JOURNAL OF HEALTH CARE FINANCE

Summer 2019

Special Commentary

Simplifying Physician Licensing Across State Lines Will Promote the Expansion of Affordable Healthcare Delivered via Telemedicine

Joyce Vollmer

I. INTRODUCTION

The advent of technology has changed nearly every aspect of life. From how we buy groceries to how we access information, almost everything has changed because of advances in technology. It saves time and expands resources that once were beyond reach or imagination. Moving at the speed of light, with each day bringing some new possibility, technology hits the headlines. 3-D printing, artificial embryos and artificial intelligence are just a few of the latest breakthroughs to be highlighted in 2018.[1]

Regulatory bodies cannot keep up. As quickly as some new breakthrough is about to change the world, ethical debates begin. Lawmakers rush to protect the rights of those affected and some advances are stopped dead in their tracks. In a setting that could benefit the most, the delivery of healthcare via telemedicine to all who need it at an affordable price, such an obstacle exists. Rule makers found a way to stymie telemedicine's reach, pointing to the state's police power and its right to ensure the public safety, by state licensing boards calling the shots on who can provide medical services. It is a quagmire of red tape and costs that progressive physicians must maneuver in order to practice across state lines.

Physician licensure is both expensive and time consuming.[2] In Texas, for example, it costs $750 to make application, and on average it takes a minimum of four to six months.[3] Each State application fee is different, and the time it takes varies. Much of the information required from the physician applicant is the same; processing includes primary source verification of education, training and work history.[4] The National Practitioner Data Bank is a resource utilized to obtain disciplinary and medical malpractice actions.[5] It is maintained by the U.S. Department of Health and Human Services (DHHS) and widely used to track information about healthcare professionals. Since each state requires the same basic information from physicians, and the information is sourced similarly by each state licensing board, credentials standardization should be straight forward.[6] Instead, physician licensing is redundant and cumbersome, with each licensing board working independently to verify the same credentials of a single provider.

Attempts to make licensing across state lines easier for physicians is partially underway, headed up by the Federation of State Medical Boards.[7] The Interstate Medical Licensure Compact (IMLC) has been adopted by nineteen states so far.[8] While progress is being made, it's still very costly. A physician who wants to become licensed regionally or nationally can expect to spend

---

[1] Gideon Lichfield, *10 Breakthrough Technologies 2018*, Cambridge, MA: MIT Technology in Review, March/April 2018 (hereinafter "Lichfield"), pgs. 36-47.

[2] American Medical Association, Navigating State Medical Licensure, Feb 10 2018, https://www.ama-assn.org/residents-students/career-planning-resource/navigating-state-medical-licensure.

[3] Medicus Healthcare Solutions, Physician Licensure Application Fees and Timelines by State, Nov 11 2018; https://medicushcs.com/physician-licensure-application-fees-and-timelines-by-state/.

[4] Physician Licensing Service, Medical Licensing Requirements by State, Feb 10 2019, https://physicianlicensing.com/resources/state-requirements/.

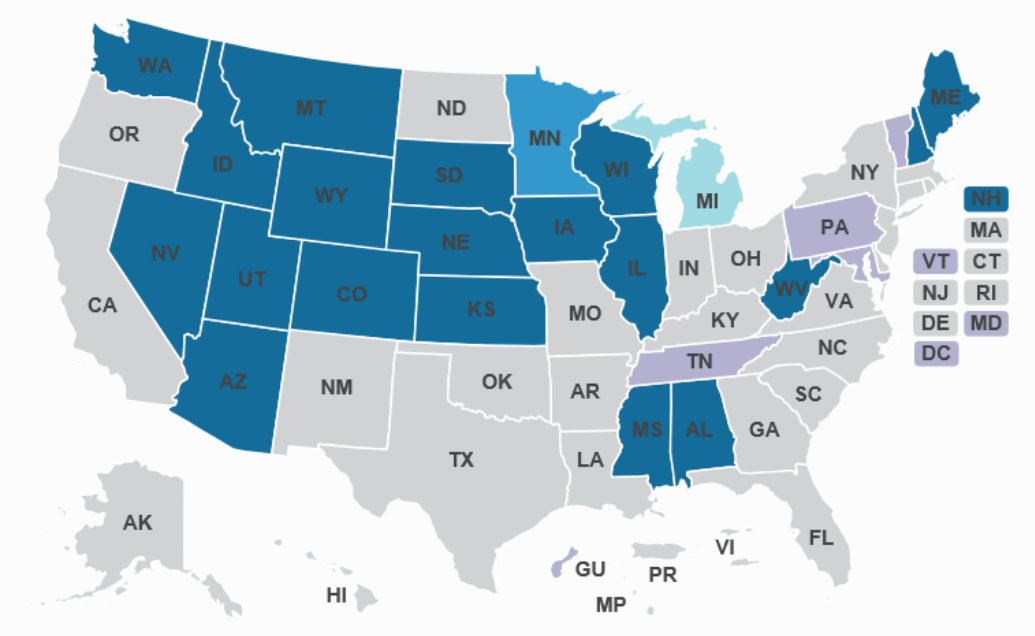
[5] https://www.npdb.hrsa.gov/.

[6] U.S. Department of Health and Human Services, National Practitioner Data Bank, NPDB Guidebook, Chapter B: Eligible Entities, Authorized Agents, https://www.npdb.hrsa.gov/guidebook/BWhoMayReportandQueryBehalfofEligibleEntities.jsp.

[7] https://telemedicine.arizona.edu/blog/practicing-telemedicine-across-state-borders-new-expedited-licenses-permit-physicians-expand.

[8] https://imlcc.org/.

from $8,000 to $30,000, not including his or her time to complete applications.[9] Many state licensing boards routinely require a criminal background check, which costs $65 or more each time. The duplication of time, money and effort is compounded by the number of states where licensing is pursued.



The IMLC, adopted in Nebraska April 3, 2017, details strict criteria that applies to physicians seeking to practice across state lines.[10] For example, one such criteria is that a physician has never been disciplined by a licensing agency in *any* jurisdiction.[11] State licensing boards and consumers alike can rest assured knowing that only those physicians in good standing within their primary state qualify.

Physicians who choose to go the Interstate Medical Licensure Compact Commission (IMLCC) route pay an application fee of $700, *plus* the state license fee.[12] IMLCC claims to be a "voluntary expedited pathway to licensure…" and helps physicians utilize existing information in their state of principal license (SPL).[12] Two things are certain; the cost of licensure is still high, and options are limited to those States that have adopted IMLC so far. If reciprocity between state licensing boards were enacted, it would be easier for physicians to become licensed across state lines, allow expansion of affordable healthcare delivered via telemedicine, and promote a free market approach to drive down health care costs. However, achieving reciprocity is time consuming, inefficient and fraught with jurisdictional challenges.[13]

---

[9] Medicus Healthcare Solutions, Physician Licensure Application Fees and Timelines by State, updated January 29, 2019, https://medicushcs.com/physician-licensure-application-fees-and-timelines-by-state/.
[10] Interstate Medical Licensure Compact, 2017 Bill Text NE L.B. 88.
[11] *Id at 1.*
[12] https://imlcc.org/.
[13] Article: A Case for Federal Regulation of Telemedicine in the Wake of the Affordable Care Act, 16 Colum. Sci. & Tech. L. Rev. 274, pg 4.

