Brooklyn Law Review

Volume 85 | Issue 3 Article 11

6-25-2020

"To Infinity and Beyond": A Limitless Approach to Telemedicine Beyond State Borders

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Recommended Citation
Kate Nelson, *"To Infinity and Beyond": A Limitless Approach to Telemedicine Beyond State Borders*, 85 Brook. L. Rev. ().
Available at: https://brooklynworks.brooklaw.edu/blr/vol85/iss3/11

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"To Infinity and Beyond"[1]

A LIMITLESS APPROACH TO TELEMEDICINE BEYOND STATE BORDERS

INTRODUCTION

An unforeseen hurricane strikes and injures thousands of civilians. There are not enough doctors to care for the devastating number of patients seeking medical help, leaving operating health care facilities overcrowded and doctors overwhelmed; compounded with damaged infrastructure, public transportation systems destroyed, hospitals ruined, roads flooded, and bridges demolished. Victims seeking urgent medical assistance are physically stuck with no way to get anywhere and, inadvertently, nowhere to go. Fortunately, technological advances provide convenient alternatives for these victims to seek necessary medical assistance without traveling anywhere at all.[2] This is the benefit of telemedicine.[3]

Telemedicine has been used to aid in post-disaster medical emergencies dating back to 1985; and today, telemedicine is used to help beyond natural disasters and emergency situations.[4] For

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[1] TOY STORY (Pixar Animation Studios 1995).

[2] After Hurricane Harvey and Hurricane Irma, health centers, hospitals, and pharmacies were damaged. These facilities had to begin a long process of rebuilding before they could reopen and resume services. In response, American Well offered Harvey victims in Texas and Louisiana free health care services via telemedicine, including psychological counseling. *How Telemedicine Can Help People Maintain Their Health and Manage Chronic Conditions After a Natural Disaster*, BIOIQ (Sept. 12, 2017), https://www.bioiq.com/how-telemedicine-can-help-people-maintain-health-and-manage-chronic-conditions-after-a-natural-disaster/ [https://perma.cc/2CNG-V56L].

[3] For convenience, this note uses "telemedicine" inclusively to refer to all health care rendered and received via telecommunication. References to "telemedicine" therefore includes common terms such as "telehealth," "e-health," and "mHealth." Telemedicine is "the natural evolution of healthcare in the digital world," that enables medical professionals to treat patients who are located in remote places through technology such as video chat apps. *ATA Capitol Hill Briefing & Congressional Reception*, AM. TELEMEDICINE ASS'N (Feb. 26, 2019), https://www.americantelemed.org/events/ata-capitol-hill-briefing-congressional-reception/ [https://perma.cc/RY29-6VDF]; *see The Ultimate Telemedicine Guide: What Is Telemedicine?*, EVISIT (May 25, 2018), https://evisit.com/resources/what-is-telemedicine/ [https://perma.cc/7YLA-65BK] [hereinafter *Ultimate Telemedicine Guide*].

[4] *See* Victoria Garshnek & Frederick M. Burkle, Jr., *Applications of Telemedicine and Telecommunications to Disaster Medicine: Historical and Future Perspectives*, 6 J. AM. MED. INFORMATICS ASS'N 26, 26, 31–35 (1999) (discussing how technology has "catalyzed" the

example, the Veterans Association (VA) uses Clinical Video Telehealth (CVT) systems to provide health care to veterans on a routine basis.[5] Likewise, internet sites and mobile applications, such as MDLive[6] and Teladoc,[7] allow patients to consult with doctors via videoconferences or phone calls to treat non-urgent medical issues, ranging from common colds to skin conditions.[8]

Laws regulating the health care sector, however, inhibit the reach of telemedicine.[9] As a whole, the regulation is bifurcated; state standards regulate physician[10] licensing while federal standards simultaneously regulate medical training and testing.[11] Specifically, state laws require physicians to procure a license in every state that they practice in, which inevitably restricts the scope of the physician's practice.[12] As a result, citizens across the country face disproportionate access to health care, particularly those in underserved areas.[13] Telemedicine offers a conceivable solution to those underserved areas by providing for remote, feasible, and equal access to health care

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reach of telemedicine beyond emergency situations). Beginning in the 1960s, NASA invested in technology to allow astronauts to receive care at a distance. Andrew T. Simpson, *A Brief History of NASA's Contributions to Telemedicine*, NASA (Aug. 16, 2013), https://www.nasa.gov/content/a-brief-history-of-nasa-s-contributions-to-telemedicine/ [https://perma.cc/TK94-C6FW].

[5] Traditionally, veterans seeking health care had to travel to a VA hospital or medical center; however, the Veterans Association realized that this was complicated for veterans in a "remote or rural area, an area with sometimes severe weather, or even an urban area where congestion and traffic makes travel difficult," or where certain injuries, like traumatic brain injury, further complicated travel abilities. *Women Veterans Health Care*, U.S. DEP'T VETERANS AFF., https://www.womenshealth.va.gov/OutreachMaterials/GeneralHealthandWellness/Telehealth.asp [https://perma.cc/JEF2-XVKL].

[6] MDLIVE, https://www.mdlive.com [https://perma.cc/C82J-RL32].

[7] *How It Works*, TELADOC, https://www.teladoc.com/how-does-it-work/ [https://perma.cc/B2WD-54AE].

[8] *See Ways We Help*, TELADOC, https://www.teladoc.com/what-can-i-use-it-for/ [https://perma.cc/3W3D-B5XX].

[9] This note focuses on the in-state license requirements which inhibit the reach of telemedicine; however, other concerns, such as physician reimbursement, privacy, and data breach continue to threaten the industry as well. *Fact Sheet: Telehealth Policy Barriers*, CTR. CONNECTED HEALTH POL'Y 1, 3 (Feb. 2019), https://www.cchpca.org/sites/default/files/2019-02/TELEHEALTH%20POLICY%20BARRIERS%202019%20FINAL.pdf [https://perma.cc/XN6J-DWVS].

[10] This note uses "physician" as a universal term to refer to all licensed medical professionals that are able to prescribe medications, including but not limited to specialists and psychiatrists.

[11] Robert Kocher, *Doctors Without State Borders: Practicing Across State Lines*, HEALTH AFF. BLOG (Feb. 18, 2014), https://www.healthaffairs.org/do/10.1377/hblog20140218.036973/full/ [https://perma.cc/68D2-3VTA].

[12] *Id.*

[13] While some portions of the country are facing physician shortages, others are facing physician surpluses. Brittany La Couture, *The Traveling Doctor: Medical Licensure Across State Lines*, INSIGHT (June 10, 2015), https://www.americanactionforum.org/insight/the-traveling-doctor-medical-licensure-across-state-lines/ [https://perma.cc/9M92-4Z4Z]; *see also* Christopher Guttman-McCabe, Comment, *Telemedicine's Imperiled Future? Funding, Reimbursement, Licensing and Privacy Hurdles Face a Developing Technology*, 14 J. CONTEMP. HEALTH L. & POL'Y 161, 162 (1997) (noting the many problems rural patients face).

throughout the country, unrestricted by geographical borders.[14] Moreover, health care in underserved areas often requires specialized intervention due to language barriers, isolation, and cultural differences.[15] Telemedicine can likewise fulfill such specialized needs by expanding the number of physicians available to treat these patients.[16] In addition to remedying scarce resources, the benefits of telemedicine are overwhelmingly evident. For example, telemedicine reduces patient travel time and expenses.[17] Patients are reportedly more comfortable discussing sensitive medical issues with a distant physician, from the comfort of their own space, rather than in-person.[18] Telemedicine increases physician autonomy, record keeping, and staff management.[19] Overall, the prospects of telemedicine are remarkable and will continue to revolutionize the health care industry in unprecedented, beneficial ways.[20]

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[14] *See* Heather L. Daley, *Telemedicine: The Invisible Legal Barriers to the Health Care of the Future*, 9 ANNALS HEALTH L. 73, 74 (2000).

[15] *See* Peter Yellowlees et al., *Using e-Health to Enable Culturally Appropriate Mental Healthcare in Rural Areas*, 14 TELEMEDICINE & E-HEALTH 486, 486–88 (2008).

[16] For example, a Czech-speaking patient living in New York has a better chance of finding a Czech-speaking physician via telemedicine because they would have direct access to doctors across all state borders and would not be limited only to physicians licensed in either New York or in a neighboring state that the patient could travel to. *See* ALEXANDER VO ET AL., BENEFITS OF TELEMEDICINE IN REMOTE COMMUNITIES & USE OF MOBILE AND WIRELESS PLATFORMS IN HEALTHCARE 1, 3 (2011).

[17] Patients often spend more time in the waiting room before seeing their physician than they actually spend consulting with their physician. The time spent traveling to the physician's office and then impatiently waiting ultimately leads to frustration, anxiety, anger, stress, and an overall bad experience. Telemedicine allows patients to make valuable use of their time since patients do not have to wait around for their appointments, nor do they have to factor in travel time and expenses. Likewise, physicians practicing telemedicine report fewer missed appointments and cancellations, enabling them to stay on schedule. WFTS Webteam, *Telemedicine Can Help You Save Time at the Doctor's Office*, ABC ACTION NEWS (Nov. 1, 2018), https://www.abcactionnews.com/news/telemedicine-can-help-you-save-time-at-the-doctor-s-office [https://perma.cc/HR2T-5CQ8]; *Is Video Conferencing HIPAA Compliant? An Overview on Telemedicine Software and Video Conferencing*, VYOPTA (Nov. 7, 2018), https://www.vyopta.com/blog/business-collaboration/telemedicine-collaboration-guide/ [https://perma.cc/UX4M-T83E]. A 2018 survey of 15,000 physicians found that physicians "can't make the best use of their time, that they lack the autonomy to provide the best care for their patients, and that they are being rushed in order to maintain their organization's profitability. [However,] [t]elemedicine, when adequately reimbursed, can help them address these challenges" by: (1) saving time, (2) increasing physician autonomy, and (3) focusing on "patients over profits." Gigi Sorenson, *3 Ways Telemedicine Reduces Provider Burnout*, PHYSICIAN'S WKLY. (July 20, 2018), https://www.physiciansweekly.com/3-ways-telemedicine-reduces-provider-burnout/ [https://perma.cc/3EM8-5EDL].

[18] Kelly K. Gelein, Note, *Are Online Consultations a Prescription for Trouble? The Uncharted Waters of Cybermedicine*, 66 BROOK. L. REV. 209, 234, 234 n.169 (2000).

[19] *See Telehealth Basics*, AM. TELEMEDICINE ASS'N (2018), https://www.americantelemed.org/resource/why-telemedicine/ [https://perma.cc/BDE2-8AZ6].

[20] *See* Bryant Furlow, *Telemedicine Facilitates Collaboration, Greater Access to Healthcare*, CLINICAL ADVISOR (Apr. 27, 2012), https://www.clinicaladvisor.com/your-career/telemedicine-facilitates-collaboration-greater-access-to-healthcare/article/238649/ [https://perma.cc/6GSJ-MW2S].

Although telemedicine's benefits are drastic, the states and the federal government have yet to amend regulations to assist in maximizing the benefits. A major legal barrier to telemedicine is the in-state licensure system, which requires physicians to be licensed in every state that they practice in.[21] Accordingly, the scope of a physician's practice is limited by the jurisdictional laws, licensing bodies, standards, and regulations within each state that they render care.[22] These limitations not only place a burden on physicians who wish to deliver their expertise across the country, but also on patients who are unable to travel out-of-state to consult with a particularly desirable physician.[23] Imagine, for example, a single mother with a full-time job living in California who is suddenly diagnosed with a rare form of cancer. An oncology center across the country in New Jersey specializes in this particular cancer, with a high rate of success. Utilizing telemedicine, the mother is able to send her medical records to the oncologist in New Jersey for review.[24] The mother can then consult with the oncologist to receive treatment and easily maintain consistent follow-up appointments through secured videoconferences from the comfort of her California home. She does not have to spend thousands of dollars or valuable time away from her children traveling across the country in order to receive the medical care that she deserves. Yet, if the New Jersey oncologist is not licensed to practice in California, then the mother is at an unfair disadvantage.[25] In such an unfortunate case, the mother's only options are to see a different doctor, sacrifice her limited resources to travel to New Jersey, or hope that the New

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[21] *See* Daley, *supra* note 14, at 87 ("[T]elemedicine laws lag behind the pace of the science. . . . The lack of legal guidance hinders the world's ability to improve health care by capitalizing on the advances in telecommunications technology.").

[22] *See* Casaundra Johnson, Comment, *Crossroads: How the Intersection of Technology, Medicine, and the Law, Impact the Administration of Healthcare in Florida and Puerto Rico*, 46 INTER-AMER. L. REV. 209, 216–19 (2015).

[23] *See* Whalen v. Roe, 429 U.S. 589, 604, 604 n.33 (1977) (stating that "a doctor's right to administer medical care has [no] greater strength than his patient's right to receive such care").

[24] Radiology was the first medical field to fully take advantage of telemedicine by creating teleradiology; however, telemedicine ultimately peaked with the development of the internet in the 1990s, and the two have continued to grow congruently. The internet paved the way for the growth of the telemedicine industry by providing faster communication, larger information storage, improved security, mobile application development, and much more. *History of Telemedicine*, MD PORTAL (Sept. 23, 2015), http://mdportal.com/education/history-of-telemedicine/ [https://perma.cc/9DRE-MYRZ].

[25] Today, "[w]ith technology's ability to span state borders, provider licensure portability is a key issue" to the success of telemedicine. NAT'L CONFERENCE OF STATE LEGISLATURES, TELEHEALTH POLICY TRENDS AND CONSIDERATIONS 4 (2015), http://www.ncsl.org/documents/health/telehealth2015.pdf [https://perma.cc/JK63-52GL]; *see also* *Navigating State Medical Licensure*, AM. MED. ASS'N, https://www.ama-assn.org/life-career/navigating-state-medical-licensure [https://perma.cc/K5NE-KYQU].

