NOTE

Trust and Antitrust: State-Based Restrictions in Telemedicine

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INTRODUCTION

The Sherman Antitrust Act aims to protect consumer welfare.[1] To that end, the Act prohibits unreasonable restraints of trade and market monopolization, with the stated goal of "preserving free and unfettered competition."[2] In economics, consumer welfare is defined as "the benefits a buyer derives from the consumption of goods and services."[3] There is theoretical disagreement about whether consumer welfare should be measured in terms of only buyers' welfare,[4] or the welfare of both buyers and sellers.[5] However, the academic debate notwithstanding, the Supreme Court largely equates consumer welfare with buyers' welfare. In *National Collegiate Athletic Association v. Board of Regents of the University of Oklahoma*, for example, the Court's articulation of consumer welfare emphasized consumer preference over economic efficiency.[6] Historically, the Court has equated consumer preference with lower prices;[7] restraints on competition that result in higher prices for consumers are typically considered unreasonable.[8] That said, the Court has also acknowledged that in some contexts lower prices do not benefit consumers, especially if the lower price is concomitant with lower product quality or consumer safety.[9] Thus, favorable verdicts on pro-restriction claims often turn

[1] *See* Reiter v. Sonotone Corp., 442 U.S. 330, 343 (1979) (stating that "Congress designed the Sherman Act as a 'consumer welfare prescription'" (citing ROBERT BORK, THE ANTITRUST PARADOX 66 (1978)).

[2] *The Antitrust Laws*, FED. TRADE COMMISSION, https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/antitrust-laws (last visited Feb. 7, 2017).

[3] Barack Y. Orbach, *The Antitrust Consumer Welfare Paradox*, 7 J. COMPETITION L. & ECON. 133, 134 n.1 (2010).

[4] *See id.* at 137-38 (equating consumer welfare with "consumer surplus" and defining consumer surplus as "the perceived welfare of buyers in a particular market").

[5] *See id.* at 138 (equating consumer welfare with "aggregate welfare" and defining aggregate welfare as "the perceived welfare of buyers *and* sellers in a particular market").

[6] Nat'l Collegiate Athletic Ass'n v. Bd. of Regents of Univ. of Okla., 468 U.S. 85, 109-10 (finding restrictions on price and output anticompetitive where those restrictions are not responsive to consumer preference).

[7] *See* Orbach, *supra* note 3, at 152 ("Antitrust laws focus on low prices to allow consumers to consume more.").

[8] *See* Herbert Hovenkamp, *Implementing Antitrust's Welfare Goals*, 81 FORDHAM L. REV. 2471, 2473 (2013) ("[E]mploying the consumer welfare principle, one would have to consider whether the challenged practice creates a sufficient inference of lower market-wide output and higher prices. If so, it is presumptively unlawful.").

[9] *See* Goldfarb v. Va. State Bar, 421 U.S. 773, 788 n.17 (1975) ("The fact that a restraint operates upon a profession as distinguished from a business is, of course,

on whether the price restraint enhances the quality of the professional service.[10]

The nuances inherent in balancing consumer preference with consumer safety are especially stark in the healthcare context. Indeed, the suggestion that competition does not translate into higher quality medical care is long-standing[11] and explains the medical market's historical insulation from free-market competition.[12] Often described in economic terms as a "market failure," this theory suggests that greater competition may actually result in lower quality care.[13] For example, law professors William Sage and Peter Hammer argue that to successfully apply antitrust frameworks to healthcare, courts must assess whether "price competition would serve quality objectives."[14]

Unsurprisingly, the consumer preference/consumer safety debate has manifested in litigation. In western Texas, the Texas State Medical Board ("TMB") adopted a new rule, Rule 190.8, requiring telemedical providers to conduct in-person medical exams before providing

relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to view the practice of professions as interchangeable with other business activities . . . . The public service aspect, and other features of professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently."); *see also* Nat'l Soc'y of Prof'l Eng'rs v. United States, 435 U.S. 679, 696 n.22 (1978) ("Courts have . . . upheld marketing restraints related to the safety of a product, provided that they . . . are reasonably ancillary to the seller's main purpose of protecting the public from harm or itself from product liability."); Cont'l T.V., Inc. v. GTE Sylvania Inc., 433 U.S. 36, 55 n.23 (1977) (allowing that price restrictions in some contexts might be justifiable in light of consumer safety concerns).

[10] *See* Arizona v. Maricopa Cty. Med. Soc'y, 457 U.S. 332, 348-49 (1982) (suggesting that had defendants argued the quality of professional services were enhanced, the alleged Sherman Act violation might "be treated differently" (citing Goldfarb v. Va. State Bar, 421 U.S. 773, 788 n.17 (1975))).

[11] *See* MILTON FRIEDMAN, CAPITALISM AND FREEDOM 152-58 (1962). In his decades-old seminal work, Friedman addressed and refuted the argument that competition in medicine lowers quality. *See id.* at 152-58 (stating that "quality is only a rationalization and not the underlying reason for [medical practice] restriction").

[12] *See* James F. Blumstein, *Health Care Reform and Competing Visions of Medical Care: Antitrust and State Provider Cooperation Legislation*, 79 CORNELL L. REV. 1459, 1465-66 (1994) (discussing medical practice as governed by a professional model versus a market model, under which control is shifted from consumers to physicians and medicine is insulated from economic forces).

[13] *See* William M. Sage & Peter J. Hammer, *A Copernican View of Health Care Antitrust*, L. & CONTEMP. PROBS., Autumn 2002, at 241, 265 ("[A] competitive health system not dominated by the medical profession may require special attention from government to safeguard values that were previously protected through professional mechanisms that are no longer viable.").

[14] *Id.* at 258.

telemedical care.[15] Telehealth[16] behemoth Teladoc filed a complaint against the TMB alleging violations of the Sherman Antitrust Act.[17] In 2015, the district judge granted Teladoc's application for a temporary injunction, pending resolution of then-existing claims under federal antitrust laws.[18] Though the subject matter of *Teladoc, Inc. v. Texas Medical Board* is state-specific, the effects of the case's resolution were thought to be national in scope.[19] Many experts considered the litigation "a litmus test for how medical boards across the country may deal with telemedicine going forward."[20] On a practical level, the antitrust analysis ultimately applied to Teladoc's anticompetitive claims raises inferences about telehealth's integration into the healthcare market.[21] More fundamentally, *Teladoc*, and cases like it that are sure to follow, are an opportunity for courts to recognize that competition in the medical market does not necessitate an either-or decision between consumer choice and quality care.[22]

This Note argues that state medical board restrictions aimed at limiting telemedical practice likely violate the Sherman Antitrust Act. Indeed, rules limiting patient access to medical services are the antithesis of consumer empowerment.[23] This Note addresses the

[15] Teladoc, Inc. v. Tex. Med. Bd., 112 F. Supp. 3d 529, 534 (W.D. Tex. 2015).

[16] For the purposes of this Note, the terms "telemedicine" and "telehealth" are used interchangeably. See *infra* p. 109 for definitional discussion.

[17] Amended Complaint at 23-29, *Teladoc*, 112 F. Supp. 3d 529 (No. 15-343), 2015 WL 4387362.

[18] *Teladoc*, 112 F. Supp. 3d at 544.

[19] *See* Dionne Lomax & Kate Stewart, *Injunction Blocks Implementation of Texas Telemedicine Regulations*, HEALTH L. & POL'Y MATTERS (June 4, 2015), https://www.healthlawpolicymatters.com/2015/06/04/injunction-blocks-implementation-of-texas-telemedicine-regulations/ (suggesting telemedical providers in other states should monitor the *Teladoc* case for guidance).

[20] Ken Terry, *Federal Judge Blocks Texas Rule Restricting Telemedicine*, MEDSCAPE (June 2, 2015), http://www.medscape.com/viewarticle/845772; *see also* Nathan Fish, *Federal Court Blocks Rule Restricting Telemedicine Practice in Texas*, DLA PIPER (June 23, 2015), https://www.dlapiper.com/en/us/insights/publications/2015/06/federal-court-blocks-rule-restricting-telemedicine/ (suggesting telemedicine's future "hangs in the balance"); Lisa Schencker, *Texas Board Asks Appeals Court to Block Suit Challenging Telemedicine Rules*, MOD. HEALTHCARE (Jan. 8, 2016), http://www.modernhealthcare.com/article/20160108/NEWS/160109890 ("Experts say the case has potential implications for how medical boards regulate telemedicine across the country.").

[21] *See* Lisa Schencker, *Supreme Court Decision Could Play into Texas Telemedicine Fight*, MOD. HEALTHCARE (May 8, 2015), http://www.modernhealthcare.com/article/20150508/NEWS/150509908 (commenting on allegations that a ruling for the TMB would "raise prices and reduce access to physicians in the state").

[22] *See* discussion *infra* Part V.A (specifically, sections V.A.1, V.A.3).

[23] *See* FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF

important implications that resolution of antitrust claims against state medical boards will have for both patients and providers. Part I provides an overview of the contemporary medical industry in the United States[24] and telemedicine's rise and development therein.[25] Part I also examines the competing justifications offered by pro-restriction and anti-restriction advocates.[26] Part II describes the current legal landscape and the application of federal antitrust law to medicine through the lens of three seminal cases[27]: *Parker v. Brown*,[28] *Goldfarb v. Virginia State Bar*,[29] and *North Carolina State Board of Dental Examiners v. F.T.C.* (hereinafter *Dental Examiners*).[30] Part III surveys telemedical practice in the fifty states,[31] and additionally examines analogues of Texas's Rule 190.8 in other states.[32] Part IV uses *Parker*, *Goldfarb*, and *Dental Examiners* as a framework for assessing *Teladoc*.[33] Part V considers *Teladoc*'s potential impact on consumer welfare[34] and state medical board structuring.[35] This Note concludes that regulation should be directed at increasing consumer choice and access and suggests that courts should apply antitrust law to further the articulated goal of consumer welfare.[36]

COMPETITION, executive summary at 4 (2004), https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf (stating that consumer welfare is typically maximized in markets with "vigorous competition" and that health care is no different). If vigorously competitive markets are understood as those wherein "rivals compete to satisfy consumer demand, and consumers make decisions about the price and quality of goods or services they will purchase," then restrictions which limit the participation of the so-called "rivals" disenfranchise consumers. *See id.*

[24] *See infra* Part I.A.

[25] *See infra* Part I.B.

[26] *See infra* Part I.C.

[27] *See infra* Part II.A–C.

[28] 317 U.S. 341 (1943).

[29] 421 U.S. 773 (1975).

[30] 135 S. Ct. 1101 (2015).

[31] *See infra* Part III.A.

[32] *See infra* Part III.B.

[33] *See infra* Part IV.A–C.

[34] *See infra* Part V.A.

[35] *See infra* Part V.B.

[36] *See infra* Conclusion.

I. OVERVIEW

A. The Medical Landscape

The United States is facing an impending healthcare crisis: there are not enough doctors.[37] The possible causes for this crisis vary, ranging from population shifts[38] to declining matriculation in particular specialties[39] to workforce misanthropy.[40] The proposed solutions are similarly varied. Some states are investing in residency programs to retain medical school graduates.[41] Others are focusing on repayment programs, scholarships, and tuition waivers to give medical students an incentive to commit to historically understaffed specialties.[42] Still others argue that state-based initiatives are insufficient and call for increased federal funding to expand medical training programs.[43] But,

[37] *See* News Release, Ass'n of Am. Med. Colls., New Physician Workforce Projections Show the Doctor Shortage Remains Significant (Mar. 3, 2015), https://www.aamc.org/newsroom/newsreleases/426166/20150303.html (projecting that "[t]he nation will face a shortage of between 46,000–90,000 physicians by 2025").

[38] IHS, INC., THE COMPLEXITIES OF PHYSICIAN SUPPLY AND DEMAND: PROJECTIONS FROM 2013 TO 2025, at 23 (2015), https://www.aamc.org/download/426242/data/ihsreportdownload.pdf ("The key dynamic affecting future service demand (and thus future physician demand) is rapidly changing population demographics. High rates of projected population growth, especially among the elderly "Baby Boomer" population, portend rapidly growing demand for health care services . . . .").

