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A CASE FOR FEDERAL REGULATION OF TELEMEDICINE IN THE
WAKE OF THE AFFORDABLE CARE ACT[†]

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Telemedicine involves the remote diagnosis and treatment of patients using technology. Its practice has been well received in the United States in recent years. However, its growth remains encumbered by a fragmented, state-based system of licensing telemedicine professionals. This system creates a heavy burden on practitioners, limiting the number of qualified doctors in this space. State-level reforms of this system have been proposed, but only a centralized federal reform effort is likely to effect change. Importantly, it has been argued that such a federal reform effort would not survive constitutional challenges. But in the wake of recent legal challenges to the Affordable Care Act (ACA), this seems not to be the case. Specifically, two responses to the ACA—National Federation of Independent Business v. Sebelius and Liberty University v. Lew—have borne rulings that, together, provide firm constitutional support for federal reform of telemedicine licensure.

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I. INTRODUCTION

Telemedicine is the treatment of patients by doctors remotely, with the aid of technology. Because of its potential to cut costs¹ and improve care,² especially for underserved populations,³ telemedicine has made impressive inroads in U.S. healthcare.⁴ This

1. See Laurence C. Baker et al., *Integrated Telehealth and Care Management Program for Medicare Beneficiaries with Chronic Disease Linked to Savings*, 30 HEALTH AFFAIRS 1689 (2011); 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 (2009); Eric Pan et al., *The Value of Provider-to-Provider Telehealth*, 14 TELEMEDICINE & E-HEALTH, 446 (2008); Stephanie V. Rojas & Marie-Pierre Gagnon, *A Systematic Review of the Key Indicators for Assessing Telehomecare Cost-Effectiveness*, 14 TELEMEDICINE & E-HEALTH 896 (2008). See also Steff Deschenes, *5 Ways Telemedicine Is Driving Down Healthcare Costs*, HEALTH IT NEWS (July 16, 2012), <http://www.healthcareitnews.com/news/5-ways-telemedicine-driving-down-healthcare-costs?single-page=true>. Relatedly, telemedicine has been shown to drive revenues for health enterprises. See Scott Mace, *How Telemedicine Drives Volume, Revenue*, HEALTH LEADERS MEDIA (Oct. 22, 2013), <http://www.healthleadersmedia.com/content/TEC-297579/How-Telemedicine-Drives-Volume-Revenue>; Madan Dharmar et al., *The Financial Impact of a Pediatric Telemedicine Program: A Children's Hospital's Perspective*, 19 J. TELEMEDICINE AND E-HEALTH 502 (2013).

2. E.g., Perry Payne, *Telemedicine Intervention Linked to Lower Infant Mortality Rate in Arkansas*, IMEDICAL APPS (Sept. 10, 2013), <http://www.imedicalapps.com/2013/09/telemedicine-infant-mortality-rate-arkansas/>; Adam Steventon et al., *Effect of Telehealth on Use of Secondary Care and Mortality: Findings from the Whole System Demonstrator Cluster Randomised Trial*, 344 BRIT. MED. J. 3874 (2012); Jami L. Dellifrairie & Kathryn H. Dansky, *Home-based Telehealth: a Review and Meta Analysis*, 14 J. TELEMEDICINE TELECare 62 (2008).

3. See Beth Kutscher, *Wiring in Rural Patients*, MOD. HEALTHCARE (Mar. 8, 2014), <http://www.modernhealthcare.com/article/20140308/MAGAZINE/303089979> (rural areas); Rifat Latifi et al., *Telemedicine and Telepresence for Trauma and Emergency Care Management*, 96 SCAN. J. OF SURG. 281, 282 (2007) (trauma care in rural areas); Pam Belluck, *With Telemedicine as Bridge, No Hospital Is an Island*, N.Y. TIMES, Oct. 9, 2012, at D4. (isolated areas); Mary C. Masland et al., *Use of Communication Technologies to Cost-Effectively Increase the Availability of Interpretation Services in Healthcare Settings*, 16 TELEMEDICINE & E-HEALTH 739 (2010) (non-English speakers); Kevin Blanchet, *Innovative Programs in Telemedicine: The Arizona Telemedicine Program*, 11 TELEMEDICINE & E-HEALTH 633, 639 (2005) (the incarcerated). See generally Mojt A.B.A. Nouhi et al., *Telemedicine and Its Potential Impacts on Reducing Inequalities in Access to Health Manpower*, 18 TELEMEDICINE & E-HEALTH 648 (2012).

4. See Anna W. Mathews, *Doctors Move to Webcams*, WALL ST. J. (Dec. 20, 2012, 7:08PM), <http://www.wsj.com/articles/SB10001424127887324731304578189461164849962>; Maya Rhodan, *Saving U.S.*

trend is not expected to abate.⁵ By 2018, the value of the U.S. telemedicine market is expected to grow to about \$1.9 billion (from about \$230 million in 2013).⁶ Furthermore, the Patient Protection and Affordable Care Act (“ACA”) of 2010 contained no less than seven provisions directing federal health officials to explore, consider, or implement telemedicine practices.⁷

But amidst this progress, one factor that continues to stifle the growth of telemedicine is the burdensome, state-based system for licensing doctors who wish to practice it.⁸ Currently, physician licensure is controlled by the states.⁹ Each of these states has their own distinct policy (or worse, no policy) for licensing telemedicine practitioners.¹⁰ This fragmented system has been called “patchwork,”¹¹ “duplicative, expensive, and burdensome,”¹² “[an]

Health Care With Skype, TIME (Sept. 16, 2013), <http://swampland.time.com/2013/09/16/saving-u-s-health-care-with-skype/>; Beth T. Hertz, *Telemedicine: Patient Demand, Cost Containment Drive Growth*, MED. ECON. (Feb. 10, 2013).

5. See John R. Graham, *Top Health Trend For 2014: Telehealth To Grow Over 50%. What Role For Regulation?*, FORBES (Dec. 28, 2013, 12:09PM), <http://www.forbes.com/sites/theapothecary/2013/12/28/top-health-trend-for-2014-telehealth-to-grow-over-50-what-role-for-regulation/> (citing report predicting 18.5 percent annual growth in telehealth *worldwide* through 2018).

6. Bruce Japsen, *ObamaCare, Doctor Shortage to Spur \$2 Billion Telehealth Market*, FORBES (Dec. 22, 2013, 9:30AM), <http://www.forbes.com/sites/brucejapsen/2013/12/22/obamacare-doctor-shortage-to-spur-2-billion-telehealth-market/> (citing a forecast by business analytics firm IHS).

7. Patient Protection and Affordable Care Act, Pub. L. No. 111-48, 42 U.S.C. §§ 2703 (f)(2), 3021 (b)(2)(B)(v), 3021 (a)(b)(2)(B)(xvi), 3021 (b)(2)(B)(xix), 3021 (b)(2)(C)(iv), 3022(2)(G), & 3024(b)(1)(A)(vi) (2010).

8. FEDERAL COMM’NS COMM’N, CONNECTING AMERICA: THE NATIONAL BROADBAND PLAN, 206 (2010), *available at* <http://download.broadband.gov/plan/national-broadband-plan.pdf> (“State-by-state licensing requirements limit practitioners’ ability to treat patients across state lines. This hinders access to care, especially for residents of states that do not have needed expertise in-state.”) (“*Connecting America: The National Broadband Plan*”).

9. U.S. DEP’T OF HEALTH & HUMAN SERVS. & THE HEALTH RES. & SERVS. ADMIN., HEALTH LICENSING BOARD REPORT TO CONGRESS, 6 (2011), *available at* <http://www.hrsa.gov/ruralhealth/about/telehealth/licenserpt10.pdf> (“2011 Health Licensing Board Report”).

10. *Infra* Appendix 1.

11. Diane Hoffman & Virginia Rowthorne, *Roundtable on Legal Impediments to Telemedicine: Legal Impediments to the Diffusion of Telemedicine*, 14 UNIV. OF MD. SCH. OF L. J. HEALTH CARE L. & POL’Y 1, 10 (2011), *available at* http://heinonline.org/HOL/Page?handle=hein.journals/hclwpo14&div=4&g_sent=1&collection=journals (“*Roundtable on Legal Impediments*”).

12. AM. BAR ASSOC., HEALTH LAW SECTION, REPORT TO THE HOUSE OF DELEGATES, 2 (AUG. 2008), *available at* <http://www.americanbar.org/content/>

economic trade barrier[] restricting the free flow of medical services,”¹³ and even “the greatest challenge to the interstate practice of telemedicine.”¹⁴ It puts a costly¹⁵ burden on would-be practitioners of interstate telemedicine, deterring some from serving patients they otherwise would serve.¹⁶ Conversely, a more centralized or harmonized system for licensing telemedicine professionals would likely increase doctor mobility and foment the spread of telemedicine (and its benefits).¹⁷

dam/A.B.A./migrated/health/04_government_sub/media/116B_Tele_Final.authcheckdam.pdf; see also Jack P. Sahl, *Cracks in the Profession's Monopoly Armor*, 82 *FORDHAM L. REV.* 2635, 2648 (2014) (making a similar argument about reducing barriers to entry in the legal field: “[o]pening the state markets to increased lawyer competition by admission by motion provides significant benefits to consumers and to the individual lawyers with little, if any, downside.”).

13. AM. TELEMEDICINE ASSOC., *MEDICAL LICENSURE AND PRACTICE REQUIREMENTS*, 1 (JUNE 2011), available at <http://www.americanTelemedicineorg/docs/default-source/policy/ata-policy-on-state-medical-licensure-and-practice-requirements.pdf> (“ATA Practice Requirements”).

14. *Roundtable on Legal Impediments*, supra note 11, at 8. See also Andis Robeznieks, *Licensing Issues Could Slow Telehealth Services*, *MODERN HEALTH* (Sept. 2013); Joy E. Sadaly, *Telemedicine's Role in Health-Care Reform Blocked by State Licensure Barriers*, *THE SCITECH LAW*, Fall 2012, at 1.

15. See e.g., AM. TELEMEDICINE ASS'N, *THIS MONTH IN TELEMEDICINE, VIDEOCAST* (Feb. 2013), available at <http://www.americanTelemedicineorg/events-detail/2013/01/09/this-month-in-telemedicine-videocast> (22% of doctors have licenses in more than one state and pay \$300 million per year for those extra licenses).

16. See Cynthia LeRouge & Monica J. Garfield, *Crossing the Telemedicine Chasm: Have the U.S. Barriers to Widespread Adoption of Telemedicine Been Significantly Reduced?*, 10 *INT. J. ENVTL. RES. PUB. HEALTH* 6472, 6476 (2013) (“Historically, the challenge of medical licensure . . . for multi-state service provision by medical providers has been burdensome and has therefore restricted growth across state lines.”); Barak D. Richman, Will Mitchell, & Kevin A. Schulman, *Organizational Innovation in Health Care*, 1(3) *HEALTH MGMT, POL. AND INNOVATION* 36, 40 (2013) (“State licensure and certification requirements prevent providers in one state from providing advice to patients in another . . . Comprehensive reforms to both state and federal laws appear to be a prerequisite to unleashing telemedicine's disruptive potential.”); Ken Terry, *Bill Seeks To Clean Telehealth State Regulations Mess*, *INFORMATIONWEEK* (Dec. 19, 2013, 1:40PM), <http://www.informationweek.com/healthcare/policy-and-regulation/bill-seeks-to-clean-telehealth-state-regulations-mess/d/d-id/1113197> (quoting the medical director of a primary care telemedicine group as saying that six states have such heavy restrictions on telehealth, “we can't practice our model of telehealth at all”).

17. See Randall Hudspeth, *Issues of a Federal Versus a State-Based Nurse Licensure System: A Below-the-Radar Discussion*, 37 *NURSING ADMIN. Q.* 83, 83 (2013) (“[T]he licensing of health care professionals with one license that would be recognized in all states would result in greater mobility of these professionals. Thus, the resolution of health care worker shortages would be enhanced because

Naturally there is pressure for reform of telemedicine licensure laws. For example, as early as 2010, the Federal Communications Commission (FCC) warned that if “states fail to develop reasonable e-care licensing policies over the next eighteen months, Congress should consider intervening to ensure that Medicare and Medicaid beneficiaries are not denied the benefits of e-care.”¹⁸ At least two bills aimed at reforming telemedicine licensure have been put before Congress since 2013.¹⁹ Meanwhile, on the state level, the Federation of State Medical Boards has advanced a draft of an interstate compact aimed at helping states cooperatively harmonize their telemedicine licensure policies.²⁰

Importantly, however, there is broad disagreement about whether this reform should be taking place at the state²¹ or federal level.²² Furthermore, there is disagreement about whether such

of this ease of mobility and removal of barriers to obtaining multiple licenses would be mitigated.”).

18. FEDERAL COMM’NS COMM’N, CONNECTING AMERICA: THE NATIONAL BROADBAND PLAN, 206 (2010) *available at* <https://transition.fcc.gov/national-broadband-plan/national-broadband-plan.pdf>.

19. *See* Erin McCann, *Proposed Bill Would Expand Telehealth Services, Bolster Federal Payouts*, HEALTH IT NEWS (Jan. 3, 2013) (discussing the Telemedicine for Medicare Act (H.R. 3077) and the Telehealth Promotion Act (H.R. 6719), both introduced in the House in 2013).

20. Press Release, Fed’n of St. Med. Bds., FSMB: Draft Interstate Compact for Physician Licensure Nears Completion (July 25, 2014), *available at* http://www.fsmb.org/Media/Default/PDF/Publications/07%2025%202014%20FSMB%20statement%20on%20draft%20compact_FINAL.pdf.

21. *E.g.*, Mark A. Cwiek et al., *Telemedicine Licensure in the United States: The Need for a Cooperative Regional Approach*, 13 TELEMEDICINE & E-HEALTH 141-147 (2007); Sarah E. Born, *Telemedicine in Massachusetts: A Better Way to Regulate*, 42 NEW ENG. L. REV. 195 (2008) (arguing against a federal licensure scheme and for more cooperation among states); 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 (2011); Janice A. Brannon, Ellen R. Cohn, & Jana Cason, *Making the Case for Uniformity in Professional State Licensure Requirements*, 4 INT’L J. TELEREHABILITATION 41 (2012).