Jersey specialist will obtain a medical license to practice in California. Unfortunately, it is unlikely that the specialist will secure a license in California as it is overly burdensome for physicians to obtain a license in every state that they wish to practice.[26] Due to this burden, the state licensing system operates as an antithesis to the goal of telemedicine, which is to provide a seamless and convenient approach to universal health care access, both for the doctor and for the patient.[27]

With the advent of emerging technology, accessing health care within the United States and beyond opens up infinite possibilities for helping the sick, regardless of where they live.[28] It is clear that if the obstacles stemming from the in-state license requirements are not resolved soon, patients will continue to disproportionately suffer from lack of physician resources and the overall inability to receive deserved medical treatment.[29] This note urges Congress to supplement the current in-state licensure laws with a federal licensing system that operates at two levels: (1) a federal certifying board that licenses individual physicians to practice telemedicine at the multistate level and (2) a federal registration system that licenses telemedicine programs.

Part I of this note summarizes the current state licensure laws, including statutory exceptions which have attempted to expand in-state patient access to out-of-state physicians, and vice versa. Part II introduces initial constitutional issues rising from the current state licensure laws, such as violations of the Dormant Commerce Clause. Part III discusses how the evolution of telemedicine has disrupted traditional legislative power and

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[26] Letter from Andrew J. Demetriou, Chair of Health Law Section, American Bar Association, to The House of Delegates (Aug. 2008) [hereinafter *American Bar Association Letter*] ("Requiring a physician to obtain multiple licenses in order to practice telemedicine across state lines is duplicative, expensive and burdensome.").

[27] The purpose of telemedicine is to expand the reach of medicine throughout the United States. *Telehealth Benefits*, AM. TELEMEDICINE ASS'N, http://www.americantelemed.org/about/about-telemedicine [https://perma.cc/6UBK-PFME]. However, by requiring state-by-state licenses, telemedicine's potential expansion is constrained. *Id.* The licensure requirement burdens physicians who want to practice at a multistate or national level, and the requirement "burdens patients' rights to choose and avail themselves of the best possible medical care irrespective of where their provider is located." *American Bar Association Letter*, *supra* note 26.

[28] While telemedicine can be used to treat patients globally, this note only addresses the realm of telemedicine throughout the United States.

[29] The Congressional Budget Office has estimated that by 2024, there will be an additional twenty-six million insured Americans, and about twenty percent of them will live in areas with physician shortages. The Association of American Medical Colleges predicts that by 2020, there will be a shortage of around ninety thousand physicians. *See* La Couture, *supra* note 13; *see also* Avery Schumacher, Note, *Telehealth: Current Barriers, Potential Progress*, 76 OHIO ST. L.J. 409, 424 (2015) (stating that telemedicine calls for a new licensing system because "[t]he historical justifications for state based physician licensure are outdated and no longer relevant . . . . [and] developments in technology and medical knowledge remove the exclusivity of health care as a local concern" (footnote omitted)).

urges federal regulation of the telemedicine industry. Part IV explains why alternative proposals to federal regulation have not yet been successful. Part V argues that the right to access medical care via telemedicine is a fundamental right and, accordingly, proposes a two-fold federal telemedicine licensing system to further this fundamental right.

I. HISTORY OF REGULATIONS GOVERNING THE HEALTH CARE INDUSTRY

Regulation of the health care industry is deeply rooted in constitutional law.[30] The Tenth Amendment seeks to preserve federalism and further the "tripartite governmental structure" between the federal government, the state government, and the people.[31] Therefore, while the federal government sets standards governing medical training and testing, the states set local standards governing the reach and the scope of the physicians' practice.[32] States have an independent interest in ensuring that health care professionals, rendering services to their in-state citizens, are fully competent.[33] As former president Franklin Delano Roosevelt said in 1932, "[t]he success or failure of any government in the final analysis must be measured by the well-being of its citizens. Nothing can be more important to a state than its public health."[34]

A. *Current State Medical License System*

Most states delegate the authority to regulate medical practices—including the issuance of physician licenses—to their

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[30] "Under current constitutional law, the federal health care law is clearly constitutional." Erwin Chemerinsky, *The Health Care Law Is Constitutional*, SCOTUSBLOG (Aug. 5, 2011), https://www.scotusblog.com/2011/08/the-health-care-law-is-constitutional/ [https://perma.cc/682G-VWW6].

[31] Richard T. Cosgrove, Comment, Reno v. Condon*: The Supreme Court Takes a Right Turn in Its Tenth Amendment Jurisprudence by Upholding the Constitutionality of the Driver's Privacy Protection Act*, 68 FORDHAM L. REV. 2543, 2545 (2000) (discussing the "tripartite governmental structure"). Under the Tenth Amendment, the individual states are vested with the power to police the medical field within their limited geographical borders. *See* U.S. CONST. amend. X; Kocher, *supra* note 11.

[32] Kocher, *supra* note 11.

[33] *See, e.g.*, Smith v. Am. Packing & Provision Co., 130 P.2d 951, 957 (Utah 1942) (holding that professional licensing statutes were intended to ensure that the public was receiving services by persons who were qualified through training and experience, and thus able to competently render the services offered in return for compensation); Daley, *supra* note 14, at 88 ("Licensing serves the essential purpose of ensuring that physicians meet academic and clinical competence standards. This helps to protect the public from unfit or impaired practitioners. Licensing also helps to enforce continuing standards." (footnote omitted)).

[34] INST. MED., THE FUTURE OF THE PUBLIC'S HEALTH IN THE 21ST CENTURY 96 (2003).

independently established state medical boards.[35] Although physician licensing standards and regulations vary from state to state, all states require that practicing physicians hold a valid license in the state where the patient is located.[36] Obtaining a license, nonetheless multiple licenses in various states, is a "rigorous process" that is extremely costly, time consuming, and strictly enforced.[37] Physicians practicing in a state without a valid license face significant penalties, including both criminal and civil liability.[38]

Furthermore, prior to qualifying for a medical license, all states require applicants to pass an exam testing their knowledge of state regulations and medical practices within their particular field of practice.[39] For example, physicians must complete either the U.S. Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA).[40] The USMLE is a three-step assessment that evaluates prospective physicians' abilities to "apply knowledge, concepts, and principles, and to demonstrate fundamental patient-centered skills, that are important in health and disease

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[35] FED'N STATE MED. BDS., U.S. MEDICAL REGULATION TRENDS AND ACTIONS 6–7 (2018), https://www.fsmb.org/siteassets/advocacy/publications/us-medical-regulatory-trends-actions.pdf [https://perma.cc/LC5P-BM2D] [hereinafter TRENDS AND ACTIONS]; *see also* Gade v. Nat'l Solid Wastes Mgmt. Ass'n, 505 U.S. 88, 108 (1992) ("States have a compelling interest in the practice of professions within their boundaries, and that as part of their power to protect the public health, safety, and other valid interests they have broad power to establish standards for licensing practitioners and regulating the practice of professions." (quoting Goldfarb v. Va. State Bar, 421 U.S. 773, 792 (1975))); Dent v. West Virginia, 129 U.S. 114, 128 (1889) (holding that every state has the right to license its physicians).

[36] *Physician Licensure*, CTEL (2011), http://ctel.org/expertise/physican-licensure/ [https://perma.cc/QLF3-CQPP].

[37] TRENDS AND ACTIONS, *supra* note 35, at 6. For example, to obtain a medical license in New Jersey, there is a non-refundable application fee of $325, an endorsement fee of $225, and a registration fee of $290 per year, and it typically takes up to three months to obtain the license after sending in an application. The Bd. of Med. Exam'rs, *Licensing and the Application Process*, NJ CONSUMER AFF. (Aug. 2017), https://www.njconsumeraffairs.gov/Documents/licenseprocess/BME-Licensing-August-2017.pdf [https://perma.cc/ZQ5V-UQ3S].

[38] INST. MED., TELEMEDICINE: A GUIDE TO ASSESSING TELECOMMUNICATIONS IN HEALTH CARE 90 (Marilyn J. Field ed., 1996).

[39] For example, optometrists must pass an examination administered by the National Board of Examiners in Optometry; state boards establish what score applicants must receive to pass. NAT'L BD. EXAMINERS IN OPTOMETRY (2020), https://www.optometry.org/state_requirements.cfm [https://perma.cc.UVD3-BEHB]. Podiatric physicians must pass the National Boards, which includes two parts. *Doctor of Podiatric Medicine*, AM. ASS'N COLLS. PODIATRIC MED., https://www.aacpm.org/becoming-a-podiatric-physician/ [https://perma.cc/QR25-2Y5J].

[40] Both exams are "national multi-part examinations . . . designed to assess the physician's knowledge, clinical and communication skills." TRENDS AND ACTIONS, *supra* note 35, at 24. Many boards put extra restrictions on the exams, such as limiting the number of times a physician can take the exam, and limiting the time period available to take the exam. *Id.*

and that constitute the basis of safe and effective patient care."[41] The COMLEX-USA assesses comparable skills, but pertains to applicants seeking to practice osteopathic medicine.[42]

B. Exceptions for Out-of-State Physicians

Various states and federal agencies have attempted to alleviate the burdens posed by the current in-state licensure system; although the states have yet to come to a consensus regarding alternative approaches to licensing.[43] State legislatures, for example, have sought to amend their laws to carve out particularized exceptions to the in-state licensure requirements in specified circumstances,[44] such as implementing a "military exception"[45] and an "emergency exception."[46] Nonetheless, as

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[41] *About USMLE*, U.S. MED. LICENSING EXAMINATION, https://www.usmle.org [https://perma.cc/V679-UN53].

[42] *See COMLEX-USA*, NAT'L BD. OSTEOPATHIC MED. EXAM'RS, https://www.nbome.org/exams-assessments/comlex-usa/ [https://perma.cc/L5S3-CK45].

[43] For example, the Federation of State Medical Boards offers a "Uniform Application" which has a one-time application fee of $60 and allows physicians to send one license application to multiple medical boards. *See UA Fees and Process*, FED'N ST. MED. BDS., https://www.fsmb.org/uniform-application/ua-process/ [https://perma.cc/SV4G-9WMW]. Physicians must also pay a fee to have all their existing licenses verified by the medical board of each state that issued the license, in addition to any other fees required by that specific state. *Id.*; *see also Licensure Verification Information*, FED'N ST. MED. BDS. (Aug. 2008), https://www.fsmb.org/globalassets/ua/x-pdfs/licensure-verification-information.pdf [https://perma.cc/7S4A-Q3SJ] (listing state-by-state medical boards' processing fees for license verifications). While the Uniform Application seeks to alleviate the burden of obtaining multiple in-state licenses, all fifty states have yet to accept the Uniform Application. *UA Participating Boards*, FED'N ST. MED. BDS., https://www.fsmb.org/uniform-application/ua-participating-boards/ [https://perma.cc/826S-492J]. For instance, New Jersey does not accept the Uniform Application suggested by the Federation of State Medical Boards. *Id.*

[44] For example, the Alabama Legislature found that, "technological advances are occurring in the practice of optometry, thereby changing the practice of optometry, and that those technological advance are in the public interest," however, the legislature noted the importance of the "state's ability to regulate and monitor" such practices to ensure "the protection of the citizens of this state and for the public interest, health, welfare, and safety" ALA. CODE § 34-22-80. Thus, in order to protect the safety of in-state patients while also endorsing the positive uses of telemedicine, the legislature enacted ALA. CODE § 34-22-85, which allows "[a] licensed optometrist, who is not licensed in Alabama . . . [to] utilize[ ] telemedicine across state lines in an emergency." Likewise, many states allow medical students to administer care to patients under the direct supervision and advisement of a licensed physician. *See, e.g.*, UTAH CODE ANN. § 58-1-307(1)(b); MD. CODE ANN., HEALTH OCC. § 14-302(1). Many states also allow team physicians to treat athletes while out-of-state at a specific sporting event. *See, e.g.*, KY. REV. STAT. ANN. § 311.560.

[45] *See, e.g.*, UTAH CODE ANN. § 58-1-307(1)(a) (allowing "an individual serving in the armed forces of the United States, the United States Public Health Service, the United States Department of Veterans Affairs, or other federal agencies while engaged in activities regulated" by that federal agency, may practice in Utah "if the individual holds a valid license . . . issued by any other state or jurisdiction recognized by the division"); FLA. STAT. § 458.3151; John A. Casciotti, *Fundamentals of Military Health Law: Governance at the Crossroads of Health Care and Military Functions*, 75 A.F. L. REV. 201, 210–11 (2016).

[46] *See e.g.*, W. VA. CODE R. § 30-14-12D (b)(3)(B); CAL. BUS. & PROF. Code § 2058. The emergency exception, however, is strictly enforced; for example, California's exception

applied and implemented by each state's medical boards, the foregoing exceptions still frustrate physicians seeking to practice across state borders.[47]

1. State-Specific Approaches to Alleviate the In-State License Requirement

Various states have also implemented exceptions that allow out-of-state licensed physicians to render care to in-state patients at the assistance of an in-state licensed physician.[48] In 2004, Pennsylvania amended their Medical Practice Act so that out-of-state physicians could provide home health care services under the "auspices of a Pennsylvania licensed home health care agency."[49] Similarly, Georgia has enacted a "peer-to-peer" consultation exception, which allows a physician licensed in another state to practice in Georgia, so long as a local licensed physician retains ultimate authority over the patient's treatment and diagnosis.[50] Florida also provides an exception for long distance care, allowing an in-state patient to consult with an out-of-state doctor, if an in-state doctor supervises the patient's treatment and controls any diagnoses.[51]

Additionally, some states recognize a "reciprocal license" for rendering telemedical services, whereby the state medical board will recognize a physician's out-of-state license, provided that the physician's license is in good standing.[52] States that recognize a reciprocal license explicitly only permit the licensee to practice medicine through interstate commerce and not through in-person consultations.[53] Moreover, while the reciprocity system seeks to expand the reach of medicine, it is constrained by the

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only applies when an in-state licensed practitioner is not readily available. People v. Mangiagli, 218 P.2d 1025, 1029 (Cal. App. Dep't Super. Ct. 1950).

[47] For example, Florida will issue a "[t]emporary certificate for practice in areas of critical need" to out-of-state physicians who currently hold a valid license in any U.S. jurisdiction, *provided that the physician pays an application fee of* $300. FLA. STAT. § 458.315(1). In addition to the $300 fee, the issuance of a temporary certificate is subject to further restrictions set by the board and the State Surgeon General. *See id.* § 458.315(3).

[48] *See infra* notes 49–51 and accompanying text.