[39] *See* Thomas S. Bodenheimer & Mark D. Smith, *Primary Care: Proposed Solutions to the Physician Shortage Without Training More Physicians*, 32 HEALTH AFF. 1881, 1881 (2013) (noting that "only 9 percent of US medical students choose family medicine and general internal medicine . . . . As the demand for adult primary care explodes, the capacity to provide that care is shrinking.").

[40] Tait D. Shanafelt et al., *Burnout and Satisfaction with Work-Life Balance Among US Physicians Relative to the General US Population*, 172 ARCHIVES INTERNAL MED. 1377, 1384 (2012) (finding that roughly 50% of physicians have symptoms of professional burnout).

[41] Rebecca Beitsch, *To Address Doctor Shortages, Some States Focus on Residencies*, PEW CHARITABLE TRS. (Aug. 11, 2015), http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/08/11/to-address-doctor-shortages-some-states-focus-on-residencies.

[42] *See, e.g.*, *Student Choice of Family Medicine, Incentives for Increasing*, AM. ACAD. FAM. PHYSICIANS, http://www.aafp.org/about/policies/all/student-choice.html (last visited Mar. 17, 2017) (calling on states and other entities to develop incentives that encourage medical students to specialize in family medicine).

[43] *See, e.g.*, Atul Grover & Lidia M. Niecko-Najjum, *Building a Health Care Workforce for the Future: More Physicians, Professional Reforms, and Technological Advances*, 32 HEALTH AFF. 1922, 1926 (2013) ("States and schools have responded already by increasing the number of medical students, but that independently will not increase the supply. The unwillingness of Congress to fund additional Medicare GME positions may lead to US medical school graduates who lack opportunities to

overall, there is consensus that the shortage will necessitate some form of workload redistribution.[44] While nurse practitioners, physician assistants, and other sub-specialists might fill the healthcare supply and demand gap,[45] endorsement of paraprofessional support has been tempered by the reluctance of organized physician groups to "cede professional turf to nurses."[46] Fortunately, the surfeit of opinion is not without common ground. Medical experts, organized and unorganized alike, acknowledge that telemedicine has a place in the future of healthcare delivery.[47] Whether, however, it is the "godsend"[48] we have all been waiting for remains to be seen.

complete their residencies.").

[44] *See* Bodenheimer & Smith, *supra* note 39, at 1882 (arguing that the gap between physician supply and patient demand could be ameliorated by reallocation of clinical responsibilities to "nonphysician team members and to patients themselves"); Richard Wootton, *Telemedicine: A Cautious Welcome*, 313 BRITISH MED. J. 1375, 1377 (1996), http://dx.doi.org/10.1136/bmj.313.7069.1375 ("Telemedicine is here to stay and is likely to play an increasing role in future health care.").

[45] *See* Grover & Niecko-Najjum, *supra* note 43, at 1925 (suggesting that "more efficient provision of subspecialty care" could be achieved by allowing physician assistants and nurse practitioners to care for patients currently managed by physicians); John K. Iglehart, *Despite Tight Budgets, Boosting US Health Workforce May Be Policy That Is 'Just Right*,' 30 HEALTH AFF. 191, 192 (quoting then U.S. Health and Human Services Secretary Kathleen Sebelius as voicing support for "boost[ing] the role of advanced-practice nurses in the delivery of primary care"); John C. Goodman, *Free the Nurses*, FORBES (June 1, 2015, 9:02 AM), http://www.forbes.com/sites/johngoodman/2015/06/01/free-the-nurses/ (stating that Nebraska became the twentieth state to permit nurses to provide treatment and prescribe medication without doctor oversight); Christine Vestal, *Nurse Practitioners Step in Where Doctors Are Scarce*, PEW CHARITABLE TRS. (Dec. 5, 2012), http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2012/12/05/nurse-practitioners-step-in-where-doctors-are-scarce (stating that nurses are capable of providing many of the services typically provided by primary-care physicians).

[46] Vestal, *supra* note 45; *see* Iglehart, *supra* note 45, at 192 (stating that the American Medical Association opposed a recommendation to expand nurses' scope of practice).

[47] *See* Robert Gordon, *Virtual Doctors — Good Thing or Bad Thing?*, MED. DIRECTIONS (Feb. 24, 2015), http://www.medical-directions.com/virtual-doctors-good-thing-bad-thing/ ("The consensus of opinion appears to be that telemedicine has a number of advantages, not the least of which is the convenience and the time and money it can save.").

[48] John C. Goodman, *Will Texas Medicine Return to the Middle Ages?*, FORBES (May 22, 2015, 10:37 AM) [hereinafter *Return to the Middle Ages*], http://www.forbes.com/sites/johngoodman/2015/05/22/will-texas-medicine-return-to-the-middle-ages/.

B. Telemedicine

"Telemedicine," from the Greek prefix *tele*, implying distance, does not have a uniformly accepted definition, but "the use of technology to deliver health care services and information at a distance in order to improve access, quality, and cost" is a common description.[49] More succinctly, telemedicine is long-distance healthcare. Today, the term encapsulates countless technologies and finds application across the gamut of medical specialization. In pathology, telemedicine enables pathologists to look through microscopes hundreds of miles away ("telepathology");[50] in geriatrics, doctors use telemedicine to implement "hospital at home" models;[51] in radiology, telemedical technology allows for long-distance transmittal of images to specialists[52] — the list goes on. Skeptics would be hard-pressed to find a field in which telemedicine did not apply, which perhaps explains its current market share.[53]

Telemedicine's roots date back more than seventy years;[54] for nearly as long, it has been referred to as a new, forgotten, or undeveloped frontier on the horizon of medicine's future.[55] Articles written in the 1970s lauded the potential of telemedicine to "free us from the

[49] Joseph Kvedar et al., *Connected Health: A Review of Technologies and Strategies to Improve Patient Care with Telemedicine and Telehealth*, 33 HEALTH AFF. 194, 194-95 (2014).

[50] Wootton, *supra* note 44, at 1375.

[51] *See, e.g.*, Lesley Cryer et al., *Costs for 'Hospital at Home' Patients Were 19 Percent Lower, with Equal or Better Outcomes Compared to Similar Inpatients*, 31 HEALTH AFF. 1237 (2012) (describing Johns Hopkins's Hospital at Home program, which provides acute hospital-level care at patients' homes to cut costs and minimize risks inherent in hospitalization for older patients).

[52] Kvedar et al., *supra* note 49, at 196 (stating that "radiologic images are now routinely read by specialists at great distances from where they are taken").

[53] *See Global Telehealth Market Growing at 24% CAGR to 2020*, PRNEWSWIRE (Aug. 13, 2015, 6:30 AM), http://www.prnewswire.com/news-releases/global-telehealth-market-growing-at-24-cagr-to-2020-521726311.html.

[54] *See, e.g.*, RASHID L. BASHSHUR & GARY W. SHANNON, HISTORY OF TELEMEDICINE: EVOLUTION, CONTEXT, AND TRANSFORMATION 318 (2009) (describing the first use of telemedicine in 1905 involving the telephonic transmission of an electrocardiogram); FRANCESCO AMENTA ET AL., TELEMEDICAL ASSISTANCE OF PATIENTS ON BOARD SHIPS (2013), http://www.cirm.it/documenti/cirm_th3-1.pdf (detailing the activities of the International Radio Medical Centre, which provided telemedical assistance to seafarers beginning in 1935).

[55] *See, e.g.*, BASHSHUR & SHANNON, *supra* note 54, at 321-23 (discussing the reasons for telemedicine's slow "migration to the mainstream"). *See generally* P. Lehoux et al., *The Theory of Use Behind Telemedicine: How Compatible with Physicians' Clinical Routines?*, 54 SOC. SCI. & MED. 889 (2002) (exploring the rationales driving telemedical adoption, or lack thereof, across different medical specialties).

limitations of time and space."[56] Twenty years later it was heralded, "[t]elemedicine will do for health care what the personal computer has done for the office."[57] But despite its long-term standing as a putative instrument of progress, telemedicine's actualization in the healthcare market was long in coming.[58] By the end of the 1990s however, the "creep" of technology had become a "tsunami," and use of telemedical technology was widespread.[59] As of late 2012, forty-two percent of U.S. hospitals were using telemedical technologies.[60] Today, telemedicine is a mainstay of the healthcare infrastructure.[61] The current market for telemedicine stands at an estimated $17.8 billion, with a projected growth of 18.4% by 2020.[62] That said, the level of its use and application remains in flux.[63] This is due in part to the restructuring of healthcare policy — in the last two decades by the rise of Health Maintenance Organizations ("HMOs") and physician

[56] Betty L. Grundy et al., *Telemedicine in Critical Care: An Experiment in Health Care Delivery*, 6 J. AM. COLL. EMERGENCY PHYSICIANS 439, 444 (1977).

[57] Wootton, *supra* note 44, at 1375.

[58] *See* Phoebe Lindsey Barton et al., *Specialist Physicians' Knowledge and Beliefs About Telemedicine: A Comparison of Users and Nonusers of the Technology*, 13 TELEMEDICINE & E-HEALTH 487, 488 (2007) ("Telemedicine technology has been available since at least 1959, but the rate of adoption of the technology as a means of providing health services has been slow."); Rashid L. Bashshur, *On the Definition and Evaluation of Telemedicine*, 1 TELEMEDICINE J. 19, 19 (1995) ("The promise of telemedicine that was heralded in the early 1970s for redressing problems of maldistribution in medical resources, uneven quality, high cost, and limited access to care has not been veritably realized.").

[59] *See* Charles R. Doarn & Ronald C. Merrell, *Editorial: Standards and Guidelines for Telemedicine — An Evolution*, 20 TELEMEDICINE & E-HEALTH 187, 188 (2014) ("From the beginning of the current telemedicine era (1990–present), technology has not crept into what we do; it has often come to us like a tsunami.").

[60] Julia Adler-Milstein et al., *Telehealth Among US Hospitals: Several Factors, Including State Reimbursement and Licensure Policies, Influence Adoption*, 33 HEALTH AFF. 207, 210 (2014).

[61] *See* Jonathan P. Weiner et al., *The Impact of Health Information Technology and e-Health on the Future Demand for Physician Services*, 32 HEALTH AFF. 1998, 1999 (2013) (stating that the healthcare system has reached a "digital tipping point" such that a majority of healthcare providers now utilize telemedical technology).

[62] *Global Telemedicine Market Outlook 2015–2020 for the $17 Billion Industry with Mckesson, Philips Healthcare, GE Healthcare, and Cerner Dominating*, PRNEWSWIRE (May 20, 2015), http://www.prnewswire.com/news-releases/global-telemedicine-market-outlook-2015-2020-for-the-17-billion-industry-with-mckesson-philips-healthcare-ge-healthcare-and-cerner-dominating-504372191.html.

[63] *See* Steve Kreitner, *Telehealth Services Networks: A Promise Not Fully Delivered*, MONT. LAW., Aug. 2014, at 24 (noting that the proliferation of telehealth networks "does not mean that they have achieved a satisfactory level of success in actually reaching patients").

unionization,[64] and in the last five years by the Affordable Care Act.[65] But largely, it is the result of state-based healthcare management systems, under which telemedicine is governed by a "patchwork of conflicting and disparate requirements."[66]

C. Competing Interests: Organized Medicine Versus Telehealth

State medical boards set the regulations governing all medical practice, including telemedicine.[67] Though the structure of each varies from state to state, most medical boards are composed primarily of physicians.[68] The majority of state medical boards require telemedical practitioners to be licensed in the state in which the patient is located, which limits the scope of telemedical practice.[69] Opinions differ as to whether doctors stand to win or lose by encouraging telemedicine's growth.[70] But whatever the case, organized medicine — including state

[64] Arushi Sinha, *An Overview of Telemedicine: The Virtual Gaze of Health Care in the Next Century*, 14 MED. ANTHROPOLOGY Q. 291, 295 (2000); *see also* John C. Goodman, *The Doctors Union*, FORBES (Sep. 3, 2014, 10:57 AM), http://www.forbes.com/sites/johngoodman/2014/09/03/the-doctors-union/ (calling the American Medical Association "the most successful labor union in the 20th century").