To illustrate the importance that national standards bring to the expansion of telemedicine, this paper begins with the globalization of healthcare and technology's low-cost entry point.[14] From there, a detailed look at current state licensing restrictions confirms the overwhelming need for a more modern approach.[15] Next, proof that telemedicine offers an affordable option for healthcare expansion is presented, along with modes that are shifting to telemedicine for practical purposes.[16] Finally, a look at how law makers can legitimately support a federally-sourced option for licensing telemedicine physicians is discussed.[17]

Included in this argument are ethical and financial considerations offering the pros and cons of reciprocity, as well as telemedicine in general.[18] Other factors affecting healthcare commerce are discussed, in conjunction with other solutions for interstate licensing.[19] A rationale for regulatory change will support widespread adoption of telemedicine and result in healthcare cost savings.[20]

II. BACKGROUND

A. The Globalization of Healthcare

Technology opened the door to globalization, making it far easier and more affordable to access a remote workforce.[21] According to one source, $340M moved from the U.S. to India in 2003 related to outsourced transcription and medical billing.[22] It should come as no surprise then that the United States wants to protect itself from losing more jobs to offshore options. International trade is a valid concern, particularly when there is such disparity in physician compensation between the U.S. and other countries.[23]

The potential to control the rising costs of healthcare is motivation enough to seek out alternative resources.[24] For this effort, we need look no further than to the U.S. government, which allows Medicare beneficiaries to access telehealth services when the beneficiary resides outside a Metropolitan Statistical Area (MSA) and lives in a rural Health Professional Shortage Area

---

[14] Article: Telemedicine; Rx for the Future of Health Care, 6 Mich. Telecomm. Tech. L. Rev. 147.
[15] Symposium: Roundtable on Legal Impediments to Telemedicine: Legal Impediments to the Diffusion of Telemedicine, 14 J. Health Care L. & Pol'y 1.
[16] *Id at 3.*
[17] *Id at 3.*
[18] Article: Enabling Globalization of Health Care in the Information Technology Era: Telemedicine and the Medical World Wide Web, 17 Va. J.L. & Tech. 1.
[19] Article: The Constitutionality of Current Legal Barriers to Telemedicine in the United States: Analysis and Future Directions of its Relationship to National and International Health Care Reform, 21 Health Matrix 385.
[20] Comment: A Call to Action: Georgia Must Adopt New Standard of Care, Licensure, Reimbursement and Privacy Laws for Telemedicine, 54 Emory L.J. 1183.
[21] Article: States Revisit The Issue Of Telemedicine As It Expands To Cover Diagnosis And Treatment, The National Law Journal, Aug 21, 2000, https://advance.lexis.com/api/permalink/8686cd2b-cf9c-4c8a-99a5-10acd1d16502/?context=1000516.
[22] Article: The Future of Telemedicine & Its Faustian Reliance On Regulatory Trade Barriers For Protection, 16 Health Matrix 443.
[23] T.R. Reid, The Healing of America: A Global Quest For Better, Cheaper, And Fairer Health Care, New York, NY, 46-51, (2010).
[24] Article: Enabling Globalization of Health Care in the Information Technology Era: Telemedicine and the Medical World Wide Web, 17 Va. J.L. & Tech. 1.

(HPSA).[25] Recognizing that rural health communities have the hardest time attracting both primary care and specialty physicians, the Department of Health & Human Services (DHHS) continues to promote telemedicine as a cost-saving option for people covered by Medicare and Medicaid.[26] This speaks nothing of where the provider of telehealth services is located. Telehealth providers are still subject to state law, as affirmed by the Centers for Medicare and Medicaid Services (CMS).[27]

Economies of scale are feasible in telehealth, even when crossing time zones.[28] For example in teleradiology, excess capacity in one market can be utilized by another market, even if the market is across the country.[29] Excess capacity is costly to the healthcare system, and hospitals cannot afford to have physicians sit idle.[30] Subspecialty physicians who are tapped as resources for a wider array of patients via telemedicine bring needed expertise to areas where specialists may not otherwise exist locally.[31] Hospitals can navigate staffing shortages by utilizing remote resources, keeping excess capacity and associated costs to a minimum.[32]

B. The Shrinking Physician Demographic

A growing demand for specialists, combined with physician burnout is destined to drive telemedicine in the future.[33] The supply of cardiologists, urologists and others treating the aging population is not enough to meet demand.[34] Hospitals and medical groups competing to fill specialist positions need only look offshore to find willing and able resources.[35]

Supply and demand drive a free market approach, and the U.S. is facing a crisis in supply as the population ages. Rising healthcare costs must be weighed against the benefits of excessive regulation, as in the case of physician licensure.[36] Approving physicians for multistate licensure should be considered a step towards increasing supply and reducing costs, while keeping resources domestically viable.

---

[25] CMS.gov, MLN Booklet; Telehealth Services, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf, pg 2.

[26] CMS.gov, MLN Booklet; Telehealth Services (hereinafter "MLN Booklet"), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf, pgs. 5-10.

[27] MLN Booklet, pg 3.

[28] Notes & Comment: Teleradiology: Images of An Improved Standard Of Medical Care, 35 Rutgers Computer & Tech. L.J. 104.

[29] Article: The Future of Telemedicine & Its Faustian Reliance On Regulatory Trade Barriers For Protection, 16 Health Matrix 443, pg 8.

[30] Abelson, R., New York Times, *A M.R.I. Machine For Every Doctor? Someone Has To Pay*, Mar 13, 2004, https://www.nytimes.com/2004/03/13/business/an-mri-machine-for-every-doctor-someone-has-to-pay.html.

[31] Definition: Center of Excellence (CoE), https://whatis.techtarget.com/definition/center-of-excellence-CoE.

[32] Article: Enabling Globalization of Health Care in the Information Technology Era: Telemedicine and the Medical World Wide Web, 17 Va. J.L. & Tech. 1.

[33] Akhil Narang MD, Shashank S. Sinha MD et al., *The Supply and Demand of the Cardiovascular Workforce: Striking the Right Balance*, Journal of the Amer College of Cardiology, Vol 68 Issue 15, Oct 2016, pgs 1680-1689.

[34] Brunk, D., MD Edge/Family Practice News, Forecast warns of urologists shortage, May 10, 2013, https://www.mdedge.com/familymedicine/article/58750/health-policy/forecast-warns-urologist-shortage.

[35] *Id at 6*.

[36] Telemedicine and Interstate Licensure: Findings and Recommendations of the CTL Licensure Task Force, 73 N.D. L. Rev. 109.