[49] Act 44, Special Notice Regarding Home Health Care Services Ordered by Out-of-State Physicians (Aug. 2004) (explaining that the intent of the Act was to "permit individuals who live in or have recently moved to Pennsylvania to retain [their] out-of-state physician").

[50] Thomas B. Ferrante & Nathaniel M. Lacktman, *10 Tips for Complying with Georgia's Telemedicine Laws*, FOLEY & LARDNER LLP (Feb. 26, 2018), https://www.healthcarelawtoday.com/2018/02/26/10-tips-for-complying-with-georgias-telemedicine-laws/ [https://perma.cc/N64V-R6CU].

[51] FLA. STAT. ANN. § 456.47(6)(b).

[52] *See* United States v. Rodriguez, 532 F. Supp. 2d 316, 326 (2007); NEV. REV. STAT. § 630.261.

[53] *See, e.g.*, OR. REV. STAT. § 677.139.

acknowledgment of reciprocity in the other states.[54] Comparably, Pennsylvania issues "extraterritorial license[s]" which allow physicians licensed in any "adjoining state" near Pennsylvania's boundary line to render medical care to patients in Pennsylvania.[55] Lastly, states have adopted legislation that permits an out-of-state licensed specialist to apply for a special-purpose license to render specialized medical services across state lines "by electronic or other means."[56]

2. Removing the In-State License Requirement Amid a Nationwide Crisis

Many state medical boards will waive the in-state license requirement in emergency situations, however, what constitutes an "emergency" is often ambiguous.[57] As of this note's publication, the United States is suffering from the COVID-19 pandemic and it is unclear if rendering care to COVID-19 patients constitutes as such an "emergency."[58] Due to the highly contagious nature of the virus, and its rapid spread, many states have implemented "shelter in place" policies instructing individuals not to leave their home.[59] As a result, even individuals who normally have access to medical care are unable to visit their health care providers in person.[60] Moreover, states may suffer from physician shortages if health care providers get sick from the virus as well.[61] The use of telemedicine, however, limits the risk of exposure and spread of the virus and

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[54] *See, e.g.*, ALA. CODE § 34-24-507 (allowing out-of-state physicians to practice medicine or osteopathy in Alabama, provided that the state of the physician's principal practice and license to practice also "permit[s] or allow[s] for the issuance of a special purpose license to practice medicine or osteopathy").

[55] 63 PA. CONS. STAT. § 422.34.

[56] Hageseth v. Superior Court, 150 Cal. App. 4th 1399, 1424, 1424 n.28 (2007); *see, e.g.*, ALA. CODE § 34-24-500 (stating that it is in the "public interest" to allow the practice of medicine or osteopathy to occur across state lines "because of technological advances and changing practice patterns").

[57] Emily H. Wein et al., *COVID-19: States Waive In-State Licensing Requirements for Health Care Providers*, FOLEY & LARDNER LLP (Mar. 17, 2020), https://www.foley.com/en/insights/publications/2020/03/covid-19-states-waive-licensing-requirements [https://perma.cc/Z3AF-DYGX].

[58] *See id.*

[59] Gregory M. Chabon et al., *Shelter In Place Orders: Are You an "Essential Business"?*, NAT'L L. REV. (Mar. 23, 2020), https://www.natlawreview.com/article/shelter-place-orders-are-you-essential-business [https://perma.cc/6QUS-U2AE].

[60] Kim Mack, *Difference Between Social Distancing, Quarantine, Isolation, and Shelter in Place*, PREEMPTIVE LOVE (Mar. 24, 2020), https://preemptivelove.org/blog/social-distancing-quarantine-isolation-shelter-in-place/ [https://perma.cc/KV6A-WW2S].

[61] Josh Archambault, *Coronavirus Requires Telehealth Update from Congress and States*, FORBES (Mar. 17, 2020), https://www.forbes.com/sites/theapothecary/2020/03/17/coronavirus-requires-telehealth-update-from-congress-and-states/#3dd89b77da55 [https://perma.cc/E9U7-2KWM].

increases the number of available physicians.[62] Acknowledging the barriers of state-by-state licensure on the reach of telemedicine, federal officials temporarily removed the in-state license requirement, opening up the option for individuals to seek medical help across state borders via telemedicine.[63]

Overall, the foregoing statutory exceptions demonstrate that the states and the federal government have begun to recognize that the traditional in-state physician license requirements are unable to operate coextensively with the current health care demands. This trend further corroborates the proposition that, in light of technological advances, state-specific licenses are no longer sensible.

II. ECONOMIC EFFECTS OF THE CURRENT IN-STATE HEALTH CARE SYSTEM

Since various economic sub-sectors encompass the health care sector, Congress can regulate the telemedicine industry under the Commerce Clause.[64] The federal government's commerce power, however, is "theoretically 'concurrent'" with the state government's commerce power.[65] The Dormant Commerce Clause, as established by the Supreme Court, is an example of this "concurrent" power dynamic.[66] Under the Dormant Commerce Clause, state laws that place an undue burden on interstate commerce are inherently deemed unconstitutional.[67] Specifically,

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[62] *Id.* (stating that "[t]he spread of disease does not stop at the state border, so our laws need to be modernized to allow providers in good standing . . . to provide care, when medically necessary, to a patient regardless of where that patient may be."); *see also* Eric Wicklund, *Feds OK Interstate Licensing, Paving Way for Telehealth Expansion*, POL'Y NEWS (Mar. 19, 2020), https://mhealthintelligence.com/news/feds-ok-interstate-licensing-paving-way-for-telehealth-expansion [https://perma.cc/ADW3-BABM].

[63] Wicklund, *supra* note 62.

[64] The Commerce Clause grants the federal government enumerated power to regulate commerce "among the several states." U.S. CONST. art. I, § 8, cl. 3; *see The Role of the Health Care Sector in the U.S. Economy*, 142 EMP. BENEFIT RES. INST. ISSUE BRIEF 3 (Oct. 1993), https://www.ebri.org/docs/default-source/ebri-issue-brief/1093ib.pdf?sfvrsn=d9e5292f_0 [https://perma.cc/S37W-2BSJ]; *see also* Shelby Livingston, *Wall Street Is Betting on Health Insurance Industry*, MOD. HEALTHCARE (Jan. 30, 2019), https://www.modernhealthcare.com/article/20190130/NEWS/190139991/wall-street-is-betting-on-health-insurance-industry [https://perma.cc/84AS-9GQ9] (discussing the health care industry in relation to Wall Street); Chemerinsky, *supra* note 30.

[65] *The Dormant Commerce Clause*, CONST. L. REP., https://constitutionallawreporter.com/dormant-commerce-clause/ [https://perma.cc/FPD5-Q9SJ].

[66] *See* Richard L. Revesz, *Federalism and Interstate Environmental Externalities*, 144 U. PA. L. REV. 2341, 2396 (1996) ("[T]he standards of the Dormant Commerce Clause flow from a vision about the appropriate relationships among states in our federal system.").

[67] U.S. CONST. art. I, § 8, cl. 3; *see also* Am. Trucking Ass'ns v. Mich. PSC, 545 U.S. 429, 433 (2005) (explaining that the Dormant Commerce Clause "prevents a State from 'jeopardizing the welfare of the Nation as a whole' by 'plac[ing]burdens on the flow of commerce across its borders that commerce wholly within those borders would not bear.'" (quoting Okla. Tax Comm'n v. Jefferson Lines, 514 U.S. 175, 180 (1995))); Pam

the Dormant Commerce Clause sets constitutional standards for invalidating state laws that (1) facially discriminate against out of state commerce,[68] (2) are facially neutral between in-state and out-of-state interests but have an impermissibly protectionist purpose or effect,[69] and (3) are facially neutral but have a disproportionate adverse effect on interstate commerce.[70] The health care industry is inherently economic in many aspects, including the sale of medical devices, medical research, development of drugs, employment of physicians and medical staff, and regulation of health insurance.[71] Hence, the economy changes in correlation with changes in the health care industry. For example, the resulting inequity of access to health care professionals, especially in rural areas, has a negative effect on the economy.[72]

The impact that the health care industry has on the Dormant Commerce Clause is particularly important today with the growing integration of technology and health at exponential levels.[73] The telemedicine industry is rapidly proliferating and is

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Brinegar & Melissa McGinley, *Telepractice and Professional Licensing: A Guide for Legislators*, COUNCIL ON LICENSURE ENFORCEMENT & REG. (1998), https://www.clearhq.org/resources/teleguide.htm [https://perma.cc/3ZR7-VUAB] (noting the "frustration" of state professional licensure on telemedicine).

[68] *See* City of Philadelphia v. New Jersey, 437 U.S. 617, 628–29 (1978) (striking down New Jersey's law that refused to let waste generated out-of-state into their in-state landfills, explaining that the law discriminated against other states).

[69] *See* Bacchus Imps. v. Dias, 468 U.S. 263, 270 (1984); Garber v. Menendez, 888 F.3d 839, 843 (6th Cir. 2018).

[70] *See* Kassel v. Consol. Freightways Corp., 450 U.S. 662, 675–76 (1981); *id.* at 680 (Brennan, J., concurring) (stating that "[i]n considering a Commerce Clause challenge to a state regulation, the judicial task is to balance the burden imposed on commerce against the local benefits sought to be achieved by the State's lawmakers." (emphasis omitted)).

[71] *See* THE ECONOMICS OF HEALTHCARE (Aug. 30, 2017), https://scholar.harvard.edu/files/mankiw/files/economics_of_healthcare.pdf [https://perma.cc/B5RT-9VWT]; *see also* Ariz. v. Maricopa Cty. Med. Soc'y, 457 U.S. 332, 349–51 (1982) (holding that health care is part of interstate trade for purposes of antitrust laws); ANNA ZARET & DARIEN SHANSKE, THE DORMANT COMMERCE CLAUSE: WHAT IMPACT DOES IT HAVE ON THE REGULATION OF PHARMACEUTICAL COSTS? 1, 2 (Nov. 2017), https://nashp.org/wp-content/uploads/2017/11/DCC-White-Paper.pdf [https://perma.cc/6B42-JGGB] (discussing how state laws regulating pharmaceutical costs may implement the Dormant Commerce Clause); *How States Can Avoid Dormant Commerce Clause Legal Challenges When Regulating Drug Costs*, NAT'L ACAD. ST. HEALTH POL'Y (Nov. 14, 2017), https://nashp.org/how-states-can-avoid-dormant-commerce-clause-legal-challenges-when-regulating-drug-costs/ [https://perma.cc/8HSG-9VF3] (discussing how "[t]he pharmaceutical industry has used [the Dormant Commerce Clause] as one way to challenge recent state laws that attempt to eradicate price gouging or bring more transparency to how the industry establishes drug prices," including challenges to a Maryland state law that protected "consumers from generic prescription drug price-gouging" and challenges to a Nevada law that required "manufacturers to provide information about the costs of manufacturing and marketing diabetes drugs").

[72] *See* La Couture, *supra* note 13 and accompanying text.

[73] Indicative of the rising use of technology-integrated health care, "[i]t is estimated that there are at least half a billion smartphone users who currently have at least one mHealth app installed on their phone." Dov Greenbaum, *Avoiding Overregulation*

predicted to increase to "[nineteen percent] annually from $38 billion in 2018 to over $130 billion by 2025," creating an entirely new stream of revenue for providers to tap into.[74] This prospective market, nonetheless, is greatly constrained by the in-state medical licensing laws.[75] For example, Pennsylvania's "extraterritorial license" exemption law facially discriminates against out-of-state physicians that wish to expand their practice to Pennsylvania residents but who are not licensed in either Pennsylvania or one of the few states adjacent to Pennsylvania's borderline.[76]

Similarly, the availability of in-state physicians on telemedicine platforms effects both the beneficial welfare of society and the financial success of the industry.[77] For example, Smart Vision Labs employs licensed optometrists who remotely review patients' auto refractor and vision exam results and then issue updated prescriptions and contact lens renewals.[78] Due to intrastate licensure restrictions, however, a patient can only reap the benefits of Smart Vision Labs if an optometrist licensed in the patient's state is employed by the platform.[79] Thus, while the objective of telemedicine is to "help as many patients as possible,"[80] that objective is greatly curtailed by each states' respective licensing requirements. For example, if there is no optometrist working for Smart Vision Labs licensed in Maryland, then Maryland residents are stripped the benefit of quick and easy access to eyecare, a benefit that patients in other states may freely enjoy. This disproportional access to health care subsequently

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in the Medical Internet of Things, *in* BIG DATA, HEALTH LAW, AND BIOETHICS 129, 132 (I. Glenn Cohen et al. eds., 2018).

[74] Zoë LaRock, *The Telemedicine Boom Is Imminent, and It's Creating Opportunities for Providers*, BUS. INSIDER (Mar. 29, 2019), https://www.businessinsider.com/telemedicine-will-boom-but-barriers-persist-2019-3 [https://perma.cc/U896-B424].

[75] *Id.*

[76] 63 PA. CONS. STAT. § 422.34.

[77] *See* Pierron Tackes, *Going Online with Telemedicine: What Barriers Exist and How Might They Be Resolved*, 11 OKLA. J.L. & TECH., 1, 22–23 (2015). For example, as of March 2020, Express Care Virtual—a telemedicine platform—only offers services from physicians licensed in California, Alaska, Montana, Oregon, and Washington. *Providence Express Care Virtual FAQs: Who Can Use Express Care Virtual?*, PROVIDENCE EXPRESS CARE, https://virtual.providence.org/faqs.html [https://perma.cc/BWW8-LBUK]. Therefore, only patients residing in those five states can use the app, placing an undue burden on the economic effects of interstate commerce.

[78] *See Why Doctors Are Embracing Telemedicine*, SMART VISION LABS (May 18, 2017), https://www.smartvisionlabs.com/blog/why-doctors-are-embracing-telemedicine/ [https://perma.cc/FX29-YHRJ]; *Frequently Asked Questions*, SMART VISION LABS (2017), https://www.smartvisionlabs.com/how-it-works/frequently-asked-questions/ [https://perma.cc/G36N-AUC3].

[79] *See Telemedicine Is the Future of Optical Retail*, SMART VISION LABS (2017), https://www.smartvisionlabs.com/telemedicine/ [https://perma.cc/FEK8-N2GD] (explaining that the test "results are sent electronically to our *state-licensed* ophthalmologists/optometrists" (emphasis added)).

