—people diagnosed with schizophrenia, schizoaffective disorder, bipolar disorder, severe major depression, and other psychotic disorders—comprising people in desperate need of psychiatric care.

40. These individuals fall into the NIMH category of "any mental illness." *See Mental Illness Statistics*, *supra* note 39.

41. Specifically, individuals with those disorders require inpatient treatment when they are "acutely ill." *See* TORREY, *supra* note 27, at 158.

42. Known within Medicaid parlance as an "institution for mental disease," an inpatient facility equipped to treat psychotic disorders "means a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services." 42 U.S.C. § 1396d(i).

43. "Continuum of care" is a broad term that mental healthcare professionals and advocates use frequently. It usually means a variety of services including but not limited to inpatient psychiatric facilities, outpatient services, housing support, integration of behavioral health and criminal justice solutions, and other services. It should include psychiatric care for individuals with mental illness at all levels of medical need. *See generally* Debra A. Pinals & Doris A. Fuller, *Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care*, TREATMENT ADVOC. CTR. 3 (Oct. 2017).

44. *See id.*

outpatient services to those individuals in the same or similar ways that it can be used to treat people with less debilitating mental health diagnoses.[45]

Mental health practitioners, like all healthcare providers, must follow the Privacy Rule when using telehealth technology just as they do when providing in-person care.[46] Although this may sound daunting to providers who are not technologically-inclined, many HIPAA-compliant telehealth platforms exist and are reasonably accessible for providers.[47] Healthcare practitioners are busy enough without having to also confirm that all their electronic platforms are HIPAA-compliant, but small practices without information-technology professionals on staff undoubtedly feel pressure not to violate the Privacy Rule. Those practitioners should always verify with OCR guidance that their platforms are indeed compliant.[48]

A. Telehealth HIPAA Exception to the Privacy Rule During the COVID-19 Pandemic

Four months after the first confirmed case of COVID-19 in the United States, the Department of Health and Human Services (HHS) announced that they would not enforce the Privacy Rule with respect to violations committed in the course of providing healthcare services using telehealth technology.[49] As long as the public health emergency (PHE) persists, or until HHS rescinds this rule, healthcare providers need not comply with the Privacy Rule when using telehealth platforms.[50]

---

45. *See* Alice Medalia et al., *Telehealth Conversion of Serious Mental Illness Recovery Services During the COVID-19 Crisis*, 71 PSYCHIATRIC SERVS. 872 (2020) (explaining the conversion of "recovery-oriented behavioral health services," *i.e.,* outpatient services at a New York clinic during the COVID-19 pandemic).

46. OCR is not enforcing the Privacy Rule with respect to telehealth platforms during the COVID-19 pandemic. *See supra* Part I.A.

47. For example, the Oklahoma State Medical Association provides free access to a HIPAA-compliant telehealth platform for its members. *See OSMA Member Benefit: Medici Connect*, OKLA. STATE MED. ASS'N, https://www.okmed.org/web/Online/Membership/Medici_Connect/Online/Member_Resources/Medici_Connect.aspx?hkey=b738e61a-8c3f-4505-a029-fb3496b6ef98 (last visited Oct. 31, 2021).

48. OCR issued guidance in October of 2020 listing examples of HIPAA-compliant telehealth platforms with some details and definitions of what they should include. *See FAQs on Telehealth and HIPAA During the COVID-19 Nationwide Public Health Emergency*, U.S. DEP'T. OF HEALTH & HUM. SERVS. (Oct. 2020).

49. 85 Fed. Reg. 22,024 (April 21, 2020).

50. This is not to say that practitioners should ignore the intentions of the Privacy Rule during the pandemic. Patient privacy is an important right whether or not OCR is enforcing

III. TELEHEALTH LAW AND THE COVID-19 PANDEMIC

The medical necessity to avoid close contact with people during the COVID-19 pandemic led to advances in telehealth technology and government support for expanded use of it. The federal government and state governments moved quickly to alter telehealth laws in order meet the rising demand for remote healthcare. Those changes are intended to reduce barriers to care through the expansion of services, but like all healthcare in the United States, the availability of services comes down to not just physical or digital access to healthcare practitioners, but also the source of payment. The question of who will pay for services must generally be answered before they become available.[51] Accordingly, the COVID-19 related changes to telehealth law discussed below are about requiring reimbursement by privately or publicly funded health plans as means to access services. The federal government has the ability to single-handedly allow reimbursement by Medicare. Medicaid is controlled by a combination of federal and state law.[52] Private insurance plans are mostly regulated by the states. This section discusses regulatory changes to federal law in the form of Medicare and Medicaid reimbursements and then statutory changes to state laws, using Oklahoma and Texas as case studies of legislatures expanding telehealth access.[53]

A. Federal Changes: Medicare and Medicaid

The Centers for Medicare and Medicaid Services (CMS) exercised emergency powers to extend coverage of many telehealth services in March of 2020. Many of those changes, which will remain in place for the

---

the rule.

51. The exception to this general rule is emergency room patients who do indeed have an emergency condition. Hospital emergency departments must stabilize those patients regardless of coverage or ability to pay. *See* 42 U.S.C. § 1395dd(b).