[65] *See* Ann Hwang et al., *State Leadership in Health Care Transformation: Red and Blue*, 314 J. AM. MED. ASS'N 349, 350 (2015) (stating that the ACA has impacted healthcare policy at "new and uneven levels").

[66] LATOYA THOMAS & GARY CAPISTRANT, AM. TELEMEDICINE ASS'N, 50 STATE TELEMEDICINE GAPS ANALYSIS: PHYSICIAN PRACTICE STANDARDS & LICENSURE 1 (2015); *see also* Julia Adler-Milstein et al., *supra* note 60, at 207 (citing state policies as perhaps the most important factor in adoption of telehealth services by hospitals); 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, 278 (2015) (stating that state-based control of physician licensing in telemedicine is stifling growth).

[67] *What Is a State Medical Board?*, FED'N ST. MED. BOARDS, https://www.fsmb.org/policy/consumer-resources/frequent-questions (last visited Dec. 12, 2016) (defining state medical boards as the bodies that set state policy and guidelines related to the practice of medicine).

[68] *See State Medical Board Membership Composition Table*, FED'N ST. MED. BOARDS (2013), https://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/GRPOL_Board_Composition_Table_2013.pdf.

[69] *See Telemedicine Policies: Board by Board Overview*, FED'N ST. MED. BOARDS, http://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/GRPOL_Telemedicine_Licensure.pdf (last visited Dec. 12, 2016).

[70] *Compare* Sinha, *supra* note 64, at 298 (stating that physicians have a positive interest in telemedicine because it has the potential to open new markets and offer their services to more patients), *and* Russ Alan Prince, *Evaluating Telemedicine Technology: A Physician's Perspective*, FORBES (July 16, 2015, 9:29 AM), http://www.forbes.com/sites/russalanprince/2015/07/16/evaluating-telemedicine-technology-a-physicians-perspective/ (listing facilitation of understanding for patients and providers, as well as cohesion of the healthcare team, as benefits of telemedicine from

medical boards and independent groups like the American Medical Association ("AMA") — is overwhelmingly viewed as the greatest impediment to telemedical practice.[71] At best, critics label state medical board restrictions on telemedicine "protectionism."[72] At worst, and more often, critics condemn organized medicine "as a cartel agent for the doctors."[73] John C. Goodman, a *Forbes* contributor and particularly outspoken critic of the AMA, recently commented, "[there is] overwhelming evidence that the long term goal of organized medicine has been to create a medieval guild — just like the guilds of old."[74]

a physician's point of view), *with* H. Hughes Evans, *High Tech vs "High Touch": The Impact of Medical Technology on Patient Care*, *in* SOCIOMEDICAL PERSPECTIVE ON PATIENT CARE 82 (Jeffrey Michael Clair & Richard M. Allman eds., 1993) (describing the viewpoint that "technology has stripped medicine of its humanistic qualities . . . creat[ing] a cold and impersonal chasm between the healer and the patient"), *and* Edward Alan Miller, *The Technical and Interpersonal Aspects of Telemedicine: Effects on Doctor–Patient Communication*, 9 J. TELEMEDICINE & TELECARE 1, 2 (2003) (exploring the idea that telemedicine increases the psychological distance between doctor and patient, increasing patient distrust, exposing physicians to greater risk of malpractice litigation, and compromising patient outcomes), *and* B. Stanberry, *Telemedicine: Barriers and Opportunities in the 21st Century*, 247 J. INTERNAL MED. 615, 626 (2000) ("The potentially dangerous consequences of the health telematics revolution . . . [will be] the deskilling this may entail for medical professionals . . . [and] threats to the quality and integrity of professional medical services caused by the growing number of sources from which we can obtain them . . . .").

[71] *See* Avery Schumacher, *Telehealth: Current Barriers, Potential Progress*, 76 OHIO ST. L.J. 409, 420 (2015); *see also* TELE-MED Act of 2015, H.R. 3081, 114th Cong. (introduced in House, referred to Subcomm. on Health) (proposing extension of Social Security Act to allow Medicare providers to provide telemedical services to beneficiaries across state lines); MARY K. WAKEFIELD, U.S. DEP'T OF HEALTH & HUMAN SERVS. HEALTH RES. & SERVS. ADMIN., HEALTH LICENSING BOARD REPORT TO CONGRESS 28 (2010) (listing state medical boards' policies as a challenge/barrier to implementing telemedicine).

[72] Marino et al., *supra* note 66, at 285 (arguing that state "protectionism" undermines the goals of reform initiatives directed at expanding telemedical practice); *see* Schumacher, *supra* note 71, at 424 (arguing that while the stated reason for restrictions is the state's interest in monitoring quality of care, "protection of state's rights, and the shielding of trade from outside competition are more likely the primary motivating factors").

[73] John C. Goodman, *Standing Between You and All the Benefits of Telemedicine: The AMA and the Federal Government*, FORBES (July 9, 2015, 11:44 AM), http://www.forbes.com/sites/johngoodman/2015/07/09/standing-between-you-and-all-the-benefits-of-telemedicine-the-ama-and-the-federal-government/; *see also* Aaron Edlin & Rebecca Haw, *Cartels by Another Name: Should Licensed Occupations Face Antitrust Scrutiny?*, 162 U. PA. L. REV. 1093, 1096, 1102 (2015) (stating that professional boards have "abused their power to insulate incumbents from competition" and calling occupational licensing boards the new cartels).

[74] Goodman, *Return to the Middle Ages*, *supra* note 48.

Lesser restrictions on telemedicine would produce a more competitive healthcare market.[75] After all, telemedicine's primary tenet is to improve access, which necessarily implies an influx of providers.[76] For example, in 2013, there were 68,717 physicians licensed in Texas to serve a population of over 26 million.[77] In metropolitan areas, like Dallas, the average wait time to see a family practice physician is five days; an appointment with a specialist averages up to seventeen days.[78] Nationwide, the wait time to see a new doctor averages almost three weeks.[79] Teladoc, the first and leading private telehealth provider in the United States,[80] employs over 3,600 board-certified physicians[81] and services 17.1 million members.[82] Teladoc's median wait time is ten minutes[83] and unsurprisingly, given the dearth of doctors physically in the state, the company has more customers in Texas than anywhere else.[84] With numbers like these, it is not difficult to see why telemedicine might be perceived as a competitive threat to traditional practitioners.[85]

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[75] *See* Carl F. Ameringer, *State-Based Licensure of Telemedicine: The Need for Uniformity but Not a National Scheme*, 14 J. HEALTH CARE L. & POL'Y 55, 84 (concluding that restrictions, such as state licensing laws, "constrain innovative approaches that would control costs and increase access to health care").

[76] *See* Bashshur, *supra* note 58, at 21 (noting that "[t]he common thread in all definitions of telemedicine" is the access element, wherein telemedicine facilitates interaction between patient and physician which would not otherwise be possible).

[77] Aaron Young et al., *A Census of Actively Licensed Physicians in the United States, 2012*, 99 J. MED. REG. 11, 21 (2013); *cf.* Erica Teichert, *Texas Drops Appeal Against Teladoc Lawsuit*, MOD. HEALTHCARE (Oct. 18, 2016), http://www.modernhealthcare.com/article/20161018/NEWS/161019900 ("Texas is experiencing a severe physician shortage, with 35 counties lacking a single practicing physician within their boundaries.").

[78] *See* MERRITT HAWKINS, 2014 SURVEY OF PHYSICIAN APPOINTMENT WAIT TIMES AND MEDICAID AND MEDICARE ACCEPTANCE RATES 5, 12 (2014), http://www.merritthawkins.com/uploadedFiles/MerrittHawkings/Surveys/mha2014waitsurvPDF.pdf.

[79] Goodman, *Return to the Middle Ages, supra* note 48; *see also* MERRITT HAWKINS, *supra* note 78, at 6 (finding that the average cumulative wait time to see a physician across 15 markets was 18.5 days).

[80] *About Our Company*, TELADOC, http://www.teladoc.com/what-is-teladoc/about-our-company/ (last visited Feb. 2, 2017).

[81] TELADOC, https://www.teladoc.com (last visited Feb. 2, 2017).

[82] *Id.*

[83] *Id.*

[84] Abby Goodnough, *Texas Medical Panel Votes to Limit Telemedicine Practices in State*, N.Y. TIMES, Apr. 10, 2015, at A9, http://www.nytimes.com/2015/04/11/us/texas-medical-panel-votes-to-limit-telemedicine-practices-in-state.html.

[85] Ameringer, *supra* note 75, at 59 (suggesting that restrictions are designed to "serve the economic interests of in-state physicians"). *But see* Ken Terry, *Does Telehealth Diminish Physician–Patient Relationships?*, MEDSCAPE (July 25, 2014)

On the other hand, the justifications given by organized medicine for telemedical restrictions are compelling. The difficulties of diagnosing medical conditions without examining the patient, of prescribing narcotics without the patient's medical history, or of ensuring appropriate follow-up without an established patient–physician relationship are just a few of the concerns voiced by restriction advocates.[86] Though the AMA does not deny that telemedicine can "improve access[,] . . . improve health outcomes[,] and reduce health care costs," it nonetheless supports restrictions issued by various state medical boards requiring a pre-existing patient–physician relationship as a foundation for telemedical services.[87] The Federation of State Medical Boards ("FSMB"), which represents and supports all seventy of the state medical boards in the United States,[88] also advocates for this type of restriction. In its model policy for telemedical practice, the FSMB guidelines require providers to establish a patient–physician relationship before dispensing telemedical services.[89] That said, even the AMA acknowledges that telemedicine has "crystallized the tension between the states' role in protecting patients from incompetent physicians and protecting in-state physicians from out-of-state competition."[90]

It would be easy to portray the telemedical controversy dualistically: patients and telemedicine versus organized physicians. But the reality is, of course, much more complicated. Many doctors have embraced digital technology.[91] Many patients are uncomfortable with remote

[hereinafter *Physician–Patient Relationships*], http://www.medscape.com/viewarticle/828874 (interviewing AMA president Dr. Robert Wah, who denied that physicians are threatened by telemedicine because "the majority of patients who use such services would be unlikely to visit a physician's office").

86 *See* Terry, *Physician–Patient Relationships*, *supra* note 85.

87 Press Release, Am. Med. Ass'n, AMA Adopts Policy Supporting the Coverage of and Reimbursement for Telemedicine (June 11, 2014) (on file with AMA), http://www.marketwired.com/press-release/ama-adopts-policy-supporting-the-coverage-of-and-reimbursement-for-telemedicine-1919735.htm.

88 *About FSMB*, FED'N ST. MED. BOARDS, http://www.fsmb.org/about-fsmb/fsmb-overview (last visited Feb. 2, 2017).

89 FED'N OF STATE MED. BDS., MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE 2-3 (2014), http://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/FSMB_Telemedicine_Policy.pdf.

90 Daniel J. Gilman, *Physician Licensure and Telemedicine: Some Competitive Issues Raised by the Prospect of Practicing Globally While Regulating Locally*, 14 J. HEALTH CARE L. & POL'Y 87, 90 n.14 (2011) (quoting a 2010 AMA update).

91 *See, e.g.*, Ken Terry, *Physicians Warm to Digital Communications with Patients*, MEDSCAPE (June 12, 2014) [hereinafter *Digital Communications*], http://www.medscape.com/viewarticle/826596 (stating that 40% of physicians have increased

providers.[92] Telemedicine's tsunamic growth has provided little opportunity thus far to truly assess its quality.[93] Though business is booming, the quality of care that telemedicine offers remains an open question. This uncertainty, in combination with the inherent risks associated with prescription medication use, is perhaps why state medical boards have zeroed in on remote prescribing practices.[94] As a result, it is likely that telemedical prescribing restrictions will serve as the trigger for litigation resolving the competing interests of organized medicine and telehealth.

technology use within the last year).