[80] *Why Doctors Are Embracing Telemedicine*, *supra* note 78.

effects interstate commerce; those Maryland patients may not have the resources available to make an in-office appointment with their local optometrist and thus may make the decision to continue wearing their expired contact lenses or outdated glasses.[81] In this scenario, the patients' decision inevitably leads to a reduction in the amount of contact lenses and eyeglasses ordered annually, further negatively effecting interstate commerce.[82] This result also places a burden on the interstate commerce of online retailers such as 1-800-Contacts[83] and Warby Parker,[84] whose business strategies are based on providing easy access to prescription eyeglasses by enabling patients to order online without requiring an in-person consultation.[85] Likewise, patients who cannot avail themselves of telemedicine may be less likely to go to the doctor for their annual check-up, especially if they are not experiencing any urgent medical problems. As a result, those patients will not start new, or update old, medications; consequently, fewer drugs will be prescribed annually which will negatively impact the interstate commerce of drugs.[86]

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[81] For example, patients may not have the financial resources to travel to, and pay for, an in-person visit with their doctor. However, private health plans, such as Medicare Advantage plans, now cover telemedicine e-visits; thus widespread use of telemedicine across state borders could positively effect commerce within the insurance industry. *See* Steven Findlay, *Virtual Doctor Visits Are Getting More Popular, but Questions Remain About Who Pays*, WASH. POST (May 6, 2018), https://www.washingtonpost.com/national/health-science/virtual-doctor-visits-are-getting-more-popular-but-questions-remain-about-who-pays/2018/05/04/cbe262f6-4c85-11e8-b725-92c89fe3ca4c_story.html [https://perma.cc/T7J9-UCA5]. Likewise, patients may not have the time to travel to the doctor's office, wait to see the doctor, sit through an eye exam, pay in-person, etc.; fortunately, however, this draining process is significantly curtailed in the telemedicine setting. *See How It Works*, SMART VISION LABS, https://www.smartvisionlabs.com/how-it-works/ [https://perma.cc/K749-4H7J] (indicating that the test takes only five minutes and no appointments are necessary); *see also* Jamie Gier, Commentary, *Missed Appointments Cost the U.S. Healthcare System $150B Each Year*, HEALTH MGMT. TECH. (Apr. 26, 2017), https://www.scisolutions.com/uploads/news/Missed-Appts-Cost-HMT-Article-042617.pdf [https://perma.cc/DDM3-PXE4] (noting total cost of missed appointments in the health care system).

[82] If patients do not have their eyes checked, they will not update their prescription. They might not even know that their prescription has changed. This could foreseeably lead to public danger; for example, if they are driving with an inadequate prescription.

[83] *See* Emily O'Brien, *Liingo Eyewear Acquired by 1-800 Contacts*, PR NEWSWIRE (Jan. 30, 2018), https://www.prnewswire.com/news-releases/liingo-eyewear-acquired-by-1-800-contacts-300590527.html [https://perma.cc/KJ72-WYDV] (stating that 1-800 Contacts is the largest contact lens retailer in the United States, serving more than 12 million customers and delivering more than 200,000 contacts daily to customers).

[84] *See* Heather Yamada-Hosley, *We Tried Warby Parker's New Prescription App*, LIFEHACKER (June 7, 2017, 10:30 AM), https://lifehacker.com/we-tried-warby-parker-s-new-prescription-app-1795874261 [https://perma.cc/EQ24-QPU9] (discussing Warby Parker's development of a mobile app that allows patients to take a brief eye exam via their iPhone or laptop which is then sent to a Warby Parker doctor for a prescription check).

[85] *Id.*

[86] A 2015 study indicated that telehealth "prompts patients to seek care for minor illnesses that otherwise would not have induced them to visit a doctor's office." Ana B. Ibarra, *Are Virtual Doctor Visits Really Cost-Effective? Not So Much, Study Says*, CAL.

Another example of how state telemedicine laws violate the Dormant Commerce Clause is demonstrated in *Teladoc, Inc. v. Texas Medical Board*.[87] Although the *Teladoc* case did not directly involve the in-state license requirement, the court's opinion is influential.[88] At issue in *Teladoc* was the Texas Medical Board's decision to amend its telemedicine laws by requiring physicians to conduct a physical, in-person, examination of all patients before rendering any telemedical care.[89] Plaintiffs argued that the law violated the Dormant Commerce Clause by discriminating "against physicians who are licensed in Texas, but are physically located out of state."[90] Defendants moved to dismiss the complaint, purporting that plaintiffs failed to state a claim under the Commerce Clause.[91] The court, however, denied the Motion to Dismiss, explaining that plaintiffs' Commerce Clause challenge was "sufficient."[92] The court noted that a future, fact-intensive inquiry was required "to determine 'the nature of the local interest involved, and [] whether it could be promoted as well with a lesser impact on interstate activities.'"[93] This decision illustrates the similar inequities and respective burdens that the in-state licensure requirements impose on physicians practicing telemedicine. Globally, in-state license laws limit the reach of telemedicine, inevitably thwarting the potential market reach of businesses and the extent of physician care.[94] This barrier poses a substantial obstacle to overall product production, health care, and economic turnaround of interstate commerce.[95]

HEALTHLINE (Mar. 6, 2017), https://californiahealthline.org/news/are-virtual-doctor-visits-really-cost-effective-not-so-much-study-says/ [https://perma.cc/KK7A-856R].

[87] Teladoc, Inc. v. Tex. Med. Bd., No. 1-15-CV-343, U.S. Dist. LEXIS 166754 (W.D. Tex. Dec. 14, 2015).

[88] Ching-Yin Chen, *Recent Development and Implication of* Teladoc, Inc. v. Texas Medical Board, MICH. BUS. & ENTREPRENEURIAL L. REV. (Nov. 13, 2016), http://mbelr.org/recent-development-and-implication-of-teladoc-inc-v-texas-medical-board/ [https://perma.cc/T8JF-LHYP] (discussing the overall implications of *Teladoc* on the telemedicine industry).

[89] Teladoc, Inc. v. Tex. Med. Bd., No. 1-15-CV-343, U.S. Dist. LEXIS 166754, at *6–7 (W.D. Tex. Dec. 14, 2015).

[90] *Id.* at *30.

[91] *Id.*

[92] *Id.* at *35.

[93] *Id.* (alteration in original) (quoting Pike v. Bruce Church, Inc., 397 U.S. 137, 142 (1970)).

[94] Tackes, *supra* note 77, at 3, 14–17.

[95] *See* Yamada-Hosley, *supra* note 84 (providing that the Warby Parker app is currently only available to patients who live in California, New York, Florida, or Virginia).

III. NATIONWIDE REGULATION OF TELEMEDICINE WOULD BENEFIT MODERN SOCIETY IN UNPRECEDENTED WAYS

Traditionally, Article X of the U.S. Constitution vests power in the individual states to regulate any activities affecting the health, safety, and welfare of those residing within the state's geographical borders.[96] Telemedicine, however, is greatly distinguished from the traditional physician-patient interaction, which historically took place within the controlled borders of one state.[97] In contrast, the very nature of the physician-patient interaction that arises out of telemedicine inevitably affects citizens amongst numerous states.[98] The innovation of telemedicine has made aspects of the health care industry more universal, which accordingly calls for innovative federal regulation.[99] While many states have already amended laws to move in this direction, the in-state medical license requirements continue to disrupt the innovation.[100]

Moreover, legislative history endorses the proposition of reevaluating the regulation of "traditional" local activities once

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[96] *See* Goldfarb v. Virginia State Bar, 421 U.S. 773, 792 (1975) ("[T]he States have a compelling interest in the practice of professions within their boundaries, and that as part of their power to protect the public health, safety, and other valid interests they have broad power to establish standards for licensing practitioners and regulating the practice of professions."); U.S. CONST. amend. X.; *see also supra* Part I.

[97] *See* INST. MED., *supra* note 38, at 89 (breaking the "physical link" between face-to-face communication of a clinician and the patient, telemedicine "challenges the traditional view of professional practice"). Traditionally, patients would call their local physician and set up an appointment. They would then drive a few blocks for their in-person doctor visit. After examination, the patient would leave the doctor's office with a physical prescription slip that they would then fill at their local pharmacy. With telemedicine, the patient never has to drive anywhere, prescriptions are filled electronically, and pharmacies use mobile applications to inform the patient when their prescriptions are available. Nothing requires the physician to be located near the patient because the patient does not have to go anywhere.

[98] Telemedicine literally means "healing at a distance." WORLD HEALTH ORG., TELEMEDICINE: OPPORTUNITIES AND DEVELOPMENTS IN MEMBER STATES 8 (2010), https://www.who.int/goe/publications/goe_telemedicine_2010.pdf [https://perma.cc/8N5Y-453G].

[99] Importantly, this note does not ignore the argument that telemedicine is just an extension of our current medical system and the states retain their long-held right to experiment and regulate certain activity. Gonzales v. Raich, 545 U.S. 1, 42 (2005) (O'Connor, J., dissenting) (noting that "State[s] may . . . try novel social and economic experiments without risk to the rest of the country" (quoting New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting))). When the states cannot efficiently regulate certain activities, however, then Congress should step in. *See* David M. Metres, *The National Impact Test: Applying Principled Commerce Clause Analysis to Federal Environmental Regulation*, 61 HASTINGS L.J. 1035, 1067 (2010); *see also* Pharmaceutical Mfrs. v. FDA, 484 F. Supp. 1179, 1188 (D. Del. 1980) ("The fact that the practice of medicine is an area traditionally regulated by the states does not invalidate those provisions of the [Food, Drug & Cosmetic Act] which may at times impinge on some aspect of a doctor's practice.").

[100] *See* CTR FOR CONNECTED HEALTH POL'Y, STATE TELEHEALTH LAWS & REIMBURSEMENT POLICIES (2019), https://www.cchpca.org/sites/default/files/2019-05/cchp_report_MASTER_spring_2019_FINAL.pdf [https://perma.cc/ECQ6-PCX5] (discussing and analyzing the states' trend towards expanding telehealth reimbursement).

they have transformed into national enterprises; such reevaluation often requires a reinterpretation of the Constitution.[101] Due to telemedicine, the health care industry has transformed from a traditional enterprise to a national enterprise. As David Strauss's theory of a "Living Constitution" acknowledges, as our technology, economy, and social mores change, "it seems inevitable that the Constitution will change, too."[102] To turn a blind eye to the health care changes that stem from telemedicine "would fit our society very badly" and "would be a hindrance, a relic that keeps us from making progress and prevents our society from working in the way it should."[103] It is thus crucial that the judiciary continuously review the Constitution's text and subsequently scrutinize governing laws to ensure that they coexist with our modern and improved society.[104]

Accordingly, the rapid evolution of medical technology has already prompted swift legal changes in the health care industry. For instance, the Ryan Haight Online Pharmacy Consumer Protection Act (Ryan Haight Act) was enacted in 2018 and set regulations for the prescription of controlled substances through telemedicine.[105] Pursuant to the Ryan Haight Act, doctors were prohibited from prescribing controlled substances to patients over telemedicine consultations, unless the doctor conducted a prior in-person medical examination with the patient, subject to seven

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[101] In *Garcia v. San Antonio Metro. Trans. Auth.*, 469 U.S. 528, 530 (1985), the Metropolitan Transit Authority (MTA) argued that Congress could not control their minimum wage and overtime requirements under the Fair Labor Standards Act (FLSA) because employer-employee relationships were traditionally regulated by the state. Overturning its previous decision in *Nat'l League of Cities v. Usery*, 426 U.S. 833, 872 (1976), the Court held that Congress could control the MTA's minimum wage and overtime requirements under the FLSA because the courts had trouble defining what constituted "traditional function[s]." 469 U.S. at 530 (internal quotation marks omitted). The Court reasoned that, since Congress is composed of representatives from the state, then Congress must make the necessary judgments about the scope of any intrusion upon state sovereignty. *Id.* at 546. Another example is reflected in Fourth Amendment jurisprudence; when the Framers enacted the Fourth Amendment, securing the right "of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures," the Framers could not have predicted whether or not cell phones would be protected. *See* Riley v. California, 573 U.S. 373, 381, 403 (2014) (re-interpreting the Fourth Amendment as applied to today's mobile technology).

[102] David A. Strauss, *The Living Constitution*, U. CHI. L. SCH. (Sept. 27, 2010), https://www.law.uchicago.edu/news/living-constitution [https://perma.cc/H4AH-7VH4].

[103] *Id.*

[104] Utilizing a non-originalist approach to interpreting the Constitution, Strauss argues that the Constitution is a "living" document that inevitably changes as the world changes "in incalculable ways . . . that no one could have foreseen when the Constitution was drafted." *Id.*

[105] Laurie T. Cohen, et al., *Trump Signs Telemedicine Law Related to Prescribing Controlled Substances*, NIXON PEABODY (Nov. 6, 2018), https://www.nixonpeabody.com/ideas/articles/2018/11/07/trump-signs-telemedicine-law [https://perma.cc/TH7H-MKSR].

"practice of telemedicine exceptions."[106] When the Ryan Haight Act was enacted, however, the Department of Justice (DOJ) and Drug Enforcement Administration (DEA) had failed to finalize the application process and requirements for some of the exceptions.[107] Acknowledging the dramatic shortage of physicians within the United States, President Trump promptly ordered the DEA to quickly finalize the process and requirements.[108]

Similarly, on January 3, 2018, Congress disrupted the traditional state regulation of health care by passing the Veterans E-Health and Telemedicine Support Act of 2017 (VETS Act).[109] The VETS Act removed the in-state license restriction, allowing VA practitioners to cross state lines to provide patient health care through telemedicine, provided that the VA practitioner be licensed in at least one state.[110] Prior to the VETS Act, VA physicians could only waive the in-state license requirement if both the veteran and the physician were located in a federally owned facility.[111] The VETS Act was implemented to ease the access of

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[106] Jacqueline N. Acosta & Nathaniel M. Lacktman, *President Signs New Law Allowing Telemedicine Prescribing of Controlled Substances: DEA Special Registration to Go Live*, NAT'L L. REV. (Oct. 25, 2018), https://www.natlawreview.com/article/president-signs-new-law-allowing-telemedicine-prescribing-controlled-substances-dea [https://perma.cc/XAP8-CLGX]; *see also Prescribing Controlled Substances Without In-Person Exam: Practice of Telemedicine Under Ryan Haight Act*, NAT'L L. REV. (Apr. 17, 2017), https://www.natlawreview.com/article/prescribing-controlled-substances-without-person-exam-practice-telemedicine-under [https://perma.cc/9FNN-WFN9] (listing the "practice of telemedicine" exceptions as follows: "(1) Treatment in a hospital or clinic," "(2) Treatment in the physical presence of a practitioner," "(3) Indian Health Service or tribal organization," "(4) Public health emergency declared by the Secretary of Health and Human Services," "(5) Special registration," "(6) Department of Veterans Affairs medical emergency," "(7) Other circumstances specified by regulation").