52. *See* 42 U.S.C. § 1396.

53. *See generally The Future of State Telehealth Policy*, NAT'L GOVERNORS ASS'N (2020) (discussing multiple aspects of telehealth law that have changed as a result of the COVID-19 pandemic). This article looks at two states that have taken different paths to enacting telehealth legislation and regulations. Broader surveys of the fifty states have been published on telehealth and related laws in recent months but a case study approach to Oklahoma and Texas allows a detailed legislative history that national studies have lacked. *See e.g.,* Mei Wa Kwong, CTR. FOR CONNECTED HEALTH POL'Y, *Executive Summary, in* STATE TELEHEALTH LAWS AND REIMBURSEMENT POLICIES, (Spring 2021), https://www.cchpca.org/2021/04/Spring2021_ExecutiveSummary.pdf.

duration of the PHE, became regulations in May of 2020.[54] Federal impact on the two programs varies greatly as does the likelihood of those changes remaining in place when the COVID-19 threat abates.

i. Medicare

Medicare began covering an array of telehealth services on March 6, 2020, under the authority of a Section 1135 waiver.[55] This waiver, granting CMS authority to suspend barriers to care during a national emergency, allowed reimbursement for some telehealth services during the COVID-19 pandemic. Medicare telehealth services fall into three broad categories.[56] First, "Medicare telehealth visits" are the type of general office visits that traditionally occur in person, e.g., checkups and examinations.[57] CMS required reimbursement parity for the duration of the pandemic and effectively waived the Medicare requirement that a practitioner-patient relationship be established in person prior to receiving telehealth services.[58] Second, "virtual check-ins" are brief interactions where a pre-existing practitioner-patient relationship exists, are synchronous (conducted in real-time), are unrelated to a medical visit in the previous seven days, and do not culminate in a medical visit in the ensuing twenty-four hours.[59] Third, "E-visits" are communications related to treatment through patient portals, i.e., not in real time and not necessarily answered or viewed for up to seven days.[60] Although CMS

54. *See* 85 Fed. Reg. 27,550 (May 8, 2020).

55. Section 1135 of the Social Security Act allows the HHS Secretary to waive federal restrictions on healthcare funding during national emergencies. 42 U.S.C. § 1320b-5; Press Release, Ctrs. for Medicare & Medicaid Servs., Medicare Telemedicine Health Care Provider Fact Sheet,
(Mar. 17, 2020), https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet (detailing the contents of the emergency expansion of Medicare authority during the early days of the PHE).

56. *See* Medicare Telemedicine Health Care Provider Fact Sheet, *supra* note 55.

57. *See* 42 U.S.C. § 1395m(m)(F)(i); *See* Press Release, *supra* note 55.

58. *See* Press Release, *supra* note 55 (announcing that CMS would not enforce this requirement during the PHE).

59. *See* 42 U.S.C. § 1395m(m); *Virtual Check-ins*, MEDICARE.GOV, https://www.medicare.gov/coverage/virtual-check-ins (last visited Nov. 21, 2021) (explaning virtual check-ins); Medicare Telemedicine Health Care Provider Fact Sheet, *supra* note 55.

60. *See generally* 42 U.S.C. § 1395m(m); *E-visits,* MEDICARE.GOV, https://www.medicare.gov/coverage/e-visits (last visited Nov. 21, 2021) (explaning e-visits); Medicare Telemedicine Health Care Provider Fact Sheet, *supra* note 55.

covered virtual check-ins and E-visits for all Medicare recipients prior to the pandemic, Medicare telehealth visits were only covered for people living in rural areas. CMS removed geographic limitations for the duration of the COVID-19 pandemic.[61]

Medicare, Telehealth, and SMI

The impact of Medicare telehealth coverage on mental healthcare is significant because of the program's historic ability to lead Medicaid and private insurers on long-term policy directives.[62] Medicare has a numerically inferior impact on the SMI patient population compared to Medicaid, but it does cover about a half-million people with SMI and another 1.2 million with mental health diagnoses.[63] Furthermore, Medicare is financially much larger than Medicaid and individual private insurers.[64] If Medicare leverages its economic size to show that telehealth is both medically and fiscally efficient, the other payer entities will likely follow suit.[65] With mental healthcare in particular, several hundred thousand people with SMI have had the ability to receive telehealth services during the pandemic. While telehealth alone will not provide all the services that people with SMI require,[66] CMS should garner a dataset from the COVID-

61. *See* 42 U.S.C. § 1395m(m)(4)(c)(i); Press Release, *supra* note 55.

62. Medicare has led private insurers on policy since its enactment. *See e.g.,* DAVID BARTON SMITH, *Civil Rights and Medicare: Historical Convergence and Continuing Legacy*, MEDICARE AND MEDICAID AT 50: AMERICAN'S ENTITLEMENT PROGRAMS IN THE AGE OF AFFORDABLE CARE 21, 35-36 (2015) (discussing the integration of southern hospitals in the years immediately following Medicaid's passage).