The U.S. Constitution may be the biggest hurdle of all, since it "gives states exclusive authority over health and safety concerns."[37] Still, the U.S. is not alone in considering nontraditional options to lower healthcare costs. Even countries with national healthcare systems are looking to telemedicine as a solution for physician shortages and as a way of lowering costs.[38]

C. The Cost of Entry is Appealing

Very little stands in the way of telemedicine's entry point, when it comes to cost. Technological advances in video-conferencing and IT security make it easy to manage healthcare remotely.[39] Platforms that incorporate patient diagnostic devices locally make it possible to gather real-time data from the patient at home, transmit the results to the provider elsewhere, who then interprets results and renders a treatment plan.[40] The physician needs little more than a handheld PDA to communicate with patients.[41] Imagine having access to a physician who is miles away, particularly a specialist, and it happens from your mobile phone.[42]

Smart phone users in the U.S. are expected to climb to 230M by 2018.[43] North American internet usage is estimated to be 95% by 2022.[44] The increase of smart phone users and internet access makes telemedicine an option for patients who may otherwise not be able to reach healthcare providers in time when faced with a complicated illness. This has given rise to a new term, *mHealth*, used to describe telehealth delivered via mobile technologies.[45]

One of the most actively researched uses of *m*Health is for remote monitoring of chronic diseases like diabetes, heart insufficiency and congestive heart disease.[46] A study analyzing telemonitoring of patients with congestive heart failure, both homebound and non-homebound, following inpatient and ambulatory care admissions and discharge, showed a trend towards fewer readmissions.[47] Heart failure affects more than five million people in the U.S. and the study concluded that not only did remote monitoring improve aftercare, but when applied to a larger population it could have a real impact for both patients and providers alike.[48] From July 2003 through December 2007, the Veterans Health Administration (VHA) evaluated Care Coordination

---

[37] Article: The Constitutionality of Current Legal Barriers to Telemedicine in the United States: Analysis and Future Directions of its Relationship to National and International Health Care Reform, 21 Health Matrix 385.
[38] Reid, T.R., *The Healing of America, A Global Quest for Better, Cheaper and Fairer Health Care*, Penguin Press, New York, NY, Aug 31, 2010.
[39] *Id at 6*.
[40] Article: Kvedar, J., Joel Coye, M., Everett, W., Connected Health: A Review Of Technologies And Strategies To Improve Patient Care with Telemedicine and Telehealth, Health Affairs, Feb 2014, 33:2, pgs 194-199, https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2013.0992.
[41] Article: Enabling Globalization of Health Care in the Information Technology Era: Telemedicine and the Medical World Wide Web, 17 Va. J.L. & Tech. 1.
[42] *Id at 195*.
[43] Statistica, The Statistics Portal, https://www.statista.com/topics/2711/us-smartphone-market/.
[44] Internet World Stats, Usage and Population Statistics, https://www.internetworldstats.com/stats.htm.
[45] Article: Kvedar, J., Joel Coye, M., Everett, W., Connected Health: A Review Of Technologies And Strategies To Improve Patient Care with Telemedicine and Telehealth, Health Affairs, Feb 2014, 33:2, pgs 194-199, https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2013.0992.
[46] World Health Organization, mHealth New Horizons for Health Through Mobile Technologies, Global Observatory for eHealth series - Volume 3, 2011, https://www.who.int/goe/publications/goe_mhealth_web.pdf.
[47] Ambar Kulshreshtha, Joseph C. Kvedar, Abhinav Goyal, Elkan F. Halpern, and Alice J. Watson, "Use of Remote Monitoring to Improve Outcomes in Patients with Heart Failure: A Pilot Trial," International Journal of Telemedicine and Applications, vol. 2010, Article ID 870959, 7 pages, 2010. https://doi.org/10.1155/2010/870959.
[48] *Id at 4*.

Home Telehealth (CCHT) by monitoring veterans with chronic conditions, including diabetes, hypertension, congestive heart failure, chronic obstructive pulmonary disease, depression and post-traumatic stress disorder.[49] The VHA's implementation showed that CCHT is a cost-effective and practical way of caring for patients with chronic disease, and application on a larger scale could have substantial benefits.[50]

For patient and provider alike, the technology is within reach.[51] Why then should physician licensing be the obstacle? How can regulations change to meet public policy objectives to lower healthcare costs and make access to healthcare more affordable for all concerned? A look at telemedicine reimbursement and payment strategies makes a convincing argument in favor of expansion, particularly as CMS announced its changes for 2019 recently.[52] Rather than limiting telehealth, CMS chose to expand coverage by developing payment for virtual check-ins, pre-recorded patient information and interprofessional internet consultation; all services that cannot be substituted by in-person visits.[53]

D. The Need to Ease Licensing Restrictions

The Center for Telemedicine Law (CTL), through its Task Force, started work in Feb 1996 reviewing licensing restrictions, and developed a white paper detailing its findings.[54] The CTL Task Force looked at all fifty states and recommended that policymakers should establish uniform standards for licensing combined with monitoring of medical services quality. At the same time, the Task Force recognized the unique circumstances that telehealth presents and the risk for abuse that could occur if strict oversight of licensing by the states did not exist. Some states had already adopted requirements for interstate practice. Twenty years later, progress is taking shape, but still falls short of a uniform system.[55]

III. TELEMEDICINE IS A SOLUTION FOR HEALTHCARE WOES

Growing physician shortages, an aging population, increasing appointment wait times and rural healthcare deficiencies create a perfect storm in healthcare delivery today. Leveraging

[49] Darkins A, Ryan P, Kobb R, 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, Telemedicine and e-Health, Dec 2008, pgs 1118-1127, http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/DD0F66183EDF57C6CA257CD20004A3A1/$File/CHSWTFsub-HP-Attachment2.pdf.

[50] *Id at 1124.*

[51] Article: Kvedar, J., Joel Coye, M., Everett, W., Connected Health: A Review Of Technologies And Strategies To Improve Patient Care with Telemedicine and Telehealth, Health Affairs, Feb 2014, 33:2, pgs 194-199, https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2013.0992.

[52] Dizon, R., National Consortium of Telehealth Resource Centers, *Big Changes in 2019 for Medicare Telehealth Policy*, Nov 6, 2018, https://www.telehealthresourcecenter.org/big-changes-in-2019-for-medicare-telehealth-policy/

[53] *Id at 1.*

[54] Telemedicine and Interstate Licensure: Findings and Recommendations of the CTL Licensure Task Force, 73 N.D. L. Rev. 109.

[55] Article: Comment: Provision of Legal and Medical Services on the Internet: Licensure and Ethical Considerations, 3 N.C. J.L. & Tech. 353.

technology in order to expand physicians' reach, improve affordability and availability as well as bring needed expertise to rural areas is exactly what is needed to satisfy new and unmet demand.[56]

A. Health Care System Shortfalls

The Medical School Association warns that the impending physician shortage could be as high as 90,000 doctors by 2025.[57] Faced with growing demand, the U.S. struggles to recruit and train enough physicians to meet the demand for medical services.[58] The shortage is not limited to specialists either; current trends show that by 2030, of the shortage as many as 49,300 could be primary care physicians.[59]

Reported wait times to see a physician are increasing too, making healthcare access more difficult.[60] Independent surveys suggest that wait times are up by as much as thirty percent (30%) in fifteen major markets around the country, with trends continuing, even though markets surveyed had a high physician-to-population ratio.[61] The survey was geared towards routine, non-emergent care, targeting cardiology, dermatology, orthopedics, obstetrics-gynecology and family practice physicians.[62]

---

[56] Article: Enabling Globalization of Health Care in the Information Technology Era: Telemedicine and the Medical World Wide Web, 17 Va. J.L. & Tech. 1.