[107] Acosta & Lacktman, *supra* note 106.

[108] *See* H.R. 5483, 115th Cong. (2018) (enacted); H.R. 6, 115th Cong. (2018) (enacted); Acosta & Lacktman, *supra* note 106.

[109] *See* Veterans E-Health and Telemedicine Support Act of 2017, S. 925, 115th Cong. (2018) (enacted); Jessica Davis, *Senate Passes VETS Act, Would Enable VA Providers to Offer Telehealth Across State Lines*, HEALTHCARE IT NEWS (Jan. 4, 2018), https://www.healthcareitnews.com/news/senate-passes-vets-act-would-enable-va-providers-offer-telehealth-across-state-lines [https://perma.cc/SJ5W-W378]; *see also* Letter from Robert L. Wergin, Board Chair, Am. Acad. of Family Physicians, to John McCain, Mac Thornberry, Jack Reed, & Adam Smith, Senate Comm. on Armed Servs. (Sept. 1, 2016) (urging that the VETS Act "would undermine the state-based system of medical licensure and 'federalize' medical licensure for physicians . . . . [and] would undermine the existing system of medical licensure, under which each state governs the practice of medicine within its borders").

[110] The Veterans E-Health and Telemedicine Support Act of 2017, S. 925, 115th Cong. § 1730B(a) (2018) (enacted) allows a licensed health care professional of the VA to practice "at any location in any State, regardless of where the covered health care professional or the patient is located, if the covered health care professional is using telemedicine to provide [VA medical health services.]" *See also VETS Act Passes the Senate*, CTR. TELEHEALTH & E-HEALTH L. (Jan. 4, 2018), https://ctel.org/2018/01/vets-act-passes-the-senate/ [https://perma.cc/WQJ3-QU2D].

[111] *Veterans' Access to Telemedicine Across State Lines Clears Major Hurdle*, YORKTEL, https://www.yorktel.com/blog/veterans-access-to-telemedicine/ [https://perma.cc/XXZ6-4JFF].

health care for veterans in rural areas, along with disabled veterans, who otherwise had to travel great lengths to federal facilities if there was no licensed VA practitioner in their state.[112]

Furthermore, in 2017, the Food and Drug Administration (FDA) acknowledged that their traditional procedures and tactics in overseeing health care products no longer coincided with the innovative products being developed, stating that they "must adapt and evolve" their procedures in order to "foster, not inhibit, [the] innovation" of digital health tools.[113] Consequently, the FDA made important amendments regarding their involvement in digital health.[114] New amendments addressed certain clinical decision support software that would no longer be categorized as medical devices and thus no longer regulated by the FDA, and further identified principles to follow for evaluating safety, effectiveness and performance of medical device software.[115] These changes are just the beginning of the legal reforms necessary to aid the use of digital innovation in medicine.

IV. THE IN-STATE LICENSURE REQUIREMENTS REMAIN A LEGAL BARRIER TO TELEMEDICINE

It is evident that the individual states have struggled to strike the balance between maintaining their in-state license regulations while also providing their citizens with the least burdensome access to health care.[116] While state statutory exceptions to the in-state medical license requirement are a step in the right direction, they fail to solve the overarching problem because not every state has implemented an exception.[117] Further, not every state is in an equal position to be able to implement

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[112] Davis, *supra* note 109.

[113] Press Release, Scott Gottlieb, U.S. Food & Drug Admin. Comm., Statement on Advancing New Digital Health Policies to Encourage Innovation, Bring Efficiency and Modernization to Regulation (Dec. 6, 2017), https://www.fda.gov/newsevents/newsroom/pressannouncements/ucm587890.htm [https://perma.cc/27X8-MTYH].

[114] *Id.*

[115] Notice of Availability, 84 Fed. Reg. 51,167, 51,167 (Sept. 27, 2019).

[116] *See supra* Part I.

[117] *See supra* Section I.B. *See generally Chart of Physician Licensing Requirements by State*, SISKIND SUSSER, P.C., http://www.visalaw.com/wp-content/uploads/2014/10/physicianchart.pdf [https://perma.cc/35RJ-PTKG]. In contrast, the legal field is similarly regulated by the states because attorneys must be admitted to their respective state bar in order to practice; however, almost all jurisdictions provide an exception whereby an out-of-state attorney can apply *pro hac vice* to temporarily represent an out-of-state client. MODEL RULES OF PROF'L CONDUCT r. 5.5 cmt. 9 (AM. BAR ASS'N 1983). While legal jurisdictions vary on their standards for granting *pro hac vice*, the availability of the temporary option in all jurisdictions makes the practice of law less rigid and less burdensome than the practice of medicine.

certain exceptions.[118] Remote, rural states are especially burdened.[119] For example, geographically isolated states that do not share a border with another state—such as Alaska and Hawaii—physically cannot enact statutory exceptions similar to Pennsylvania's "extraterritorial license" exemption.[120] From this perspective, the current legislative attempts to relax the in-state license requirement in certain states, such as Pennsylvania, result in discrimination against underserved, out-of-state patients.[121] This inequity further implicates the Dormant Commerce Clause, calling for congressional intervention.[122]

Therefore, this note proposes that Congress, through their constitutionally enumerated powers, set forth regulations for medical licensing within the telemedicine industry.[123] The majority of past proposals to alleviate the state-border limitations and burdens of in-state license laws have pegged congressional power under either the Commerce Clause or the Spending Clause.[124] These attempts, however, have not been successful in removing the licensure barrier. Taking a different approach, this proposal seeks congressional regulation of telemedical professionals under the Due Process clause.

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[118] *See Why Our Doctors Need National Licensure*, INTOUCH HEALTH, https://intouchhealth.com/removing-telehealth-barriers-with-national-licensing/ [https://perma.cc/CK2E-8D3K].

[119] *See* EMILY HELLER ET AL., NAT'L CONF. OF STATE LEGISLATURES, IMPROVING ACCESS TO CARE IN RURAL AND UNDERSERVED COMMUNITIES: STATE WORKFORCE STRATEGIES 1 (AUG. 2017), https://www.ncsl.org/documents/health/WorkforceStrategies2017.pdf [https://perma.cc/24VH-6HZQ].

[120] *See supra* note 55 and accompanying text.

[121] Pursuant to Pennsylvania's exception, Pennsylvania residents may be treated by out-of-state physicians licensed in one of the states bordering Pennsylvania. 63 PA. CONS. STAT. § 422.34. There are six states bordering Pennsylvania: West Virginia, Delaware, Ohio, New York, New Jersey, and Maryland. *See United States Map with Capitals*, MAPS WORLD, https://www.mapsofworld.com/usa/usa-state-and-capital-map.html [https://perma.cc.TH9G-BRUK]. Comparably, however, even if states such as Florida were to enact similar legislation, the residents in Florida still would not have as much physician access as the Pennsylvania residents because only two states surround Florida: Georgia and Alabama. *See id.* Therefore, because of its physical location, Florida residents are disproportionately affected as compared to more centrally-located residents in states such as Pennsylvania.

[122] *See supra* Part II.

[123] *See infra* Part V.

[124] The Spending Clause authorizes Congress to regulate activities affecting the general welfare. U.S. CONST. art. I, § 8, cl. 1. The Commerce Clause authorizes Congress to regulate intrastate activities that are economic and have a substantial effect on interstate commerce. *Id.* cl. 3.

A. *Redefining the "Originating Site" or "Place of Service"*

Scholars have proposed that Congress redefine the "originating site" or "place of service"[125] from the state of the receiving patient to the state of the delivering physician.[126] Under this approach, physicians could render their services across state lines, while only retaining a license to practice in their home state.[127] Regardless of where the patient's treatment occurred, the physician would only be subjected to the rules and regulations of their home state.[128] If physicians are only bound by their home state's laws, then traditional litigation rules and procedures may have to be reconsidered as they apply to telemedicine; for example, personal jurisdiction and choice of law rules may need to be amended.[129] This approach also loses sight of the legislatures' original intent for requiring physicians to obtain medical licenses in the residing state of the patient, which was to protect the safety of the individual state's citizens.[130] By changing the "place of service" to the residing state of the physician, state legislatures would be unable to monitor and oversee health care services delivered to their in-state citizens.[131]

B. *The Interstate Medical Licensure Compact*

The Interstate Medical Licensure Compact (IMLC) is an agreement among participating states, which offers a voluntary and expedited process for physicians to obtain out-of-state

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[125] *Telehealth: Can NPs Treat Out-of-State Patients?*, MIDLEVEL U (Sept. 30, 2016), https://www.midlevelu.com/blog/telehealth-can-nps-treat-out-state-patients [https://perma.cc/QR8M-R96J] ("When it comes to telehealth, the location of the patient is considered by federal law to be the 'place of service.'").

[126] Shirley Svorny, *Liberating Telemedicine: Options to Eliminate the State-Licensing Roadblock*, CATO INST. (Nov. 15, 2017), https://www.cato.org/publications/policy-analysis/liberating-telemedicine-options-eliminate-state-licensing-roadblock [https://perma.cc/J5S4-YZWV].

[127] *Id.*

[128] *Id.*

[129] *See* Bonnie Ackerman, *Is the Doctor In? Medical Malpractice Issues in the Age of Telemedicine*, WILSON ELSER (Apr. 16, 2019), https://www.professionalliabilityadvocate.com/2019/04/is-the-doctor-in-medical-malpractice-issues-in-the-age-of-telemedicine/#page=1 [https://perma.cc/SM7W-VBT6]; CHRISTA M. NATOLI, CTR. TELEHEALTH & E-HEALTH LAW, SUMMARY OF FINDINGS: MALPRACTICE AND TELEMEDICINE (Dec. 2009), http://www.ctel.org/research/Summary%20of%20Findings%20Malpractice%20and%20Telemedicine.pdf [https://perma.cc/TDC6-P3C5].

[130] Drew Carlson & James N. Thompson, *The Role of State Medical Boards*, AM. MED. ASS'N J. ETHICS (Apr. 2005), https://journalofethics.ama-assn.org/article/role-state-medical-boards/2005-04 [https://perma.cc/JW3E-YUZ5].

[131] Since telemedicine creates a physician-patient relationship behind closed doors, such as in the privacy of one's home, legislatures may have no way of knowing where physicians are rendering patient care from. This could lead to fraud and deception, which is what the current in-state license scheme sought to avoid.

licenses.[132] The IMLC is based on a "mutual recognition" model, with a mission "to increase access to health care for patients in underserved or rural areas and allowing them to more easily connect with medical experts through the use of telemedicine technologies."[133] Twenty-nine states currently belong to the IMLC.[134] The IMLC, however, does not sufficiently resolve the overarching problem of maintaining licenses in multiple states. First, professionals seeking licensure under the IMLC still face in-state barriers because approval ultimately remains within the individual state medical board's discretion and physicians still need to retain a license in every state they practice in.[135] Second, not all fifty states have joined the IMLC.[136] Third, only physicians who belong to the American Board of Medical Specialties or the American Osteopathic Association's Bureau of Osteopathic Specialists are eligible to participate in the IMLC.[137] If the IMLC truly seeks to expand the availability of physicians in underserved areas, then it should not restrict any qualified doctors from applying.[138] Under the current standards set by the IMLC, just 80 percent of physicians are eligible for IMLC licensure.[139] Fourth, states—and their respective physicians—participating in the IMLC are exposed to more disciplinary action because all participating states assume liability for each other's actions by agreeing to work together and sharing information with each other.[140] As a result, the IMLC imposes additional costs and risks on participating states due to nontraditional fiduciary responsibilities.[141] Liability under the IMLC further raises issues

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[132] *The IMLC*, INTERSTATE MED. LICENSURE COMPACT, https://imlcc.org [https://perma.cc/D3U4-3YE5] [hereinafter *IMLC*].

[133] *Id.*; *see Article I: Commission Purpose, Function and Bylaws*, INTERSTATE MED. LICENSURE COMPACT, https://imlcc.org/wp-content/uploads/2018/03/IMLC-Bylaws-Article-I-Purpose.pdf [https://perma.cc/9WEE-T3X9].

[134] *IMLC*, *supra* note 132.

[135] The application process leverages the physician's information previously submitted to their state of principal license (SPL). *Id.* The SPL then verifies the physician's information and conducts an updated background check. *Id.* After obtaining verification from the SPL, the physician will receive qualification through the IMLC and can then select from any number of participating IMLC states to practice in. *Id.* However, the Medical Board's discretion to approve the physician for an expedited out-of-state license is wholly discretional. *Id.*

[136] *Id.*

[137] *Vote 'No' on the Interstate Medical Licensure Compact*, AM. BD. PHYSICIAN SPECIALTIES, https://www.abpsus.org/medical-licensure-compact-opposition [https://perma.cc/KW2W-VP33].

[138] *See IMLC*, *supra* note 132.

[139] *Id.*

[140] Thomas Sullivan, *Interstate Medical Licensure Compact – Expands to 17 States*, POL'Y & MED. (May 5, 2018), https://www.policymed.com/2016/06/interstate-medical-licensure-compact-expands-to-17-states.html [https://perma.cc/VTN5-BQCE].