22. *E.g.*, Peter D. Jacobson & Elizabeth Selvin, *Licensing Telemedicine: the Need for a National System*, 6 TELEMEDICINE & E-HEALTH, 429-39 (2000); Fran Turisco, *The Government Needs to Remove Telemedicine Roadblocks*, WASH. POST (May 8, 2011), http://www.washingtonpost.com/business/capital-business/commentary-the-government-needs-to-remove-telemedicine-roadblocks/2011/05/04/AFW9YtRG_story.html; Amy E. Zilis, *The Doctor Will Skype You Now: How Changing Physician Licensure Requirements Would Clear the Way for Telemedicine to Achieve the Goals of the Affordable Health Care Act*, 2012 U. ILL. J.L. TECH. & POL’Y 193 (2012). *See also* Carmen E. Lewis, *My Computer, My Doctor: A Constitutional Call for Federal Regulation of Cybermedicine*, 32 AM. J.L. & MED. 585, 585-86 (2006).

reform, if it takes place at the federal level, is constitutional.²³ This Article tackles both of these issues. In Part I, we conclude that federal reform of telemedicine licensure is preferable to state-driven reform. This is because of the disadvantages and poor track record of state-driven reform of licensure and, conversely, the advantages and successful track record of federal reform of licensure. In Part II, we detail the constitutional issues surrounding federal reform. These include the argument that health professional licensure is the exclusive domain of the states as part of their Police Power under the Tenth Amendment, as well as the opposing argument that federal reform of such licensure is within Congress' Commerce Clause, Necessary and Proper Clause and Spending powers. Lastly, in Part III, we explain how the ACA and the subsequent legal challenges to it have laid some of these constitutional concerns to rest and paved the way for undaunted federal reform of telemedicine licensure. Particularly, we focus on *National Federation of Independent Business v. Sebelius*²⁴ (*NFIB*). Because it is narrowly tailored and does not disturb existing precedent (which is highly deferential to Congress), we explain how this ruling improves the constitutional standing for federal telemedicine licensure reform with regard to the Commerce Clause, Necessary and Proper Clause, and Spending powers. We also analyze *Liberty University v. Lew*²⁵ (*Liberty*) and explain why its ruling and interpretation of *NFIB* increases the likelihood that federal telemedicine licensure reform will find support in the Commerce Clause.

II. A UNIFORM AND CENTRALIZED FEDERAL EFFORT IS BETTER POSITIONED TO ACHIEVE THE GOALS OF TELEMEDICINE LICENSURE REFORM THAN DISPARATE STATE EFFORTS

The fragmented nature of our current state-based system of telemedicine licensure creates a considerable burden on qualified doctors who wish to treat patients across state lines.²⁶ Replacing this system with a more uniform and centralized one will increase doctor mobility and stimulate the proliferation of telemedicine.²⁷ That in

23. See *infra* note 108.

24. *NFIB*, 132 S. Ct. 2566 (2014).

25. *Liberty Univ.*, 733 F.3d 72 (4th Cir. 2013).

26. See *supra* Introduction.

27. James J. Brudney, *Mediation and Some Lessons from the Uniform State Law Experience*, 13 OHIO ST. J. ON DISP. RESOL. 795, 813 (1997-1998) (stating that in the mediation law context, uniformity of law “should enable individuals to have easier and better informed access” to mediation and “save money . . . for

turn will raise the quality and lower the cost of healthcare for many people²⁸ at a time when the “American health care system *must* find ways to slow the rate of spending while delivering quality care.”²⁹ Uniformity and centralization will also lower the administrative cost of licensure, benefitting governments and taxpayers.³⁰ For this reason, uniformity and centralization have rightfully been the goals of past professional licensure reform³¹ and should rightfully be the goals of telemedicine licensure reform.³²

But increased doctor mobility—and its benefits—is unlikely to materialize if telemedicine licensure reform is left to the different states to accomplish in cooperation with each other. As prior state-driven efforts to increase professional mobility have shown, such reform is likely to fall victim to delay or premature dissolution, to result in watered-down legislation, or to exacerbate the fragmentation that it aims to cure.³³ By contrast, whenever Congress, rather than the states, has spearheaded such reform, it has generally been marked by swift passage and has resulted in uniformity of both the law and its implementation.³⁴ In addition, in the case of telemedicine licensure, there are specific factors—notably, the convergence of state licensing standards and the universal nature of

individuals who will find it less costly to participate”); Brief for Air Transport Assoc. of America, Inc., as Amicus Curiae in Support of Appellant US Airways, Inc., Seeking Reversal, *US Airways, Inc. v. O’Donnell*, 627 F. 3d 1318 (10th Cir. 2010), 15-16 (states should not be able to add their own “overlapping regulations on top of the FAA’s now-uniform national regulation” because it “risks producing an infeasible patchwork” of regulation and that the “costs of complying with such a regulatory patchwork could well upset the industry’s delicate economic balance.”).

28. Martin E. Donaldson, et al., *Dental Education in a Flat World: Advocating for Increased Global Collaboration and Standardization*, 72 J. DENTAL EDUC. 408, 413 (2008) (“When licensure limitations restrict the mobility of health professionals, it can ultimately lead to higher costs for health care services because the normal free market economic mechanisms are, in effect, disabled.”).

29. Editorial, *A Formula for Cutting Health Costs*, N.Y. TIMES, July 21, 2012, at SR10.

30. Brudney, *supra* note 26, at 813 (stating that in the mediation law context, uniformity of law would “save money . . . for governments by avoiding duplication of effort”).

31. Abigail R. Moncrieff, *Federalization Snowballs: The Need for National Action in Medical Malpractice Reform*, 109 COLUM. L. REV. 844, 882 (2009) (stating that within professional regulation, uniformity is seen as a “virtue”). See also Cristina M. Rodriguez, *Uniformity and Integrity in Immigration Law: Lessons from the Decisions of Justice (and Judge) Sotomayor*, 123 YALE L.J. 499, 502 (2014) (“The aspiration to uniformity in the interpretation and administration of the law cuts across legal domains.”).

32. Ameringer, *supra* note 20, at 56.

33. See *infra* Part I.A.

34. See *infra* Part I.B.

telemedicine—which make federal reform more appropriate.³⁵ Accordingly, allowing Congress, and not the states, to direct telemedicine licensure reform increases the odds that its goals will be met.

*A. Slow Adoption and Uneven Implementation and Enforcement Generally
Render State-Driven Reform Ineffective*

State-driven reform of professional licensure has historically demonstrated slow, uneven adoption and disparate implementation. Under the Constitution, states are sovereign and cannot be forced by other states to pass laws.³⁶ As a consequence, state-driven efforts to harmonize policy (or otherwise increase professional mobility) necessarily entail a multi-step process wherein states (often via compact³⁷) mutually agree on a set of policies and then individually encode those policies into law.³⁸ In telemedicine licensure, for example, state-driven reform efforts might involve the states—perhaps through intergovernmental bodies like the Federation of State Medical Boards (FSMB)³⁹—coming to an agreement via compact⁴⁰ on a set of licensure policies that would promote doctor mobility (e.g., mutual recognition of each other’s licenses⁴¹ or a

35. See *infra* Part I.C.

36. *Quill Corp. v. North Dakota*, 504 U.S. 298 (1992).

37. VT. BD. MED. PRACTICE, FEDERATION OF STATE MEDICAL BOARDS WORKING ON AN INTERSTATE COMPACT FOR MEDICAL LICENSING, NEWSLETTER (July 17, 2014) (“Absent an interstate compact, it would be very difficult to convince multiple state legislatures to make identical changes to their laws.”).

38. *E.g.*, MILITARY INTERSTATE COMPACT CHILDREN’S COMM’N, INTERSTATE COMPACT ON EDUCATIONAL OPPORTUNITY FOR MILITARY CHILDREN, available at http://www.opi.mt.gov/pdf/Superintendent/MCEOMC/MIC3_Brochure.pdf (last visited Oct. 20, 2014) (outlining the interstate compact process and highlighting that because participation is “voluntary,” “[e]ach state must adopt the Compact through their legislative process.”).

39. Robert Pear, *Medical Boards Draft Plan to Ease Path to Out-of-State and Online Treatment*, N.Y. TIMES, July 30, 2014, at A11 (stating that the FSMB has worked to establish both a national telemedicine licensure compact and the Interstate Compact for Physician Licensure).

40. Eric M. Fish, Shiri A. Hickman & Humayun J. Chaudhry, *State Licensure Regulations Evolve to Meet Demands of Modern Medical Practice*, THE SCITECH LAWYER, 6 (Mar. 26, 2014) (“Interstate compacts . . . provide a dynamic solution that can address shared regulatory issues and . . . provide flexibility to evolve and meet the challenges that may arise as telemedicine and the cross-border practice of medicine becomes more widespread.”).

41. *E.g.*, 2011 HEALTH LICENSING BOARD REPORT, *supra* note 9, at 33; George Hesselberg, *Conference Aims to Allow Doctors to Practice ‘Telemedicine’ Outside State Lines*, WIS. ST. J. (Nov. 1, 2010, 5:45 PM),

centralized licensure process⁴²). Then, participants would individually ask their state legislatures to ratify those policies.⁴³ But unfortunately, as prior state-driven professional licensure reform efforts have shown, each of these steps is not as straightforward as it seems.

Many state-driven reform efforts have, for example, foundered⁴⁴ at the first stage: agreeing on policies.⁴⁵ States are usually hesitant to let other states craft their policies, especially in areas where they expect a high degree of sovereignty.⁴⁶ This

http://host.madison.com/news/local/health_med_fit/conference-aims-to-allow-doctors-to-practice-telemedicine-outside-state/article_144e5448-e60c-11df-925f-001cc4c002e0.html.

42. Virginia Rowthorn & Diane Hoffmann, *Legal Impediments to the Diffusion of Telemedicine*, 14 J. HEALTH CARE LAW & POL'Y 14, 21 (2011) (stating that the American Telehealth Association supports establishing a “national multi-state clearinghouse,” a single place that telemedicine practitioners can register in every state). *See also* OFFICE FOR ADVANCEMENT TELEHEALTH, GRANTEE PROFILES 2012-2013, 95 (2012) (stating that the Association of State and Provincial Psychology Boards has sought to build a centralized, multistate license application system for psychologists); Press Release, Fed. of State Med. Bds., *Interstate Compact for Physician Licensure Moves Forward with Consensus Principles* (Oct. 7, 2013) (stating that the FSMB has proposed a Federation Credentials Verification Service, which would let doctors build a centralized portfolio of credentials that could be forwarded to state medical boards, and the Interstate Compact for Physician Licensure, which would create a clearinghouse to help states share information on doctors, both aimed at streamlining multistate licensure).

43. U.S. DEP'T OF COMMERCE & THE DEP'T OF HEALTH & HUMAN SERVS., *TELEMEDICINE REPORT TO CONGRESS, EXECUTIVE SUMMARY* (Jan. 31, 1997) (arguing that in order to keep policies truly uniform under the compact, states would have to have little leeway to “impose significant additional standards”).

44. *E.g.*, Robert W. Adler, *Revisiting the Colorado River Compact: Time for a Change?* 28 J. LAND, RESOURCE & ENVTL. L. 19, 23 (2008) (describing the difficulty states had negotiating the Colorado River Compact).

45. Charles E. McClure, *The Difficulty of Getting Serious About State Corporate Tax Reform*, 67 WASH. & LEE L. REV. 327, 328 (2010) (stating that an “ideal system of state corporate income taxes would exhibit uniformity” but that such uniformity “will not come about soon” because “states cannot agree to act in accord”); Sanford Schram & Gary Krueger, *Interstate Variation in Welfare Benefits and the Migration of the Poor: Substantive Concerns and Symbolic Responses*, INST. RESEARCH ON POVERTY, 1 (1994) (stating that national welfare reform has proven hard to achieve because welfare policy is largely controlled by states and getting them “to agree on uniform standards . . . has historically been difficult.”); Richard W. Stevenson, *Securities Bill Emerges in House As G.O.P. Drops Some Demands*, N.Y. TIMES (Mar. 8, 1996) (“If the states cannot agree among themselves within three years on the uniform standards, the House legislation would require responsibility for small-stock regulation and broker licensing to shift automatically to the Federal level.”).

46. Joey Ridenour, *Nurse Licensure Compact Council on Licensure, Enforcement & Regulation, Presentation*, slide 35 (Sept. 11, 2009) (the “[c]eding of

includes health professional licensure, where states are especially wary of letting other states set their standards for admitting, collecting complaints on, or disciplining in-state professionals.⁴⁷ For example, in 2001, the Oklahoma Attorney General warned his state not to join the Nurse Licensing Compact (NLC) because doing so would “authorize[] the legislatures of other states to determine by absolute reciprocity the qualifications of persons admitted to practice nursing in Oklahoma.”⁴⁸ Such protectionism can make negotiating shared policies a long, arduous process,⁴⁹ or worse, result in watered-down policies that undermine the goals of reform.⁵⁰ Both

traditional state authority makes some states reluctant to join the compact”) (“NCSBN presentation”); *see also* McClure, *supra* note 45, at 338 (stating that in the context of corporate tax laws, states are not “necessarily interested in uniformity, which they reject so they will be able to cater to business, in order to attract investment—or simply to retain sovereignty for its own sake.”); AM. BAR ASS’N, *THE EVOLVING USE AND THE CHANGING ROLE OF INTERSTATE COMPACTS: A PRACTITIONER’S GUIDE*, 29 (2006) (stating that it is hard to get state legislatures to adopt compacts due to the “tendency of parochial political interests to trump consideration for interstate cooperation”).

47. *See, e.g.*, Mass. Med. Soc’y, *Comments of the Massachusetts Medical Society Before the Division of Insurance Regarding Telemedicine Provisions of Chapter 244 of the Acts of 2012* (Sept. 27, 2013) (stating that Massachusetts should maintain control over the licensing of telemedicine practitioners there because its Board of Registration in Medicine is well-equipped to ensure the quality of practitioners it registered, but ill-equipped to ensure the quality of those it did not); *see also* Fed’n of St. Bds. of Phys. Therapy, *Feasibility of Establishing a Multistate Compact for Physical Therapy Licensure, Report to the Delegate Assembly on 2010 Delegate Assembly Motion DEL-10-05*, 6 (2011) (stating that “loss of authority” was one of states’ top “arguments in opposition of the NLC”).

48. Janet Boivin, *United States of Nursing: Changes in Healthcare Delivery May Grow the Appeal of Nurse Licensure Compact*, NURSE.COM (Sept. 18, 2013); *see also* Victor Li, *Reciprocity Fight Returns as Lawsuits Press the A.B.A.-Advocated Issue*, A.B.A. J. (Feb. 1, 2014) (arguing that similar protective tendencies hinder bar reciprocity efforts).