63. SOC. SECURITY ADMIN., PUB. NO. 13-11826, ANNUAL STATISTICAL REPORT ON THE SOCIAL SECURITY DISABILITY INSURANCE PROGRAM, 2019, 25 (Oct. 2020) https://www.ssa.gov/policy/docs/statcomps/di_asr/2019/di_asr19.pdf.

64. Medicare spending is about $800 billion annually. *NHE Factsheet*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet (last modified Dec. 16, 2020). Private health insurance spending is over a trillion dollars annually, but that is for the entire industry. *See id.* The nation's largest private insurer, UnitedHealth Group, earned about $257 billion in 2020, less than half of Medicaid. *See* UNITEDHEALTH GRP., ANNUAL REPORT (Form 10-K), 36, 53 (Dec. 31, 2020). https://www.unitedhealthgroup.com/viewer.html?file=/content/dam/UHG/PDF/investors/2020/UNH-Form-10-K.pdf.

65. As they did in the late 1960s. *See e.g.,* SMITH, *supra* note 62, at 25-27, 32-33, 35.

66. ANNUAL STATISTICAL REPORT ON THE SOCIAL SECURITY DISABILITY INSURANCE PROGRAM, 2019, *supra* note 63.

19 era to drive future decisions on telehealth coverage for people living with mental illness.

ii. Medicaid

The Medicaid program's structure means that most policies, including telehealth coverage, are set by state governments.[67] However, some flexibility for states to extend telehealth services under federal Medicaid regulations already existed prior to the COVID-19 pandemic. First and foremost, states are not required to seek CMS's approval to provide reimbursement for telehealth services so long as they do so with reimbursement parity.[68] CMS also grants authority to states for telehealth home-based care services (HBCS) under Section 1915 waivers, which can be useful for many Medicaid recipients, but particularly people with SMI who are participating in assisted outpatient treatment (court-ordered, community-based treatment plans) and do not require inpatient psychiatric care.[69]

B. State Changes

Some states enacted telehealth laws in response to the COVID-19 pandemic and others were able to apply previously enacted legislation to make telehealth services available and reduce the amount of care provided

67. *See* 42 U.S.C. § 1396. Medicaid is administered jointly by CMS and the states. Each state, D.C., and the territories with permanent populations have Medicaid departments. Federal law sets the tone for Medicaid policies, but actual implementation is done at the state level. State insurance laws also directly govern many aspects of Medicaid.

68. States are permitted to use Medicaid funds to cover telehealth services if reimbursement rates are the same, but if they plan to charge different rates, they must submit a state plan amendment (SPA) and seek CMS' approval first. *See Medicaid State Plan Fee-for-Service Payments for Services Delivered Via Telehealth*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-telehealth-services.pdf (stating that, "States are not required to submit a State plan amendment (SPA) to pay for telehealth services if payments for services furnished via telehealth are made in the same manner as when the service is furnished in a face-to-face setting . . . [but a] state would need an approved State plan payment methodology (and thus, might need to submit a SPA) to establish rates or payment methodologies for telehealth services that differ from those applicable for the same services furnished in a face-to-face setting.").

69. *See* Brian Stettin et al., *Implementing Assisted Outpatient Treatment: Essential Elements, Building Blocks and Tips for Maximizing Results*, TREATMENT ADVOC. CTR. & NE. OHIO MED. U., 8 (2019) (defining Assisted Outpatient Treatment).

in person.[70] Oklahoma and Texas both had some pieces in place to facilitate telehealth prior to March of 2020, but neither of their legal structures were complete. During the pandemic, both states reduced barriers to telehealth. Oklahoma's positive changes are likely in place long-term, but Texas needs legislative action to extend one temporary COVID-era telehealth access improvement that may soon expire.[71]

Effective telehealth legislation should have, *inter alia*, three significant pieces to allow implementation of platforms that make it accessible for patients and financially viable for healthcare providers. These three necessary provisions are related but separate aspects of parity between telehealth and in-person insurance coverage. First, telehealth legislation should ensure parity of services offered. Practitioners should be able to offer any services that can be provided via telehealth. Second, health insurance plans must reimburse at equal rates for telehealth and in-person care. This is a piece of telehealth policy rooted in common sense and impacting both practitioners and health insurance plans. If insurers were to reimburse providers at a lower rate for a service provided by telehealth than for the same service provided in-person, it would financially disincentivize providers from offering remote care. Conversely, if a statutory scheme required higher reimbursement rates for telehealth services as a means of incentivizing providers, it would financially disincentivize health plans from covering them.[72] Third, health plans must charge the same copay for the same service, whether it is provided via telehealth or in-person. If copays for one method of delivering healthcare services are significantly higher than another, then the members of those plans will likely choose the method with the lowest

---

70. At least twenty-three states have made changes to their telehealth laws during the COVID-19 pandemic that are not temporary. *The Future of State Telehealth Policy, supra* note 53, at 4 (citing *Executive Summary: Tracking Telehealth Changes State-by-State in Response to COVID-19,* MANNATT, https://www.manatt.com/insights/newsletters/covid-19-update/executive-summary-tracking-telehealth-changes-stat. (last updated Nov. 4, 2021).