[92] Vanessa Hiratsuka et al., *Patient and Provider Perspectives on Using Telemedicine for Chronic Disease Management Among Native Hawaiian and Alaska Native People*, 72 INT'L J. CIRCUMPOLAR HEALTH (SUPP. 1) 930, 932 (2013) ("Both patients and providers articulated some unease about the lack of physical contact and hands-on interaction when using telemedicine technologies. Patients focused on issues of non-verbal communication and personal 'connection' or the need to develop a relationship between the patient and the provider.").

[93] *See* Lori Uscher-Pines & Ateev Mehrotra, *Analysis of Teladoc Use Seems to Indicate Expanded Access to Care for Patients Without Prior Connection to a Provider*, 33 HEALTH AFF. 258, 259 (2014) (noting that "little is known about the overall impact . . . of such telehealth services on care"); Darius Tahir, *Telehealth Services Surging Despite Questions About Value*, MOD. HEALTHCARE (Feb. 21, 2015), http://www.modernhealthcare.com/article/20150221/MAGAZINE/302219981 ("The business of offering consumers virtual visits with physicians is booming even as questions about the quality of care and cost effectiveness of those services remain unresolved.").

[94] *See, e.g.*, Eric Kintner, *Colorado Medical Board Adopts New Telehealth Policies*, JDSUPRA BUS. ADVISOR (Sept. 1, 2015), http://www.jdsupra.com/legalnews/colorado-medical-board-adopts-new-62794/ (reporting Colorado Medical Board's adoption of a preexisting relationship requirement before telemedical providers may issue prescriptions); Kris R. Kwolek, *Big Redial — Texas Telephone Medicine Terminated?*, LEXOLOGY (Jan. 27, 2015), http://www.lexology.com/library/detail.aspx?g=9593e00a-f0be-4929-8f7a-464cbebee1a5 (reporting the TMB's requirement that an in-person evaluation is needed to prescribe medication); Ken Terry, *All Eyes on Texas as It Considers Tough New Telemedicine Rule*, MEDSCAPE (Feb. 20, 2015), http://www.medscape.com/viewarticle/840162 (reporting Utah Board of Medicine's decision to discipline physician for prescribing antibiotics to a patient without a preexisting relationship while working for a telemedicine company); Terry, *Digital Communications*, *supra* note 91 (reporting that a Idaho medical licensing board disciplined physician for prescribing antibiotic to patient she had only spoken with on the telephone); *see also* Tahir, *supra* note 93 (quoting Dr. Karen Rheuban of the Office of Telemedicine at the University of Virginia Health System as saying that virtual visits result in more prescriptions than face-to-face visits).

II. ANTITRUST LAW IN THE MEDICAL MARKET

For decades following the enactment of the Sherman Act (and its progeny), the Supreme Court considered the scope of its reach.[95] The Court recognized antitrust exemptions in specific industries,[96] but discredited exemption claims in far more.[97] In 1943, the Court established the *Parker* immunity doctrine, which continues to have profound implications in the context of healthcare.[98]

A. Parker v. Brown

In 1933, the state of California adopted the Agricultural Prorate Act for regulating the harvesting and marketing of the California raisin crop.[99] Under the Act, state officials were empowered to prevent raisin surpluses in the market and restrict competition among raisin growers.[100] In evaluating the plaintiff raisin producer's antitrust claims, the Supreme Court considered whether actions that would ordinarily violate the Sherman Act, if conducted by private individuals or corporations, were immunized if conducted under the auspices of state authority.[101] The Court held that the Sherman Act "gives no hint that it was intended to restrain state action or official action directed by a state."[102] The Court's sanction of anticompetitive restraints

[95] *See* discussion *infra* Part II.A–C and cases cited *infra* notes 96–97.

[96] *See, e.g.*, Credit Suisse Sec. (USA) LLC v. Billing, 551 U.S. 264 (2007) (granting individuals acting under the scope of the Securities and Exchange Act antitrust immunity); Gordon v. N.Y. Stock Exch., 422 U.S. 659 (1975) (implied immunity for individuals acting under the SEA); United Mine Workers v. Pennington, 381 U.S. 657 (1965) (finding that joint efforts to influence public officials do not violate antitrust laws); E.R.R. Presidents Conf. v. Noerr Motor Freight, Inc., 365 U.S. 127, 138 (1961) ("[S]olicitation of governmental action with respect to the passage and enforcement of laws" does not violate antitrust laws); Fed. Baseball Club v. Nat'l League of Prof'l Baseball Clubs, 259 U.S. 200 (1922) (recognizing antitrust exemption for major league baseball).

[97] *See e.g.*, Silver v. N.Y. Stock Exch., 373 U.S. 341 (1963) (applying antitrust law to the New York Stock Exchange); U.S. v. S.-E. Underwriters Ass'n, 322 U.S. 533 (1944) (declining to recognize insurance industry exemption).

[98] *See, e.g.*, Daniel J. Gilman & Julie Fairman, *Antitrust and the Future of Nursing: Federal Competition Policy and the Scope of Practice*, 24 HEALTH MATRIX 143, 159-62 (2014) (discussing *Parker* immunity in the context of nursing); Joshua Rosenstein, *Active Supervision of Health Care Cooperative Ventures Seeking State Action Antitrust Immunity*, 18 SEATTLE U. L. REV. 329 (1995) (considering the state action doctrine's application to health reform programs).

[99] Parker v. Brown, 317 U.S. 341, 346 (1943).

[100] *Id.*

[101] *Id.* at 351-52.

[102] *Id.* at 351.

imposed by states acting in their sovereign capacity has become known as the state action doctrine or, alternatively, *Parker* immunity.[103] Under it, traditional state entities, including state legislatures, political actors, and courts,[104] are shielded from antitrust liability.[105] Before the Supreme Court's decision in *Dental Examiners*, circuit court decisions granted immunity to lower-level state entities, like regulatory commissions and licensing boards, inconsistently.[106] That said, courts assumed more frequently than not that professional boards were eligible for *Parker* immunity.[107]

When *Parker* immunity was created, state licensing boards were scarce and operated in a select few industries.[108] Today, however, twenty-nine percent of the American workforce requires a license to legally work in their chosen profession;[109] licensing boards now dictate professional practice in industries ranging from beekeepers to interior designers to fortune tellers.[110] In the healthcare context, there are now seventy existing professional medical boards, one in each of

103 *See* OFFICE OF POLICY PLANNING, FED. TRADE COMM'N, REPORT OF THE STATE ACTION TASK FORCE 5 (2003), https://www.ftc.gov/sites/default/files/documents/reports/report-state-action-task-force-recommendations-clarify-and-reaffirm-original-purposes-state-action/stateactionreport_0.pdf ("The state action doctrine is the product of the Supreme Court's 1943 opinion in *Parker v. Brown*, which reasoned that, in light of states' sovereign status and principles of federalism, Congress would not have intruded on state prerogatives through the Sherman Act without expressly saying so.").

104 *See, e.g.*, *Parker*, 317 U.S. at 350-52; *see also* Bates v. State Bar of Ariz., 433 U.S. 350 (1977).

105 *See* OFFICE OF POLICY PLANNING, *supra* note 103, at 1.

106 *Id.* at 18-19 (listing conflicting decisions reached by circuit courts on the question of state board eligibility for *Parker* immunity). For example, in *Earles v. State Bd. of Certified Public Accountants of Louisiana*, 139 F.3d 1033, 1039 (1998), the Fifth Circuit granted *Parker* immunity to Louisiana's Board of CPAs and in *Hass v. Oregon State Bar*, 883 F.2d 1453, 1461 (1989), the Ninth Circuit granted immunity to "[a] state bar operating as an instrumentality of the state." *See* OFFICE OF POLICY PLANNING, *supra* note 103, at 18. On the other hand, in *Federal Trade Commission v. Monahan*, 832 F.2d 688, 689 (1987), the First Circuit held that the Massachusetts Board of Registration in Pharmacy did not qualify for *Parker* immunity. *See* OFFICE OF POLICY PLANNING, *supra* note 103, at 19.

107 Edlin & Haw, *supra* note 73, at 1096.

108 *Id.* ("When only about five percent of American workers were subject to licensing requirements during the 1950s, the anticompetitive effect . . . was relatively small.").

109 *Id.* 1096 n.7 (citing Morris M. Kleiner & Alan B. Krueger, *Analyzing the Extent and Influence of Occupational Licensing on the Labor Market*, 31 J. LAB. ECON. S173, S198 (2013)).

110 Debbie Feinstein & Geoffrey Green, *The When and What of Active Supervision*, FED. TRADE COMM'N (Oct. 14, 2015, 12:28 PM), https://www.ftc.gov/news-events/blogs/competition-matters/2015/10/when-what-active-supervision.

the fifty states, plus the District of Columbia, U.S. territories, and U.S. commonwealths.[111] Moreover, state medical boards now regulate virtually every aspect of professional medical practice, from pre-licensing educational and training requirements to professional conduct and discipline throughout a physician's practicing career.[112] Most significantly, state medical boards determine occupational licensing requirements, which limit competition in the healthcare market and restrict consumer access to medical services.[113] In short, the *Parker* immunity doctrine suggested that anticompetitive conduct within the medical profession was effectively legitimized as state action.

B. Goldfarb v. Virginia State Bar

Even after *Parker*, until the mid-1970s, "[t]he possibility that professionals might be in a different legal category than competitors of other kinds had long been entertained."[114] Medicine was considered something of a "heroic exception" in terms of federal regulation.[115] More so than many other professionals, physicians enjoyed an unusual amount of professional autonomy.[116] A *per se* exception had not been recognized in either statutory law or jurisprudence, but the theory that a medical professional exemption might exist in antitrust law was not without historical support. Indeed, it was tied to the once-commonly

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[111] *See Directory of State Medical and Osteopathic Boards*, FED'N ST. MED. BOARDS, https://www.fsmb.org/state-medical-boards/contacts (last visited Mar. 22, 2017).

[112] FED'N OF STATE MED. BDS., U.S. MEDICAL REGULATORY TRENDS AND ACTIONS 6-7 (2014).

[113] Edlin & Haw, *supra* note 73, at 1096.

[114] Clark C. Havighurst, *Health Care as a (Big) Business: The Antitrust Response*, 26 J. HEALTH POL., POL'Y & L. 939, 940-41 (2001) (explaining that the belief that there might be a physician exemption in antitrust law "rested comfortably on the widespread belief that certain callings are higher than others and . . .that competition does not work well when consumers cannot accurately appraise the quality of services they receive").

[115] *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE: THE RISE OF A SOVEREIGN PROFESSION AND THE MAKING OF A VAST INDUSTRY 420 (1982) ("In the twentieth century, medicine has been the heroic exception that sustained the waning tradition of independent professionalism. Physicians not only escaped from corporate and bureaucratic control in their own practices; they channeled the development of hospitals, health insurance, and other medical institutions into forms that did not intrude upon their autonomy.").

[116] *See* Peter J. Hammer, *The Architecture of Health Care Markets: Economic Sociology and Antitrust Law*, 7 HOUS. J. HEALTH L. & POL'Y 227, 237 (2007) (stating that "[f]rom a historical perspective, the story of American health care is a story of physician dominance").

accepted idea[117] that healthcare is a unique market to which normal economic forces do not apply.[118] That idea has been supplanted today by economic realities generally[119] and antitrust doctrine specifically.[120] It would go too far to say that the medical market is just like any other; extensive regulation, third-party payment models,[121] and asymmetry of information[122] are certainly unique characteristics that distinguish healthcare from other markets.[123] But in terms of competition policy, healthcare is not a "special good" — a fact that was finally confirmed in 1975.[124]

In *Goldfarb v. Virginia State Bar*,[125] the Supreme Court rejected the argument that "learned professionals" were entitled to any kind of antitrust exemption.[126] The case involved a minimum-fee schedule set by the Fairfax County Bar Association that recommended minimum

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117 *See* William M. Sage & Peter J. Hammer, *Competing on Quality of Care: The Need to Develop a Competition Policy for Health Care Markets*, 32 U. MICH. J.L. REFORM 1069, 1075 (1999) ("In early disputes [regarding application of a market model in healthcare], quality considerations were often invoked by professionals to justify collective action to keep prices high.").