[141] The Compact is made up of two appointed Commissioners from each state. *IMLC*, *supra* note 132.

regarding inconsistent standards, enforcement policies, and administration protocol among each participating state.[142] The individual states have established their own standards and policies of professionalism pursuant to the particular needs and concerns of their local citizens; it is questionable that these states would be willing to accept higher or lower standards and obligations than previously followed.[143] For example, unprofessional conduct is defined by each state's Medical Practice Act and thus may vary from state to state.[144] Therefore, states may be reluctant to join the IMLC, and physicians may be reluctant to participate under the regime, because they do not want to be subjected to more or less obligations than are already imposed by their home state medical board.[145]

V. PROPOSED FUNDAMENTAL RIGHT TO HEALTH CARE IN THE DIGITAL ERA

This note proposes that Congress regulate the telemedicine industry under the Fourteenth Amendment, which limits the power of the states so that no person shall be deprived of "life, liberty, or property, without due process of law."[146] Under the Due Process Clause of the Fourteenth Amendment, Congress may strike down state laws pursuant to the following three standards. First, any state law that impinges on or unduly

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[142] Laura E.A. Wibberley, Comment, *Telemedicine in Illinois: Untangling the Complex Legal Threads*, 50 J. MARSHALL L. REV. 885, 910-14 (2017) (discussing how the standard of care for telemedicine varies from state to state). Moreover, even the process for qualifying for multi-state licenses among the IMLC's participating states differ; some IMLC member states expedite the license process by "leveraging the physicians existing information previously submitted in their state of principal license (SPL)." *IMLC*, *supra* note 132. The SPL then verifies the information and conducts a background check. *Id.* Whereas other member states, such as Minnesota, do not refer to SPL to issue licenses. *Id.* Furthermore, issues arising from IMLC licensing are deferred to the "respective state boards." *Id.* Since state requirements and procedures governing the issuance of medical licenses differ from state to state, this deference to the state boards may ultimately lead to inconsistency among the execution of the Compact Member States. *See State Specific Requirements for Initial Medical Licensure*, FED'N ST. MED. BOARDS, https://www.fsmb.org/step-3/state-licensure/ [https://perma.cc./PQ5V-HCLH] (outlining the differences among each state with regards to licensing procedures).

[143] *See* Bill Marino et al, *A Case for Federal Regulation of Telemedicine in the Wake of the Affordable Care Act*, 16 COLUM. SCI. & TECH. L. REV. 274, 286–88 (2015); TELEMEDICINE REPORT TO CONGRESS (Jan. 31, 1977), https://www.ntia.doc.gov/legacy/reports/telemed/legal.htm [https://perma.cc/97LE-YJEH].

[144] *See* TRENDS AND ACTIONS, *supra* note 35, at 7.

[145] For example, the IMLC implements higher standards to receive an expedited license by requiring physicians to be board certified; comparably, no individual state requires board certification for licensing. FED. TRADE COMM'N, POLICY PERSPECTIVES: OPTIONS TO ENHANCE OCCUPATIONAL LICENSE PORTABILITY 21 (Sept. 2018), https://www.ftc.gov/system/files/documents/reports/options-enhance-occupational-license-portability/license_portability_policy_paper_0.pdf [https://perma.cc/89KT-K4X5].

[146] U.S. CONST. amend. XIV, § 1.

burdens a fundamental right is reviewed under strict scrutiny.[147] The law will only be upheld if it is narrowly tailored and the least restrictive means to achieve a compelling governmental interest.[148] Second, state laws that negatively affect a protected class are reviewed under intermediate scrutiny.[149] The law will only be upheld if it is "substantially related to an important governmental interest."[150] Third, a state law that does not affect a fundamental right or protected class will be upheld, so long as it is "rationally related to a legitimate state interest."[151]

This proposal requires the courts to identify a new fundamental right; specifically, a fundamental right to receive telemedicine services across all state borders.[152] Under this approach, the current in-state license laws, as determined by the patient's residency, pose an undue burden on the proposed fundamental right to receive telemedicine and thus are subject to strict scrutiny.[153] Crucially, the state laws do not survive constitutional scrutiny because they are not the least restrictive means of achieving a compelling governmental interest and are not narrowly tailored.[154] Here, the states' alleged compelling interest is in protecting patients from "the vulnerabilities that are an inherent part of being a patient."[155] With technological capabilities, however, these vulnerabilities can be protected in much less burdensome ways.[156] The state laws are also over-

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[147] *See* Roy G. Spece & David Yokum, *Scrutinizing Strict Scrutiny*, 40 VT. L. REV. 286, 293 (2015).

[148] Washington v. Glucksberg, 521 U.S. 702, 720 (1997) (explaining that the Due Process Clause "provides heightened protection against government interference with certain fundamental rights and liberty interests").

[149] Robert C. Farrell, *Successful Rational Basis Claims in the Supreme Court from the 1971 Term Through* Romer v. Evans, 32 IND. L. REV. 357, 363 (1999).

[150] *Id.*

[151] Bankers Life & Casualty Co. v. Crenshaw, 486 U.S. 71, 83 (1988) (quoting Cleburne v. Cleburne Living Ctr., Inc., 473 U.S. 432, 440 (1985)).

[152] As science progresses, new fundamental rights will reasonably arise. *See* Lawrence O. Gostin, *Public Health Reform*, 91 AM. J. PUB. HEALTH 1365, 1366 (2001) (stating that "many public health laws predate the vast changes in constitutional (e.g., equal protection and due process) and statutory (e.g., disability discrimination) law that have transformed social and legal conceptions of individual rights").

[153] *See* Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2298 (2016) (holding that when a law's burden to a fundamental right is outweighed by the law's benefits, the law is deemed unconstitutional).

[154] *See* Spece & Yokum, *supra* note 147, at 295.

[155] Harrison Blythe, Note, *Physician-Patient Speech: An Analysis of the State of Patients' First Amendment Rights to Receive Accurate Medical Advice*, 65 CASE WESTERN RES. L. REV. 795, 796 (2015).

[156] As this note later discusses, technology can ensure telemedical patient safety through digitized capabilities, such as fingerprint identification, facial and voice recognition, and audio and visual recordings. *See* Shirley V. Svorny, *Does Physician Licensing Serve a Useful Purpose?*, INDEP. INST. (July 10, 2000), https://www.independent.org/news/article.asp?id=266 [https://perma.cc/QAZ5-8QG6] (arguing that "[t]he presumption underlying state licensing of physicians is that the state offers consumers needed protection through its efforts

inclusive because they apply to *all* citizens, thus covering ranges of people with vastly disproportionate economic resources, social statuses, and geographical standings.[157]

A. *Overview of Judicially Established Fundamental Rights Under the Fourteenth Amendment*

An analysis of Supreme Court precedent indicates that a fundamental right is constitutionally recognized if the right is "deeply rooted in this Nation's history and tradition."[158] Accordingly, fundamental rights bear some relation to individual "autonomy" or "privacy."[159] Judicially established fundamental rights include, but are not limited to, the right to marry,[160] the right of parents to make decisions regarding their children,[161] and the right to travel.[162] Courts have taken two identifiable approaches to establishing fundamental rights: (1) the "history and tradition" framework;[163] and (2) the penumbras framework.[164] In practice, the former approach limits fundamental rights to those "traditionally protected and deemed fundamental to the American scheme of ordered liberty by the framers."[165] Limiting the constitutional protection of fundamental rights to what the Framers intended, however, would overly thwart the evolution of

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toward monitoring physician competence" no longer applies because technological software can manage physician competence and performance).

[157] Spece & Yokum, *supra* note 147, at 307 (an overinclusive law "includes inapplicable persons or entities").

[158] Washington v. Glucksberg, 521 U.S. 702, 720–21 (1997) (quoting Moore v. City of E. Cleveland, 431 U.S. 494, 503 (1977)).

[159] Thomas Wm. Mayo, *Constitutionalizing the "Right to Die,"* 49 MD. L. REV. 103, 112 (1990).

[160] Obergefell v. Hodges, 135 S. Ct. 2584, 2598, 2604–05 (2015).

[161] Troxel v. Granville, 530 U.S. 57, 66 (2000).

[162] Saenz v. Roe, 526 U.S. 489, 502–03 (1999); Dunn v. Blumstein, 405 U.S. 330, 334 (1972).

[163] Moore v. City of E. Cleveland, 431 U.S. 494, 503 (1977).

[164] *See* Glenn H. Reynolds, *Penumbral Reasoning on the Right*, 140 U. PA. L. REV. 1333, 1334–37 (1992). The penumbral approach recognizes fundamental rights that are not explicitly stated in the Constitution's text but that can be derived from other enumerated rights. *See* Phoebe C. Ellsworth, *Legal Reasoning*, *in* THE CAMBRIDGE HANDBOOK OF THINKING AND REASONING 685, 686 (Keith J. Holyoak & Robert G. Morrison eds., 2005) (discussing deductive legal analysis); Brannon P. Denning & Glenn Harlan Reynolds, *Comfortably Penumbral*, 77 B.U. L. REV. 1089, 1092 (1997); John Adams Rizzo, Note, *Beyond* Youngberg*: Protecting the Fundamental Rights of the Mentally Retarded*, 51 FORDHAM L. REV. 1064, 1073 (1983).

[165] Branson D. Dunlop, Comment, *Fundamental or Fundamentally Flawed? A Critique of the Supreme Court's Approach to the Substantive Due Process Doctrine Under the Fourteenth Amendment*, 39 U. DAYTON L. REV. 261, 262 (2014).

telemedicine.[166] Conversely, the latter approach provides more flexibility among the courts to identify new, non-textual rights.[167]

1. Established Fundamental Rights Within the Medical Field

The courts have already begun recognizing that the right to receive health care bears some relation to an individual's "privacy."[168] Advocates have long acknowledged the privity between health and autonomy; for example, in 1998, President Clinton urged Congress to pass a Consumer Bill of Rights, asserting that "every American deserves quality [health] care," including the right to see a doctor of their choice.[169] Similarly, the World Health Organization (WHO) advocates that "[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[170] The WHO further contends that all citizens should have equal access to health care whenever, and wherever, they need it and that "[n]o one should get sick and die just because . . . they cannot access the health services they need."[171]

Accordingly, courts have formerly recognized fundamental rights within the medical arena.[172] Dating back to 1973, in the landmark decision *Roe v. Wade*, the Supreme Court held that a right to privacy included a woman's decision to have an abortion.[173] In *Planned Parenthood v. Casey*, the Court subsequently reaffirmed *Roe*, further establishing that a woman's decision to have an abortion is a fundamental right.[174] In *Planned*

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[166] Our "world has changed in incalculable ways" since the Constitution was adopted over 220 years ago, including technological changes, economical changes, social and changes "in ways that no one could have foreseen when the Constitution was drafted." Strauss, *supra* note 102. Thus, "an unchanging Constitution would fit our society very badly" by hindering innovation. *Id.*

[167] *See* Griswold v. Connecticut, 381 U.S. 479, 482–84 (1965); Kent v. Dulles, 357 U.S. 116, 125–26 (1958).

[168] Gregory D. Curfman, King v. Burwell *and a Right to Health Care*, HEALTH AFF. (June 26, 2015), https://www.healthaffairs.org/do/10.1377/hblog20150626.048913/full/ [https://perma.cc/DNM5-FCVJ].

[169] William J. Clinton, President of the U.S., State of the Union Address (Jan. 27, 1998).

[170] Tedros Adhanom Ghebreyesus, *Health Is a Fundamental Human Right*, WORLD HEALTH ORG. (Dec. 10, 2017), https://www.who.int/mediacentre/news/statements/fundamental-human-right/en/ [https://perma.cc/FN76-9F26].

[171] *Id.*

[172] *See* Curfman, *supra* note 168.

[173] Roe v. Wade, 410 U.S. 113, 153 (1973) (acknowledging a privacy right in a woman's freedom to choose whether or not to terminate her pregnancy).

[174] Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 869–79 (1992).

Parenthood, the Court established a novel standard, holding that the states could continue regulating abortions so long as the regulations do not place an "undue burden" on a woman's right to choose whether or not to have an abortion.[175] Applying the undue burden test in *Whole Woman's Health v. Hellerstedt*, the Court struck down a Texas law that required abortion facilities to meet certain statutory requirements.[176] The Court reasoned that there were only seven centers in the state that would meet the statutory requirements and therefore women who did not live near one of those seven facilities would have to travel long distances in order to have an abortion.[177] Additionally, the limited number of clinics further created an undue burden by providing "fewer doctors, longer waiting times, and increased crowding."[178] Overall, the Court concluded that the burdens posed by the challenged law outweighed the benefits, deeming the law unconstitutional.[179]

Furthermore, in *Brown v. Plata*, the Supreme Court acknowledged a right to health care for prisoners.[180] Justice Kennedy's majority opinion noted that "adequate medical health care" is compatible with the concept of "human dignity."[181] Notably, Justice Kennedy has used this "human dignity" language in past decisions to strike down laws that both discriminated against a particular class and precluded that class from accessing a fundamental right.[182] Overall, these cases demonstrate judicial precedent acknowledging the privity between human dignity, privacy, and health care.

Following the above Supreme Court decisions, under the "penumbral approach," if specific medical procedures such as abortions are deemed a fundamental right, then it logically follows that the broader, general right "to freely receive medical treatment" ought to be established. The Court in *Zablocki v. Redhail* applied this framework in deeming marriage a fundamental right, explaining that "it would make little sense to recognize a right of privacy with respect to other matters of family

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[175] *Id.* at 878.

[176] *See* Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2318–20 (2016).

[177] *Id.* at 2316.

[178] *Id.* at 2313.

[179] *Id.* at 2320.

[180] Brown v. Plata, 563 U.S. 493, 511 (2011).

[181] *Id.* at 510–11 (stating that "[p]risoners retain the essence of human dignity inherent in all persons" and a prison depriving prisoners of "adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society").

[182] *See, e.g.*, United States v. Windsor, 570 U.S. 744, 770 (2013) (indicating the fact that DOMA interfered "with the equal dignity . . . conferred by the States in the exercise of their sovereign power, was more than an incidental effect of the federal statute"); Lawrence v. Texas, 539 U.S. 558, 567 (2003) (stating that what relations adults choose to enter in their own private lives is their own "dignity as free persons").

life and not with respect to the decision to enter the relationship that is the foundation of the family in our society."[183] Likewise, it would make little sense to recognize a right with respect to a specific medical procedure and not with respect to the decision to seek medical care in the first place.