71. Texas's reimbursement parity is a temporary measure and will expire when the Governor determines the state is no longer in an emergency. *See infra* Part III.B.ii.

72. Effective telehealth legislation must remove several inherent barriers to accessing remote care, but this article focuses mainly on the parities listed here. Without parities of coverage, reimbursement, and copays, it is impractical for practitioners to offer, and for patients to seek, telehealth services. *See generally* Tony Yang, *Health Policy Brief: Telehealth Parity Laws*, HEALTH AFFS. (Aug. 15, 2016) https://www.healthaffairs.org/do/10.1377/hpb20160815.244795/full/healthpolicybrief_162.pdf (discussing reimbursement parity).

copay, even if one method is generally more convenient or medically efficacious.[73] Of the two states discussed in this section—Oklahoma and Texas—Texas had two of those provisions in place prior to the COVID-19 pandemic and Oklahoma enacted all three in response to the pandemic.

i. Oklahoma

Oklahoma legalized telehealth in 1997, required coverage parity and made other changes to the law in 2017, and fully expanded its telehealth statutes during the COVID-19 pandemic by requiring parities of reimbursement and copay. Absent statutory action specifically allowing telehealth services, most healthcare providers cannot provide remote services.[74] To that end, the Oklahoma Legislature passed Senate Bill (S.B.) 48 in 1997.[75]

S.B. 48 defined "telemedicine" and partially eliminated the in-person requirement for medical treatment in Oklahoma.[76] It also protected PHI—both the patient's right to access PHI and need for written consent before a healthcare provider may transmit PHI—but only as it relates to telehealth.[77] The bill was vague on whether non-physician practitioners could take advantage of the enabling legislation[78] and required coverage parity but not parity of reimbursement or copays.[79] The Oklahoma Legislature made no further statutory changes to telehealth law until 2016, when they removed a technical requirement for an in-person written agreement for insurance purposes.[80]

The interlude between legislative changes saw several administrative regulations impact the practice of telehealth in Oklahoma. The Oklahoma Health Care Authority (OHCA) promulgated ten different rules from the

73. Especially during a pandemic, telehealth laws should not incentivize patients to seek in-person treatment over telehealth services.

74. *See supra* text accompanying note 37.

75. Oklahoma Telemedicine Act, S.B. 48, 46th Leg., Reg. Sess. (Okla. 1997).

76. *See id.*

77. Section 4 of the Oklahoma Telemedicine Act required some protections guaranteed federally six years later with the promulgation of the HIPAA Privacy Rule. *See id.*

78. *See id.*

79. *Id.* § 3(A) (explaining parity of coverage: "For services that a health care practitioner determines to be appropriately provided by means of telemedicine, health care service plans, disability insurer programs, workers' compensation programs, or state Medicaid managed care program contracts . . . shall not require person-to-person contact between a health care practitioner and a patient.").

80. Act of April 25, 2016, H.R. 2547, 55th Leg., Reg. Sess. (Okla. 2016).

early days of telehealth in the state through the present regarding definitions and basic requirements.[81] Additionally, regulations pertaining specifically to mental health and substance use disorder encouraged the use of telehealth technology by including "telemedicine" in definitions regarding patient exams and emergency detentions.[82]

In the 2017 legislative session, S.B. 726 clarified that a physician-patient relationship may be established solely through the use of telehealth technology,[83] defined "store and forward technologies," i.e., actual handling of telehealth data that is not provided in a live, real-time interaction between patient and provider,[84] and added a new definition of "telemedicine" as "the practice of health care delivery, diagnosis, consultation, evaluation and treatment, transfer of medical data or

81. Oklahoma telehealth practices are regulated by section 317:30-3-27 of the Oklahoma Administrative Code. OKLA. ADMIN. CODE § 317:30-3-27. The Oklahoma Health Care Authority has made several regulatory changes in the last thirteen years. *See* 26 Okla. Reg. 249 (Dec. 15, 2008) (defining "telemedicine" and clarifying that "[p]sychiatric services performed via telemedicine are subject to the requirements found in OAC 317:30-3-27"); 26 Okla. Reg. 1053 (May 1, 2009) (clarifying that telehealth services are covered in rural areas); 26 Okla. Reg. 3025 (Sept. 1, 2009) (emergency promulgation adding Indian Health Service (IHS) facilities to previous language); 27 Okla. Reg. 831 (May 3, 2010) (making the emergency adoption of 26 Okla. Reg. 3025 permanent); 28 Okla. Reg. 1397 (June 15, 2011) (adding, "[t]he coverage of all telemedicine services is t the discretion of OHCA," regarding patients covered by SoonerCare, Oklahoma's Medicaid program); 30 Okla. Reg. 1124 (June 17, 2013) (adding, *inter alia*, language to cover some behavioral health services and requiring that services be HIPAA compliant); 32 Okla. Reg. 1036 (Aug. 17, 2015); 34 Okla. Reg. 641 (Aug. 15, 2017) (related to technical definitions).

82. *See e.g.*, OKLA. ADMIN. CODE § 450:17-5-176 (requiring certified community behavioral health clinics provide some telehealth services).