118 FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, *supra* note 23, executive summary at 7 (noting that "many members of the public and many health care providers view health care as a 'special' good, not subject to normal market forces").

119 *See* discussion *supra* Part I.A.

120 Sage & Hammer, *supra* note 117, at 1075 ("The major contribution of antitrust doctrine . . . was to pull aside the curtain on assertions of patient protection that concealed economically self-interested behavior by health care providers, and thereby affirm consumer sovereignty as a guiding principle in health care as in other industries.").

121 *See* Clark C. Havighurst, *Competition in Health Services: Overview, Issues and Answers*, 34 VAND. L. REV. 1117, 1131 (1981) [hereinafter *Competition in Health Services*] (stating that while the healthcare market is unusual because "[t]hird parties pay the bills for many highly discretionary services, and consumers find it difficult to know in advance what they are buying," its uniqueness does not amount to a true market failure).

122 *See* Roger D. Blair & Christine Piette Durrance, *Licensing Health Care Professionals, State Action and Antitrust Policy*, 100 IOWA L. REV. 1943, 1945 (2015) (describing asymmetric information as existing when "the service provider knows something about his or her qualifications and competence that the patient or client does not know").

123 *See* FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, *supra* note 23, at 4-7 (overviewing the features of healthcare markets that can limit competition).

124 *See id.* at 4 (allowing that while "competition is not a panacea for all of the problems with American health care," competition nonetheless provides important benefits in healthcare).

125 421 U.S. 773 (1975).

126 *Id.* at 774 ("Congress did not intend any sweeping 'learned profession' exclusion from the Sherman Act . . . .").

prices for common legal services.[127] The plaintiffs were a married couple who, as a matter of state law, needed a member of the Virginia State Bar to examine the title of a home they wanted to buy.[128] After nineteen lawyers refused to do so for less than the amount recommended by the fee schedule, the plaintiffs brought an action for violation of the Sherman Act.[129] Though the Supreme Court's decision in *Goldfarb* involved lawyers, its dictates were broad and readily applicable to medical professionals. In ruling that Congress intended the Sherman Act to reach members of the learned professions as a general matter,[130] the Court opened the door to antitrust regulation in medical markets and ostensibly set an important limitation on the scope of *Parker* immunity.[131]

C. North Carolina State Board of Dental Examiners v. F.T.C.

The *Goldfarb* limitation seemed to be a severe curtailment of state action immunity.[132] Indeed, for several years, the Supreme Court applied *Goldfarb* stringently.[133] But by the mid-1980s *Parker* immunity was again a robust defense, largely due to the Court's presumption that state agencies operate as subsidiaries of the state itself.[134] In a series of decisions including *Town of Hallie v. City of Eau Claire*[135] and *Southern Motor Carriers Rate Conference, Inc. v. United States*,[136] the Supreme Court "transformed the limits on *Parker* immunity into empty gestures."[137] Specifically in *Hallie*, the Court failed to provide a

[127] *Id.* at 776.

[128] *Id.* at 775.

[129] *Id.* at 776.

[130] *Id.* at 774.

[131] *See, e.g.*, Arizona v. Maricopa Cty. Med. Soc. 457 U.S. 332, 357 (1982) (applying antitrust regulations to medical foundations); Hosp. Bldg. Co. v. Trustees of Rex Hosp., 425 U.S. 738, 746-47 (1976) (holding that a private, tax-exempt hospital is subject to antitrust regulations); *see also* FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, *supra* note 23, ch. 1, at 33-34 (noting that after *Goldfarb*, the Supreme Court applied antitrust regulation to medical markets previously thought immune).

[132] Timothy Sandefur, *Freedom of Competition and the Rhetoric of Federalism:* North Carolina Board of Dental Examiners v. FTC, 195 CATO SUP. CT. REV. 195, 205-06 (2015).

[133] *Id.* at 206 (citing *Cantor v. Detroit Edison Co.* and *Bates v. State Bar of Arizona* as instances of strict application).

[134] Edlin & Haw, *supra* note 73, at 1124.

[135] 471 U.S. 34 (1985).

[136] 471 U.S. 48 (1985).

[137] Sandefur, *supra* note 132, at 207.

clear test for determining a state agency's immunity status.[138] Instead, the Court included a footnote,[139] which lower courts usually interpreted as immunizing state licensing boards from antitrust claims.[140] Doctrinally, this interpretation was especially problematic because licensing boards are typically composed of market participants with a direct interest in crafting self-serving regulations[141] — and medical boards are no exception. For example, as of 2017, the Texas State Medical Board has nineteen members, twelve of whom are practicing physicians.[142] The California Medical Board has fifteen members, eight of whom are practicing physicians,[143] and the New York Medical Board has twenty-four members, twenty of whom are practicing physicians.[144] The composition of the Texas, California, and New York medical boards is illustrative of the general rule across the United States, not the exception.[145]

In North Carolina, as in many states, the State Board of Dental Examiners is the state agency charged with issuing dental licenses, promulgating rules of dental practice, and enforcing laws related to the practice of dentistry.[146] In 2003, non-dentists began offering teeth-whitening services at rates significantly lower than those offered by licensed dentists.[147] Responding to complaints from dentists — not consumers[148] — the Board issued cease-and-desist orders to teeth-whitening providers, "successfully expell[ing] non-dentist providers

138 Edlin & Har, *supra* note 73, at 1124.

139 The footnote in *Hallie* reads: "In cases in which the actor is a state agency, it is likely that active state supervision would also not be required, although we do not here decide that issue." 471 U.S. 34, 46 n.10 (1985).

140 Edlin & Haw, *supra* note 73, at 1124.

141 *Id.* at 1095-96.

142 *Texas Medical Board Overview*, TEX. MED. BOARD, http://www.tmb.state.tx.us/page/medical-board (last visited Feb. 2, 2017).

143 *Members of the Medical Board and Executive Staff*, MED. BOARD CAL., http://www.mbc.ca.gov/About_Us/Members/ (last visited Mar. 15, 2017).

144 *See Statutory Composition & Current Membership*, N.Y. ST. EDUC. DEP'T, http://www.op.nysed.gov/boards/bdcomp.htm#med (last visited Mar. 15, 2017).

145 *See* FED. TRADE COMM'N, FTC STAFF GUIDANCE ON ACTIVE SUPERVISION OF STATE REGULATORY BOARDS CONTROLLED BY MARKET PARTICIPANTS 1 (2015), https://www.ftc.gov/system/files/attachments/competition-policy-guidance/active_supervision_of_state_boards.pdf ("[A]cross the United States, 'licensing board are largely dominated by active members of their respective industries' . . . . That is, doctors commonly regulate doctors . . . .").

146 N.C. ST. BOARD DENTAL EXAMINERS, http://www.ncdentalboard.org/ (last visited Nov. 15, 2015).

147 N.C. State Bd. of Dental Exam'rs v. FTC, 717 F.3d 359, 365 (4th Cir. 2013).

148 Sandefur, *supra* note 132, at 209.

from the North Carolina teeth-whitening market."[149] When the Federal Trade Commission ("FTC") charged the Board with violating antitrust laws, the Board claimed immunity under the *Parker* state action doctrine.[150] Significantly, eight of the Board's ten members were practicing dentists who had earned substantial income from teeth-whitening services.[151] By the time the case reached the Supreme Court in 2015, an administrative law judge, the FTC, and the Fourth Circuit had all found that the Board could not claim *Parker* immunity.[152] The Supreme Court affirmed, finding that the state of North Carolina had not actively supervised the Board's actions, precluding the Board from claiming a *Parker* defense.[153]

The Supreme Court's decision in *Dental Examiners* was an important clarification on the scope of state action immunity. In finding that "active market participants cannot be allowed to regulate their own markets free from antitrust accountability,"[154] the Court implicated state board composition as a relevant factor in the immunity analysis. The FTC has since called the decision an "important win," indicating a curtailment on immunity for state boards composed of market participants.[155] On the other hand, some commentators are skeptical that *Dental Examiners* presages any substantive analytic shift. Timothy Sandefur, an adjunct scholar and regular think tank contributor, argues that the Board of Dental Examiner's unique appointment structure — in which members were chosen by other practicing dentists instead of by the public or elected officials — means that *Dental Examiners* will have limited applicability in cases where state board members are appointed by entities other than practicing professionals.[156] Though this argument is relevant, especially given that most members of state medical boards are appointed by the governor,[157] the Supreme Court's focus on board composition in

149 *Dental Exam'rs*, 717 F.3d at 365.

150 *Id.* at 366.

151 N.C. State Bd. of Dental Exam'rs v. FTC, 135 S. Ct. 1101, 1108 (2015).

152 *See id.* at 1109.

153 *Id.* at 1117.

154 *Id.* at 1111.

155 *See* DEBORAH L. FEINSTEIN, DIRECTOR'S REPORT SPRING 2015, FED. TRADE COMM'N1 (2015), https://www.ftc.gov/system/files/documents/public_statements/637441/bc_directors_report_-_spring_2015.pdf.

156 *See* Sandefur, *supra* note 132, at 215 (discussing the unusual structure of the North Carolina Board and concluding that the "case seems unlikely to cause much change").

157 *See* FED'N OF STATE MED. BDS., ELEMENTS OF A STATE MEDICAL AND OSTEOPATHIC BOARD 8 (2015), https://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/GRPOL_

Dental Examiners suggests that the relevant inquiry for immunity is membership of active market participants and whether the State superficially or substantively supervises those market participants.[158]

III. TELEMEDICAL PRACTICE IN THE UNITED STATES

A. Telemedicine in the Fifty States

State regulatory frameworks reflect an amalgam of local preferences and policy choices — a virtual "crazy-quilt"[159] of regulation. Every state requires physicians to meet state-specific licensure requirements to practice any type of medicine, including telemedicine, within state lines.[160] Historically, because cross-jurisdictional medical practice was rare, questions regarding the scope of state licensure were also rare.[161] The advent of telemedicine increased medical practice across state lines and altered the jurisdictional status quo[162] such that it became necessary to clarify which state law applied in cases of cross-jurisdictional practice.[163] The general rule has since been that the law of the state in which the patient is located applies, regardless of the physician's location.[164] Significantly, most doctors are licensed to

Elements_Modern_Medical_Board.pdf.

158 Jonah Comstock, *Why Texas Wants Teladoc's Antitrust Suit Thrown Out*, MOBIHEALTHNEWS (Sept. 28, 2015), http://mobihealthnews.com/47067/why-texas-wants-teladocs-antitrust-suit-thrown-out/ (quoting former acting Attorney General of the United States, Stuart Gerson, as saying, "the nut of the NCDB case is, in order to avail themselves of the state action defense, the board not only has to be duly constituted, but the activity that it is involved in needs to be directed by the state. There has to be what's called 'active supervision.' And that's what the Supreme Court made clear.").

159 *See* Ameringer, *supra* note 75, at 69.

160 *See id.* at 68 ("[S]tate laws have defined the practice of medicine to include most any activity having to do with the diagnosis, treatment, and curing of any human disease or ailment . . . ."); P. Greg Gulick, *E-Health and the Future of Medicine: The Economic, Legal, Regulatory, Cultural, and Organizational Obstacles*, 12 ALB. L.J. SCI. & TECH. 351, 365 (2002) ("[P]hysicians are required to be licensed in any state in which they practice medicine.").

161 *See* Ameringer, *supra* note 75, at 57 (noting that jurisdictional questions were rarely raised because "care of patients almost always occurred face-to-face").

162 *See* Gulick, *supra* note 160, at 352 (describing the advent of telemedicine as a "paradigm shift" away from in-person treatment models toward long-distance care).

163 *See* Ameringer, *supra* note 75, at 58.