49. *The Evolving Use and the Changing Role of Interstate Compacts*, *supra* note 45, at 28 (stating that the disadvantages of state compacts are “the long negotiations and arduous course they must run before becoming effective,” “the ceding of traditional state sovereignty to quasi-independent bodies . . . and the reluctance of states to cede such authority,” and “compliance and enforceability.”); NCSBN presentation, *supra* note 46 (stating that a disadvantage of interstate compacts is that “[s]ome states experience long negotiations and arduous course before legislative process is successful”).

50. *See* Christoph Kurowski et al., *Towards a Regional Strategy to Strengthen the Nurse Workforce of the English-speaking CARICOM: International Legal Instruments, Agreements and Obligations*, THE WORLD BANK HNP DISCUSSION PAPERS, Jan. 2012, 16 (stating that this problem afflicts multilateral efforts to set global nursing standards); CS Hartig, *Regulatory Barriers When Implementing E-Prescribing of Controlled Substances: Could Model Language Be The Solution?*, 5 ST. LOUIS U.J. HEALTH L. & POL’Y 213, 243 (2011)

these problems currently afflict the FSMB's model policy on the appropriate use of telemedicine; despite a year-long gestation, its latest draft was called everything from a "bold step" to a "step backward" by conflicting participants.⁵¹

Another risk of multilateral state-driven reform is that, even if drafters agree on a set of policies, state legislatures will still be slow to ratify those policies, ratify different versions of those policies, or not ratify them at all.⁵² For example, it took nearly a decade for some member states to ratify the NLC.⁵³ Anticipating similar delays, the Model Interstate Compact for Emergency Medical Services Personnel Licensure recently budgeted thirty months for ratification (on top of eighteen months for drafting).⁵⁴ Some state legislatures may never ratify, of course, leaving a patchwork of adoption that is as hard for practitioners to navigate as the pre-compact landscape.⁵⁵

(stating that this problem afflicts the effort to set model language for e-prescription laws); Adler, *supra* note 44, at 23 n.25 (stating that this problem occurred during the formation of the Colorado River Compact).

51. Ken Terry, *New Telemedicine Policy Pleases Some, Others Have Issues*, MEDSCAPE MED. NEWS (Apr. 29, 2014); *see also* Lisa A. Robin, *Medical License Portability and Evolving Telemedicine Standards: Protecting Patients and Expanding Access*, FTC Examining Healthcare Competition Workshop, Presentation, slide 11 (Mar. 20, 2014) (chronicling the already lengthy drafting process of the Interstate Compact for Medical Licensure) ("FSMB Presentation").

52. Boivin, *supra* note 48 (stating that potential foils of the ratification process include "competing state political interests, such as unions," "state legislatures that work grindingly slow," "the quirks of individual state laws," "misinformation about how the compact works," and "reluctance to change the status quo."); *see also* Fed'n of St. Bds. of Phys. Therapy, *Feasibility of Establishing a Multistate Compact for Physical Therapy Licensure, Report to the Delegate Assembly on 2010 Delegate Assembly Motion DEL-10-05*, 6 (2011) ("For over ten years, the state boards of nursing have had the option of joining the NLC, yet fewer than half of the states have joined. . . . Typically, arguments in opposition of the NLC fall into one of five categories: control/loss of authority, lack of uniform standards, cost/loss of revenue, concerns about increased ease of strike breaking, and misinformation about the Compact/lack of independent evaluation.").

53. Boivin, *supra* note 48 ("Missouri was the last state to join after almost a 10-year struggle."); *see also* Adler, *supra* note 44, at 23 (stating that it took seven years for all member states to ratify the Colorado River Compact).

54. NAT'L ASS'N OF ST. EMS OFFICIALS, MODEL INTERSTATE COMPACT FOR EMERGENCY MEDICAL SERVICES PERSONNEL LICENSURE FOR STATE ADOPTION PROJECT PROPOSAL (2012), *available at* <http://www.nasemso.org/Projects/InterstateCompacts/documents/NASEMSO-Interstate-Compact-Project-Background-Scope-Oct2012.pdf>.

55. Dionne Austin, *Myths Surrounding the Nurse Licensure Compact*, THE PRECHECK BLOG (Aug. 15, 2012), <http://www.precheck.com/blog/myths-surrounding-nurse-licensure-compact> ("the rules surrounding the Nurse Licensure Compact . . . can be quite confusing. Some questions . . . may include the

This problem has afflicted the FSMB's Uniform Application (only ratified by twenty states)⁵⁶, the Military Spouse License Portability Laws (only ratified by twenty three states),⁵⁷ the Uniform Bar Exam (only ratified by fourteen states),⁵⁸ and the NLC (only ratified by twenty states, with none ratifying since 2009).⁵⁹ Lastly, states may ratify altered versions of agreed-upon policies. The American Bar Association's Model Rule on Admission by Motion,⁶⁰ for example, has suffered this problem.⁶¹ The net effect of such legislative tweaks is to exacerbate the patchwork effect described above and to undermine uniformity and, therefore, mobility.⁶²

A different risk of multilateral state-driven reform is that policies, even if encoded identically by states, will be disparately

following: Which states are considered compact states under the Nurse Licensure Compact (NLC) legislation?").

56. *Uniform Application for Physician State Licensure*, FED'N ST. MED. BOARDS, available at <http://www.fsmb.org/pdf/ua-update.pdf>.

57. Brad Cooper, *23 States Have Now Passed Pro-Military Spouse License Portability Measures*, WHITEHOUSE.GOV (June 26, 2012, 4:23 PM), <https://www.whitehouse.gov/blog/2012/06/26/23-states-have-now-passed-pro-military-family-licenses-portability-measures> (stating that states honor out-of-state professional licenses of military spouses under this compact).

58. *Jurisdictions That Have Adopted the UBE*, NAT'L CONF. BAR EXAM'RS, <https://www.ncbex.org/exams/ube/> (last visited Oct. 20, 2014).

59. *FAQs - Multistate Recognition - Nurse Licensure Compact*, TX. BD. MED., <http://www.bne.state.tx.us/olv/faqs-msr.html> (last visited Oct. 20, 2014); see generally Terri Gaffney, *The Regulatory Dilemma Surrounding Interstate Practice*, 4 ONLINE J. ISSUES IN NURSING 1 (1999); ATA Practice Requirements, *supra* note 13, at 2-4 ("Several states were quick to adopt the Compact, but . . . progress stalled out several years ago with less than half . . . participating."); Boivin, *supra* note 48.

60. A.B.A. Comm. on Ethics 20/20, *Resolution 105E* (Aug. 6, 2012).

61. Sahl, *supra* note 12, at 2643 n.47 (citing A.B.A. Ctr. for Prof'l Responsibility Pol'y Implementation Comm., *Admission by Motion Rules* (2014)) (stating that some of the thirty-nine states who have adopted the rule have adopted iterations that require reciprocity from the attorney's home state, while others have not). Trying to avoid this outcome, the NLC demands that members pass model legislation "without material differences." *Id.*; see also Arthur F. Greenbaum, *Multijurisdictional Practice and the Influence of Model Rule of Professional Conduct 5.5 - An Interim Assessment*, 43 AKRON. L. REV. 729, 737-758 (2010) (cataloguing the different versions of the American Bar Association's similarly-themed Rule 5.5 Model Rule on Multijurisdictional Practice that states have adopted).

62. *Id.* at 733 (providing that in the context of an A.B.A. model rule for practice across jurisdictions, "absent substantial uniformity, a patchwork set of reforms across the states could lead to an 'end result . . . worse than having no reform at all") (quoting Mark Hansen, *MJP Picks Up Steam: More States Are Looking at A.B.A. Proposals to Ease Rules on Multijurisdictional Practice*, A.B.A. J., Jan. 2004, 1, 44)).

implemented and enforced. This can be caused by preexisting disparities in states' regulatory landscapes: within the NLC, for example, it has been said that “[d]iffering laws, standards and staffing levels at state agencies . . . make [the compact’s system of mutual reciprocity] difficult.”⁶³ Or, state agencies may simply interpret and apply the compact policies differently.⁶⁴ Lastly, state courts may interpret the codification differently, resulting in uneven case law.⁶⁵ Such asymmetries amplify to the “patchwork”⁶⁶ effect previously discussed, and may destabilize the reform effort, deterring uncommitted states from joining it and crippling its advance.⁶⁷

All of these dangers—an arduous negotiation process, uneven adoption results, and disparate implementation—along with other well-documented disadvantages of multistate policymaking (such as

63. Tracy Weber & Charles Ornstein, *Bad Nurses Able to Keep Working in Other States*, USA TODAY (July 15, 2010, 12:11 PM), http://usatoday30.usatoday.com/news/health/2010-07-15-1Anurses15_CV_N.htm (“Most states have the ability to immediately suspend a nurse's license, but some can't . . . Likewise, some states require criminal background checks as a condition of getting a license, while others don't.”). This may be one reason it seems to be failing. Christina DePasquale & Kevin Stange, *State Regulation and the Mobility of Nurses: An Examination of the Nurse Licensure Compact 1* (June 25, 2014) (unpublished manuscript) (on file with Dep’t of Econ., Emory Univ.), available at http://economics.emory.edu/home/assets/workingpapers/depasquale_14_14_paper.pdf (“Our results indicate no effect of NLC adoption on employment and labor force participation.”).

64. Interstate Comm. for Adult Offender Supervision, *Annual Business Meeting Minutes* (Aug. 28, 2013) (stating that the lack of clarity of certain offender reporting instructions in the Interstate Compact Offender Tracking System (“ICOTS”), part of the Interstate Compact on Adult Offender Supervision, meant that certain states “may fail to follow the ICOTS procedures, creating a patchwork of practices and uncertainty about the right course to follow.”) [hereinafter Interstate Comm. for Adult Offender Supervision Meeting Minutes].

65. Michael Risch, *A Failure of Uniform Laws?*, 159 U. PA. L. REV. 1, 18 (2010) (highlighting disparate treatment by courts as fueling the “failure of the [Uniform Trade Secrets Act] to provide a uniform body of precedent to be used in all the states adopting it”); Fritz Enderlein, *Uniform Law and Its Application By Judges and Arbitrators*, in INTERNATIONAL INSTITUTE FOR THE UNIFICATION OF PRIVATE LAW, INTERNATIONAL UNIFORM LAW IN PRACTICE 329 (1987) (“The problem of the application of uniform law is as old as uniform law itself.”). Importantly, this problem may be magnified in the context of telemedicine since “there is not much case law on telemedicine.” Meera Shenoy, *United States v. Valdivieso Rodriguez: The Trend of Telemedicine*, 13 SMU SCI. & TECH. L. REV. 239, 246 (2010).

66. Interstate Comm. for Adult Offender Supervision Meeting Minutes, *supra* note 64.

67. Weber, *supra* note 63 (citing the lack of a criminal background check as a licensing requirement in some compacting states as one reason the Ohio Board of Nursing elected not to join the NLC).

the potential need for Congress to approve⁶⁸ compacts and the difficulty of amending compacts⁶⁹) weigh against state-driven licensure reform of telemedicine. Luckily, federally-driven reform, which is largely free from these risks, presents a promising alternative.

B. By Contrast, Federally-Driven Licensure Reform Generally Offers Swift Adoption and Uniform Implementation and Enforcement

Unlike state-driven licensure reform, federal licensure reform is characterized by a comparatively swift adoption process and uniform implementation and enforcement. Congress' centralized legislative process is, by design, faster and more efficient than the process of sovereign states trying to negotiate policy.⁷⁰ Further, there is no opportunity for participants to opt out or to adopt different iterations of policies, so uniformity of policy is guaranteed.

⁷¹ And, once those are adopted, their uniform implementation and

68. Justin N. Hesser, *The Nature of Interstate Groundwater Resources and the Need for States to Effectively Manage the Resource Through Interstate Compacts*, 11 WYO. L. REV. 25, 34 (noting that, under the Compact Clause of the Constitution, interstate compacts—or at least those that "increase[] a state's political power at the expense of federal government"—require Congressional approval).

69. Guy Gugliotta, *Officials Opposed to U.S. Health-care Law Seeking Interstate Compact*, WASH. POST (Sept. 17, 2011), http://www.washingtonpost.com/national/health-science/officials-opposed-to-us-health-care-law-seeking-interstate-compact/2011/09/16/gIQAVE0QaK_story.html (noting that the amending process for a compact involves all participating states agreeing to an amendment and then resubmitting the bill to their legislatures, "a hard pill to swallow" for "elected officials who want to put their stamp on their states' laws"); FREDERICK L. ZIMMERMAN & MITCHELL WENDELL, *THE LAW AND USE OF INTERSTATE COMPACTS* (The Council of St. Gov'ts, Lexington, Ky.), 1976, available at <http://www.csg.org/knowledgecenter/docs/ncic/LawAndUse.pdf> (outlining criticisms of the compact approach to policymaking, including their inflexibility with regard to amending and the need for federal approval, including for changes).

70. Jacob A. Werrett, *Achieving Meaningful Mortgage Reform*, 42 CONN. L. REV. 319, 344 (2009) (the "Framers know that complete state sovereignty of states would be a slow and ineffective way to govern the country and thus . . . ventured to create a centralized government to regulate, govern, negotiate, tax, and legislate"); Stephen Sugarman, *Should Congress Engage in Tort Reform?*, 1 MICH. L. & POL'Y REV. 129, 130 (1996) (describing how the "mechanism of Congress" was designed by the Framers to quash the "perverse incentive problem that prevents individual action by states and requires, instead what is in effect concerted action.").