83. *See* Act of May 10, 2017, S.B. 726, 56th Leg., Reg. Sess. (Okla. 2017) (allowing establishment of the relationship through telehealth, but specifying that the relationship is not established merely by the physician receiving a patient's information). Note that S.B. 726 only contemplated the establishment of a practitioner-patient relationship when the practitioner is a doctor.

84. *See id.* In the twenty years between the passage of Oklahoma's enabling legislation and 2017, the platforms facilitating telehealth had changed significantly. Although the original definition of telemedicine in the Oklahoma Telemedicine Act probably covers technology in use at the time of this article's publication ("[H]ealth care delivery, diagnosis, consultation, treatment, transfer of medical data, or exchange of medical education information *by means of audio, video, or data communications*") (emphasis added), the legislature rightly added with S.B. 726 a definition for "store and forward" technology to accommodate a rising use of online patient portals and mobile apps designed to increase efficiency by allowing both patient and provider to enter and review information at their respective convenience.

exchange of medical education information by means of a two-way, real-time interactive communication, *not to exclude store and forward technologies*, between a patient and a physician" (emphasis added).[85] In addition to being somewhat superfluous, the 2017 definition added to the telehealth statute without removing or even editing the existing definition enacted in 1997. This convolution of definitions set the stage for the Legislature to clarify the definition of "telemedicine" whenever they felt it necessary to revisit the code. That necessity arose during the COVID-19 pandemic, but not until after the state's executive branch temporarily intervened.

At the onset of the pandemic, Oklahoma Governor J. Kevin Stitt issued an executive order declaring an emergency and suspending many statutory and regulatory provisions in response to the COVID-19 pandemic, including one provision related to telehealth.[86] His order waived the "preexisting patient relationship requirement for telemedicine, as required by 59 O.S. § 478.1." [87] That would have been an expedient and efficient way to promote safer physician-patient interactions during the pandemic if that statute indeed required a preexisting patient relationship. It does not.[88]

On March 24, 2020, one week after Governor Stitt's executive order, then-Oklahoma Attorney General Mike Hunter issued an opinion stating that current law "provide[d] few barriers to healthcare workers addressing the needs of Oklahomans related to this pandemic via telemedicine. The existing restrictions on telemedicine do not appear to hinder effective COVID-19 response."[89] He elaborated that current law allowed the establishment of physician-patient relationships through telehealth technology, and that Oklahoma had coverage parity.[90] The former point created an inconsistency of legal analysis with Governor Stitt's executive order. The Attorney General was correct that physicians could establish patient relationships under the 2017 law, but his overall assessment of

85. *Id.* (emphasis added).

86. 37 Okla. Reg. 642 (April 15, 2020).

87. *Id.*

88. *See* 59 OKLA. STAT. tit. § 478.1(A). However, current law only specifically applies to "physicians." The executive order may have been intended to either expand this rule to other practitioners or lift an actual restriction within the same section precluding the establishment of the physician-patient relationship "solely based on the receipt of patient health information by a physician." *Id.* § 478.1(D).

89. 2020 OK AG 7, ¶1.

90. *See id.*

telehealth laws was flawed on two levels, one related to the lack of parities in Oklahoma telehealth law and the other related to treatment of COVID-19. Oklahoma did not have parity of reimbursement or copay in 2020.[91] His legal analysis ignored the two types of telehealth payment parities and the barriers created by lack of such provisions, despite the fact that other states had already enacted statutes to address this by 2020.[92] Furthermore, no one, including the healthcare or legal communities, fully understood effective treatment of COVID-19 at the time of Attorney General Hunter's opinion.

The Oklahoma Legislature clarified and codified a more applicable definition of "telemedicine" in response to the pandemic, as well as requiring parity of reimbursement and copays.[93] Specifically, S.B. 674, signed by Governor Stitt on May 5, 2021, and effective January 1, 2022, requires insurers to:

> [R]eimburse the treating healthcare professional . . . for the diagnosis, consultation or treatment of the patient delivered through telemedicine services on the same basis and at least at the rate of reimbursement that the insurer is responsible for coverage for the provision of the same, or substantially similar, services through in-person consultation or contact.[94]

The bill also ensured copay parity and requires the Oklahoma Department of Health to compile and report data on the number of providers and utilizers of telehealth and "[t]he overall cost and cost savings associated with the utilization of telehealth services."[95] S.B. 674 will eliminate the major legal barriers to telehealth in Oklahoma by ensuring those parities that earlier Oklahoma statutes and regulations kept in place.[96]

---

91. Oklahoma will have those parities, however, when S.B. 674 goes into effect on Jan. 1, 2022. *See* Act of May 5, 2021, S.B. 674, 58th Leg., Reg. Sess. (Okla. 2021).

92. *See e.g., infra* Part III.B.ii.

93. *See* S.B. 674.

94. *Id.*

95. *Id.* at p. 7.