164 WAKEFIELD, *supra* note 71, at 7 ("Physicians or other licensed health professionals are considered to be practicing their professions in the state where the patient is located and are subject to that state's licensing laws unless there is an exception in statute . . . ."); Amy E. Zilis, *The Doctor Will Skype You Now: How*

practice in only one state,[165] and most states have rejected the concept of licensure portability.[166]

In May 2015, the American Telemedical Association ("ATA") released a report on telemedical policy across the fifty states.[167] The report collated information from state statutes, regulations, medical board statements, and state policy reports to address two areas of telemedical practice: physician practice standards and licensure.[168] Each of the two areas was evaluated on the basis of four indicators — (1) whether the state set more stringent standards for telemedical providers as compared to physical providers,[169] (2) whether the state required a doctor to be physically with a patient during a telemedicine encounter,[170] (3) whether the state required more stringent informed consent procedures for telemedical encounters as compared to physical encounters,[171] and (4) whether the state's policy recognized licensure exemptions or reciprocity for out-of-state telemedical providers.[172] States were then assigned a composite grade on a scale of A through F.[173]

On the first indicator, most states do not set a significantly higher bar for telemedical providers.[174] That is, forty-seven states and the District of Columbia received a C or higher; in those places, telemedical providers are held to the same standard of care as

Changing Physician Licensure Requirement Would Clear the Way for Telemedicine to Achieve the Goals of the Affordable Care Act, 2012 U. ILL. J.L. TECH. & POL'Y 193, 201-02 ("When a physician consults with, treats, or prescribes medicine to a patient, the physician is said to be practicing medicine wherever the patient is located.").

165 Zilis, *supra* note 164, at 202 (stating that "[o]f the 774,000 licensed active physicians in the United States, only 22% maintain licenses in multiple jurisdictions").

166 *See* THOMAS & CAPISTRANT, *supra* note 66, at 3-5, 9 (calling licensure portability a "contentious issue" and finding that "every state imposes a policy that makes practicing medicine across state lines difficult"); *see also* Ameringer, *supra* note 75, at 58-59 (stating that 21 states do not recognize a telemedical exemption for cross-jurisdictional practice and instead require physicians to hold a full-service license to practice across state lines).

167 *See* THOMAS & CAPISTRANT, *supra* note 66.

168 *See id.* at 4-5.

169 *Id.* at 7.

170 *Id.*

171 *Id.* at 8.

172 *Id.* at 9.

173 *Id.* at 5. The grades are measures of "existing policy barriers that inhibit the use of telemedicine that would enable patient and provider choice to quality health care services," with an "A" grade roughly indicating a telemedicine-friendly policy landscape. *See id.* at 1-5.

174 *See id.* at 2-3.

traditional providers.[175] Alabama, Arkansas, and Texas received F's because they require telemedical providers to meet more stringent clinical practice standards.[176] Alabama and Texas, for example, require an in-person follow-up consultation after every telemedical encounter.[177] On the second indicator, most states do not require a physical doctor to be present every time a patient receives telemedical care.[178] However, in states where establishment of a proper physician–patient relationship via an in-person physical exam is a threshold requirement for accessing telemedical services,[179] lenient rules regarding the physical provider's presence after the first exam do little to alleviate telemedical barriers. On the third indicator, sixteen states and the District of Columbia have informed consent requirements peculiar to telemedical practice.[180] In Alabama, Indiana, Oklahoma, Texas, and Washington verbal consent does not suffice; the patient must give consent in writing.[181] Finally, on the fourth indicator, not one state received an A in terms of licensure policy.[182] The vast majority of states continue to require physicians to be licensed in the state where the patient is located.[183] Broadly, this requirement means that every state's current policy framework makes practicing medicine across state lines difficult.[184] More narrowly, it means that every state makes it near impossible for out-of-state medical providers to reach in-state patients via telemedicine without first acquiring full licensure in that state.[185]

B. Rule 190.8 and Its Counterparts

A number of states have considered implementing regulations that would restrict telemedical practice. For example, the Delaware Board of Occupational Therapy scheduled a public hearing on November 4,

[175] *Id.*

[176] *Id.* at 7.

[177] *Id.*

[178] *Id.* at 3.

[179] For example, Texas allows establishment of a physician–patient relationship via telemedicine only when the patient is located at an established medical site — otherwise, an in-person exam is required. *See id.* at 54.

[180] *Id.* at 3.

[181] *Id.* at 8.

[182] *Id.* at 9.

[183] *Id.* at 5.

[184] *Id.* at 9.

[185] *See* Ameringer, *supra* note 75, at 59.

2015 to review a proposed revision to its telehealth regulations.[186] The proposed rule, Rule 4.2.4.4, would have required all patient evaluations to be performed face-to-face.[187] In Mississippi, the Board of Medical Licensure considered a proposal that would have required telemedical providers to establish formal relationships with Mississippi-based healthcare providers before treating patients.[188] Though it was ultimately withdrawn,[189] the Mississippi Board continues to tinker with telemedical restrictions.[190] On the other hand, some states, including North Dakota,[191] Colorado,[192] and Washington,[193] have taken steps toward opening state healthcare markets to telemedical practice.

[186] Public Notice, 19 Del. Reg. Regs. 276 (Oct. 1, 2015), http://regulations.delaware.gov/register/october2015/proposed/19%20DE%20Reg%20276%2010-01-15.pdf.

[187] *Id.* ("All evaluations, including initial evaluations, and re-evaluations and scheduled discharges shall be performed face to face and not through telehealth."). The American Telemedical Association submitted public comments calling the proposal an "unwarranted barrier[] for residents wanting a telehealth provided service. Jonathan D. Linkous, *RE: Proposed Rulemaking and Public Notice on on Telehealth* (Nov. 3, 2015), http://dev.americantelemed.org/docs/default-source/policy/ata-comments-to-de-ot-board.pdf. In August 2016, the FTC also submitted public comments expressing "reservations about the potential effects of proposed § 2000-4.2.4.4." FTC STAFF, FTC STAFF COMMENT BEFORE THE DELAWARE BOARD OF OCCUPATIONAL THERAPY 4 (2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-delaware-board-occupational-therapy-concerning-its-proposed-telehealth-regulation/v160014_delaware_ot_proposed_advocacy.pdf. Ultimately, the Delaware Board opted for a decidedly less restrictive rule. Public Notice, 19 Del. Reg. Regs. 1074 (June 1, 2016), http://regulations.delaware.gov/register/june2016/proposed/19%20DE%20Reg%201074a%2006-01-16.pdf.

[188] Steve Wilson, *Proposed Mississippi Telemedicine Rule Goes Temporarily Offline*, MISS. WATCHDOG (July 17, 2015), http://watchdog.org/229825/proposed-mississippi-telemedicine-rule-goes-temporarily-offline/.

[189] *Id.* (reporting that the Mississippi Board of Medical Licensure temporarily withdrew the proposal but would re-open it pending completion of an economic impact statement); *see also Mississippi Steps Back from New Telehealth Rules*, MHEALTHINTELLIGENCE.COM (Nov. 3, 2016), http://mhealthintelligence.com/news/mississippi-steps-back-from-new-telehealth-rules (noting that the Mississippi Board of Medical Licensure "withdrew its proposal in the face of opposition").

[190] *Mississippi Steps Back from New Telehealth Rules*, *supra* note 189 (reporting that the Mississippi State Medical Association was against allowing telemedical providers to establish a doctor–patient relationship via a phone-based consult).

[191] Nathaniel M. Lacktman & Jacqueline N. Acosta, *Five Takeaways from North Dakota's Proposed Telemedicine Rules*, FOLEY & LARDNER LLP (Nov. 9, 2015), https://www.healthcarelawtoday.com/2015/11/09/five-takeaways-from-north-dakotas-proposed-telemedicine-rules/.

[192] Kintner, *supra* note 94.

[193] *Governor Signs Priority Telemedicine Bill*, WASH. ST. MED. ASS'N (Apr. 22, 2015), https://www.wsma.org/wcm/For_Members/Membership_Memo_Content/Membership

IV. *TELADOC V. TEXAS STATE MEDICAL BOARD*

A. Facts

The Texas State Medical Board ("TMB") is a state agency charged with licensing physicians, promulgating rules for and regulating medical practice, and enforcing said rules and regulations within the state of Texas.[194] Teladoc is the first and leading telehealth provider in the United States[195] and generates twenty-three percent of its business revenue via consultations with Texas patients.[196] In October 2010, the TMB amended its existing rules for telemedical practice and adopted Rule 190.8, under which telemedical providers are required to establish a proper "physician–patient relationship"[197] (i.e., conduct an in-person medical evaluation) before prescribing medication telephonically.[198] Acting pursuant to its enforcement authority, the TMB issued what was effectively a cease-and-desist letter, advising Teladoc that allowing its physicians to prescribe medications on the basis of telephone consultations violated Rule 190.8.[199] Teladoc filed an application for a preliminary injunction, alleging that Rule 190.8 is a thinly veiled attempt to insulate Texas physicians from telemedical competition.[200]

B. Procedural Posture

Because *Parker* immunity so robustly insulates state licensing boards, plaintiffs are typically forced to make constitutional claims.[201] The common route for challenging state licensing restraints has therefore been to allege violations under the Due Process or Equal Protection Clauses of the Fourteenth Amendment.[202] Unfortunately, these types of claims are hard to win because the Supreme Court evaluates both under the rational review standard.[203] Currently,

_Memo_Issues/April_22_issue/Governor_signs_priority_telemedicine_bill.aspx.

194 *See Texas Medical Board Overview*, *supra* note 142.

195 TELADOC, *supra* note 80.

196 *See* Teladoc, Inc. v. Tex. Med. Bd., 112 F. Supp. 3d 529, 541 (W.D. Tex. 2015).

197 22 TEX. ADMIN. CODE § 174.8 (2016).

198 *See Teladoc*, 112 F. Supp. 3d at 534.

199 *See id.*

200 *See id.* at 537.

201 *See* Edlin & Haw, *supra* note 73, at 1118-19.

202 *Id.* at 1127-30.

203 *See id.*

Schware v. Board of Bar Examiners,[204] decided in 1957, remains the only case involving restrictions on occupational licensing to fail rational review.[205] Plaintiffs have similarly found little success under the Dormant Commerce Clause[206] because courts tend to find a legitimate state interest in restrictive licensing policies.[207]

The procedural posture of the *Teladoc* case is somewhat unusual. After *Dental Examiners*, the possibility of succeeding on claims brought under federal antitrust law is ostensibly greater. As one of the first cases following the Court's 2015 decision, *Teladoc* is considered something of a test case for future antitrust litigation.[208] However, strictly in terms of legal precedent, *Teladoc*'s impact is de minimis;[209] the antitrust analysis applied by the district court is of limited utility because the TMB failed to claim any immunity, including a *Parker* defense.[210] That said, the district court's reference in its antitrust analysis to *Dental Examiners*,[211] and its ultimate conclusion that the anticompetitive effect of Rule 190.8 was not justified on public safety

[204] 353 U.S. 232 (1957).

[205] *See* Edlin & Haw, *supra* note 73, at 1128.

[206] *Id.* at 1130.

[207] Teladoc alleged claims under the Dormant Commerce Clause in addition to its claims under the Sherman Act, but the Court declined to address the constitutional claims because it found Teladoc had shown a likelihood of success on its antitrust claim. *See* Teladoc, Inc. v. Tex. Med. Bd., 112 F. Supp. 3d 529, 540-41 (W.D. Tex. 2015).

[208] *See* Lisa Schencker, *Judge Allows Teladoc Lawsuit Against Texas Medical Board to Proceed*, MOD. HEALTHCARE (Dec. 14, 2015), http://www.modernhealthcare.com/article/20151214/NEWS/151219924 (quoting telemedical attorney Nathaniel Lacktman as saying that *Teladoc*'s resolution will impact state medical boards' telemedicine policies going forward and that the litigation thus far should be interpreted as "a word of warning . . . to medical boards in other states that their activities may not be protect[ed] by the sovereign immunity doctrine . . . ."); Edgar Walters, *Virtual Doctors Making Medical Board Really Nervous*, TEX. TRIB. (Feb. 12, 2015, 6:00 AM), http://www.texastribune.org/2015/02/12/texas-telemedicine-fight-wages/ (stating that *Teladoc* "will have seismic consequences for the future of the industry").