[57] Bernstein, L., U.S. Faces 90,000 doctor shortage by 2025, medical school warns, The Washington Post-Health, Mar 3, 2015, https://www.washingtonpost.com/news/to-your-health/wp/2015/03/03/u-s-faces-90000-doctor-shortage-by-2025-medical-school-association-warns/?utm_term=.697c76887d6c.

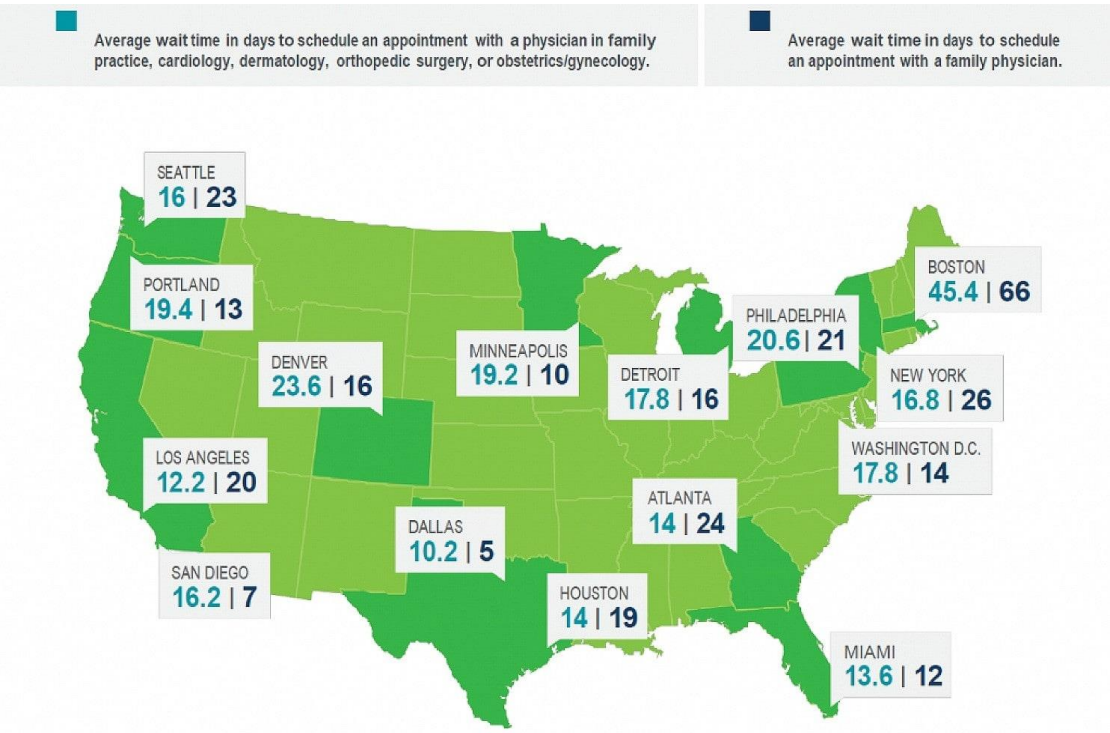
[58] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. Technical Documentation for HRSA's Health Workforce Simulation Model. Rockville, Maryland: U.S. Department of Health and Human Services, 2015, pgs 8-13, (hereinafter DHHS HRSA), https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/simulationmodeldocumentation.pdf.

[59] American Association of Medical Colleges, AAMCNews, New research shows increasing physician shortages in both primary and specialty care, Press Release, April 11, 2018, https://news.aamc.org/press-releases/article/workforce_report_shortage_04112018/.

[60] Merritt Hawkins, 2017 Survey of Physician Appointment Wait Times, Mar 17, 2019, https://www.merritthawkins.com/uploadedFiles/MerrittHawkins/Content/Pdf/mha2017waittimesurveyPDF.pdf.

[61] *Id at 15-18.*

[62] Merritt Hawkins, 2017 Survey of Physician Appointment Wait Times, Mar 17, 2019, pgs 17-20, https://www.merritthawkins.com/uploadedFiles/MerrittHawkins/Content/Pdf/mha2017waittimesurveyPDF.pdf.



[63]

Demand for healthcare access is growing because of an aging population and influx of chronic diseases.[64] When combined with high quality-low cost initiatives demanded by government and private payers, it is clear that the U.S. must find alternatives that expand the reach of healthcare at a more affordable price.[65]

B. Bench Strength for Improving Service Delivery

Contemporaries supporting telemedicine and mHealth focus on the benefits of its expansion, including cost savings within the healthcare continuum.[66] With physician numbers falling far short, finding qualified resources does not stop at U.S. borders.[67] It extends internationally, especially since the U.S. pays better wages for medical services than many other countries, making it an appealing option for foreign medical graduates willing to become licensed

[63] Bernstein, L., U.S. Faces 90,000 doctor shortage by 2025, medical school warns, The Washington Post-Health, Mar 3, 2015, https://www.washingtonpost.com/news/to-your-health/wp/2015/03/03/u-s-faces-90000-doctor-shortage-by-2025-medical-school-association-warns/?utm_term=.697c76887d6c.

[64] Infiniti Research, Growing Demands of Healthcare Services Market, Feb 10, 2019, https://www.infinitiresearch.com/thoughts/healthcare-services-market.

[65] Symposium: Roundtable on Legal Impediments to Telemedicine: 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.

[66] Article: Kvedar, J., Joel Coye, M., Everett, W., Connected Health: A Review Of Technologies And Strategies To Improve Patient Care with Telemedicine and Telehealth, Health Affairs, Feb 2014, 33:2, pg 196.

[67] Article: Enabling Globalization of Health Care in the Information Technology Era: Telemedicine and the Medical World Wide Web, (hereinafter "Enabling Globalization"), 17 Va. J.L. & Tech. 1.

in the U.S.[68] Challenges facing the U.S. are shared among many other developed *and* developing countries. Working together on broad-based solutions that incorporate technology as a platform, and convincing regulators to ease domestic and international barriers, can achieve a positive impact on global healthcare needs.[69] Not only can consumers benefit, but so too can providers. Dissemination of information about healthcare changes, including diagnoses, treatments, cutting edge drugs and devices, public health and the like are instantaneous thanks to the World Wide Web.[70]

While opposition remains critical of global health initiatives that would make it easy for any willing provider to participate in supplying medical services, many support the belief that removing regulatory barriers will become necessary in order to avoid a world health crisis in the future.[71]

C. Telemedicine Necessary for Rural Healthcare

The ability to treat a growing number of patients is possible when taking out travel and wait time, and this expands the productivity of a single provider. Vitals monitoring can happen real-time, and ordering treatments made ready with the click of a mouse. For the patient, a telehealth visit is equally efficient to an in-person visit, particularly for those who live in rural settings miles from the nearest hospital or provider.[72] Rural health is where CMS first approved payment for telehealth visits, targeting areas identified as a Health Professional Shortage Area (HPSA).[73] Included in the telehealth list approved for payment by CMS are services like consultations, office visits, individual psychotherapy, pharmacologic management, end-stage renal disease home dialysis related services, nutrition therapy, alcohol and substance abuse therapy, high-intensity behavioral counseling, advanced care planning, annual wellness and other cancer screening.[74] Recognizing that these services can successfully and affordably be delivered to Medicare and Medicaid recipients opens the door for expansion.