71. Robert Verchick & Nina Mendelson, *Preemption and Theories of Federalism*, in WILLIAM W. BUZBEE, *PREEMPTION CHOICE* 13 (2008) (a "centralized federal approach [to policy making] promises uniformity"); see also Australian Law Reform Comm., *ALRC Report 108*, AUSTL. PRIVACY L. AND

enforcement is more likely under a single federal supervisory body.⁷²

These advantages are on full display in the various federal occupational licensure schemes that currently exist. Take, for example, federal licensure of airmen.⁷³ Prior to 1926, there was only scattered licensing, by some states, of airmen.⁷⁴ President Herbert

PRAC., Jan. 16, 2013 (an Australian national privacy law would provide “guaranteed uniformity across the jurisdictions”); Lea Brilmayer, *Interstate Preemption: The Right to Travel, The Right to Life, and the Right to Die*, 91 MICH. L. REV. 873, 873 n.2 (1993) (arguing that in the context of abortions, largely regulated by disparate state statutes, uniformity “is guaranteed only to the extent that federal law mandates some particular outcome.”); John P. Ludington, *The Supreme Court and the Post-Erie Federal Common Law*, 31 L. Ed. 2d 1006 § 3 (“The need for uniformity is the most frequently cited reason for the fashioning of federal common law.”); Thomas L. Hazen, *Treatise on the Law of Securities Regulation*, § 13.8, at 127-28 (2d ed. 1990) (“[The] weight of scholarly authority favors the application of a federal limitations period [on 17 C.F.R. § 240.10b-5 securities claims] in order to promote uniformity.”); Kevin L. Vick & Jean-Paul Jassy, *Why A Federal Right of Publicity Statute Is Necessary*, 28 COMM. LAW 14, 14 (2011) (“National content providers should not be required to navigate a hodgepodge of right of publicity laws” and that “[t]he best solution to this problem is a federal right of publicity statute that . . . brings uniformity and predictability to right of publicity law.”); Charles S. Rhyne, *Federal, State and Local Jurisdiction over Civil Aviation*, 11 LAW & CONTEMP. PROBS. 459, 464 (1946) (“With respect to [aviation] safety regulations, all authorities agree that uniformity of regulation is not only desirable but . . . essential to the public welfare” and that “[e]xclusive regulation by the Federal government obviously would assure such uniformity.”); Alexee D. Conroy, *Lessons Learned from the Laboratories of Democracy: A Critique of Federal Medical Liability Reform*, 91 CORNELL L. REV. 1159, 1180 (2014) (“[A]dvocates of federal tort reform legislation argue that the patchwork of individual state laws and the variability in their application hinders efficiency by imposing unnecessary costs on businesses and patients. Proponents of federal tort reform emphasize the benefits of uniformity, citing the potential savings for businesses that [do business] in multiple states.”).

72. Margaret H. Lemos, *State Enforcement of Federal Laws*, 86 N.Y.U. L. REV. 698, 718 (2011) (whereas federal enforcement is “marked by centralization” because “[m]ost federal civil statutes vest public enforcement authority in a single federal agency,” “enforcement at the state level lacks an equivalent mechanism of centralized national control, thereby creating the potential for more than fifty disparate approaches to the exercise of enforcement discretion.”).

73. ATA Practice Requirements, *supra* note 13, at 4.

74. Marcos E. Carreno, *International Regulation of Commercial Civil Aircraft: Regulatory Agencies and Requirements of Governing Large Transport Aircraft Certification*, 25 (Feb. 7, 2003) (unpublished Master’s thesis, Massachusetts Institute of Technology) (on file with author); C. Robert Esherrick, *Jurisdiction of the Federal Government in Civil Aviation*, 1 CATH. U. L. REV. 13, 13 (1951); *The Second Tentative Draft of a Uniform Aviation Act*, in NAT’L CONFERENCE OF COMMISSIONERS ON UNIF. STATE LAWS, HANDBOOK OF THE NATIONAL CONFERENCE OF COMMISSIONERS ON UNIFORM STATE LAWS, AND

Hoover and others argued that the licensing of pilots “by some central authority” was needed for the further development of the industry and that said “authority” “must be the Federal Government.”⁷⁵ Toward that end, in May 1926, Congress passed the Air Commerce Act, authorizing the Department of Commerce to license airmen.⁷⁶ The Department then established an Aeronautics Branch,⁷⁷ which issued a regulation on December 1926 requiring all pilots to hold federal aviation licenses by March 1 (later extended to May 1) 1927.⁷⁸ Despite its short gestation, this licensure scheme is still in place today⁷⁹ and is credited with helping enable aviation’s growth into a “mainstream transportation technology”⁸⁰ and helping birth an industry that is valued at \$904 billion (roughly nine percent of GDP) and provides 11.2 million jobs.⁸¹

That is not the only federal professional licensure success. Federal licensure of railroad engineers was initiated quickly, in the year following a much-publicized train accident,⁸² but endures into the present.⁸³ Ship pilots, too, are federally licensed (and have been for over one hundred and forty years).⁸⁴ Outside of the U.S.,

PROCEEDINGS OF THE ANNUAL MEETING 313-322 (1921) (“Nearly every one agrees that Federal control of licensing and Federal regulations are desirable ends in the interest of uniformity . . .”).

75. Pres. Herbert Hoover, Speech Before San Francisco Chamber of Commerce (Sept. 2, 1926).

76. *The First U.S. Federal Pilot License*, FED. AVIATION AUTHORITY, available at https://www.faa.gov/about/history/celebration/media/first_pilots_license.pdf; see also Nick A. Komons, BONFIRES TO BEACONS: FEDERAL CIVIL AVIATION POLICY UNDER THE AIR COMMERCE ACT 96 (1978); Rhyne, *supra* note 71, at 460, 462-63.

77. *The First U.S. Federal Pilot License*, *supra* note 76.

78. 14 C.F.R. § 61 (2015).

79. Miranda Anger, *International Aviation Safety: An Examination of the U.S., E.U., and the Developing World*, 72 J. AIR L. & COM. 141, 143-144 (2007).

80. McMillan Houston Johnson V., *Taking Off: The Politics and Culture of American Aviation, 1920-1939* (May 2011) (unpublished Ph.D. dissertation, University of Tennessee) (on file with University of Tennessee).

81. *Vorhees v. Naper Aero Club, Inc.*, 272 F.3d 398, 406 n.1 (7th Cir. 2001).

82. See David Briscoe, *Federal Railroad Administration Laying Down New Track on Safety*, SPOKANE CHRON., May 30, 1989, at 8, available at <http://www.apnewsarchive.com/1989/Federal-Railroad-Administration-Laying-Down-New-Track-on-Safety/id-332edc67686f3cfdb9a6729b96f13cf0>; Rail Safety Improvement Act of 1988, Pub. L. No. 100-342, 102 Stat. 164 (1988).

83. FED. R.R. ADMIN., ENGINEER CERTIFICATION QUESTIONS AND ANSWERS (2005), available at <http://www.fra.dot.gov/Elib/Document/1597>.

84. Paul G. Kirchner & Clayton L. Diamond, *Unique Institutions, Indispensable Cogs, and Hoary Figures: Understanding Pilotage Regulation in the United States*, 23 U.S.F. MAR. L.J. 168, 177-79 (2010-11) (recounting the history of

Australia and Mexico practice federal licensure of all doctors and dentists.⁸⁵ And, with regard to telemedicine, the European Commission has achieved its own iteration of federally-directed licensure uniformity across the European Union by dictating that practitioners can practice in any member state so long as they are licensed in the member state from which they deliver care,⁸⁶ a rule that is credited with providing “expanded access to care.”⁸⁷ Differently, Malaysia’s entire telemedicine system, including licensure, is nationalized,⁸⁸ a fact that has put it “at the forefront in the use of telehealth technologies and service programs amongst developing countries.”⁸⁹ Perhaps inspired by these federal licensure successes, stakeholders have consistently advocated for federal licensure in other professions where uniformity of licensure is desirable but thwarted by inconsistent state licensure regimes.⁹⁰

federal ship pilot licensing through the Act of February 28, 1871, 16 Stat. at 440 (1871)).

85. *Who We Are*, AUSTL. HEALTH PRAC. REG. AGENCY, <http://www.ahpra.gov.au/About-AHPRA/Who-We-Are.aspx> (last visited Oct. 20, 2014); Luz Maria Gonzalez-Robledo, Maria Cecilia Gonzalez-Robledo & Gustavo Nigenda, *Dentist Education and Labour Market in Mexico: Elements for Policy Definition*, 10 HUM. RES. HEALTH 31, 31 (2012), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3515346>.

86. Council Directive 2005/36, of the European Parliament and of the Council of 7 September 2005 on the Recognition of Professional Qualifications, 2005 O.J. (L 255) 22 (EC).

87. Dana Pirvu & Rachel Snyder, *E.U. Way Ahead of the Game on Telehealth*, TECHHEALTH PERSPECTIVES (Mar. 21, 2013), <http://www.techhealthperspectives.com/2013/03/21/e-u-way-ahead-of-the-game-on-telehealth/>.

88. Siti N. Maon & Sisira Edirippulige, *An Overview of the National Telehealth Initiative in Malaysia*, 161 STUDIES IN HEALTH TECH. & INFORMATICS 95 (2010).

89. Mansour Saeed Alharthi, *Telehealth Practice in Eight Countries*: masters thesis, Massey University) (on file with Massey University).

90. See Michael S. Young & Rachel K. Alexander, *Recognizing the Nature of American Medical Practice: An Argument for Adopting Federal Medical Licensure*, 13 DEPAUL J. HEALTH CARE L. 145 (2010) (detailing arguments advocating federal licensing of doctors); Darren A. Heitner & Andrew B. Delaney, *Have Some Standards: How the Sports Agent Profession Should Be Effectively Regulated*, 21 NYSBA ENT. ARTS & SPORTS L.J. 41, 42 (2010) (discussing arguments advocating for federal licensure of sports agents because it “would be to eliminate the inconsistencies among states”); Eric Willenbacher, *Regulating Sports Agents: Why Current Federal and State Efforts Do Not Deter the Unscrupulous Athlete-Agent and How a National Licensing System May Cure the Problem*, 78 ST. JOHN’S L. REV. 1225, 1242-43 (2004) (providing arguments advocating for federal licensure of sports agents).

C. Telemedicine in Particular Mutes the Disadvantages and Amplifies the Advantages of Federal Licensure Reform

In the context of telemedicine, specifically, the supposed drawbacks of federal licensure reform are muted and its advantages are heightened, providing one more reason to choose federal telemedicine licensure reform over state-led reform. For example, in telemedicine, the notion that states should control licensure because they can produce “better tailored responses to local peculiarities” when it comes to health loses currency is not true.⁹¹ First, few such “peculiarities” remain because state physician licensure rules have converged so much in recent years,⁹² especially in the specialties that telemedicine is most likely to affect.⁹³ Some aspects of education and specialization are already subject to national standards.⁹⁴ Medicare and Medicaid already impose

91. Lars Noah, *Ambivalent Commitments to Federalism in Controlling the Practice of Medicine*, 53 U. KAN. L. REV. 149, 156 (2004); see also Zilis, *supra* note 22, at 214, for the proposition that “it is commonly believed that states are better able to protect their residents from unqualified physicians”; R.R. Bovbjerg, J.M. Wiener & M.G. Housman, *State and Federal Roles in Health Care: Rationales for Allocating Responsibilities*, in JOHN HOLAHAN, ALAN WEIL & JOSHUA M. WIENER, FEDERALISM AND HEALTH POLICY 25 (2003) (“With regard to knowing the territory, states are better able to understand their unique problems, craft policy responses, and implement them flexibly. . . . Geographic diversity may have a particularly strong effect on health care services because health care institutions, medical practice patterns, and referral networks, and market behavior are mainly local.”).

92. NAT. GOVS. ASS’N, ANALYSIS OF LICENSURE LAWS, RULES AND PROCEDURES AS THEY RELATE TO E-HEALTH AND TELEHEALTH 1 (Aug. 2007) (“Over the last fifty years, the basic requirements set by states to practice medicine have become largely uniform. The testing and education requirements for physicians are almost the same in all states.”); Rowthorn & Hoffman, *supra* note 42, at 13 (according to Jonathan Linkous, CEO of the American Telemedicine Association, although “quality of care is often cited as the primary basis for state-based licensure,” “[q]uality differences . . . are less and less of an issue as all licensing jurisdictions require successful completion of three parts of the United States Medical Licensing Exam. . . . Moreover, differences in licensing requirements between states ‘are fewer and fewer each year.’”).

93. A.B.A. Health Law Sec., *Report 120A 5* (Aug. 2008) (“State requirements for medical licensure are very close to uniform . . . standards of practice—particularly in the medical specialties, which are likely to be the greatest arenas for telemedicine practice—are no longer local. All radiologists, pathologists, dermatologists, etc., are subject to national standards of care In sum, the substantial and ongoing administrative, financial and legal burdens that are imposed by requirements for multiple licenses for telemedicine practice outweigh any potential arguments in their favor.”).

94. I. GLENN COHEN, THE GLOBALIZATION OF HEALTH CARE: LEGAL AND ETHICAL ISSUES 367 (2013).

accreditation standards on health care entities in exchange for funding.⁹⁵ Second, any lingering advantages of localization are neutralized by the nature of telemedicine.⁹⁶ The very goal of telemedicine is to erase geographic differences and provide the best care possible.⁹⁷ Thus, in telemedicine, the factors that shape licensure, such as requisite training and knowledge, are not “state-specific” but “science-based and universal,” reducing the advantage of states licensing telemedicine.⁹⁸

On top of this, the benefits of localism are offset by the increasingly national scope of telemedicine, the national scope of healthcare, and the need to address health problems with solutions, such as telemedicine, that are nationally scalable. Because telemedicine is often a cross-border affair, state-based solutions are

95. *Id.* (citing 42 U.S.C. § 1395X (e-m) (2006); 42 C.F.R. §§ 48.1-.55 (2001)).

96. Amar Gupta & Deth Sao, *The Unconstitutionality 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, 413, 420 (2010) (“[T]he reasons behind the traditional belief that local authorities are in the best position to police the health care industry are no longer valid in the context of telemedicine,” where there are no “local peculiarities.”).

97. See Lindsey T. Goehring, *Expansion of Quality or Quantity in Telemedicine in the Rural Trenches of America?*, 11 N.C.J. L. & TECH. 99, 112 (2009) (“[A] standard of similar locality and knowledge cannot likely be sustained when telemedicine, by design, bridges a gap which enables practitioners to remain in urban areas while the patient lives in a rural town.”); Joy E. Matak, *Telemedicine: Medical Treatment via Telecommunications Will Save Lives, But Can Congress Answer the Call?: Federal Preemption of State Licensure Requirements Under Congressional Commerce Clause Authority & Spending Power*, 22 VT. L. REV. 231, 245 (1997) (arguing that technological advances have undone the distinction between what is “inherently national” and “traditionally local”).

98. Jacobson & Selvin, *supra* note 22, at 435 (“[I]t would not be difficult to implement national standards for the practice of telemedicine” because “unlike professions such as the law, where knowledge is state specific, training in health care professions is science based and universal.”) (quoting REGULATION OF THE HEALTHCARE PROFESSIONS (Timothy S. Jost ed., 1997)).

frequently a poor fit⁹⁹ and even counter-productive.¹⁰⁰ Relatedly, health care is a social problem of national scope.¹⁰¹ In the face of such problems, state-level solutions are inadequate and, again, even counter-productive.¹⁰² Meanwhile, the ability to deploy tools that are scalable on a national level, such as telemedicine¹⁰³, becomes more valuable.¹⁰⁴ And only the federal government is in a position to deploy such tools consistently and effectively nationwide.¹⁰⁵

99. *Overcoming the Psychological Barriers to Telemedicine: Empowering Older Americans to Use Remote Health Monitoring Services*, NEW MILLENNIUM RESEARCH COUNCIL 6 (Feb. 2007), http://www.newmillenniumresearch.org/archive/Telemedicine_Report_022607.pdf (“Health care policies for telemedicine practices need focus on a national scope, since the technology is not limited by state borders.”); Michael Gill, *A National Telehealth Strategy For Australia – For Discussion*, AUSTRALIAN NAT’L CONSULTATIVE COMM. ON ELEC. HEALTH 2 (2011), available at http://www.who.int/goe/policies/countries/aus__support_tele.pdf (“Telehealth is not a local issue but offers the health system, both public and private, the opportunity to provide new models of care efficiently.”).