96. Although the Oklahoma Legislature brought down the significant legal barriers to telehealth in 2021, practical barriers remain. *See infra* note 108 and accompanying text.

ii. Texas

Texas statutorily enabled telehealth in 2003, years after many other states, but when the COVID-19 pandemic hit the Lone Star State in 2020, it already had parity of coverage and copays in place.[97] Executive action by Governor Greg Abbott and the Texas Department of Insurance in March of 2020 temporarily ensured reimbursement parity.[98] Governor Abbott has continually renewed the emergency order and has publicly stated that reimbursement parity should continue permanently.[99] Meanwhile, grassroots advocates, healthcare providers, and other organizations continue to lobby the Texas Legislature to permanently codify reimbursement parity immediately.[100]

The different codes governing Texas telehealth have nuances not contained in Oklahoma law, at least one of which is potentially problematic. Texas defines and governs telehealth in both its Occupations Code and its Insurance Code.[101] The relevant parts of the Insurance Code define telehealth services, practitioners, and insurance plans, as well as provide for the two parities of coverage and copays mentioned above.[102] The Occupations Code contains, *inter alia*, the requirements for the establishment of a practitioner-patient relationship for telehealth services,

97. *See* Act of June 21, 2003, § 1455.004, 78th Leg., Reg. Sess. Tex. 2003) (providing basic definitions, parity of coverage, "health plan may not exclude telemedicine . . . because the service is not provided through a face-to-face consultation," and parity of copay, "[t]he abount of the deductible, copayment, or coinsurance may not exceed the amount of the deductible, copayment, or coinsurance required for a comparable medical service provided through a face-to-face consultation"). The Texas Legislature modified the code in 2017 and partially compromised coverage parity, *See* Act of May 27, 2017, § 1455.004, 85th Leg., Reg. Sess. (Tex. 2017) (specifying that insurers need not cover audio-only or email only consultations). *See* Act of June 16, 2021, § 1455.004, 87th Leg., Reg. Sess. (Tex. 2021) (baring coverage of phone and email consultations does not necessarily preclude audio-only telehealth services, but the vague language of that chapter creates a potential loophole for health plans to refuse payment.

98. *See* 28 TEX. ADMIN. CODE. § 35.1(d) (2020) (COVID-19 Emergency Rule requiring health plans to reimburse for telehealth "on the same basis and at least at the same rate that the plan is responsible for reimbursement . . . in an in-person setting.").

99. *See e.g,* John Engle, *Gov. Gregg Abbott Wants to Permanently Expand Telemedicine Access in Texas*, KXAN (Feb. 2, 2021), https://www.kxan.com/news/texas-politics/gov-greg-abbott-wants-to-permanently-expand-telemedicine-access-in-texas/.

100. H.B. 980 would have permanently expanded reimbursement parity. It passed the House Committee on Insurance by a vote of 5-2 but did not receive a floor vote. *See* H.B. 980 87th Leg., Reg. Sess. (Tex. 2021)

101. *See* TEX. OCC. CODE §§ 111.001-.007; TEX. INS. CODE §§ 1455.001-.006.

102. *See* TEX. INS. CODE §§ 1455.001-.004.

as well as the standard of care for telehealth.[103] Significantly with regard to telehealth during the COVID-19 pandemic, the code allows for the establishment of the practitioner-patient relationship without in-person contact.[104] The Occupations Code also specifically omits mental health services from the provisions in the relevant chapter.[105] The practical implications of the mental health provision are unclear; at the very least it must create confusion for both healthcare providers and patients as to the standard of care and establishment of practitioner-patient relationships. At worst, it denies the protections for telehealth patients contained in the Occupations Code to patients of mental healthcare providers. At the time of this Article's writing, there has been no judicial or administrative action to clarify the intent or meaning of omitting mental health services from the Occupations Code. Until that clarification exists, mental health services are allowed via telehealth in Texas under the Insurance Code and mental health practitioners are providing services in Texas.[106] The Texas Legislature should either address that provision or repeal it in order to ease the ongoing transition from in-person to telehealth for many mental health services, especially as the national PHE persists and more patients look to remote care.

Texas and Oklahoma both entered the COVID-19 pandemic with significant deficiencies in their telehealth statutes and regulations, all of which their executive and legislative branches addressed, at least on a temporary basis (in the case of reimbursement parity in Texas) if not permanently (Oklahoma S.B. 674).

103. *See* TEX. OCC. CODE §§ 111.001, .005, .007.

104. *See supra* Part III.B.i (discussing confusion within the Oklahoma state government on this issue).

105. *See* TEX. OCC. CODE § 111.008 ("This chapter does not apply to mental health services.").

106. For an example of news coverage of mental health practioners' support of H.B. 980 see Monica Ortiz, *Mental Health Practices Pushing for Texas Telehealth Reimbursement Bill*, SPECTRUM NEWS 1 (May 13, 2021), https://spectrumlocalnews.com/tx/south-texas-el-paso/news/2021/05/12/mental-health-practices-pushing-for-texas-telehealth-bill-.