Consumers are driving the new model of healthcare, with greater demand for online visits.[75] Telehealth is becoming more popular with employer-sponsored health benefit plans, for the simple fact that it saves money.[76] As more health care cost shifts to individuals, consumers look for more affordable options as well. Not only does telehealth cost less, it allows workers to

---

[68] Reid, T.R., *The Healing of America, A Global Quest For Better, Cheaper and Fairer Health Care*, (hereinafter "The Healing of America"), Penguin Press, New York, NY, Aug 31, 2010, pgs 46-65.
[69] *Id at 49.*
[70]Enabling Globalization, pg 4.
[71] Enabling Globalization, pg 5.
[72] Comment: Telemedicine's Imperiled Future? Funding, Reimbursement, Licensing and Privacy Hurdles Face a Developing Technology, 14 J. Contemp. Health L. & Pol'y 161.
[73] Centers for Medicare and Medicaid Services, MLN Booklet (Medical Learning Network), (hereinafter "MLN Booklet"), Telehealth Services, 2017, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf.
[74] MLN Booklet, pgs 5-10
[75] Article: Comment: Provision of Legal and Medical Services on the Internet: Licensure and Ethical Considerations, 3 N.C. J.L. & Tech. 353.
[76] Employee Benefit Solutions, How Telemedicine Benefits Providers, Employers, and Members, Sep 1, 2016, https://selectebs.com/how-telemedicine-benefits-providers-employers-and-members/.

be more productive and lose less time from work. This is appealing to both employers and employees alike.[77]

D. Outsourcing Offshore

Outsourcing telemedicine offshore is controversial and burdened with regulatory challenges. Although there are willing health care providers who operate internationally, only those physically based in the U.S. and who maintain active credentials within their primary state can legitimately provide telehealth services to U.S. beneficiaries.[78] Medical tourism in the U.S. is on the rise, however, and the opposite is not true when it comes to physicians in the U.S. supplying telehealth to consumers located outside the U.S. This opens yet another avenue for physicians seeking ways to supply healthcare electronically for payment, further supplanting shrinking numbers of physicians.

Radiology and pathology are two of the most common specialties seeking to utilize physicians offshore, due to a shortage of eligible providers. Reportedly, about three hundred (300) U.S. hospitals use some international outsourcing model for radiology.[79] Although a legitimate need exists, regulatory boundaries keep the percentages of hospitals using offshore models to fifteen percent (15%) or less. Foreign radiologists earn much less than those in the U.S., and it helps when professional interpretation of images takes place off hours, allowing fast turnaround time. Rural health is still the only area able to take advantage of offshore telehealth components. Other factors influencing more widespread adoption are medical liability issues and licensing guidelines.[80]

IV. REGULATORY BARRIERS AT STATE LEVEL

States have sovereign authority over health and welfare concerns within their borders as provided in the Constitution.[81] In order to expand telemedicine across state borders, the federal government needs to assume responsibility for standardization of physician licensing.[82] Supporters agree that professional licensing reform is more likely to succeed at the federal level than at the state level, because much more cooperation is needed between different states and their licensing boards.[83]

A. U.S. Constitution Gives States Ultimate Control

---

[77] Knebel, Kristen, Pension and Benefits Daily, More Companies Offer Telehealth; Now Workers Need to Use It, Aug 24, 2016, https://www.bna.com/companies-offer-telehealth-n73014446756/.

[78] Article: Enabling Globalization of Health Care in the Information Technology Era: Telemedicine and the Medical World Wide Web, 17 Va. J.L. & Tech. 1.

[79] Notes & Comment: Teleradiology: Images of an Improved Standard of Medical Care, 35 Rutgers Computer & Tech. L.J. 104.

[80] Article: A Case for Federal Regulation of Telemedicine in the Wake of the Affordable Care Act, (hereinafter "A Case for Federal Regulation), 16 Colum. Sci. & Tech. L. Rev. 274.

[81] USCS Const. Amend. 10, 59. Public health, safety and welfare.

[82] Symposium: Roundtable on Legal Impediments to Telemedicine: 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.

[83] *Id at 4*.

To better understand the regulatory barriers that exist in preventing telemedicine from becoming widely adopted across state lines, one need look no further than Amendment 10 of the U.S. Constitution.[84] States have sovereign authority over health and welfare concerns within their borders as provided in the Constitution.[85] As such, states have ultimate authority over those who practice medicine in their territories. Among the states, there are different rules, including the actual definition of the "practice of medicine."[86] The idea that an interstate system can exist relies upon the federal government to intervene.[87] Even if the states agree on standard policies and procedures, implementation on a state-by-state basis will be time-consuming, with the potential for widespread interpretation and codification.[88] Federal licensing reform would allow for faster adoption and implementation, preventing an opt in/opt out approach from the states.[89]

B. A Call to Action in Georgia and Other States

A number of different states have struggled with how best to handle telehealth, including South Carolina, Georgia and Maryland, opting to focus on activities within their state and working in conjunction with State Medical Boards to accomplish guidelines.[90] The State of Georgia first began its efforts to expand healthcare via telemedicine in the early 1990s, when the Medical College of George (MCG) developed one of the biggest systems in the U.S. with sixty (60) locations linked to the college.[91] During that time, Georgia passed Senate Bill 144, The Distance Learning and Telemedicine Act of 1992, with the goal to establish a state-wide telemedicine network to deliver healthcare throughout the state.[92] Georgia has 118 rural counties, and 90 are designated as Health Professional Shortage Areas (HPSAs), so they qualify for telemedicine service coverage by Medicare and Medicaid according to DHHS.[93] Georgia also implemented telemedicine for its prison system, where it incorporated specialty clinics and a mobile van that comes to the prison.[94] Unfortunately, Georgia's early adoption and formation of a telemedicine network have not helped reform professional licensing standards so needed today.[95] Efforts to lead telemedicine initiatives do not extend beyond Georgia's borders, making it one of many states that holds fast to the doctrine of states sovereign authority over public health, safety and welfare.[96]

---

[84] Article: The Constitutionality of Current Legal Barriers to Telemedicine in the United States: Analysis and Future Direcctions of its Relationship to National and International Health Care Reform, 21 Health Matrix 385.
[85] *Id at 1*.
[86] A Case for Federal Regulation, pg 5.
[87] A Case for Federal Regulation, pg 6.
[88] Article: A Case for Federal Regulation of Telemedicine in the Wake of the Affordable Care Act, (hereinafter "A Case for Federal Regulation), 16 Colum. Sci. & Tech. L. Rev. 274, pgs 6-7.
[89] *Id at 7*.
[90] Lacktman, Nathanial M. and Ferrante, Thomas B., Health Care Law Today (Foley & Lardner), South Carolina Enacts New Telemedicine Law: What You Should Know, [O*riginally, this post was an alert sent to the American Health Lawyers Association's (AHLA) Health and Information Technology Practice Group Members.*]
[91] Comment: A Call to Action: Georgia Must Adopt New Standard of Care, Licensure, Reimbursement, and Privacy Laws for Telemedicine, 54 Emory L.J. 1183.
[92] *Id at 4*.
[93] *Id at 4*.
[94] *Id at 6*.
[95] *Id at 2*.
[96] USCS Const. Amend. 10, 59. Public health, safety and welfare.