100. Gupta & Sao, *supra* note 96, at 442 (stating that because the “cross-border nature of telemedicine . . . creates jurisdictional conflicts within and among nations,” there is a “need to relinquish local control in favor of centralized authority”).

101. ROBERT L. HOLLINGS & CHRISTAL PIKE-NASE, PROFESSIONAL AND OCCUPATIONAL LICENSURE IN THE UNITED STATES: AN ANNOTATED BIBLIOGRAPHY AND PROFESSIONAL RESOURCE 27 (1997) (stating that although “[t]he power to regulate professionals has been determined to be reserved to the states,” because “[s]ociety problems, such as . . . health care, have taken on what are increasingly perceived to be of a national character,” “some have begun to argue that there is a need for more uniformity among state regulatory schemes.”).

102. *Id.*; see also Abbe R. Gluck, *Federalism From Federal Statutes: Health Reform, Medicaid, and the Old-Fashioned Federalists’ Gamble*, 81 FORDHAM L. REV., 1748, 1753 (“Nationalists also argue that state-level health reform is impossible given the national market for health care: providers and insurers will simply leave aggressive states if other states have fewer restrictions.”).

103. Zack McCartney, *Health IT Takes Hold Around the World*, HEALTHCARE IT NEWS (Oct. 24, 2013), <http://www.healthcareitnews.com/news/health-it-takes-hold-around-world> (“Telehealth services are scalable and able to provide an increased volume of care without a corresponding increased cost.”).

104. Rashid L. Bashshur & Gary W. Shannon, *National Telemedicine Initiatives: Essential to Healthcare Reform*, 15 TELEMEDICINE & E-HEALTH 600, 603 (2009) (“[T]he available evidence to date clearly suggests that the appropriate deployment of integrated telemedicine systems through-out the country would have the potential to address the problems of access, cost, and quality simultaneously.”).

105. OFFICE OF THE NAT’L COORDINATOR FOR HEALTH INFO. TECH., HEALTH IT STRATEGIC FRAMEWORK: STRATEGIC THEMES, PRINCIPLES, OBJECTIVES, AND STRATEGIES (Mar. 3, 2010), available at http://library.ahima.org/xpedio/groups/public/documents/government/bok1_047203.pdf (setting “standards, implementation specifications, and certification criteria”

Accordingly, the specific facts surrounding contemporary telemedicine licensure tip the scales affirmatively in favor of federal—rather than state-led—telemedicine licensure reform.

III. THE CONSTITUTIONAL ISSUES SURROUNDING FEDERAL REFORM

Despite the patent advantages of federal telemedicine licensure reform, states will, for different reasons, resist any attempt by Congress to act in this arena. These states may, like some of those who resisted the ACA, see the regulation of health as “a quintessential component of [their] sovereign powers” under the Constitution.¹⁰⁶ Or, they may wish to protect licensing fee revenues or the cartel-like ability of medical boards to limit physician competition in-state.¹⁰⁷ Either way, most states have adopted “restrictive” telemedicine licensure laws¹⁰⁸ and will challenge, in court, any federal effort to usurp them. These challenges will likely be based on the notion that federal reform of this arena overreaches

are among the “roles that only the Federal government can play in promoting the adoption and use of [health information technology.]”).

106. Florida ex rel. Att’y Gen. v. U.S. Dep’t Health & Human Servs., 648 F.3d 1235, 1305 (11th Cir. 2011).

107. Rowthorn & Hoffman, *supra* note 42, at 26-27 (2010) (according to Jonathan Linkous, CEO of the American Telemedicine Association, there are “two issues [that] . . . are the primary reasons why national licensure approaches will probably not be adopted anytime soon. [First,] . . . States . . . are reluctant to cede their power to license and collect licensing fees: ‘Money is a part of the state’s rights debate’ . . . [And, second] . . . trade protection, i.e., physicians, have defended strong licensure laws in order to prevent out-of-state physicians from practicing in their state where they would compete for patients.”); *see also* Shirley V. Svorny, *Licensing Doctors: Do Economists Agree?*, 1 ECON. J. WATCH 279, 286 (2004) (“In granting sole authority to the boards to issue licenses, society has, in effect, given considerable power to organized medicine to restrict the supply of physicians . . . for the benefit of the profession”); Paul Spradley, *Telemedicine: The Law Is the Limit*, 14 TUL. J. TECH. & INTELL. PROP. 307, 319-20 (2011) (“Reluctance to relinquish control of licensing power and collection of licensing fees is a major concern for the states. . . . For this reason, federal preemption of state licensing powers will not be easy to achieve. . . . The ‘unspoken heart’ of the medical licensure issue is trade protectionism. Physicians and specialty groups have long encouraged steep licensing requirements for out-of-state physicians in an effort to prevent competition for patients and health services. The emergence of telemedicine will only aggravate the selfish interests of those who support trade protectionism.”).

108. Spradley, *supra* note 107, at 318; *see, e.g.*, Med. Ass’n of Ga., Comm. C, *Resolution 302C.13 - Telemedicine Licensure* (Oct. 2013) (Federal telemedicine licensure “would likely help unqualified practitioners gain access to all states simultaneously, and . . . would allow for easier restriction of licensure by the federal government for all physicians in the practice of telemedicine.”).

Congress' Commerce Power or violates the states' Tenth Amendment sovereignty or Police Powers.¹⁰⁹ What these challenges must overcome is the fact that the deference given to Congress with regard to its Commerce Clause, Necessary and Proper Clause, and Spending powers is, with few exceptions, increasingly expansive. It has not always been clear which side would prevail in this conflict. But, as we outline next, the judicial aftermath of the ACA has certainly given the advantage to Congress.

A. The Constitutional Defenses for State-based Licensure (the Police Power and State Sovereignty) Are Inadequate

Constitutional defenses for state control of telemedicine licensure rely¹¹⁰ on the mistaken notion that oversight of health matters and professional standards belongs to the states under the Police Power¹¹¹ reserved to them under the Tenth Amendment.¹¹²

109. *E.g.*, Rowthorn & Hoffman, *supra* note 42 at 11 n.19 ("A national licensure system is likely to raise Tenth Amendment concerns"); Brian Darer, *Telemedicine: A State-Based Answer to Health Care in America*, 3 VA. J. L. & TECH. 4, 22 n.49 (Spring 1998) ("If Congress implements a federal licensing scheme against the wishes of the individual states, the states . . . could sue alleging that the federal law is an unconstitutional exercise of the federal commerce power."). Note that these two constitutional provisions are often at odds with each other. See JOHN E. NOWAK & RONALD D. ROTUNDA, CONSTITUTIONAL LAW §§ 4.1-4.10, 4.7 (4th ed. 1991) (stating that many Supreme Court Commerce Clause decisions define Congress' power under the Clause in relation to the restriction of the Tenth Amendment which reserves power to the states); Walter Donat, *ERISA and the Preemption of State Law*, 6 FORDHAM URBAN L. J. 599, 619 (1977) (arguing that the Tenth Amendment "prevents Congress from regulating states under the commerce power in a manner that adversely affects the states' ability to function effectively in the federal system.").

110. Born, *supra* note 21, at 205; Linda Gobis, *An Overview of State Laws and Approaches to Minimize Licensure Barriers*, TELEMEDICINE TODAY MAGAZINE (Dec. 1997) (arguing that because state laws governing the practice of medicine "were enacted under the police power reserved to the states by the U.S. Constitution," "legal precedent supports maintaining single state licensure.").

111. Wendy E. Parmet, *Regulation and Federalism: Legal Impediments to State Health Care Reform*, 19 AM. J. L. & MED. 121 (1993) (arguing that stemming from an "ancient power of sovereigns to regulate their internal affairs to ensure the health and safety of the citizenry," the Police Power is defined as "the authority [of the States] to provide for the public health, safety, and morals," *Brown v. Maryland*, 25 U.S. 419, 442-43 (1827), and is one of the "core" functions of states that are protected by the Tenth Amendment); Christopher D. Supino, *The Police Power and Public Use: Balancing the Public Interest against Private Rights through Principled Constitutional Distinctions*, 110 W.VA. L. REV. 2, 10 n.14 (2008).

112. U.S. CONST. amend. X.

Health regulation has long been the domain of the states¹¹³, it is said, and by entering this domain, Congress violates state sovereignty.¹¹⁴ Likewise, it is said, occupational standards are “a traditional area of state police power” upon which Congress may not trespass.¹¹⁵ Based on these notions, prior federal health legislation like ERISA¹¹⁶ and the ACA¹¹⁷ were deemed constitutionally suspect and federal control of telemedicine licensure has been called everything from “problematic”¹¹⁸ to “unlikely.”¹¹⁹

113. 2011 Health Licensing Board Report, *supra* note 9, at 6 (“For over 100 years, healthcare in the United States has primarily been regulated by the states.”); *Gonzalez v. Oregon*, 546 U.S. 243, 271-74 (2006) (“[R]egulation of health” is “primarily, and historically, a matter of local concern” and “traditionally supervised by the States’ police power.”) (citing *Hillsborough Cnty v. Automated Med. Labs, Inc.*, 471 U.S. 707, 719 (1985)).

114. *Roundtable on Legal Impediments*, *supra* note 11, at 15 n.85.

115. Jennesa Calvo-Friedman, *The Uncertain Terrain of State Occupational Licensing Laws for Noncitizens: A Preemption Analysis*, 102 GEO. L.J. 1597, 1605 (2014); see also Carolyn R. Cody, *Professional Licenses and Substantive Due Process: Can States Compel Physicians to Provide Their Services*, 22 WM. & MARY BILL RTS. J. 941, 943 (2014) (“In the American federalist system the authority to issue most licenses lies at the state level, within the purview of each state’s police power.”); *Cal. Div. of Labor Stds. Enforcement v. Dillingham Constr.*, 519 U.S. 316, 330 (1997) (holding that California construction apprenticeship standards were not preempted by ERISA because “apprenticeship standards . . . have long been regulated by the States”); *Willmar Elec. Serv. v. Cooke*, 212 F.3d 533, 537 (10th Cir. 2000) (“The appropriate degree of supervision required for apprentices performing electrical work is a matter related to occupational and public safety and, as such, has traditionally been subject to the state’s police powers.”).

116. *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661-62 (1995) (holding that ERISA could invoke Tenth Amendment concerns because health was “historically . . . a matter of local concern.”).

117. *Florida ex rel. Att’y Gen. v. U.S. Dep’t Health & Human Servs.*, 780 F. Supp. 2d 1256, 1266 (N.D. Fla.), *aff’d in part and rev’d in part*, 648 F.3d 1235 (11th Cir. 2011), *aff’d in part and rev’d in part sub nom.*, *NFIB v. Sebelius*, 132 S. Ct. 2566 (2012).

118. *Lewis*, *supra* note 22, at 587 (“Federal regulation of cybermedicine initially appears problematic and counterintuitive because the Constitution traditionally reserves the power to regulate medicine to the states.”); *Born*, *supra* note 21, at 205 (stating that one argument for keeping telemedicine licensure in the hands of the states is that “[f]ederal and state courts have consistently held that the Tenth Amendment grants state legislatures the power to regulate licensing requirements for certain professions.”).

119. *Zilis*, *supra* note 22, at 213 (arguing that although a “national physician licensure would enable telemedicine to be utilized to its fullest,” “constitutional concerns and significant resistance make the implementation of a national licensure system unlikely.”).

Importantly, though, these defenses ignore “nearly half a century of extensive federal involvement in the . . . health services sectors.”¹²⁰ Congress has long regulated health,¹²¹ as well as the

120. *Liberty Univ., Inc. v. Geithner*, 671 F.3d 391, 438 (4th Cir. 2011) (“Through ERISA, [and] enactments like Health Insurance Portability and Accountability Act of 1996 . . . the federal government has come to occupy much of the field of the regulation of health benefits, and many state and local attempts to regulate health insurance have been held preempted” so it cannot “be said that health insurance or health services have always been the province of the states”) (internal quotations omitted); *see also* *NFIB v. Sebelius*, 132 S. Ct. 2566, 2628 (2012) (Ginsburg, J.) (“As evidenced by Medicare, Medicaid, [the Employee Retirement Income Security Act of 1974 (“ERISA”)], and [the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”)], the Federal Government plays a lead role in the health-care sector, both as a direct payer and as a regulator.”); *Florida ex rel. Att’y Gen. v. U.S. Dep’t Health & Human Servs.*, 648 F.3d 1235, 1302-03 (11th Cir. 2011), *aff’d in part and rev’d in part sub nom.*, *NFIB v. Sebelius*, 132 S. Ct. 2566 (2012) (Congress has the power under the Commerce Clause to regulate “broadly” in the healthcare arena and “has legislated expansively and constitutionally in the fields of [health] insurance and health care.”); *see also* Wendy E. Parmet, *After September 11: Rethinking Public Health Federalism*, 30 J. L. MED. & ETHICS 201, 202-04 (Summer 2002) (The “federal government’s involvement in public health dates back to the early years of the Republic,” going as far back as the establishment, in 1798, of the U.S. Marine Hospital Services to provide for the care of sick sailors.).