2. Current State Laws Fail Constitutional Scrutiny

If the courts conclude that the right to receive medical care is a fundamental right, then the current licensing laws—requiring that doctors are licensed in the receiving patient's state—would not survive strict scrutiny because such laws do not represent the least burdensome approach, nor are they narrowly tailored. First, although the legislatures typically contend that the in-state license requirement serves a compelling government interest in protecting the public from "incompetent, unprofessional, and improperly trained physicians,"[184] as applied to telemedicine, this requirement is not the least burdensome approach to achieve the foregoing compelling interest.[185] Alternatively, technology provides a less burdensome approach: states can individually monitor the competency of physicians, without requiring a license in every state that the physician practices in, by screening and verifying physicians' credentials digitally through "biometric verification" such as facial recognition, voice pattern recognition, and finger print recognition.[186] The current statutory exceptions to the in-state license requirement also indicate that less burdensome approaches, as compared to the current licensure system, are available and workable.[187] The government's asserted compelling interest is also undermined by the fact that telemedicine programs operated by the federal government are not restricted by any state licensure laws.[188] Second, the in-state license requirement is not narrowly tailored and is overly inclusive. The current licensing laws affect *all* patients seeking consultation via telemedicine; however, in practice the laws disproportionately affect vulnerable patients in isolated, underserved communities, as compared to patients in more prosperous and well-resourced cities.

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[183] Zablocki v. Redhail, 434 U.S. 374, 386 (1978).

[184] Carlson & Thompson, *supra* note 130.

[185] Jake Stroup, *Biometric Identification and Identity Theft*, BALANCE (Dec. 11, 2019), https://www.thebalance.com/biometric-identification-and-identity-theft-1947595 [https://perma.cc/MW7K-KQKY].

[186] *Id.*

[187] *See supra* Section I.B.

[188] Telemedicine in the military, veteran, and prison contexts are not subject to state licensure requirements. INST. OF MED., *supra* note 38, at 89.

Even if the courts do not apply strict scrutiny, the current licensing laws would not even survive the lower "undue burden" standard from *Planned Parenthood v. Casey*.[189] Although the standard in *Planned Parenthood* was established in the abortion context, that case was decided over two decades ago, and the current bench would likely support extending the standard to other fundamental rights within the health care context.[190] Thus, comparable to the burdens in *Whole Woman's Health*, the current medical licensure laws impose substantial obstacles to patients seeking medical care in underserved areas.[191] For example, patients located in isolated states, such as Alaska, might have to drive long distances to get an appointment with a physician.[192] Such an undue burden cannot withstand a compelling justification in light of the fact that telemedicine can feasibly remove such obstacles.[193]

Nonetheless, this note recognizes the reality that urging the Court to recognize a new fundamental right is a difficult task.[194] For example, in *Rose v. Borsos*, the district court refused to recognize "the [fundamental] right to access health care services at one's own expense from willing medical providers."[195] In *Abigail Alliance for Better Access to Developmental Drugs v.*

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[189] Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 874, 876–77 (1992). Courts have typically only applied the undue burden test for abortion-related laws; for example, in *Tucson Woman's Clinic v. Eden*, 379 F.3d 531, 540 (9th Cir. 2004), the court explained that "the undue burden standard is not triggered at all if a purported health regulation fails to rationally promote an interest in maternal health on its face."

[190] *The Undue Burden Standard After* Whole Woman's Health v. Hellerstedt, CTR. FOR REPRODUCTIVE RTS., https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/WWH-Undue-Burden-Report.pdf [https://perma.cc/9HZH-B4ZN] (noting that the use of the undue burden standard "within and *beyond* the abortion context are just starting to take shape." (emphasis added)). In fact, scholars have even proposed extending the undue burden test beyond the Fourteenth Amendment and beyond medically related rights. Clay Calvert & Minch Minchin, *Can the Undue-Burden Standard add Clarity and Rigor to Intermediate Scrutiny in First Amendment Jurisprudence? A Proposal Cutting Across Constitutional Domains for Time, Place & Manner Regulations*, 69 OKLA. L. REV. 623, 650 (2017) (proposing that the undue burden standard be extended to apply to the First Amendment).

[191] *See supra* notes 176–189 and accompanying text.

[192] *See Medically Underserved Area (MUA) Designation*, ALASKA DEP'T HEALTH & SOC. SERVS, http://dhss.alaska.gov/dph/HealthPlanning/Pages/primarycare/mua.aspx [https://perma.cc/LEF3-DQQT].

[193] Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2309 (2016) (indicating that when the burdens imposed from abortion laws outweigh the law's benefits, then the law is unconstitutional).

[194] *See* Shannon L. Pederson, Comment, *When Congress Practices Medicine: How Congressional Legislation of Medical Judgment May Infringe a Fundamental Right*, 24 TOURO L. REV. 791, 808–09 (2008) (noting that "convincing the Court to find a new fundamental right is a difficult proposition").

[195] Rose v. Borsos, No. 13-CV-204, 2018 U.S. Dist. LEXIS 139466, at *22 (E.D. Tenn. Aug. 17, 2018).

Von Eschenback,[196] however, a divided D.C. Circuit Court panel held that terminally ill patients should have unrestricted access to experimental drugs, explaining that "mentally competent, terminally ill adult patients"[197] have a fundamental "right of control over one's body"[198] and, consequently a right to make decisions about their "life free from government interference."[199] In an *en banc* opinion, the full D.C. Circuit Court "reframed the issue not as a personal autonomy right . . . but as a right to access something that is presently inaccessible: drugs that FDA has not yet approved for marketing and use by the public,"[200] reversing the divided panel's earlier decision, and holding that there is no fundamental right to access experimental drugs.[201] Although the court ultimately did not recognize the proposed fundamental right, the decision explicitly did "not address the broader question of whether access to medicine might ever implicate fundamental rights."[202] Consequently, such an issue remains ripe for judicial review.[203] Nonetheless, if such a proposed fundamental right ultimately fails, the government still has congressional power to establish a federal telemedicine licensure system under either the Commerce Clause or the Spending Clause.[204]

B. Proposed Federal Regulation of Telemedicine

The revolution of health-related technology calls for changes in the law, including a federal law regulating the care provided by medical doctors within the telemedicine industry.[205]

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[196] Abigail Alliance for Better Access to Developmental Drugs v. Von Eschenback, 445 F.3d 470 (D.C. Cir. 2006).

[197] *Id.* at 472.

[198] *Id.* at 480.

[199] *Id.* at 472, 483–84 (stating that the right for terminally ill patients to have access to drugs that have been deemed safe by the FDA after Phase I trials is "squarely within the realm of the rights the Supreme Court has held are 'implicit in the concept or ordered liberty'" (quoting Palko v. Connecticut, 302 U.S. 319, 325 (1937))).

[200] Elizabeth Weeks Leonard, Symposium, *Right to Experimental Treatment: FDA New Drug Approval, Constitutional Rights, and the Public's Health*, 37 J.L. MED. & ETHICS 2, 4 (2009).

[201] *Abigail Alliance for Better Access to Developmental Drugs*, 495 F.3d at 711.

[202] *Id.* at 700.

[203] Leonard, *supra* note 200, at 4.

[204] *See* U.S. CONST. art. I, § 8.

[205] The state laws regulating care provided by medical doctors cannot be feasibly implemented along with the rising use of telemedicine, for example, it is likely that future technology and innovation within artificial intelligence may lead to widespread use of robots that could render medical care. *See* Harold Stark, *Prepare Yourselves, Robots Will Soon Replace Doctors in Healthcare*, FORBES (July 10, 2017), https://www.forbes.com/sites/haroldstark/2017/07/10/prepare-yourselves-robots-will-soon-replace-doctors-in-healthcare/#3c650faa52b5 [https://perma.cc/9G33-FN7P]. Since robots are merely artificial intelligence—a scientifically programmed object and not an actual person—the current state licensure system would prove inadequate. *See, e.g.*, Dom Galeon, *For the First Time, a Robot Passed a Medical Licensing Exam*,

This note proposes federal regulation of telemedicine by establishing a two-fold licensing system. First, all physicians must receive a telemedicine license to practice telemedicine. Second, all telemedicine platforms must apply for and receive a license to operate. This section proceeds to consider the logistics of such a licensing system.

1. Mandated Oversight: The Federal Trade Commission and the Food & Drug Administration

At the outset, the Federal Trade Commission (FTC), alongside the FDA, are the most compatible agencies to regulate and issue telemedical licenses, as both agencies have established an interest in the industry.[206] Analogous to the original rationale for requiring physicians to be licensed in the state of the patient, the FTC's mission is to "[p]rotect[] consumers and competition by preventing anticompetitive, deceptive, and unfair business practices through law enforcement, advocacy, and education without unduly burdening legitimate business activity."[207] Under this objective, the FTC has signaled a concern regarding in-state medical licensing laws and their effects on antitrust laws.[208] For example, in 2016, the FTC endorsed an Alaskan State Bill, seeking to eliminate the requirement that only in-

FUTURISM (Nov. 20, 2017), https://futurism.com/first-time-robot-passed-medical-licensing-exam [https://perma.cc/UMS8-GXKE] (discussing the medical licensing of a robot in China via China's national medical licensing exam).

[206] Michael H. Cohen, *FDA Regulates Telemedicine on Smart Phones*, CAM L. BLOG (Sept. 4, 2011), http://www.camlawblog.com/articles/new-regulation/fda-regulates-telemedicine-on-smart-phones/ [https://perma.cc/U4AQ-HF4N] (indicating the FDA's connection with telemedicine by regulating certain devices, such as mobile phones, that are used for telemedicine); *The Growing Influence of The Federal Trade Commission in Telehealth Policy*, AI HEALTHCARE (Sept. 21, 2016), https://www.aiin.healthcare/topics/connected-care/growing-influence-federal-trade-commission-telehealth-policy [https://perma.cc/B85E-EM2F] [hereinafter *FTC in Telehealth*] (indicating that "the FTC has now provided its input in four instances involving state medical boards' ability to regulate its professionals").

[207] *About the FTC*, FED. TRADE COMMISSION, https://www.ftc.gov/about-ftc [https://perma.cc/J6DJ-JVQ3].

[208] *See, e.g.*, N.C. State Bd. of Dental Exam'rs v. F.T.C., 135 S. Ct. 1101, 1108–09 (2015); Letter from the Fed. Trade Comm'n, Office of Policy Planning, to LaTonya Brown, Admin. of the Del. Bd. of Dietetics/Nutrition (Aug. 16, 2016) (on file with author) [hereinafter Letter to Delaware Nutrition Board] (noting that the FTC's interest in the health care market is reflected by their "recent state advocacy comments . . . address[ing] scope of practice and supervision provisions that unnecessarily limit the range of procedures or services a practitioner may provide, or unnecessarily restrict a particular type of practitioner from competing in the market"); Letter from the Fed. Trade Comm'n, Office of Policy Planning, to Del. Bd. of Occupational Therapy Practice, (Aug. 3, 2016) [hereinafter Letter to Delaware Occupational Therapy] (commenting on Delaware's proposed regulation granting occupational therapists and occupational therapy assistants the license and authority to determine whether telehealth is appropriate for patients and, if so, what level of supervision is required).

state Alaskan providers could write prescriptions for Alaskan patients when services were rendered through telemedicine.[209] In favor of the bill, the FTC wrote a letter stating that:

> These provisions would likely increase the supply of telehealth providers, enhance competition, and reduce health care costs, thereby benefiting Alaskans, especially underserved populations with limited access to health care.
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> . . . Competition is at the core of America's economy, and vigorous competition among sellers in an open marketplace gives consumers the benefits of lower prices, higher quality products and services, and increased innovation. Because of the importance of health care competition to the economy and consumer welfare, anticompetitive conduct in health care markets has long been a key focus of FTC law enforcement, research, and advocacy.[210]

Likewise, in 2016, the FTC commented on the revisions to a Delaware code that required "[a]ll initial evaluations [to] be performed face to face and not through telehealth."[211] The FTC urged the Delaware Board to eliminate the in-person requirement, contending that it "may unnecessarily discourage the use of telehealth and limit its potential benefits" and "may restrict entry of qualified telehealth practitioners, potentially decreasing competition, innovation, and health care quality, while increasing price."[212] Overall, the FTC's standpoint urged against "imposing rigid and unwarranted . . . supervision requirements"[213] and supported the "reduction of barriers to telemedicine."[214] Further, in support of the Veterans Affairs rule,[215] the FTC stated that the rule would "increase access to telehealth services, increase the supply of telehealth providers, increase the range of choices available to patients, improve health care outcomes, and reduce long-term costs by reducing hospitalizations and treatment of advances disease, and reduce travel costs incurred by the VA."[216] The FTC also recognized that the rule could set a leading example to non-VA

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[209] S.B. 74, 29th Leg., 2nd Sess., § 1-7 (Alaska 2016) (FIN Committee Substitute, amended, Mar. 11, 2016), http://www.legis.state.ak.us/PDF/29/Bills/SB0074E.PDF.

[210] Letter from Marina Lao et al., FTC, to Steve Thompson, House Finance Committee Co-Chair, ALASKA STATE LEG. (Mar. 25, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-alaska-state-legislature-regarding-telehealth-provisions-senate-bill-74-which/160328alaskatelehealthcomment.pdf [https://perma.cc/A65Y-VZ74].

[211] 3800 State Board of Dietetics/Nutrition, 19 Del. Reg. Regs. 1075 (proposed June 1, 2016) (Telehealth regulation to be codified at 24 Del. Admin. Code § 3800-9).

[212] Letter to Delaware Nutrition Board, *supra* note 208.

[213] *Id.*

[214] Letter to Delaware Occupational Therapy, *supra* note 208.

[215] As of June 11, 2018, VA health care providers can treat patients through telemedicine, irrespective of where the patient is located. Authority of Health Care Providers to Practice Telehealth, 83 Fed. Reg. 21,897 (May 11, 2018) (codified at 38 U.S.C. § 1730C).