[209] *See* Sasha Volokh, *Antitrust State-Action Immunity and Market-Participant-Dominated Boards*, WASH. POST (Nov. 8, 2016), https://www.washingtonpost.com/news/volokh-conspiracy/antitrust-state-action-immunity-and-market-participant-dominated-boards/ (noting that the district court's opinion "has no precedential value").

[210] *See Teladoc*, 112 F. Supp. 3d at 535 ("This case presents an atypical situation under antitrust laws . . . [because] the TMB declined to assert any immunity defenses, including *Parker* immunity . . . . The normal deference afforded to a state under antitrust law is, therefore, not an issue . . . .").

[211] *Id.* at 535-36.

grounds,[212] suggests that Teladoc's anticompetitive claims "may have some persuasive value if the same issue arises in other states."[213]

C. Impact Predictions

Because the TMB did not raise a *Parker* defense, the district court focused wholly on whether Teladoc had demonstrated an "antitrust injury" — that is, an "injury of the type the antitrust laws were intended to prevent."[214] To that end, the court evaluated whether Rule 190.8 would actually cause increased prices, reduced choice, reduced access, reduced innovation, and a reduced overall supply of physician services, as Teladoc claimed.[215] The court's evidentiary findings[216] belied statements made by the TMB that Teladoc's alleged injuries were purely speculative and that Rule 190.8 was necessary to ensure quality medical care.[217] The court granted Teladoc's request for a preliminary injunction and enjoined enforcement of Rule 190.8.[218]

The fact that the TMB declined to assert *Parker* immunity as to Teladoc's application for a preliminary injunction[219] would not have precluded the TMB from doing so on appeal. Indeed, the amicus curiae briefs submitted on behalf of the TMB broached the issue.[220] The Federation of State Medical Boards, for instance, argued that state action immunity applied because rules issued by the TMB are reviewable by the Texas state courts.[221] Similarly, the Texas Attorney General's Office submitted a brief requesting Teladoc's claims be dismissed under the state action defense.[222] The availability of *Parker*

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212 *See id.* at 540.

213 Volokh, *supra* note 209.

214 *See Teladoc*, 112 F. Supp. 3d at 536.

215 *Id.* at 537.

216 For example, the court found that the availability of Teladoc services reduced travel time, waiting time, and delays in treatment, and that Teladoc services reduced monthly healthcare costs and expanded access to patients (particularly in rural areas of Texas suffering from a shortage of doctors). *Id.* at 537-38.

217 *See id.* at 543.

218 *Id.* at 544.

219 *Id.* at 535 (noting that the TMB declined immunity "solely as to Plaintiff's application for a preliminary injunction").

220 *See infra* notes 221 & 226.

221 Brief of Federation of State Medical Boards as Amicus Curiae in Opposition to Plaintiffs' Application for Temporary Restraining Order and Preliminary Injunction, Teladoc, Inc. v. Tex. Med. Bd., 112 F. Supp. 3d 529 (W.D. Tex. 2015) (No. 1-15-CV-00343 RP), 2015 WL 4064002.

222 *See* Brief for Defendants-Appellants at 21, Teladoc, Inc. v. Tex. Med. Bd., No. 16-50017, 2016 WL 3383026, at *21 (5th Cir. June 17, 2016) (arguing on behalf of

immunity as a potential defense was slated to be a substantive issue on appeal.[223]

Dental Examiners made clear that boards composed of active market participants may not avail themselves of *Parker* immunity absent "active supervision" by the State.[224] Here, a majority of the TMB's members are active market participants.[225] And, as conceded even by the Federation of State Medical Boards in its amicus brief, it is not at all clear that judicial review of state agency action constitutes active state supervision.[226] *Dental Examiners* emphasized board composition as a greatly influential factor in the antitrust analysis.[227] That fact, in combination with the district court's finding that Rule 190.8 produces exactly the kind of harms antitrust laws were enacted to prevent,[228] suggests that appellate review would likely turn in Teladoc's favor.

Unfortunately, on October 17, 2016, the TMB withdrew its Fifth Circuit collateral order appeal,[229] sending the case back to the district court. Though the TMB is expected to reassert its state-action immunity defense at trial,[230] *Teladoc* represents a lost opportunity. A Fifth Circuit decision in Teladoc's favor would have provided an

the TMB that "state-court judicial review constitutes active supervision of the Board's formal rulemaking for purposes of state-action immunity").

223 In early December 2015, the district court denied the Texas Medical Board's motion to dismiss, holding that the Board is not immune from antitrust liability under the state action doctrine. Dionne Lomax & Farrah Short, *Antitrust Suit Continues to Stymie New Texas Telemedicine Regulation*, HEALTH L. & POL'Y MATTERS (Dec. 17, 2015), https://www.healthlawpolicymatters.com/2015/12/17/antitrust-suit-continues-to-stymie-new-texas-telemedicine-regulation/. The Texas Medical Board filed an appeal on its motion to dismiss with the Fifth Circuit Court of Appeals. David Pittman, *Anxiety over Newly Passed Hardship Law*, POLITICO (Dec. 22, 2015, 9:59 AM), http://www.politico.com/tipsheets/morning-ehealth/2015/12/politicos-morning-ehealth-anxiety-over-newly-passed-hardship-law-tech-hampers-drug-monitoring-usability-at-heart-of-acp-ehra-meeting-211890.

224 N.C. State Bd. of Dental Exam'rs v. FTC, 135 S. Ct. 1101, 1106 (2015).

225 *See* TEX. MED. BD., *supra* note 142.

226 Brief of Federation of State Medical Boards, *supra* note 221 ("To be sure, the Supreme Court has never squarely decided whether judicial review of a regulation of a state agency constitutes "active state supervision" for purposes of the state action doctrine.").

227 *See Dental Exam'rs*, 135 S. Ct. at 1113-15.

228 Teladoc, Inc. v. Tex. Med. Bd., 112 F. Supp. 3d 529, 537 (W.D. Tex. 2015).

229 Ilya Shapiro, *Texas Wisely Concedes Economic Liberty Case*, CATO INST. (Oct. 17, 2016, 4:08 PM), https://www.cato.org/blog/texas-wisely-concedes-economic-liberty-case (claiming that "the quality of amicus briefs certainly contributed to Texas's decision to abandon the medical board's appeal").

230 Matthew Loughran, *Texas Telemedicine Case Heads Back to Trial*, BLOOMBERG BNA (Oct. 19, 2016), http://www.bna.com/texas-telemedicine-case-n57982078853/.

interpretation of *Dental Examiners* consistent with the purpose of the Sherman Act. More significantly, that interpretation would have had precedential effect. That said, the TMB's withdraw might also be viewed as "a victory of a different sort."[231] The staunch support Teladoc received in the form of amicus briefs from influential public and private entities[232] portends a promising future for telemedical practice, in Texas and elsewhere.

V. *TELADOC*'S IMPLICATIONS: ANTITRUST GOALS AND STATE MEDICAL BOARDS

In the antitrust context, restrictions on competition are tolerated only in narrow circumstances, like when there is a consumer safety risk.[233] Given that telehealth policy in the states is far from established — indeed it remains largely in flux — *Teladoc*, even absent a circuit decision, will have implications for patients and physicians nationwide.[234]

A. Consumer Welfare: Implications for Patients

1. Access Implications

The district court's discussion of the competing claims in *Teladoc* is a helpful starting point for evaluating access implications because the access dilemma in Texas can be extrapolated to the country at large. There is an acute shortage of doctors in Texas. Indeed, of Teladoc's 2.4 million patients in that state,[235] roughly fifty percent do not have a

[231] Volokh, *supra* note 209 (noting that although a precedent-setting opinion would have been ideal, the district court's decision, left standing, will allow Teladoc to continue its operations in Texas and suggests that "[t]he trend is thus in favor of keeping a tight lid on the market-participant-dominated agencies").

[232] Shapiro, *supra* note 229 (noting that "the range of briefing was impressive, particularly for a case that hadn't yet reached the Supreme Court"); Teichert, *supra* note 77 (noting that both the FTC and the U.S. Department of Justice filed amicus briefs on Teladoc's behalf); Volokh, *supra* note 209 ("At the Fifth Circuit, a group of 55 antitrust and competition scholars — mostly law or economics professors — filed an amicus brief . . . . These scholars included . . . the authors of an antitrust professors' Supreme Court amicus brief in N.C. Dental . . . .").

[233] FED. TRADE COMM'N, *supra* note 145, at 2.

[234] *See* THOMAS & CAPISTRANT, *supra* note 66, at 4 (noting that there has been "a considerable amount of state policy activity" in the telehealth sector and that over half the states have considered new proposals to revise current telemedical standards).

[235] Ken Terry, *Teladoc Sues Texas over Impending Telemedicine Restrictions*, MEDSCAPE (Apr. 30, 2015), http://www.medscape.com/viewarticle/844001.

regular physician.[236] Similarly, in a 2012 study, the RAND Corporation analyzed Teladoc services received by roughly 2,700 California Public Employees' Retirement System (CalPERS) members.[237] The researchers found that twenty-one percent of Teladoc's patients had not seen a doctor in 2011 (and ostensibly only did so in 2012 because Teladoc's services were added as a covered benefit in April 2012).[238] The researchers concluded that Teladoc was an "entry point into the health care system for people who did not have frequent contact with a primary care provider or had difficulty accessing their regular physician."[239] In 2014, there were between 241 to 265.5 active physicians per 100,000 patients in California.[240] In states like Nevada, Idaho, Utah, Wyoming, Kansas, Oklahoma, Iowa, Arkansas, Alabama, and Mississippi, where the number of active physicians are in a range like that of Texas — 184.7 to 214.2 per 100,000 patients — the access dilemma is more severe.[241] Teladoc has providers licensed in all fifty states[242] and services 17.1 million patients across the nation.[243] An appellate decision sanctioning Rule 190.8 as non-violative of antitrust law would limit access to medical services for millions of patients and would deprive the medical workforce of a network of over 2,000 board-certified professionals.[244] At a time when demand for physicians continues to grow faster than supply,[245] narrowing the available market for healthcare would negatively impact consumers, which is, as the district court noted, "a classic antitrust injury."[246]

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[236] Teladoc, Inc. v. Tex. Med. Bd., 112 F. Supp. 3d 529, 537 (W.D. Tex. 2015).

[237] Uscher-Pines & Mehrotra, *supra* note 93, at 259.

[238] *See id.* at 259, 262-63.

[239] *Id.* at 263.

[240] ASS'N OF AM. MED. COLLS., CTR. FOR WORKFORCE STUDIES, 2015 STATE PHYSICIAN WORKFORCE DATA BOOK 141 (2015).

[241] *Id.*

[242] *See* TELADOC, TELADOC — INNOVATION AND INVESTMENT, OPPORTUNITY AND GROWTH 13 (2013), http://www.ehcca.com/presentations/hcisummit1/gorevic_pc2.pdf.

[243] *See* TELADOC, *supra* note 81.

[244] Press Release, Teladoc, Inc., Teladoc Conducts 1 Millionth Telehealth Visit (Oct. 20, 2015), http://www.teladoc.com/news/2015/10/20/teladoc-conducts-1-millionth-telehealth-visit/.

[245] IHS INC., *supra* note 38, at v (finding a projected shortfall in physician supply of between 46,100 and 90,400 by 2025).

[246] Teladoc, Inc. v. Tex. Med. Bd., 112 F. Supp. 3d 529, 537 (W.D. Tex. 2015).