121. *E.g.*, Federal Food, Drug, and Cosmetic Act, Pub. L. No. 75-717, 52 Stat. 1040 (1938) (giving the Food and Drug Administration oversight of drugs); Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965) (establishing Medicare and Medicaid); Clinical Laboratory Improvement Act of 1967, Pub. L. No. 90-174, § 5, 81 Stat. 533 (1967) (regulating medical laboratories of a certain size); Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (1974); National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (1974) (encouraging state responses to rising healthcare costs and the availability of healthcare); Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82 (1986) (regulating workers’ health benefits); Clinical Laboratory Improvement Act of 1988, Pub. L. No. 100-578, 102 Stat. 2903 (1988) (expanding federal oversight of laboratories); Patient Self-Determination Act, passed as part of the Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, 104 Stat. 1388 (1991) (requiring health facilities to provide certain information to admittees); Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996); Mammography Quality Standards Act, Pub. L. No. 102-539, 106 Stat. 3547 (1992); Breast and Cervical Cancer Mortality Prevention Act of 1990, Pub. L. No. 101-354, 104 Stat. 409 (1990); Food and Drug Administration Modernization act of 1997, Pub. L. No. 105-115, § 123(h), 111 Stat. 2296 (1997); Clients’ Health Research and Prevention Amendments of 1998, Pub. L. No. 105-340, 112 Stat. 3193 (1998); the ACA, *supra* note 9.

standards¹²² and licensure¹²³ of health professionals. Yes, there are (generally older) court decisions suggesting that health regulation,¹²⁴ including the practice of medicine¹²⁵ and health professional

122. 42 C.F.R. § 485 (2009) (regulating the qualifications of medical personnel in facilities that receive Medicare reimbursements).

123. *E.g.*, Health Care Quality Improvement Act, Pub. L. No. 99-660, 100 Stat. 3743 (1988) (requiring state medical boards to report certain licensure disciplinary actions to a federal clearinghouse); *see generally* R. Kuelthau, *Ambulatory Surgery Centers - Medical Clinics and the National Practitioner Data Bank*, 79 MARQ. L. REV. 819 (1996).

124. *Gonzalez v. Oregon*, 546 U.S. 243, 270 (2006) (“Numerous Supreme Court decisions have identified the regulation of health matters as a core facet of a state’s police powers”); *Hill v. Colorado*, 530 U.S. 703, 715 (2000) (quoting *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 475 (1996)) (“It is a traditional exercise of the States’ ‘police powers to protect the health and safety of their citizens.’”); *Barnes v. Glen Theatre, Inc.*, 501 U.S. 560, 569 (1991) (“The traditional police power of the States is defined as the authority to provide for the public health, safety, and morals.”); *Head v. New Mexico Bd. of Exam’rs in Optometry*, 374 U.S. 424, 428 (1963) (“[A statute] directly addressed to protection of the public health . . . falls within the most traditional concept of what is compendiously known as the police power”); *Barsky v. Bd. of Regents*, 347 U.S. 442, 449 (1954) (“[A] state has broad power to establish and enforce standards of conduct within its borders relative to the health of everyone there. It is a vital part of a state’s police power.”); *Jacobson v. Massachusetts*, 197 U.S. 11, 25 (1905) (“According to settled principles, the police power of a state must be held to embrace . . . such reasonable regulations . . . as will protect the public health and the public safety.”); *see also* Edward P. Richards, *The Police Power and the Regulation of Medical Practice: A Historical Review and Guide for Medical Licensing Board Regulation of Physicians in ERISA-Qualified Managed Care Organizations*, 8 ANNALS OF HEALTH L. 201, 237 (1999) (“The police power to regulate matters that affect the health of the citizenry was well established in the colonies When the Constitution was written, this power was reserved to the states.”).

125. *See* *Minnesota ex rel. Whipple v. Martinson*, 256 U.S. 41, 45 (1921) (“There can be no question of the authority of the state in the exercise of its police power to regulate the . . . prescription . . . of dangerous and habit-forming drugs”); *Lambert v. Yellowley*, 272 U.S. 581, 596 (1926) (“[T]here is no right to practice medicine which is not subordinate to the police power of the States.”); *McNaughton v. Johnson*, 242 U.S. 344, 348-49 (1917) (“[A] state may regulate the practice of medicine”); *Blass v. Weigel*, 85 F. Supp. 775, 779-80 (D. N.J. 1949) (“A long line of decisions have upheld the right of a state to regulate the practice of medicine.”); *see also* *Linder v. United States*, 268 U.S. 5 (1925) (State could govern whether a doctor could prescribe narcotics to addicts); *Miller v. St. Bd. of Dental Exam’rs*, 287 U.S. 563 (1932) (State could prohibit medical corporations from practicing if employees were not licensed); *Dr. Bloom Dentist, Inc., v. Cruise*, 288 U.S. 588 (1933) (allowing state to regulate advertising by dentists); *Head v. N.M. Bd. of Exam’rs in Optometry*, 374 U.S. 424 (1963) (permitting state to regulate advertising by medical professionals); *Washington v. Glucksberg*, 521 U.S. 702 (1997) (allowing state to ban physician-assisted suicide); *see generally* Richards, *supra* note 126, at 201 (discussing the historical factors that may explain why the practice of medicine came to fall under the Police Power).

licensure¹²⁶ in particular, are vital components of states' Police Power.¹²⁷ But there are also decisions (including newer ones, like *Gonzales v. Raich*,¹²⁸ *Gonzales v. Oregon*¹²⁹, and, in telemedicine, *U.S. v. Rodriguez*¹³⁰ from 2005, 2006, and 2007 respectively) that uphold the authority of Congress to regulate health.¹³¹ Even NFIB

126. *Hawker v. New York*, 170 U.S. 189, 192-93 (1898) (“[L]egislation which . . . defines qualifications of one who attempts to practice [*sic*] medicine is a proper exercise of [a state’s police] power.”); *see also* *Gray v. Connecticut*, 159 U.S. 74 (1895) (State could license preparers of medicinal compounds); *Dent v. West Virginia*, 129 U.S. 114 (1889) (medical practitioners); *Watson v. Maryland*, 218 U.S. 173 (1910) (physicians); *Collins v. Texas*, 223 U.S. 288 (1912) (osteopaths); *Crane v. Johnson*, 242 U.S. 339 (1917) (practitioners of faith-based medicine); *Douglas v. Noble*, 261 U.S. 165 (1923) (dentists); *Graves v. Minnesota*, 272 U.S. 425 (1926) (dentists); *Louisiana St. Bd. of Med. Exam’rs v. Fife*, 162 La. 681 (La. 1926) (chiropractors); *Semler v. Oregon State Bd. of Dental Exam’rs*, 294 U.S. 608 (1935) (dentists); *State Bd. of Med. Exam’rs v. Grossman*, 48 A.2d 700, 700 (1946) (chiropractors). *See also* *Williamson v. Lee Optical Co.*, 348 U.S. 483 (1955) (State could bar opticians from filling lens orders without a doctor’s prescription); *McNaughton*, 242 U.S. at 344 (State could bar ophthalmologists from optometry); *Lawton v. Bd. of Med. Exam’rs*, 299 P.2d 362 (Cal. App. 2d 1956) (State could decide who could call themselves an “M.D.”); *Reetz v. Michigan*, 188 U.S. 505 (1903) (State may inquire into credentials of a physician before permitting them to practice); *see generally* *New Jersey Chiropractic Ass’n v. State Bd.*, 79 F. Supp. 327, 334-336 (1948) (tracing the history of the Supreme Court as regards licensing of medical professionals).

127. *Robin*, *supra* note 51, at slide 5 (citing this line of precedent in support of the FSMB’s proposed state-driven telemedicine licensure compact).

128. *Gonzales v. Raich*, 545 U.S. 1 (2005) (upholding the part of the CSA that criminalized the production and use of home-grown marijuana, which California had legalized for medicinal purposes). In his dissent, Justice Clarence Thomas said that the CSA “encroached on States’ traditional police powers . . . to protect the health, safety, and welfare of their citizens.” *Id.* at 66 (Thomas, J., dissenting). But the majority upheld the CSA’s application, finding that it was within Congress’s authority to “make all Laws which shall be necessary and proper” to regulate interstate commerce. *Id.* at 22.

129. *Oregon*, 546 U.S. at 274 (“[A]lthough regulation of health and safety is ‘primarily, and historically, a matter of local concern’...there is no question that the Federal Government can set uniform national standards in these areas”) (citing *Hillsborough Cnty. v. Automated Med. Labs., Inc.*, 471 U.S. 707, 719 (1985)).

130. *United State. v. Rodriguez*, 532 F. Supp. 2d 316, 330-32 (2007) (D.P.R. 2007) (applying *Oregon* and *Raich*’s rulings to the government’s prosecution, under the CSA, of two men in Puerto Rico who were dispensing controlled drugs to out-of-state patients over the internet and finding that the government’s action *was* constitutional, even though a Puerto Rico statute authorized the men to prescribe such drugs to internet clients).

131. *E.g.*, *Helvering v. Davis*, 301 U.S. 619 (1937) (upholding the Social Security Act, to which Medicare is an amendment, as an exercise of the Spending power); *NFIB v. Sebelius*, 132 S. Ct. 2566 (2014) (upholding the individual mandate portion of the ACA, while leaving the remainder of the ACA intact); *see also* *Gibbons v. Ogden*, 22 U.S. 1, 72 (1824) (stating that although “health laws of

allowed the vast majority of the ACA's health regulations to stand.¹³² For that reason, it has been said that, "a state has no constitutional basis to claim exclusive authority over health regulation."¹³³

These defenses also ignore the fact that Congress has long regulated professional standards.¹³⁴ Congress, for example, currently regulates to some degree the professional conduct of

every description" fall within the "police power" of the states, that police power must give way to proper exercises of Congress' Commerce Clause power); *Minnesota v. Barber*, 136 U.S. 313 (1890) (undoing state food inspection laws that conflicted with similar federal laws); *Lambert v. Yellowley*, 272 U.S. 581 (1926) (sustaining a federal law restricting the amount of alcohol a physician could dispense for medical purposes); *Hewlett-Packard Company v. Barnes*, 425 F. Supp. 1294, 1301 n.19 (N.D. Cal. 1977) (ERISA withstood Tenth Amendment scrutiny and was supported by the Commerce Clause power); *Stamps v. Collagen Corp.*, 984 F.2d 1416, 1422 (5th Cir. 1993) (federal laws governing medical devices may prevent state law tort claims surrounding those devices); *Slater v. Optical Radiation Corp.*, 961 F.2d 1330 (7th Cir. 1992) (also finding that federal laws governing medical devices may prevent state law tort claims surrounding those devices); *King v. Collagen Corp.*, 983 F.2d 1130 (1st Cir. 1993) (again finding that federal laws governing medical devices may prevent state law tort claims surrounding those devices); see also Mallory Jensen, *Is ERISA Preemption Superfluous in the New Age of Health Care Reform?*, 2011 COLUM. BUS. L. REV. 464, 465 (2011) (arguing that ERISA has "long preempted a variety of state health reform efforts"); *NFIB*, 132 S. Ct. at 2628 (Ginsburg, J.) ("It is more than exaggeration to suggest that the minimum coverage provision improperly intrudes on 'essential attributes of state sovereignty.' First, the Affordable Care Act does not operate 'in [an] are[a] such as criminal law enforcement or education where States historically have been sovereign. As evidenced by Medicare, Medicaid, the Employee Retirement Income Security Act of 1974 (ERISA), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Federal Government plays a lead role in the health-care sector, both as a direct payer and as a regulator.") (internal citations omitted).

132. *NFIB*, 132 S. Ct. at 2607-08; John E. McDonough, *The Road Ahead for the Affordable Care Act*, 367 N. ENGL. J. MED. 199, 200 (2012) (arguing that the ACA's entire Medicaid expansion as well as its "numerous system reforms, such as accountable care organizations, patient-centered medical homes, the Prevention and Public Health Fund, and the Patient-Centered Outcomes Research Institute" were all left unmolested by *NFIB*).

133. Gupta & Sao, *supra* note 96, at 413.

134. *Supra* note 45.

lawyers,¹³⁵ accountants¹³⁶, financial advisors¹³⁷, and air and sea pilots¹³⁸, as well as occupational health and safety more generally.¹³⁹ Yes, some courts have claimed that the states may regulate such standards as part of its Police Power.¹⁴⁰ But state laws in this arena have also been undone when they conflict with federal constitutional powers.¹⁴¹

135. Fred C. Zacharias, *Understanding Recent Trends in Federal Regulation of Lawyers*, PROF. LAW, SYMP. Issue, 1 (2003) (“Federal laws always have governed the practice of law.”). *E.g.*, 8 C.F.R. § 292.3(a)(3) (1994) (pertaining to attorneys practicing before the Immigration and Naturalization Service); 31 C.F.R. § 10.34(a) (1994) (pertaining to attorneys practicing before the Internal Revenue Service); Implementation of Standards of Professional Conduct for Attorneys, 17 C.F.R. 205 (2003) (pertaining to attorneys practicing before the Securities and Exchange Commission).

136. *E.g.*, Sarbanes-Oxley Act of 2002, Pub. L. 107-204 (2002).

137. *E.g.*, Act of Sept. 13, 1960, Pub.L. 86-750 (1960); Act of Dec. 14, 1970, Pub.L. 91-547 (1970).

138. *See supra* Part I.B.

139. *E.g.*, Occupational Safety and Health Act of 1970, 29 U.S.C. §§ 651 et seq. (1970).

140. *E.g.*, *Watson v. Maryland*, 218 U.S. 173, 176 (1910) (“[T]he police power of the states extends to the regulation of certain trades and callings.”); *Goldfarb v. Virginia St. Bar*, 421 U.S. 773, 792–93 (1975) (“[A]s part of their power to protect public health, safety and other valid interests, [states] have broad power to establish standards for licensing practitioners and regulating the practice of the professions”); *Gade v. Nat’l Solid Wastes Mgmt. Ass’n*, 505 U.S. 88, 108 (1992) (holding that the state, as part of its police powers, may license legal professionals); *LeClerc v. Webb*, 419 F.3d 405, 424 (5th Cir. 2005) (stating that a state can prevent nonimmigrant aliens from sitting for the bar as part of its “broad . . . police powers to regulate employment within its borders”) (internal quotations omitted).