Critics of the current system that gives states exclusive authority over licensing of medical providers point to the fact that although quality and patient safety are heralded as the reasoning behind it, that it is really about limiting outside competition.[97] Supporters argue that it is easier for states to police physician quality when care is provided via telemedicine through its use of technology, and that setting minimum standards that qualify a licensed physician *without* oversight is no further guarantee of quality.[98] Those in favor of states maintaining authority insist that the states are better equipped to assess competency, and that allowing standard citizens to choose whether they will seek care from an out-of-state provider puts consumers at risk of unscrupulous marketing ploys.[99] A comparison of this type suggests that the argument is for keeping patients within the state's economy rather than about quality of the provider.

V. OPPOSITION TO EASING REGULATORY RESTRAINT IS REAL

The American Medical Association (AMA) is opposed to national licensing of physicians.[100] The AMA is also opposed to any rules that would promote more acceptable telemedicine activities, like consultations between physicians.[101] One of the legitimate concerns from opposition is the role that advertising on the internet might play in influencing ethical violations.[102] False or misleading representations could lead to unrealistic expectations of results that can be achieved.[103] This concern is addressed in certain states under Rules of Professional Conduct, such is the case in North Carolina.[104] Admittedly, it is hard to police these types of violations and law makers struggle with determining who should be responsible for making sure solicitors adhere to standards set by professional organizations.[105]

A. Abusive Utilization is Considered a Real Threat

There is criticism that while telehealth increases access, at the same time it increases utilization because it is easy and affordable, and this is additive to health care spending, making some question its use as an option to reducing healthcare costs.[106] A study conducted by the Rand Corporation of 300,000 employees who had access to Teladoc found that eighty-eight percent (88%) of telehealth visits were additive.[107] It begs the question, why then assume that telemedicine is a cost saving measure? The Centers for Medicare & Medicaid Services argues that higher adoption of telehealth will, in the end, replace high cost trips to the Emergency Department (E.D.)

---

[97] Article: Crossing Borders: The Licensure of Interstate Telemedicine Practitioners, 25 J. Legis. 1, pg 6.
[98] *Id at 5*.
[99] *Id at 5*.
[100] Article: Comment: Provision of Legal and Medical Services on the Internet: Licensure and Ethical Considerations, 3 N.C. J.L. & Tech. 353, pg 6.
[101] *Id at 6*.
[102] *Id at 8*.
[103] *Id at 8*.
[104] *Id at 8-9*.
[105] *Id at 10*.
[106] Comstock J., Why the utilization conversation in telemedicine is bigger than dollars and cents, MobiHealthNews, Mar 9, 2017, (hereinafter "Why the Utilization Conversation"), https://www.mobihealthnews.com/content/why-utilization-conversation-telemedicine-bigger-dollars-and-cents.
[107] Why the Utilization Conversation, pg 1.

and prevent more readmissions, as touted in its newly released report on Medicare Telehealth.[108] While true that employers are seeing a spike in access of newly offered telehealth benefit options, the true cost savings must include both an analysis of reduced lost time from work combined with fewer E.D. visits and readmissions.[109]

B. Case Law Arguments Against Easing Restrictions

A vast number of court cases involving telemedicine center around illegitimate prescribing of drugs via the internet, where a provider does very limited medical screenings via the telephone or internet questionnaires, and subsequently authorizes prescriptions for drugs like Viagra, Cialis or Levitra, drugs used for the treatment of erectile dysfunction.[110] In similar cases, the illegitimate internet prescribing involved physicians who authorized excessive quantities of controlled substances, like hydrocodone, for use by patients outside of medical necessity guidelines and who potentially became addicted to these drugs.[111] It is reasonable to understand why, when presented with case law of this kind, that states choose to strictly regulate physician licensing in an effort to prevent physician abusers from preying on the unsuspecting public. Even in cases where both provider and patient reside within the state, an issue that tends to surface in telemedicine case law is whether the physician was able to perform a physical exam *in person*, and or whether the physician had an established relationship with the patient prior to the internet visit as a prerequisite for determining appropriate care.[112]

C. Ethical Considerations Supported by Opposition

In spite of its lack of support for national licensing of physicians, the AMA promotes ethical responsibility of all physicians who participate in telemedicine, particularly as it relates to disclosing financial interests in telehealth and when posting health content on websites.[113] The AMA encourages physicians to inform users about the limitations of telehealth, how to arrange for follow up care and to let their primary care physicians know about on-line consultations even if in-person care is not needed.[114]

Some states, like South Carolina, have taken steps to ensure that telemedicine meets the same standard of care by passing laws that hold telehealth physicians as accountable as any other standard licensee providing in-person care in a more traditional method.[115] This approach preempts concerns from consumer protection groups, and leaves less up for grabs by unscrupulous providers looking to make a quick buck. Adhering to current practice standards, providing an

---

[108] Centers for Medicare & Medicaid Services (CMS), Information on Medicare Telehealth, Nov 15, 2018, (hereinafter "CMS Info on Telehealth"), pgs. 23-28.
[109] Why the Utilization Conversation, pg 1.
[110] *Low Cost Pharmacy, Inc. v. Ariz. State Bd. of Pharmacy*, No. 1 CA-CV 07-0547, 2008 Ariz. App. Unpub. LEXIS 790 (Ct. App. May 20, 2008)
[111] *United Prescription Servs. v. Gonzalez*, No. 8:06-CV-1977-T-30MAP, 2006 U.S. Dist. LEXIS 92792 (M.D. Fla. Dec. 22, 2006) .
[112] *Teladoc, Inc. v. Tex. Med. Bd*., 112 F. Supp. 3d 529 (W.D. Tex. 2015)
[113] American Medical Association, Ethical Practice in Telemedicine, Code of Medical Ethics Opinion 1.2.12, https://www.ama-assn.org/delivering-care/ethics/ethical-practice-telemedicine.
[114] *Id at 1*.
[115] South Carolina Telemedicine Act, 2015 Bill Text SC S.B. 1035.

appropriate evaluation prior to diagnosis and treatment and prohibiting evaluation by questionnaire are all required in South Carolina.[116] In addition, the physician need not reside in South Carolina, but must have a license to practice medicine in the state.[117] Taking into account the vast number of people living in rural areas within the state who need better access to affordable healthcare options, South Carolina would be better served offering out-of-state telehealth providers a limited, low cost license, while upholding the same guidelines.

VI. SOLUTIONS FOR INTERSTATE LICENSING ADDRESSED

One of the solutions addressing more widespread use of telemedicine involves better defining what it encompasses within the practice of medicine, thereby allowing for *special licensing* of practitioners seeking to engage across state lines.[118] The Federation of State Medical Boards has proposed a limited license that would tighten the range of services a physician could provide.[119] Typical telemedicine services, like video conferencing with other physicians, would be covered along with counseling internet users and prescribing medications.[120] The physician would have to meet certain minimum requirements and he/she would be prohibited from entering the state to practice otherwise. Although restrictive, the concept of a limited license is a much needed first step in telemedicine expansion across state lines.

