

**STATEMENT OF
COMMISSIONER JESSICA ROSENWORCEL**

Re: *Promoting Telehealth for Low-Income Consumers*, WC Docket No. 18-213.

According to the American Hospital Association, 60 million Americans—one-fifth of the population—live in rural communities. But crisscross the country and you will learn that many of those millions in remote areas lack access to the most essential healthcare.

Take pregnancy. For any woman who is pregnant, having a hospital delivery room nearby means knowing that when the baby arrives medical assistance will be at hand. But for too many women in rural America this comfort is no longer available—and it is putting too many births at risk.

The facts are stark. More than 179 counties across the country have lost obstetric care in hospitals during the past decade and a half. As a result, 54 percent of rural counties no longer have a hospital with a maternity ward.

As a mom myself, I can attest that giving birth is hard work. But it gets more difficult if every meeting with a healthcare professional to monitor everything from blood pressure to blood sugar is far from home. Routine appointments with health care providers can be all but impossible when they require a full day of travel, time off from work, foregone wages, and special arrangements for childcare. And yet failure to monitor the small things during pregnancy can have big consequences. They can lead to serious problems in childbirth—and in the United States the maternal mortality rate is going up. In fact, this country is the only industrial nation that has seen an increased rate of maternal deaths in the last several years. The loss of obstetric services in rural areas may be a driving force behind this statistic. That's because the most common causes of serious pregnancy-related complications are avoidable with regular monitoring and medical care.

What is happening with pregnant women in rural communities is a piece of a larger story. In remote areas, the cost of offering service is high relative to the revenues sparsely-populated areas generate. That difficult math creates vulnerabilities for rural Americans as hospitals close, facilities shutter, and doctors and nursing shortages grow more acute. These problems impact not only obstetric services but also diabetes and cancer treatment. They pose challenges for stroke patients. They create hurdles for those with mental health difficulties and dependency on opioids. In fact, any condition that benefits from regular monitoring becomes a special challenge when reliable care is neither nearby nor easy to access.

Of course, these difficulties are by no means limited to the most remote areas. They are present in low-income communities everywhere. That's not only a fact I know from the sources cited in today's inquiry. It's one I know from childhood. You could say it's in my blood. That's because my father served in the Air Force as a physician. After he left the service for civilian life, he practiced medicine. For three decades, he ran a low-income city clinic for hypertension and kidney failure. Growing up, dinner table conversations were about chronic disease, dialysis, and the challenges of securing reliable care for those least likely to afford it.

Of course, not one of us is a doctor on this dais. Not one of us is a nurse. Nor are we health care authorities. But we sit here today because more than two decades ago Congress charged the Federal Communications Commission with making telecommunications available to health providers in rural areas. In the intervening years, this agency has developed two programs.

The first program, known as the Telecommunications Program is laid out in detail in the Telecommunications Act. Section 254(h)(1) directs the agency to support public or non-profit health care providers in rural areas by offering funding for telecommunications services, to the extent that rates are higher than those charged for similar services in urban areas.

The second program, known as the Healthcare Connect Fund, is of more recent vintage. Pursuant to Section 254(h)(2), it offers support for high-capacity broadband through state and regional health care provider networks. To be eligible for support, more than half of the sites served need to be in rural areas. This second program got its start as a pilot program.

Today we propose a new pilot program. There is a lot of good that can come of this—if we do this right. At the outset, it is terrific that the agency is looking at health programs in a modern way. It is important to build a record that reflects how connected care is changing and how remote patient monitoring technologies are evolving. I firmly believe the FCC can play a role expanding how communications is used in treatment to improve health care outcomes. I particularly appreciate that my colleagues were willing to add multiple questions about the state of obstetric care in rural communities to this inquiry. I thank them for that.

But let me now add a note of caution. We need to be honest about the legal ground on which this proposal rests. For starters, it does not neatly fit in the statutory scheme of the programs we have for health purposes under Section 254. Those programs are designed to serve “health care providers” in “rural areas.” This inquiry speaks more broadly and contemplates subsidizing service to patients in their home in areas that may or may not be rural. The statutory authority available for doing *this* is the Lifeline program.

The Lifeline program is older than our health care programs. In fact, it began nearly three decades ago. When it was established communicating required a telephone with a cord and jack in the wall. Back then, it helped support the cost of voice calling in low-income households. Today, it continues to help those in need by supporting low-cost access to communications. However, the program has been changed in one significant way—it has been modernized to support wireless service.

Nationwide, millions of American rely on the Lifeline program for communications service. But last year this agency announced plans to gut the service in a way that could impact 70 percent of current users. To the extent there are problems with companies abusing this program or enrolling those who are ineligible, we should fix them. But I believe there are ways to do this without harming those who need and rely on Lifeline. Instead, however, this agency has destabilized this program with its proposal—with a cruel disregard for the people across the country who may be harmed by our actions.

Let’s review who they are.

We can start with the roughly 20,000 women, men, and children across the country who call a domestic violence hotline every day. Seventy-seven percent of domestic violence prevention programs distribute phones to help those who truly need a lifeline for safety.

We can note that more than 500,000 Americans who live in Puerto Rico rely on the Lifeline program for basic communications. In the aftermath of Hurricane Maria, they used this program to reach out for emergency assistance, call their loved ones, seek health care, and coordinate recovery. Nearly a year later, one in five residents continue to count on this program for basic communications.

We can note that there are 650,000 homeless young people who identify as lesbian, gay, bisexual, or transgender. They are at special risk of bullying, discrimination, and assault. As research from the University of Southern California demonstrates, access to communications—including through Lifeline—helps homeless youth in impossibly tough circumstances find support networks, reach potential employers, and access health care.

We can point out that more than 1.3 million veterans who have honored us with their service now rely on the Lifeline program in their civilian life. Moreover, we have encouraged their participation by expanding the program to cover those who participate in the Veterans Pension as part of an effort to help former service members and their families in need.

One more data point—there are nearly 2.2 million senior citizens who rely on Lifeline for communications service. Age, of course, brings new health care challenges. But it is going to be hard to improve access to telemedicine when we simultaneously are pursuing policies that strand senior citizens without basic communications service.

So before this agency decides to give out \$100 million in grants for a new health care pilot program it has to answer for its actions. It has to recognize that it has destabilized communications services that millions of Americans rely on today. It cannot borrow from the authority of the Lifeline program for a new project without first reconciling the damage it has proposed to do to those who already depend on it.

To be clear, that does not undermine the good we propose here. The possibilities of improving care for rural Americans, low-income Americans, and let me end where I started—pregnant Americans—are real. But we have a lot to do before we make that happen—and I hope my colleagues will commit to rolling up their sleeves and working with me to do it.