141. *Goldfarb*, 421 U.S. at 792; *Ferguson v. Skrupa*, 372 U.S. 726, 731 (1963); *Dent v. West Virginia*, 129 U.S. 114, 122 (1889); *Head v. New Mexico Bd. of Exam’r in Optometry*, 374 U.S. 424, 428-29 (1963) (holding that a law prohibiting certain advertising practices by optometrists could be undone if it unconstitutionally burdened interstate commerce); *Nat’l Pharms., Inc. v. De Melecio*, 51 F. Supp. 2d 45, 56 (D.P.R., 1999) (“The subject laws on the practice of pharmacy within Puerto Rico’s territory constitute a legitimate exercise of its police powers to regulate a profession whose practice affects the health of Puerto Rico’s citizens. These laws, however, must comply with—and are not exempt from—the limitations of the Commerce Clause.”); *Gade*, 505 U.S. at 90-91 (finding that state authority to license attorneys must yield to federal antitrust laws); *see also* *In re Lyon*, 301 Mass. 30, 34-35 (1938) (reasoning that although the “regulation in the public interest of occupations and professions such as those of law, medicine and others which, if uncontrolled, may develop methods and practices inimical to the public welfare, is historically and logically, and we think also legally, a matter primarily of State concern,” that would yield to “any valid rule, order or established practice of the Federal courts controlling the practice of law in respect to matters within their jurisdiction.”); *Dietze v. Siler*, 414 F. Supp. 1105, 1113 (E.D. La. 1976) (“Thus retained is the traditional right of each state to enforce the

B. Meanwhile, the Constitutional Defenses for Federal Oversight of Telemedicine Licensure Are Increasingly Powerful

Support for federal control of telemedicine licensure is found in Congress' Commerce Clause,¹⁴² Necessary and Proper Clause¹⁴³, and Spending powers.¹⁴⁴ Under the Commerce Clause, Congress may regulate or license telemedicine as a channel of interstate commerce, as an instrumentality of interstate commerce, or as an activity that substantially affects interstate commerce,¹⁴⁵ even over Tenth Amendment objections.¹⁴⁶ If Congress cannot regulate telemedicine licensure by relying on the Commerce Clause alone, the Necessary and Proper Clause may "extend" the reach of the Commerce Clause in order to cover it.¹⁴⁷ Lastly, the Spending

standards of state pilotage laws as to acts under state licenses, free of the possibility that the same acts will be subject to federal investigation and the same pilots subject to sanction under federal law.").

142. U.S. CONST. art. I, § 8, cl. 3.

143. U.S. CONST. art. I, § 8, cl. 18.

144. U.S. CONST. art. I, § 8, cl. 1.

145. Born, *supra* note 21, at 210-11 ("[T]he federal government may create a national telemedicine licensing scheme if it can show that telemedicine falls under one of the three categories of commerce power" outlined in *United States v. Lopez*, 514 U.S. 549 (1995)); Jacobson, *supra* note 22, at 436 ("Telemedicine provides a strong justification for national intervention based on the Interstate Commerce Clause."); 2003 Telemedicine Licensure Report, 4 ("The federal government has the authority to play a more active role in setting national licensure standards for certain health professionals, particularly in an area such as telehealth where interstate commerce is clearly involved."); *see also* Matak, *supra* note 97, at 247 ("Since telemedicine involves the administration of public health, a matter traditionally regulated by the states, federal legislation creating a national telemedicine licensing scheme must satisfy the *Lopez* framework . . . Legislation would satisfy the *Lopez* test by defining teledoctors figuratively as the instrumentalities of interstate commerce. Doctors practicing telemedicine are the couriers of medical information, the commodity exchanged across telehealth networks, which serve as the channels of interstate commerce in a national telemedicine scheme.").

146. Born, *supra* note 21, at 199 (arguing that although states "have traditionally governed the practice of medicine and physician licensure, "because of the national scope of telemedicine, the federal government could pre-empt state regulation in this area to promote the practice of telemedicine across state lines."); Lewis, *supra* note 22, at 587-88 (reasoning that because "[t]he interstate nature of the Internet and the unconventional medical relationships spawned by cybermedicine render state attempts at taming the growing use of medico-cyberspace feeble and ineffective . . . the federal government can regulate cybermedicine under the Commerce Clause.").

147. Mark A. Hall, *Commerce Clause Challenges to Health Care Reform*, 159 U. PA. L. REV. 1825, 1847 (2011); *Gonzales v. Raich*, 545 U.S. at 34-35 (2005) (explaining that the Necessary and Proper Clause lets the Commerce Clause

power could support a federal spending program implementing telemedicine licensure if such a program “provides for the general welfare of the citizens of this country.”¹⁴⁸

Importantly, each of these constitutional defenses is buoyed by the fact that “assertions of federal power” have, with few exceptions,¹⁴⁹ “seemed unassailable since the New Deal.”¹⁵⁰

Contemporary Commerce Clause doctrine gives Congress a virtual “blank check” to regulate “the production, distribution, and consumption of anything.”¹⁵¹ The Necessary and Proper Clause has also been recently fortified.¹⁵² Lastly, the Spending power remains “extremely broad” and, though it has been “relied on . . . to accomplish a large number of . . . policy objectives,” it is “rarely”

power reach activities that “substantially affect interstate commerce” but are not “themselves part of interstate commerce” and are therefore off-limits under the Commerce Clause alone, as well as “*intrastate* activities that do not themselves substantially affect interstate commerce,” if doing so is necessary to make a regulation of interstate commerce effective); Wilson R. Huhn, *Constitutionality of the Patient Protection and Affordable Care Act Under the Commerce Clause and the Necessary and Proper Clause*, 32 J. LEG. MED. 139 (2011) (arguing that the Necessary and Proper Clause supported the ACA).

148. Born, *supra* note 21, at 211-12; Matak, *supra* note 97.

149. Rebecca Buckwalter-Poza, *How Obamacare Will Be Settled: A Primer on the Commerce Clause*, THE ATLANTIC, (Mar. 26, 2012, 8:06 AM), <http://www.theatlantic.com/national/archive/2012/03/how-obamacare-will-be-settled-a-primer-on-the-commerce-clause/254872/> (“The Rehnquist Court limited the exercise of the Commerce Clause in a pair of critical cases in 1995 and 2000, but returned to the prior, expanded view of the power based on the same criteria [in *Gonzales v. Raich*, 545 U.S. 1 (2005)].”).

150. Linda Greenhouse, *The Revolution Next Time?*, N.Y. TIMES (Dec. 16, 2010, 8:00 PM), <http://opinionator.blogs.nytimes.com/2010/12/16/the-revolution-next-time/>; *see also infra* notes 153-155.

151. Scott Boykin, *The Commerce Clause, American Democracy, and the Affordable Care Act*, 10 GEO. J.L. & PUB. POL'Y 89, 109 (2012) (quoting *United States v. Lopez*, 514 U.S. 549, 602 (1995) (Thomas, J., concurring)). *See also* Alicia Ouellette, *Health Reform and the Supreme Court: The ACA Survives the Battle of the Broccoli and Fortifies Itself Against Future Attack*, 76 ALB. L. REV. 87, 95 (2013) (arguing that the “settled rule” is that “Congress [can] regulate virtually anything that affected interstate commerce.”); Randy E. Barnett, *Revisiting the Constitution: Amend the Commerce Clause*, N.Y. TIMES (July 8, 2012, 10:01 PM), <http://www.nytimes.com/roomfordebate/2012/07/08/another-stab-at-the-us-constitution/revisiting-the-constitution-amend-the-commerce-clause> (“[P]ost-New Deal Supreme Court precedents . . . have allowed Congress to exercise powers well beyond the original meaning of the commerce clause.”).

152. Lauren E. Marsh, *The Revival of the “Sweeping Clause”: An Analysis of Why the Supreme Court Had to “Breathe New Life” into the Necessary and Proper Clause in United States v. Comstock*, AMER. UNIV. CRIM. LAW Brief 5, no.2, 34 (2010).

the subject of constitutional challenges.¹⁵³ Because of all this, when the lawsuits against the ACA were first filed, “the overwhelming consensus among constitutional scholars was that the claim that Congress lacked the authority to pass the ACA was specious.”¹⁵⁴ And they have treated the claim that Congress lacks the authority to pass telemedicine licensure reform as specious, too.¹⁵⁵ Scholars have even directly stated that either the Commerce Clause or the Spending power could support federal telemedicine licensure, even in the face of Tenth Amendment claims about the traditional power of states to oversee health.¹⁵⁶

The “conflict” between these two forces (the states’ traditional police power to regulate health and the ever-expanding constitutional powers of Congress), as well as the fact that courts have not addressed this conflict,¹⁵⁷ has long created a “question”¹⁵⁸

153. Eloise Pasachoff, *Conditional Spending After NFIB v. Sebelius: The Example of Federal Education Law*, 62 AM. UNIV. L. REV. 577, 589-90 (2013).

154. Ouellette, *supra* note 151, at 94-95.

155. Daniel J. Gilman, *Physician Licensure and Telemedicine: Some Competitive Issues Raised by the Prospect of Practising Globally While Regulating Locally*, 14 J. HEALTH CARE L. & POL’Y 87, 115 (2011) (stating that in telemedicine licensure, the fact that licensing has “traditionally been ceded to the states” is a “political problem more than a constitutional one” because “the extension or application of commerce clause authority into diverse areas of health and safety regulation has been frequent and largely sustained, at least since the New Deal.”).

156. Gupta, *supra* note 96, at 427-33; Goehring, *supra* note 97, at 112 (2009) (“The Tenth Amendment . . . grants states the power to regulate the practice of medicine. . . . This grant, however, does *not* preclude the federal government from regulating telemedicine. . . . [Because] the expansion of telemedicine will likely take medical practice across state lines . . . telemedicine could fall under the umbrella of interstate commerce.”) (emphasis in original); Cohen, *supra* note 94 (“Although state authority over health care regulation is historically rooted in the Tenth Amendment of the U.S. Constitution, the Constitution also arguably provides grounds for federal authority over the practice of cross-border telemedicine through the Interstate Commerce and Spending Power Clauses.”); *see also* Young, *supra* note 90, 194-95 (stating that the same is true of physician licensure in general).

157. 2011 Health Licensing Board Report, *supra* note 9, 6-7 (Although states regulate the “practice of clinical care” under the Police Power, that power “may not be absolute” because the Commerce Clause “limits states’ ability to erect barriers against interstate trade and the practice of healthcare has been held to be interstate trade for the purpose of antitrust laws,” but noting that this “potential conflict between the states’ power to regulate health professionals and the prohibition against restraints on interstate commerce has not been addressed by the courts.”).

158. Goehring, *supra* note 97, at 112.

or “dilemma”¹⁵⁹ about the constitutionality and prospects for federal telemedicine licensure reform. Luckily, the courtroom aftermath of the passage of the ACA—another instance of federal health reform, albeit on a broader scale—has given courts an opportunity to dispel some of this ambiguity.¹⁶⁰ Specifically, the *NFIB* and *Lew* courts’ analyses of the interlocking set of constitutional provisions which bear on the federal telemedicine licensure reform’s constitutionality (namely, the Tenth Amendment and the Commerce, Necessary and Proper, and Taxing and Spending clauses) have cemented the notion that such reform is constitutional.¹⁶¹

IV. THE LEGAL CHALLENGES TO THE ACA HAVE IMPROVED THE OUTLOOK FOR FEDERAL TELEMEDICINE LICENSURE REFORM

In 2010, Congress enacted the ACA “to increase the number of Americans covered by health insurance and decrease the cost of health care.”¹⁶² From the start, it was “hotly criticized as an affront to state power”¹⁶³ and its constitutionality was debated.¹⁶⁴ States

159. Carolyn M. Hutcherson, *Legal Considerations for Nurses Practicing in a Telehealth Setting*, 6 ONLINE J. ISSUES NURSING 4 (2001), available at <http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume62001/No3Sept01/LegalConsiderations.aspx> (“A second regulatory dilemma is whether jurisdiction over telemedicine/telehealth will remain in the domain of traditional State’s Rights provisions (as is most traditional health care) with the issues being resolved by the states, or whether the practice will be deemed as interstate commerce.”).

160. See *infra* Part III.

161. *Id.*

162. *NFIB v. Sebelius*, 132 S. Ct. 2566, 2580 (2012).

163. Brendan S. Maher & Radha A. Pathak, *Enough About the Constitution: How States Can Regulate Health Insurance Under the ACA*, 31 YALE L. & POL’Y REV. 275, 276 (2013).

164. *E.g.*, Robert Book, *Could the PPACA’s Medicaid Expansion be Unconstitutional?*, FORBES (Jan. 27, 2012), <http://www.forbes.com/sites/aroy/2012/01/27/could-the-ppacas-medicaid-expansion-be-unconstitutional/>; Mark A. Hall, *The Constitutionality of Mandates to Purchase Health Insurance*, 37 J. L. MED. & ETHICS (Specialty Supplement S2) 38, 41 (2009) (“either state or federal mandates for either individuals or employers to purchase health insurance will pass scrutiny under the U.S. Constitution.”); Seth Stern, *Sharpening Clause*, CQ WKLY., Feb. 7, 2011, at 292, 296 (“Charles Fried, a Harvard Law School professor . . . called [Constitutional challenges to the ACA] ‘ridiculous[]’ . . . [and, if they succeeded] offered to ‘come on [Fox News] and eat a hat . . . made of kangaroo skin’); Andrew Koppelman, *Bad News for Mail Robbers: The Obvious Constitutionality of Health Care Reform*, 121 YALE L.J. ONLINE 1 (2011), (“the constitutional objections are silly”); J. Kenneth Blackwell & Kenneth A. Klukowski, *Why The ObamaCare Tax Penalty Is Unconstitutional*, WALL ST. J. (July 22, 2010, 12:01 AM), <http://www.wsj.com/>

resisted its provisions¹⁶⁵ and, arguing that it violated state sovereignty,¹⁶⁶ initiated constitutional challenges to it “minutes after the President signed” it into law.¹⁶⁷ Most have failed.¹⁶⁸ But in failing, they have strengthened the constitutional grounds for future federal health legislation, including telemedicine licensure reform. Most impactful in this regard has been *NFIB*, the 2012 Supreme Court decision that has been called “the most significant federalism decision since the New Deal.”¹⁶⁹ But lower court decisions, including *Lew*, have also played an important supporting role. Let

articles/SB10001424052748703724104575378910443018730; Ryan C. Patterson, “Are You Serious?": Examining the Constitutionality of an Individual Mandate for Health Insurance, 85 NOTRE DAME L. REV. 2003 (2010); Ilya Shapiro, *A Long, Strange Trip: My First Year Challenging the Constitutionality of Obamacare*, 6 FIU L. REV. 29 (2010).

165. Rhodan, *supra* note 4 (“Thirty-four states have refused to establish their own exchanges.”).

166. Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 434 (2014) (“The states have claimed . . . that the PPACA violate principles of federalism and the Tenth Amendment and that Medicare expansion is an ‘unprecedented encroachment’ on the sovereignty of states”) (citing Complaint at 4, Florida ex rel. Att’y Gen. v. U.S. Dep’t Health & Human Servs., 780 F. Supp. 2d 1256 (N.D. Fla. 2011) (No. 3:10-cv-91) (alleging that the ACA exceeds Congress’ enumerated powers and violates the Tenth Amendment)).