A. Standards for Licensure

Another closely related option is an actual certification process for internet activities.[121] Certification would take into the account the unique risks associated with internet activities, like giving advice online. Both the Federation of State Medical Boards' *limited license* and the internet certification are likely to be met with the same opposition because they circumvent the state's ability to regulate physician licensing.[122]

Still another option proposes that a patient living in one state who contacts a provider in another state is *electronically-transported* to the state where the provider is located, making them subject to the laws of the state where the provider resides.[123] Confusion about what laws apply when and to whom make this a poor model as far as consumer advocates are concerned, since patients may not know what rights are afforded to them in their home state, and how this changes when seeking care from an internet provider elsewhere.[124]

While lawmakers debate the rules and how to apply them in a changing world, advances in technology continues to drive consumers to the internet for answers to healthcare ailments.[125]

---

[116] South Carolina Telemedicine Act, 2015 Bill Text SC S.B. 1035, (C) (1) (2).
[117] South Carolina Telemedicine Act, 2015 Bill Text SC S.B. 1035. (C) (9).
[118] Article: Comment: Provision of Legal and Medical Services on the Internet: Licensure and Ethical Considerations, 3 N.C. J.L. & Tech. 353.
[119] *Id at 6*.
[120] *Id at 6*.
[121] *Id at 6*.
[122] *Id at 6*.
[123] Article: Comment: Provision of Legal and Medical Services on the Internet: Licensure and Ethical Considerations, 3 N.C. J.L. & Tech. 353.Provision of Legal & Medical, pg 7.
[124] *Id at 7*.
[125] Telemedicine and E-Health Law § 1.02, pg 1.

And consumers aren't the only ones seeking advice on the internet; so too are physicians.[126] The vast amounts of medical information once only accessible to medical students, scholars and practicing physicians is now at the fingertips of anyone willing to search online.[127] The stampede of people seeking healthcare related answers is beyond comprehension and ordinary citizens do not see the harm in reaching out beyond geographic borders to get whatever answers please them, irrespective of whether the physician is properly licensed or not or possesses the appropriate skillset.[128] As a result, reliance on some form of licensure is paramount, and may be the best objective criteria by which purveyors of telehealth services are held to standards.[129]

B. Broadband Adoption

Very little stands in the way of widespread adoption of telehealth as far as connectivity and access is concerned. According to the Brookings Institution, by 2014, three-quarters of all U.S. households had a broadband internet subscription, with the increase from 2013 to 2014 growing by 1.7%.[130] Broadband adoption rates are indicative of a digital economy and are shown to be impacted by higher levels of income, educational level and telecommuting.[131] Policymakers pay close attention to broadband adoption in order to ensure fair and equitable distribution of services to low-income and underserved urban and rural areas, and to promote digital literacy programs.[132] The government's role in ensuring digital literacy across the U.S. is a platform for telehealth in reaching populations that can benefit the most from increased healthcare options.

Some states are embracing telemedicine for Medicaid recipients, another area of the underserved populations that desperately need access to healthcare in both the physical and mental health arenas.[133] Texas, for example, has been working since 2005 to establish and develop participation and reimbursement of telehealth providers for when face-to-face consultations are not possible.[134] Many areas of the government serving the Veterans Administration, Medicare and Medicaid recipients, have developed telehealth programs in order to expand and afford coverage in gap areas.[135] The more that regulatory burdens are eased for telehealth providers, the more rapidly that telehealth expansion can bring more affordable options to the marketplace; some is better than none for many who forego healthcare all together.

VII. ARGUMENT FOR TELEHEALTH LIMITED LICENSING

Many components of healthcare can be achieved via telemedicine, like reviewing x-ray images, reading and interpreting EKGs, magnifying and diagnosing skin lesions, and studying

---

[126] *Id at 3*.
[127] *Id at 2*.
[128] *Id at10*.
[129] *Id at 11*.
[130] Tomer A, Kane J, Metropolitan Policy Program at Brookings, Broadband Adoption Rates and Gaps in U.S. Metropolitan Areas, Dec 2015, pg 3, https://www.brookings.edu/wp-content/uploads/2016/07/Broadband-Tomer-Kane-12315.pdf.
[131] *Id at 6*.
[132] Broadband Adoption Act of 2013, 113 H.R. 1685, 2013 H.R. 1685, 113 H.R. 1685.
[133] Tex. Gov't Code § 531.0216 (LexisNexis, Lexis Advance through the 2017 Regular Session and 1st C.S., 85th Legislature) .
[134] Tex. Gov't Code § 531.0216 (C) (1) (2).
[135] Veterans Telemedicine Act of 2011, 112 S. 1124, 2011 S. 1124, 112 S. 1124.

internal organs during endoscopic procedures.[136] All can be accomplished with the help of technology, so the question sometimes asked is what *cannot* be accomplished by telemedicine, and how can telemedicine fit into the care model in a safe and effective way? The obvious limitation of telemedicine, when utilized solely by remote, is the inability to palpate, touch or smell without the help of a local professional.

A. Rationale for Due Process

An acceptable solution for simplifying professional licensing of telehealth providers is the concept of a limited license offered at the state level.[137] In some states, like Texas, a physician can apply for an "Out-of-State Telemedicine License" where the holder is limited exclusively to:

- "the interpretation of diagnostic testing and reporting of results to a Texas fully licensed physician practicing in Texas or;"
- "for the follow-up of patients where the majority of patient care was rendered in another state."[138]

In Texas, the license holder is specifically prohibited from physically practicing medicine in the state if operating under this license.[139] Likewise, although the State of Washington rules do not specifically address telemedicine, a provider licensed in another state is permitted the practice of medicine so long as he/she does not open an office in Washington.[140] The limited license, while at minimum is a step towards recognizing out-of-state providers, still requires the full cost and application process applied to in-state physicians.[141] An argument for due process remains for telehealth providers seeking relief from high costs and regulatory burdens associated with licensing on a state-by-state basis, and the same is true whether there is reciprocity between states or harmonization of licensing standards.[142]

B. Protecting the Consumer or Competitors

In many respects, Medical Boards are comprised of physicians dominated by industry interests, many of whom act as representatives for industries with much at risk economically.[143] It stands to reason that some physicians might be biased against other modes of practice, competition from out-of-state providers or even technology itself.[144] Outside interests of Medical

---

[136] Comment: Telemedicine's Imperiled Future? Funding, Reimbursement, Licensing and Privacy Hurdles Face a Developing Technology, 14 J. Contemp. Health L. & Pol'y 161.
[137] Telemedicine and E-Health Law § 1.02, pg 8.
[138] Texas Medical Board, Out-of-State Telemedicine License, License Quick Links, 06 Apr 2019, http://www.tmb.state.tx.us/page/telemedicine-license.
[139] *Id at 1*.
[140] Telemedicine and E-Health Law § 1.02, pg 8.
[141] *Id at 11*.
[142] *Id at 11-12*.
[143] Symposium: Roundtable on Legal Impediments to Telemedicine: 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, pg. 14.
[144] *Id at 14-16*.