IV. ASSESSING THE PERPETUANCE OF RECENT CHANGES AND THEIR IMPACT ON THE TREATMENT OF MENTAL ILLNESS

A. Telehealth

States like Oklahoma that statutorily removed barriers to telehealth used the opportunity presented by the COVID-19 pandemic to improve healthcare delivery on a permanent basis. The provisions of S.B. 674 will not change in the foreseeable future unless the Legislature reverses its own policy or the Judiciary finds it contrary to the state or federal constitution. There are no grounds for a judicial reversal and the Legislature will not change its mind as long as patients and practitioners see the benefits of telehealth and the private insurance industry has no significant cost increases related to reimbursements.[107] Oklahoma has therefore removed the substantive legal barriers to providing telehealth services.[108]

Texas is in a different situation due to the potential expiration of reimbursement parity when Governor Abbot's executive order eventually

---

107. S.B. 674 gives Oklahoma a chance to empirically verify or disprove the financial and medical efficiency of telehealth. It contains a provision requiring the Oklahoma Department of Health to report data on both the utilization and, "cost and cost savings" of telehealth. *See* S.B. 674, § (2)(L), 57th Leg., Reg. Sess. (Okla. 2021).

108. *See generally* Camille A. Clare, *Telehealth and the Digital Divide as a Social Determinant of Health During the COVID-19 Pandemic*, 10 NETWORK MODELING ANALYSIS IN HEALTH INFORMATICS AND BIOINFORMATICS 26 (2021) (discussing the overall problem of the digital divide as a barrier to telehealth access). The legal barriers will soon be gone in Oklahoma, but practical barriers remain. The paramount practical barrier to telehealth access is the digital divide, *i.e.*, the lack of access to communications technology and/or the inability to utilize it. Policymakers have a responsibility not only to ensure access and payment parities, but also to promote patient access and competence regarding the patient end of telehealth platforms.; *See also* Kendall Cortelyou-Ward et al., *Navigating the Digital Divide: Barriers to Telehealth in Rural Areas*, 31 J. OF HEALTH CARE FOR THE POOR & UNDERSERVED 1546 (2020) (discussing the need for better quality internet in rural areas in order to access telehealth); *and* Tina Norris et al., *The American Indian and Alaska Native Population: 2010*, U.S. CENSUS BUREAU 7 (Jan. 2012). The two states discussed in this article, Oklahoma and Texas, have the second and fourth highest Native American populations among the states respectively. *See* Michael Toedt, *IHS Expanded Telehealth to Provide Care During COVID-19 Pandemic*, INDIAN HEALTH SERVICE (April 28, 2021), ihs.gov/newsroom/ihs-blog/april2021/ihs-expanded-telehealth-to-provide-care-during-covid-19-pandemic/. To illustrate the telehealth digital divide for Native Americans, 80 percent of the telehealth services delivered by the Indian Health Service (IHS) during the COVID-19 pandemic have been over telephone only, with no video component. That statistic is alarming given Texas's vaguely worded statutory reimbursement parity exception for audio-only (*e.g.*, telephone) platforms. *See* sources cited *supra* note 97; TEX. INS. CODE 1455.004(c).

expires.[109] Absent legislation requiring reimbursement parity, Texas practitioners and patients, particularly mental health patients, will suffer.[110] There is a growing movement among Texas healthcare advocates to pass legislation cementing reimbursement parity, which succeeded in a bill (H.B. 980) moving out of a House Committee before it died without receiving a floor vote.[111] Hopefully, momentum will continue to add that vital and missing piece to Texas's telehealth law.

At the federal level, Medicaid treats telehealth services the same as in-person services and it is up to the states to seek the appropriate waivers and state plan amendments to extend coverage.[112] Medicare, however, faces an uncertain future regarding telehealth coverage. Expansion of services during the COVID-19 pandemic that were brought on by the PHE are set to expire at the end of the emergency.[113] Many of those changes should stay in place to increase access to healthcare for the over sixty-million Medicare enrollees. CMS should continue the policy of establishing practitioner-patient relationships over telehealth platforms and should work with Congress to ensure coverage of Medicare telehealth visits regardless of whether the patient resides in a rural area.

B. HIPAA

Of all federal changes to telehealth policy during the COVID-19 pandemic, one that is unequivocally temporary is the ban on enforcement of the Privacy Rule for services provided via telehealth.[114] While there are rational and ethical arguments to keep other changes in place, allowing this particular policy to endure after the PHE ends would leave no federal guarantee for the privacy of information exchanged via telehealth platforms.[115]

---

109. *See* 28 TEX. ADMIN. CODE. § 35.1(d) (2020). Governor Abbott has continued renewing the emergency declaration at the time of publication, but the Texas healthcare system is dependent on the governor to continue doing so until the legislature acts. *See* Proclamation by the Governor of the State of Texas (Sept. 28, 2021) (renewing the state's disaster proclamation for one month).

110. *See* Ortiz, *supra* note 106.

111. *See supra* text accompanying note 100.

112. *See supra* note 68 and accompanying text.

113. *See* 42 U.S.C. § 1320b-5 (discussing emergency authority granted to HHS is temporary by definition and expires at the end of an emergency).

114. *See supra* Part II.A.