2. Cost Implications

Antitrust law is purposefully directed at fostering competition to preserve lower prices for consumers.[247] Telemedicine is cheaper than traditional care in a variety of contexts.[248] After compiling forty years of research on telemedical outcomes, the American Telemedicine Association found that peer-reviewed and scientifically rigorous studies consistently showed that telemedicine saved costs for patients and providers.[249] In *Teladoc*, the Court noted that Teladoc had presented evidence that, "the average costs of visits to a physician or emergency room are $145 and $1957, respectively, and the cost for a Teladoc consultation is typically $40."[250] Teladoc's evidentiary support is roughly reflective — if not overly generous[251] — of healthcare estimates across the nation. For example, according to Fair Health Consumer,[252] a thirty-minute office consultation for a patient in Boston, Massachusetts costs approximately $436.[253] In Des Moines,

[247] *See* Nilavar v. Mercy Health Sys.–W. Ohio, 494 F. Supp. 2d 604, 617 (S.D. Ohio 2005).

[248] *See, e.g.*, CUSACK ET AL., CTR. FOR INFO. TECH. LEADERSHIP, THE VALUE OF PROVIDER-TO-PROVIDER TELEHEALTH TECHNOLOGIES 2-3 (2007), http://telehealth.utmb.edu/presentations/CITL%20-%202007%20-%20The%20Value%20of%20Provider-to-Provider%20Telehealth%20Technologies.pdf (finding that telehealth technologies would generate costs savings of $537 million per year in emergency rooms, $210 million in correctional facilities, and $479 million in nursing homes); Cryer et al., *supra* note 51; Adam Darkins et al., *Care Coordination/Home Telehealth: The Systematic Implementation of Health Informatics, Home Telehealth, and Disease Management to Support the Care of Veteran Patients with Chronic Conditions*, 14 TELEMEDICINE & E-HEALTH 1118 (2008), http://online.liebertpub.com/doi/abs/10.1089/tmj.2008.0021 (finding that the Veterans Health Administration's implementation of a national home telehealth program substantially reduced costs and improved patients' outcomes).

[249] AM. TELEMEDICINE ASS'N, EXAMPLES OF RESEARCH OUTCOMES: TELEMEDICINE'S IMPACT ON HEALTHCARE COST AND QUALITY (2013), http://www.amdtelemedicine.com/telemedicine-resources/documents/ATATelemedicineResearchPaper_impact-on-healthcare-cost-and-quality_April2013.pdf.

[250] *Teladoc*, 112 F. Supp. 3d at 537.

[251] Fair Health Consumer estimates the cost of an office consultation for a patient in Dallas, Texas at approximately $257. *Fair Health Consumer Cost Lookup*, FAIR HEALTH CONSUMER, http://fairhealthconsumer.org/medicalcostlookup.php (last visited Feb. 2, 2017).

[252] Fair Health Consumer's FH Medical Cost Lookup Calculator estimates out-of-pocket costs according to what healthcare professionals commonly charge for a wide range of medical procedures, services, and supplies. *See Understanding Your Medical Cost Estimate*, FAIR HEALTH CONSUMER, https://fairhealthconsumer.org/resources.php?id=11&terms=understanding-your-medical-cost-estimate (last visited Feb. 2, 2017).

[253] FAIR HEALTH CONSUMER, *supra* note 251.

Iowa, the same consultation costs approximately $235.[254] In Los Angeles, California, the cost is $295.[255] By contrast, the cost of a telehealth consultation averages $38, regardless of where the patient is located.[256] If an appellate court upholds Rule 190.8 (and by extension, iterations of it in other states), consumer patients will be forced to either pay higher medical premiums or go without care.

3. Quality of Care Implications

Health policy is often conceptualized as an "iron triangle" with three vertices: access, cost, and quality.[257] Though all three vertices are important in any health system,[258] the quality vertex has special significance in the telemedical context because state medical boards, with the support of organized medical groups like the AMA and the FSMB, have relied on maintaining quality of care as the justification for telemedical restrictions.[259] Fittingly, the TMB's sole justification for Rule 190.8 in the *Teladoc* litigation (i.e., that it will lead to improved quality of medical care for Texans)[260] typifies the responses given by organized medicine to charges of anticompetitive conduct. *Teladoc*'s resolution will be a benchmark in assessing the veracity of those claims.

In terms of broader safety analyses, the district court's evaluation of the TMB's claims is useful. The TMB's allegations at trial were threefold: (1) telemedical treatment results in higher rates of misdiagnosis,[261] (2) telemedicine puts patients at risk by increasing the likelihood that patients will need but not receive follow-up care,[262] and (3) telemedicine fragments healthcare.[263] First, the TMB provided anecdotal evidence in its affidavits of misdiagnoses produced by telephone consultations; specific examples included an erroneous

254 *Id.*

255 *Id.*

256 TELADOC, INC., HEALTH CARE AND BUSINESS: USING NEW TECHNOLOGIES TO REDUCE COSTS, IMPROVE ACCESS AND INCREASE EMPLOYEE SATISFACTION 7 (2012), http://communications.teladoc.com/resources/Telehealth-Special-Report.pdf.

257 FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, *supra* note 23, executive summary at 6 ("Health policy analysts commonly refer to an 'iron triangle' of health care. The three vertices of the triangle are the cost, quality, and accessibility of care.").

258 *See generally* Donald M. Berwick et al., *The Triple Aim: Care, Health, and Cost*, 27 HEALTH AFF. 759 (2008) (discussing the goals of the U.S. care health system in terms of the "triple aim").

259 *See, e.g.*, Press Release, Am. Med. Ass'n, *supra* note 87.

260 Teladoc, Inc. v. Tex. Med. Bd., 112 F. Supp. 3d 529, 538 (W.D. Tex. 2015).

261 *See id.* at 539.

262 *See id.*

263 *Id.*

prescription for antibiotic ear drops where the correct diagnosis of sinus infection was only made following an in-person exam, and a telemedical provider's failure to correctly diagnose an acute shoulder injury based on left shoulder pain.[264] Second, the TMB argued that the California RAND study found that Teladoc consultations "could lead to misdiagnosis and higher need for follow-up visits."[265] Third, the TMB suggested that unlike traditional consultations, treatment notes from telemedical consultations do not become a part of the patient's permanent medical record.[266] The TMB argued that this prevents future providers from appropriately gauging a patient's medical history, resulting in fragmented care.[267]

The court made several important observations regarding each of the three claims. First, the danger of misdiagnosis is not limited to the telemedical context. Teladoc submitted expert testimony on prescribing practices that showed "widespread improper antibiotic prescribing by physicians following in-person physical examination."[268] In fact, five percent of patients, roughly 12 million people, are misdiagnosed annually in the United States.[269] Further, diagnostic errors account for ten percent of patient morbidity and constitute the leading type of medical malpractice claim.[270] Second, the RAND study, contrary to the TMB's characterization, did not find that Teladoc consultations lead to either higher rates of misdiagnosis or higher need for follow-up visits. Ateeva Mehrotra, one of the two researchers who authored the study, submitted an affidavit on Teladoc's behalf stating that the TMB had mischaracterized his research.[271] Indeed, the article publishing the study's results explicitly stated, "contrary to concerns expressed in the literature, the rate of follow-up visits was *not* higher for Teladoc visits than for visits to other care settings. In fact, enrollees who used Teladoc had fewer follow-up visits . . . ."[272] The article went on to note that there was

[264] *Id.* at 538.

[265] *Id.* at 540.

[266] *Id.* at 538-39.

[267] *See id.*

[268] *Id.* at 538.

[269] Joydeep Bhattacharyya, *Going Beyond the Symptoms: The Case for Telemedicine*, HUFFINGTON POST: BLOG (Oct. 21, 2015, 1:17 PM), http://www.huffingtonpost.com/joydeep-bhattacharyya/going-beyond-the-symptoms_b_8315294.html.

[270] INST. OF MED., IMPROVING DIAGNOSIS IN HEALTH CARE 2 (2015), https://iom.nationalacademies.org/~/media/Files/Report%20Files/2015/Improving-Diagnosis/DiagnosticError_ReportBrief.pdf.

[271] *Teladoc*, 112 F. Supp. 3d at 539-40.

[272] Uscher-Pines & Mehrotra, *supra* note 93, at 261 (emphasis added).

very little evidence of misdiagnosis by Teladoc providers.[273] The study additionally observed that lack of follow-up care did not necessarily indicate negligent or sub-par care.[274] Rather, a lack of follow-up might simply mean that follow-up care was not necessary, indicating that Teladoc providers are successfully diagnosing and treating patients.[275] Finally, the charge that telemedicine fragments patient care was similarly unsupported by the evidence.[276] Teladoc's practice policy allows its providers to send patients' medical records to their primary physicians with patient consent.[277] Moreover, the district court noted that in the modern healthcare industry patients rarely have a single provider anyway, making the idea of a "singular 'permanent medical record'" unrealistic.[278]

The available empirical evidence, both presented by Teladoc at trial and available in the National Library of Medicine's over 2,000 evaluative studies on telemedicine,[279] does not support the argument that telemedical practice diminishes the quality of patient care. As such, an appellate decision affirming the trial court's decision in *Teladoc* would not put patient consumers at risk.

B. State Medical Boards: Implications for Structuring and Regulatory Practices

After the Supreme Court's decision in *Dental Examiners*, Oklahoma Governor Mary Fallin issued an executive order requiring the Oklahoma Attorney General's Office to review all rulemaking by state boards composed of active market participants.[280] Further, the order mandated that board members who fail to comply with the Attorney General's advice be subject to removal for misconduct.[281] Governor Fallin's order, directed at securing antitrust immunity under the state action doctrine, is indicative of the type of state policy action federal court decisions engender. Indeed, the *Teladoc* litigation is itself a

[273] *Id.* at 263.

[274] *See id.*

[275] *See id.*

[276] *See Teladoc*, 112 F. Supp. 3d at 539.

[277] *Id.*

[278] *Id.* (quoting a declaration issued by researcher Ateeva Mehrotra).

[279] AM. TELEMEDICINE ASS'N, *supra* note 249.

[280] *See* Randy Ellis, *OK Governor's Order Gives Attorney General New Power*, OKLAHOMAN (July 22, 2015, 12:40 PM), http://newsok.com/ok-governors-order-gives-attorney-general-new-power/article/5435226/?page=2.

[281] *Id.*

product of the *Dental Examiners* decision.[282] *Teladoc*'s ultimate resolution will have implications for state regulation of telemedicine both in and out of Texas. Specifically, assuming the TMB reasserts a state action defense at trial, a decision in favor of Teladoc would likely incentivize actions of the type taken by Governor Fallin. That is, it would be in states' interest to insulate their state boards from antitrust review by adopting clear procedures for state oversight. Alternatively, instead of strengthening official oversight mechanisms, it is possible states will seek to diversify board composition. Boards not consisting predominantly of active members of the professions they regulate are unlikely to draw antitrust scrutiny.[283] By contrast, a decision in favor of the TMB might encourage states to relax official oversight of state board regulatory action. Further, a ruling upholding the TMB's actions might empower state boards to adopt restrictive rules in the vein of Rule 190.8.

CONCLUSION

While it may be true that the healthcare industry does not fit the textbook definition of a competitive market,[284] healthcare and antitrust law are not antithetical. Competition policy can and does promote the triple aim of healthcare.[285] Specifically, the FTC has found that competition broadens access to medical products and services, promotes the provision of treatment options "in a manner and location consumers desire," and affects the development and distribution of medical products resulting in cheaper prices for consumers.[286] Antitrust law was designed to safeguard the interests of consumers, and integration of telemedicine into the healthcare market will benefit consumers. Integration does not require that telemedicine wholly substitute or replace traditional care. Rather, integration necessitates that consumer-benefitting products and services, like telemedicine, be allotted a place in the healthcare delivery model. State regulation should be aimed at increasing consumer choice and access.

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[282] *See FTC Guidance Expected State Boards Compliance with Court Ruling*, CTR. FOR TELEHEALTH & E-HEALTH L. (June 19, 2015), http://ctel.org/2015/06/ftc-guidance-expected-for-state-regulatory-boards-compliance-with-court-ruling/.

[283] *See* FED. TRADE COMM'N, *supra* note 145, at 4-5.

[284] *See* Havighurst, *supra* note 121, at 1131.

[285] *See* FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, *supra* note 23, executive summary at 4.

[286] *See id.*

Courts should not hesitate to apply antitrust law to further its articulated goal: consumer welfare.