Board members could have an impact on health policy decisions, including justifications for licensing rules and reducing the supply of practitioners in a given area, giving patients fewer options and forcing them to seek care elsewhere or forego care completely.[145]

To the extent that states harden regulatory barriers by refusing to modernize physician licensing guidelines, or by slowing adoption of telemedicine advances and provider choice, critics suggest that state licensing practices should be subjected to antitrust scrutiny.[146] Regulatory barriers that restrict competition do not necessarily protect consumers, and in many ways the rules restrict consumer options, limit access and increase costs.[147] Standardizing professional licensing rules between states is costly and time consuming, and without reciprocity or mutual recognition by state medical boards does nothing to improve telemedicine's reach.[148]

Congress has ultimate power to control commerce, as granted by the Constitution, irrespective of the size or volume of the market.[149] The constitutional authority of the federal government in regulating commerce related to health and safety has precedence, as referenced in *United States v. Walsh* involving claims of shipping of vitamin products.[150] In its report to Congress in 1997, the U.S. Department of Commerce in conjunction with the Department of Health and Human Services, clearly stated that "Should Congress desire to regulate telemedicine licensure, it could do so."[151] In matters involving commerce, telemedicine fits within these parameters particularly as the country faces impending shortfalls in its supply of physicians and as demand increases.

C. Practical Difficulties for Conscientious Providers

Complying with each state's medical board licensing regulations is a challenge for conscientious physicians who want to participate in telemedicine. Advances in medicine cannot be disseminated as quickly without expansion of early adopters willing to promote new treatments via telemedicine, and the utility of the doctor-patient relationship is bound by geographic borders even though the technology has no bounds.[152] Rule makers could not anticipate how quickly

---

[145] *Id at 16.*

[146] *Id at 17.*

[147] Connected Health: A Review of Technologies And Strategies To Improve Patient Care With Telemedicine and Telehealth, Kvedar, J, Coye, Molly J., Everett, Wendy, Health Affairs, Feb 2014.

[148] Symposium: Roundtable on Legal Impediments to Telemedicine: 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, pgs. 17-18.

[149] USCS Const. Art. I, § 8, Cl 3.

[150] *United States v. Walsh*, 331 U.S. 432, 67 S. Ct. 1283 (1947) *The Federal Food, Drug, and Cosmetic Act rests upon the constitutional power resident in Congress to regulate interstate commerce. To the end that the public health and safety might be advanced, it seeks to keep interstate channels free from deleterious, adulterated and misbranded [****4] articles of the specified types.*

[151] Telemedicine Report to Congress, U.S. Department of Commerce, Jan 31, 1997, Legal Issues--Licensure and Telemedicine, https://www.ntia.doc.gov/legacy/reports/telemed/legal.htm. [Excerpt: "*The Supremacy Clause of the Constitution preempts state laws that interfere with, or are contrary to, the laws of the Federal government.(12) But there is a strong presumption against preemption.(13) The Supreme Court has acknowledged that the regulation of health and safety matters has primarily and historically been a matter of exclusive state concern, and therefore preemption of state law should not occur in the absence of Congress' clear intent to supersede the state law(14). However, the Supremacy Clause mandates that even state regulation designed to protect vital state interests must give way to paramount Federal legislation.(15)"]*

[152] Article: Crossing Borders: The Licensure of Interstate Telemedicine Practitioners, 25 J. Legis. 1, pg 3.

technology would make expansion possible, forcing a new look at quality controls better situated at the federal level.[153] The practice of medicine is governed by state licensure when considering its current entry point, restricting competition under the guise of quality control.[154] There are no guarantees that licensing restrictions protect consumers from harm, particularly given variations in each state related to how scope of practice is defined.[155]

A bigger debate is the definition of "practice of medicine" as it pertains to telemedicine, and whether or not the "medium" of its delivery is of relevance, since so many states use different statutory language.[156] This is compounded by the various boards that govern different occupations like nursing, physician assistants, midwives and other allied health professionals within the same jurisdiction, each interpreting scope of practice differently and sometimes at cross-purpose.[157] For these reasons, the federal government is better positioned to detail uniform guidelines for licensing of telemedicine providers, defining the criteria by which telemedicine providers operate and simplifying the process.

VIII. CONCLUSION

Technology has changed the way we live, work and play; its widespread adoption continues growing at a rapid rate, and its improving affordability makes it possible for much of the U.S. population to be connected electronically.[158] The physician demographic is shrinking, and by 2025, physician supply is expected to be in crisis with a shortage of as many as 90,000 doctors.[159] At the same time, wait times to see a physician are increasing, due in large part to growing demand as baby boomers age and chronic diseases become more prevalent.[160] Technological advances in health information technology and video-conferencing make diagnosis, treatment and management of healthcare remotely possible.[161]

Physician licensure is managed by each individual state medical board, and the constitution gives the state its police power to protect the health, safety and wellbeing of its population.[162] It is both expensive and time consuming and on average it can take four to six months.[163] Promoting widespread use of telemedicine involves better defining what it encompasses within the practice of medicine, thereby allowing for *special licensing* of practitioners seeking to engage across state

---

[153] *Id* at pg 6.
[154] *Id* at pg 7.
[155] *Id* at pg 11.
[156] *Id* at pgs 11-12.
[157] *Id* at pg 13.
[158] https://www.statista.com/topics/2237/internet-usage-in-the-united-states/ [Excerpt: "With nearly 290 million internet users as of 2016, the United States is one of largest online markets worldwide. About 76.2 percent of the U.S. population accessed the internet as of 2016."].
[159] Bernstein, L., U.S. Faces 90,000 doctor shortage by 2025, medical school warns, The Washington Post-Health, Mar 3, 2015, https://www.washingtonpost.com/news/to-your-health/wp/2015/03/03/u-s-faces-90000-doctor-shortage-by-2025-medical-school-association-warns/?utm_term=.697c76887d6c.
[160] Merritt Hawkins, 2017 Survey of Physician Appointment Wait Times, Mar 17, 2019.
[161] Article: The Constitutionality of Current Legal Barriers to Telemedicine in the United States: Analysis and Future Directions of its Relationship to National and International Health Care Reform, 21 Health Matrix 385, pg 6.
[162] Article: Comment: Provision of Legal and Medical Services on the Internet: Licensure and Ethical Considerations, 3 N.C. J.L. & Tech. 353, pg 3.
[163] American Medical Association, Navigating State Medical Licensure, Feb 10 2018, https://www.ama-assn.org/residents-students/career-planning-resource/navigating-state-medical-licensure.

lines.[164] The Veterans Administration, Medicare and Medicaid have developed telehealth programs in order to expand and afford coverage in gap areas, and the federal government is better suited to develop telemedicine licensure guidelines and standardize the process for interstate commerce.[165] Congress has ultimate power to control commerce, as granted by the Constitution, irrespective of the size or volume of the market.[166] As a result, physician licensure for telemedicine should be administered by the federal government, so that simplifying physician licensing across state lines will promote the expansion of affordable healthcare delivered via telemedicine.

[164] *Id* at pg 4.
[165] Veterans Telemedicine Act of 2011, 112 S. 1124, 2011 S. 1124, 112 S. 1124; see also Symposium: Roundtable on Legal Impediments to Telemedicine: 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, pg. 14.
[166] USCS Const. Art. I, § 8, Cl 3.