[216] *Id.* at 21,899.

health care providers, such as state legislatures, to make similar amendments improving access to health care.[217]

The FTC further affirmed their interest in the telemedicine field by filing an amicus brief in response to the lawsuit filed by Teladoc against the Texas Medical Board (TMB).[218] Teladoc's complaint asserted that the rule requiring in-person consultations prior to any telemedicine consultation violated antitrust laws and constituted self-dealing because the TMB consisted of practicing doctors within Texas who have a financial interest in limiting the reach of telemedicine.[219] On behalf of Teladoc, the FTC noted that the regulation in question was not supported by the review of a disinterested state official, as required by the Supreme Court in *North Carolina State Board of Dental Examiners v. FTC*.[220]

In addition to the FTC, the FDA—in their traditional role of regulating medical devices and drugs—has contributed to the ongoing discussion of telemedicine.[221] With innovative uses of digital devices—such as taking your temperature with your iPhone via a mobile application rather than a thermometer—the FDA accordingly drafted guidelines regarding the definition of "mobile medical applications," identifying what mobile devices and applications should be subjected to FDA regulation.[222] Notably, there is much criticism around the FDA's involvement in the telemedicine sector. Specifically, opponents of FDA involvement argue that "[t]he FDA doesn't have a depth of experience . . . that necessarily justifies them [in] heavily regulating this area . . . . FDA involvement in the regulation of these products may kill off the innovation that we're looking

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[217] The FTC's proposition indicates that they have an interest in ensuring that state legislators do not pose substantial burdens on the telemedicine market. *Id.* at 21,897.

[218] Brief for the United States and the Federal Trade Commission as Amici Curiae Supporting Plaintiff-Appellees at 7, Teladoc, Inc. v. Tex. Med. Bd. No. 16-50017 (Sept. 9, 2016) [hereinafter Teladoc Appellee Brief].

[219] Teladoc, Inc. v. Tex. Med. Bd., 112 F. Supp. 3d 529, 533–35 (W.D. Tex. 2015); *see also FTC in Telehealth*, *supra* note 206.

[220] Teladoc Appellee Brief, *supra* note 218, at 7. Comparably, this note's proposal resolves concerns of biases among interested individuals on state medical boards because the proposed federal regulation would not be state specific; therefore, oversight will intrinsically consist of disinterested regulators in accordance with Supreme Court precedent. *See* N.C. Bd. of Dental Exam'rs v. FTC, 135 S. Ct. 1101, 1114, 1116-17 (2015 (holding that "a state board on which a controlling number of decisionmakers are active market participants in the occupation the board regulates" must be actively supervised by the state pursuant to judicially enforced rules to ensure that the board's decisions are not self-motivated).

[221] *See* Cohen, *supra* note 206; Notice, 76 Fed. Reg. 43,689, 43,689–90 (July 21, 2011).

[222] Notice, 78 Fed. Reg. 186 (Sept. 25, 2013); *see also* 21st Century Cures Act, H.R. 34, 114th Cong. (2015); U.S. FOOD AND DRUG ADMIN., FDA-2011-D-0530, POLICY FOR DEVISE SOFTWARE FUNCTIONS AND MOBILE MEDICAL APPLICATIONS (2019).

for."[223] It appears that Congress has also been reluctant to grant the FDA sole authority over the telemedicine industry; for example, the Medical Electronic Data Technology Enhancement for Consumers Health Act (MEDTECH) excluded certain health applications from FDA regulation.[224] Addressing the foregoing concerns, this note's proposal would grant the FDA a very limited role: merely ensuring that the technology enabling telecommunication and thus implementing transmission of telemedicine—i.e., the actual mobile application or internet website—complies with the formal regulations set by the FTC.[225]

2. Proposed National Standards for Regulating Telemedical Licenses

Under the proposed regulation, physicians would be required to pass an amended USMLE.[226] The amended test would add a new section, titled the "Uniform Telemedicine Exam" (UTE), which would be entirely voluntary. This additional section would test a physician's knowledge specifically on telemedicine, including substantive knowledge as well as procedural knowledge such as effective telecommunication skills.[227] Physicians who have already taken and passed the USMLE would only be required to take the

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[223] Greenbaum, *supra* note 73, at 134 (quoting Jeffrey K. Shapiro, a member of the Washington, D.C. law firm of Hyman Phelps & McNamara P.C.).

[224] *Id.* at 134–35.

[225] As mentioned later in this note, the FTC would regulate and issue a telemedicine license to doctors; however, telemedicine platforms will have to comply with particular safety measures, such as facial recognition. Therefore, the FDA will have to ensure that all medical devices used for telemedicine comply with such requirements.

[226] *See About USMLE*, *supra* note 41 and accompanying text. This section refers to the USMLE as the general exam required to obtain a medical professional license; however, depending on the professional's field, the UTE may be added to an exam comparable to the USMLE. For example, in the optometry field, the UTE would be added to the National Board of Examiners in Optometry exam. *See supra* note 39 and accompanying text.

[227] With the increasing use of telemedicine, medical schools and teaching hospitals are offering courses to train physicians on effective skills to succeed in virtual care. Robin Warshaw, *From Bedside to Webside: Future Doctors Learn How to Practice Remotely*, ASS'N AM. MED. COLLS. (Apr. 24, 2018), https://news.aamc.org/medical-education/article/future-doctors-learn-practice-remotely/ [https://perma.cc/6FCC-C2KD].
During the 2013-2014 academic year, about forty-one percent of medical schools offered telemedicine training as a course. *Id.* In 2016-2017, about fifty-eight percent of medical schools offered telemedicine as either a required course or an elective course. *Id.* At Weill Cornell Medicine in New York City, residents and fourth-year students can take electives in telemedicine and digital health. *Id.* In 2018, the UA College of Medicine, Tucson opened a new health sciences "innovation building" for telemedicine training, which included a large video wall. *Id.* A research study identified that the following "themes" of interpersonal skills were important in delivering effective telehealth to patients: "pre-interactional, verbal communication, non-verbal communication, relational, environmental, educational, and an added Management/Operations theme." Beverly W. Henry et al., *Experienced Practitioners' Views on Interpersonal Skills in Telehealth Delivery*, 16 INTERNET J. ALLIED HEALTH SCI. & PRAC., 2018, at 1, 9.

supplemented telemedicine portion of the exam. Prior to taking the UTE, physicians would be required to complete a course that focuses on telemedicine etiquette, including modules on how to use telemedicine devices, the implications of verbal utterances such as hesitations, and nonverbal communication cues such as body language.[228] Completion of a telemedicine course is crucial because telemedicine may otherwise negatively "impact provider-patient communication through depersonalization of the provider-patient relationship, participatory enhancements and impediments, and sensory and non-verbal limitations" due to "absence" of physical touch.[229] Physicians must provide proof that they have completed the course and passed the final exam in order to register for the UTE. Upon passing the UTE, an established Telemedicine Licensing Board (TLB), acting under the authority of the FTC's Bureau of Consumer Protection and comprised of state representatives, would provide physicians with a federal "certified telemedicine number" (CTN), which they may use to practice across state lines on any FDA-certified telemedicine platform.[230]

In addition to administering physicians' unique CTN, the TLB would continuously monitor physician activity and patient data derived from each telemedicine platform.[231] The state representatives that comprise the TLB would have access to state-specific data that would enable the states to retain some sovereignty over their citizens. For example, the representatives would each have access to a digital platform that retains records from all physicians that have treated patients in their state, compiled from all telemedicine platforms. Accordingly, one of the FTC's requirements for a telemedicine platform to be FDA-licensed would be the capacity to transmit day-to-day data to the respective states of the platform's receiving patients.[232] Moreover,

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[228] *See* Jonathan Silverman & Paul Kinnersley, Editorial, *Doctors' Non-verbal Behaviour in Consultations: Look at the Patient Before You Look at the Computer*, BRIT. J. GEN. PRAC., Feb. 2010, at 76–78, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2814257/pdf/bjgp60-076.pdf [https://perma.cc/95DP-NHU6].

[229] EDWARD ALAN MILLER, TELEMEDICINE AND THE PROVIDER-PATIENT RELATIONSHIP: WHAT WE KNOW SO FAR 2, 20 (2010), http://nuffieldbioethics.org/wp-content/uploads/Miller-E-2010-Evidence-review-Telemedicine-and-the-Provider-Patient-Relationship-what-we-know-so-far.pdf [https://perma.cc/JQB2-DF36].

[230] *See Bureaus & Offices*, FED. TRADE COMMISSION, https://www.ftc.gov/about-ftc/bureaus-offices [https://perma.cc/U9LN-DVAV] ("The Bureau of Consumer Protection's mandate is to protect consumers against unfair, deceptive or fraudulent practices. . . . Its actions include individual company and industry-wide investigations . . . and consumer and business education").

[231] State representatives must have an adequate medical background, as approved by the FTC's Telemedicine Licensing Board.

[232] To comply with patient privacy, no personal information would be provided from the telemedicine platform to the state representatives. All that would be transcribed is the doctor's name, doctor's location, patient's location, timing of the consultation, and

members of the TLB would utilize telecommunication, such as videoconferencing, for board meetings.[233]

Accordingly, each telemedicine platform—such as all medical mobile applications—must also be licensed. The FTC's TLB would set forth specific requirements for certification, which all telemedicine platforms must follow.[234] Acknowledging that the initial rationale of the in-state license requirement was to protect the public from "the unprofessional, improper, incompetent, unlawful, fraudulent, deceptive, or unlicensed practice of medicine," these requirements, and ultimate certification, aim to protect the public at large.[235] Acting alongside the FTC's TLB, the FDA would establish a separate department that would be responsible for licensing the telemedicine platforms. In order for businesses to obtain platform licensure, the FDA must certify that the platform complies with the requirements set forth by the FTC's TLB. For example, with the advent of digitalization and other technological advances that are literally available at our fingertips, such as messaging from a watch and videoconferencing from a cell phone, it is now easier than ever to monitor activities at a national level. To further promote the states' concerns of public safety, every physician's CTN would be associated with their digital fingerprint, facial recognition, and/or voice recognition. These identification tools would protect patients against fraudulent acts. To further protect state citizens, platforms must provide state representatives of the TLB access to data regarding their in-state patients.[236] The FDA, prior to granting licenses to telemedicine platforms, would evaluate compliance with, and efficiency of, these protective measures.

Lastly, the proposed federal regulation would not undermine the traditional in-state medical license system because the telemedicine certification system would not abolish the current state medical boards and their relative processes.[237] The federal

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whether the doctor prescribed the patient a controlled substance. This also allows the states to retain their own security breach laws and procedures. *See* Timothy M. Hale & Joseph C. Kvedar, *Privacy and Security Concerns in Telehealth*, AM. MED. ASS'N J. ETHICS (Dec. 2014), https://journalofethics.ama-assn.org/article/privacy-and-security-concerns-telehealth/2014-12 [https://perma.cc/WD3A-FHKL] (discussing that a major concern of patients in telemedicine is the increased risk of a security data breach).

[233] State representatives do not have to worry about traveling across state borders for meetings since they will be able to easily communicate through virtual technology.

[234] *See* FED'N STATE MED. BDS., GUIDELINES FOR THE STRUCTURE AND FUNCTION OF A STATE MEDICAL AND OSTEOPATHIC BOARD 9, 12 (Apr. 2018), http://www.fsmb.org/siteassets/advocacy/policies/guidelines-for-the-structure-and-function-of-a-state-medical-and-osteopathic-board.pdf [https://perma.cc/LA7G-R3NR].

[235] *Id.*

[236] *See supra* text accompanying note 232.

[237] A major concern among the enactment of the VETS Act was that it "would undermine the state-based system of medical licensure and 'federalize' medical licensure for physicians . . . . [and] would undermine the existing system of medical licensure,

system described herein merely supplements the current in-state license system, which would continue to apply to the traditional in-person patient-doctor interaction that it was originally intended to govern. Further, while the aspects of virtual technology, such as Computer-Mediated Communication (CMC),[238] have become a norm in many day-to-day conversations, these technological innovations are continuously developing. Thus, physicians licensed to practice telemedicine by the FTC, pursuant to the above procedures, would be required to attend yearly continuing education programs on telemedicine.[239] Physicians that fail to attend continuing education programs would lose their telemedicine license; however, these physicians would still be able to provide in-person health care to patients where their respective state medical boards have independently license them to practice in. Moreover, in the event that a physician loses their telemedicine license, they may still communicate with patients in their state via "traditional" telecommunication—such as follow-up phone calls, but may not make any diagnoses through any telemedicine portal—so long as the physician has had an in-person consultation with the patient within twenty-four hours.

CONCLUSION

From a utilitarian perspective, society would be better off with the widespread, unrestricted use of telemedicine. The deontological proposed federal regulations set forth within this note acknowledge that the benefits of telemedicine and citizens' rights to health care are paramount. Telemedicine can provide invaluable benefits to patients who were previously unable to access health care. As with all new industries, however, rules and regulations based on antiquated systems must be rewritten. In the past, brick-and-mortar establishments were the only option for a doctor-patient consultation to ensue; but technology

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under which each state governs the practice of medicine within its borders." Letter from Robert L. Wergin, Bd. Chair, Am. Acad. of Family Physicians, to John McCain, Mac Thornberry, Jack Reed, & Adam Smith, Senate Comm. on Armed Servs. (Sept. 1, 2016) (on file with author). Similar concerns will likely be made against the telemedicine certificate issued by the completion of the proposed UTE; thus, it is important to stress that the telemedicine certification system does not take away the state medical licensure system, but only revolutionizes it.

[238] Ned Kock, *The Psychobiological Model: Towards a New Theory of Computer-Mediated Communication Based on Darwinian Evolution*, 15 ORG. SCI. 327, 330 (2004).

[239] *See The Importance of Continuing Education*, SOUTH U. (Aug. 10, 2016), https://www.southuniversity.edu/whoweare/newsroom/blog/the-importance-of-continu ing-education-98201 [https://perma.cc/XHE5-V72Z] ("Continuing education is required for workers to stay current with the latest developments, skills, and new technologies required for their fields.").

has changed this traditional system, yielding a world of medicine with infinite possibilities. Cyber and digital technology now allow patients and physicians to directly communicate and easily transmit forms, records and documents all over the world; accordingly, the law should assist in achieving this purpose and not hamper its reach. The legislatures created an unintended barrier to telemedicine when they primitively established the in-state licensure system. With medical evolution, however, the traditional notion of local health care has progressed into a national enterprise. By removing the in-state license requirement for care rendered and received via telemedicine, we can improve the status quo governing access to health care and ultimately achieve a limitless approach—to infinity and beyond—of providing care across state borders.

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