115. *But see,* e.g., 20 U.S.C. § 1232g (2019), which provides a federal guarantee for information protected by the Family Educational Rights and Privacy Act (FERPA), *i.e.*,

The HIPAA Privacy Rule creates no barrier at all to telehealth during the federal PHE, but once the emergency is over, it should pose only a minimal barrier, easily overcome by diligent healthcare providers who understand the law.[116] Furthermore, proposed changes to the Privacy Rule should allow more communication between practitioners and third parties, but only if healthcare providers understand the exceptions that allow disclosures in the best interest of the patient or to prevent a foreseeable threat.

C. Impact on Treatment of SMI

Despite potential limitations, continued expansion of telehealth, combined with more thoughtful application of the HIPAA Privacy Rule, will benefit the SMI population, their families, and mental health practitioners. The treatment of SMI poses a difficult situation regarding HIPAA in a post-pandemic environment that could take a similar form as the problems caused by misinterpretation of the Privacy Rule for in-person care. Family members and caregivers already have great difficulty establishing two-way communication with mental healthcare providers due to misinterpretations of the rule and this might be exacerbated by remote communication.[117] However, families facing SMI-related emergencies will likely be dealing with inpatient healthcare providers, lessening the complications of the Privacy Rule and remote care. Whether a loved one with SMI is utilizing inpatient or outpatient care, rational interpretation of the Privacy Rule can prevent the tragic outcomes discussed in Part II.[118]

As mentioned in Part II, the potential for telehealth and the treatment of mental healthcare generally is vast, if somewhat limited as it relates to SMI.[119] People with SMI can see greater access to healthcare with the expansion of telehealth though, so long as it is expanded in a thoughtful

---

records related to education held by institutions that receive funds from the Department of Education. For an example of a state privacy law that expands upon or generally exceeds HIPAA's reach see TEX. HEALTH & SAFETY CODE §§ 181.001-.207.

116. *See supra* Part I.A (discussing proper and improper applications of the Privacy Rule).

117. *See supra* Part II (describing the issues that family member caregivers encounter because of misinterpretations of the Privacy Rule).

118. *See id.*

119. *See supra* Part II (discussing the benefits and limitations of telehealth in the treatment of SMI).

way that takes into account their symptoms and the socioeconomic impact of SMI on patients. Telehealth services should expand to include more platforms and treatment methods that account for symptoms of SMI. People living with SMI may be more hesitant to engage with unfamiliar types of video platforms than the general public due to paranoia, cognitive difficulties caused by SMI or medication side effects, or other symptoms.[120] Furthermore, the digital divide impacts people with SMI in different ways than the general public, not only because of issues directly related to their symptoms, but also because they are more likely to live in poverty.[121] Living with lower incomes means they have limited access to high-speed internet and the devices necessary to utilize telehealth platforms. If practitioners and patients can overcome these barriers, specific aspects of outpatient treatment plans can integrate phone conferencing and check-ins with patients, as well as tailor different telehealth platforms on a patient-by-patient basis. An additional medical benefit of telehealth for people living with SMI is its ability to facilitate social distancing during the pandemic, which is especially important for schizophrenia patients. Schizophrenia is the highest risk factor for mortality in COVID-19 patients, other than age.[122] Policymakers and healthcare providers should keep all of these barriers to telehealth in mind and work to ensure increased access to telehealth for people with SMI, both during and after the COVID-19 pandemic.

V. CONCLUSION

The COVID-19 pandemic is an application of the scientific method to test the hypothesis of telehealth advocates. That hypothesis is that telehealth is a more efficient way to provide most healthcare services because of its convenience to the patient, convenience to practitioners, and

120. *See* Medalia et al,, *supra* note 45; TORREY, *supra* note 27, at 180.

121. *See* Brandon Vick et al., *Poverty and Severe Psychiatric Disorder in the U.S.: Evidence from the Medical Expenditure Panel Survey*, 15 J. OF MENTAL HEALTH POL'Y & ECON. 83 (2012) (documenting the relationship between mental health diagnoses and poverty); Christopher G. Hudson, *Socioeconomic Status and Mental Illness: Tests of the Social Causation and Selection Hypotheses*, 75 AM. J. OF ORTHOPSYCHIATRY 3 (examining possible reasons for the relationship between mental illness and poverty).

122. *See* Elizabeth Sinclair Hancq et al., *COVID-19 Vaccination for People with Severe Mental Illness: An International Survey of Clubhouses*, TREATMENT ADVOC. CTR. 1 (Sept. 2021) (citing K. Nemani et al., *Association of Psychiatric Disorders with Mortality Among Patients with COVID-19*, 78 J. AM. MED. ASS'N. PSYCHIATRY 380 (2021)).

lower long-term costs for public and privately funded health plans. Governmental actions, born of necessity, expanded access to telehealth during the pandemic. Some of those changes will last through the foreseeable future. It is up to patients, practitioners, and advocates for more accessible healthcare to tear down remaining telehealth access barriers and ensure more ethical applications of the HIPAA Privacy Rule. Otherwise, the healthcare system will lose life-saving lessons from the COVID-19 pandemic and waste a valuable opportunity to improve treatment of SMI.