167. Florida ex rel. Att’y Gen., 780 F. Supp. 2d at 1263; *see generally* Warren Richey, *Attorneys General in 11 States Poised to Challenge Healthcare Bill*, CHRISTIAN SCI. MONITOR (Mar. 22, 2010), <http://www.csmonitor.com/USA/Justice/2010/0322/Attorneys-general-in-11-states-poised-to-challenge-healthcare-bill>; Kevin Sack, *Terrain Shifts in Challenges to the Health Care Law*, N.Y. TIMES, Dec. 28, 2010, at A10.

168. *E.g.*, Mead v. Holder, 766 F. Supp. 2d 16, 33-35 (D.D.C.), *aff’d*, *Seven-Sky v. Holder*, 661 F.3d 1 (D.C. Cir. 2011); Thomas More Law Ctr. v. Obama, 720 F. Supp. 2d 882 (E.D. Mich. 2010), *aff’d*, 651 F.3d 529 (6th Cir. 2011); Liberty Univ. v. Geithner, 753 F. Supp. 2d 611 (W.D. Va. 2010), *vacated*, 671 F.3d 391 (4th Cir. 2011); Virginia ex rel. Cuccinelli v. Sebelius, 702 F. Supp. 2d 598 (E.D. Va. 2010), *rev’d*, 656 F.3d 253 (4th Cir. 2011); Goudy-Bachman v. U.S. Dep’t of Health & Human Svcs., 764 F. Supp. 2d 684 (M.D. Pa. 2011); Peterson v. United States, 774 F. Supp. 2d 418 (D.N.H. 2011); Calvey v. Obama, 792 F. Supp. 2d 1262 (W.D. Okla. 2011); N.J. Physicians, Inc. v. Obama, 757 F. Supp. 2d 502 (D.N.J. 2010), *aff’d*, 653 F.3d 234 (3d Cir. 2011); Bryant v. Holder, 809 F. Supp. 2d 563 (S.D. Miss. 2011); Baldwin v. Sebelius, No. 10-cv-1033, 2010 WL 3418436 (S.D. Cal. Aug. 27, 2010), *aff’d*, 654 F.3d 877 (9th Cir. 2011); Sissel v. U.S. Dep’t Health & Human Servs., 951 F. Supp. 2d 159 (D.D.C. 2013), *aff’d*, 760 F.3d 1 (D.C. Cir. 2014); Halbig v. Sebelius, 27 F. Supp. 3d 1 (D.D.C.), *rev’d*, Halbig v. Burwell, 758 F.3d 390 (D.C. Cir. 2014); *cf.* King v. Burwell, 759 F.3d 358 (4th Cir.), *cert. granted*, 135 S.Ct. 475 (2014).

169. Adam Liptak, *Supreme Court Upholds Health Care Law, 5-4, in Victory for Obama*, N.Y. TIMES, June 28, 2012, at A1.

us examine each of these decisions and their pertinent Constitutional holdings.

A. NFIB Did Not Curb the Ability of the Commerce and Necessary and Proper Clause Powers to Support Federal Telemedicine Licensure Reform and Bolstered the Ability of the Taxing and Spending Clause to Support Federal Telemedicine Licensure Reform

In *NFIB*, the Supreme Court, for the first time, considered the constitutionality of certain parts of the ACA. *NFIB*'s underlying action began in 2010, when Florida and twenty-five other states sued the U.S. Department of Health and Human Services ("HHS") in the U.S. District Court for the Northern District of Florida, challenging the constitutionality of the ACA.¹⁷⁰ Specifically, these states challenged the so-called "individual mandate" (the part of the ACA requiring most Americans to obtain health insurance by 2014) as well as the parts of the ACA that reduced the Medicaid funding of states that did not comply with its terms.¹⁷¹ The District Court granted the HHS summary judgment with respect to the Medicaid claim.¹⁷² It also found that the individual mandate was beyond Congress's Commerce and Necessary and Proper Clause powers¹⁷³ and, since it found the mandate could not be severed from the rest of the ACA, struck down the entire ACA.¹⁷⁴ On appeal, the Eleventh Circuit Court of Appeals affirmed the District Court's holding that the individual mandate was unconstitutional, but, contrary to the District Court, held that the individual mandate *could* be severed, leaving the rest of the ACA intact.¹⁷⁵ On November 14, 2011, the U.S. Supreme Court granted certiorari to the appeal of that decision and two related cross-appeals of the Eleventh Circuit's opinion, including one filed by the National Federation of Independent Business.¹⁷⁶

On the eve of the *NFIB* decision, it was unclear what the Court would do. Would it follow the Police Power cases cited by the Eleventh Circuit¹⁷⁷ that kept health regulation in the hands of the

170. Florida ex rel. Att'y Gen., 780 F. Supp. 2d at 1256.

171. *Id.* at 1265-66.

172. *Id.* at 1269.

173. *Id.* at 1273-99.

174. *Id.* at 1299.

175. Florida ex rel. Att'y Gen. v. U.S. Dep't Health & Human Servs., 648 F.3d 1235, 1320-28 (11th Cir. 2011), *aff'd in part and rev'd in part sub nom.*, *NFIB v. Sebelius*, 132 S. Ct. 2566 (2012).

176. *Id.*

177. *Id.* at 1305 ("The health care industry...falls within the sphere of traditional state regulation.") (citing *Gonzales v. Oregon*, 546 U.S. 243, 270; (2006);

states, strike down some or all of the ACA, and thus cast doubt on future federal health regulation efforts like telemedicine licensure reform?¹⁷⁸ Would the Court, inspired by *Raich* and *Oregon*, uphold the ACA's challenged provisions under Congress' Commerce Clause power, providing a foundation in that clause for future federal regulation of health?¹⁷⁹ Or would the Court find support in another constitutional provision, establishing that provision as a future foundation for federal regulation?¹⁸⁰ In the end, the decision split these categories, finding support for the individual mandate in Congress' Taxing and Spending Power,¹⁸¹ but undoing the Medicaid provisions of the ACA as a "coercive" exercise of the Spending Power.¹⁸² Further, in reaching their decision, the Court both declined to substantively restrict the Commerce Clause and Necessary and Proper Clause's broad abilities to support federal telemedicine licensure reform and shored up the ability of the Spending Power to support such reform.¹⁸³ A clause-by-clause survey of *NFIB*'s holding and opinions reveals why this is so.

1. *NFIB*'s Commerce Clause Holding Demonstrates that Federal Telemedicine Licensure Reform Will Find Support in This Clause

In *NFIB*, a majority of Justices declined to find that the Commerce Clause power supported the individual mandate, reversing the 11th Circuit.¹⁸⁴ But it is clear that this ruling is a narrow

Hill v. Colorado, 530 U.S. 703, 715 (2000); Barnes v. Glen Theatre, Inc., 501 U.S. 560, 569 (1991); Head v. New Mexico Bd. of Exam'rs in Optometry, 374 U.S. 424, 428 (1963); Barsky v. Bd. of Regents of New York, 347 U.S. 442, 449 (1954); Jacobson v. Massachusetts, 197 U.S. 11, 25 (1905); Gonzales v. Raich, 545 U.S. 1, 42 (2005) (O'Connor, J., dissenting); see also *supra* note 99.

178. David B. Rivkin Jr. & Lee A. Casey, *The Supreme Court Weighs ObamaCare*, WALL ST. J. (Mar. 21, 2012, 7:16 PM), <http://www.wsj.com/articles/SB10001424052702304636404577291883293776326>.

179. Greg Stohr, *Obama Health Care Hangs on Clause Queried by U.S. Court*, BLOOMBERG NEWS (May 23, 2012, 3:04 PM), <http://www.bloomberg.com/news/articles/2012-05-23/obama-health-care-hangs-on-clause-queried-by-u-s-court>; cf. Boykin, *supra* note 153, at 111.

180. See Buckwalter-Poza, *supra* note 149, at 2.

181. See *NFIB v. Sibelius*, 132 S. Ct. 2566, 2593-2601 (2012) (Roberts, C.J.); *Id.* at 2628-29 (Ginsburg, J., joined by Breyer, Sotomayor, Kagan, JJ.).

182. *Id.* at 2601-09, 2629-42.

183. See *infra* Part III.B.1.

184. *NFIB*, 132 S. Ct. at 2585-91 (Roberts, C.J.); *id.* at 2642-50 (Scalia, J., concurring); *id.* at 2677 (Thomas, J.); but see *id.* at 2615-2625 (Ginsburg, J., dissenting) (finding power under Commerce Clause to support individual mandate).

one, constrained by the anomalous facts of the case, which are highlighted in the majority opinions of Chief Justice John Roberts and Justice Antonin Scalia. Because it is so narrow, *NFIB's* Commerce Clause ruling does not disturb the broad reading of the Clause that has powered federal legislation since the New Deal.¹⁸⁵ That precedent, which is on display in Ginsburg's minority opinion, indicates that federal telemedicine licensure reform will find support in the Commerce Clause.¹⁸⁶ Thus, the net effect of *NFIB's* Commerce Clause ruling on such reform is *positive*.

a. *NFIB's* Commerce Clause Holding, Limited by Its Unprecedented Facts, Will Not Be Applied to Hamper Federal Telemedicine Licensure Reform

Although, in *NFIB*, a majority of Justices declined to find that the Commerce Clause supported the individual mandate, this ruling is too limited by its facts to hamper federal telemedicine licensure reform. In fact, the unique facts surrounding the individual mandate played such a pivotal role that *NFIB's* Commerce Clause ruling may apply “only to individual mandates or regulations predicated on forced participation in a national market.”¹⁸⁷ The pivotal role played by these facts is clear from the individual opinions¹⁸⁸ of the two Justices who wrote on the topic (Chief Justice

185. *Id.* at 2586-87, 2642-48.

186. *Id.* at 2615-25.

187. Lawrence B. Solum, *How NFIB v. Sebelius Affects the Constitutional Gestalt*, 91 WASH. U. L. REV. 1, 34 (2013); see also Mark D. Rosen & Christopher W. Schmidt, *Why Broccoli? Limiting Principles and Popular Constitutionalism in the Health Care Case*, 61 UCLA L. REV. 66, 79 (2013) (*NFIB* engaged in “localist reasoning” by narrowly answering the Commerce Clause question before it); Michael M. Rosen, *The New Textualists' Finest Hour?*, THE AMERICAN (June 28, 2012), <http://www.aei.org/publication/the-new-textualists-finest-hour/> (*NFIB's* Commerce Clause ruling was “narrow”); ‘Up w/ Chris Hayes’ for Saturday June 30, 2012, (MSNBC television broadcast June 30, 2012) (according to Randy Barnett, professor at Georgetown University Law Center, *NFIB's* Commerce Clause ruling “only applies to [the individual mandate], so it’s a narrow ruling.”).

188. Importantly, the precedential value of the individual Justice’s *NFIB* opinions is debatable. See *Liberty Univ. v. Lew*, 733 F.3d 72, 92-95 (4th Cir. 2013) (it is debated whether Roberts’ Commerce Clause analysis was dicta or precedent); *United States v. Henry*, 688 F.3d 637, 641 n.5 (9th Cir. 2012) (“There has been considerable debate about whether the statements about the Commerce Clause [in *NFIB*] are dicta or binding precedent.”); *United States v. Robbins*, 729 F.3d 131, 135 (2d Cir. 2013) (“*NFIB* may not say anything binding about the Commerce Clause at all” and “is not clear whether anything said about the Commerce Clause in *NFIB's* primary opinion—that of Chief Justice Roberts—is more than dicta”) (citations omitted); *United States v. Spann*, 2012 U.S. Dist. LEXIS 136282, at *8

John Roberts and Justice Antonin Scalia), each of which highlights the unprecedented nature of the legislation before the Court.¹⁸⁹

Roberts, for example, who found that the Commerce Clause could not support the individual mandate, was clearly influenced by the fact that the mandate is a “legislative novelty”¹⁹⁰ as well as an unprecedented attempt by to rely on its Commerce Clause power “to compel individuals not engaged in commerce to purchase an unwanted product.”¹⁹¹ Said Roberts, the “power to *regulate* commerce presupposes the existence of commercial activity to be regulated.”¹⁹² But the individual mandate does not regulate existing commercial activity.¹⁹³ Instead, it compels individuals to *become active* in commerce by buying insurance (on the ground that not doing so affected interstate commerce).¹⁹⁴ “Construing the Commerce Clause to permit Congress to regulate individuals precisely *because* they are doing nothing would open a new and potentially vast domain to congressional authority,”¹⁹⁵ something Roberts refused to do.

Scalia, the only other Justice to write discursively on the topic, also found that the Commerce Clause could not support the individual mandate.¹⁹⁶ Like Roberts, Scalia was moved to find this way because of the anomalous facts.¹⁹⁷ At the outset, Scalia called this aspect of *NFIB* a “question[] of first impression” which asks if the “failure to engage in economic activity (the purchase of health insurance) is subject to regulation under the Commerce Clause”.¹⁹⁸ He then noted that the individual mandate did not apply “only to persons who purchase all, or most, or even any, of the health care services or goods that the mandated insurance covers.”¹⁹⁹ Rather, it covered only those who “have no intention of purchasing most or even any of such goods or services and thus no need to buy insurance for those purchases.”²⁰⁰ This meant the size of the

(N.D. Tex. Oct. 9, 2012); *see also* United States v. Roszkowski, 700 F.3d 50, 58 n.3 (1st Cir. 2012) (declining to opine on *NFIB*'s precedential value).

189. *See NFIB*, 132 S. Ct. at 2586 (Roberts, C.J.); *id.* 2642 (Scalia, J., joined by Kennedy, Thomas, and Alito, JJ.).

190. *NFIB*, 132 S. Ct. at 2586 (Roberts, C.J.).

191. *Id.*

192. *Id.* at 2586.

193. *Id.* at 2587.

194. *Id.*

195. *Id.*

196. *Id.* at 2642.

197. *Id.*

198. *Id.*

199. *Id.* at 2647.

200. *Id.*

“market” Congress felt it could regulate under the Commerce Clause was “essentially universal.”²⁰¹ Scalia said that such a “definition of market participants” was “unprecedented” and if it “were it to be a premise for the exercise of national power...would have no principled limits.”²⁰² This, Scalia said, “exceeds federal power” and was unconstitutional.²⁰³

Because the decision rested on these unusual facts, it has not, as some have predicted,²⁰⁴ been applied broadly to prevent the Commerce Clause from supporting federal regulation. In fact, those lower courts that have not entirely avoided *NFIB* because of its dicta issue²⁰⁵ have used its facts to distinguish it from their own cases,²⁰⁶

201. *Id.* at 2648.

202. *Id.*

203. *Id.*

204. Liptak, *supra* note 169 (quoting Akhil Reed Amar, Yale Law School professor, as saying that, because of *NFIB*'s “new limits on regulating commerce,” this “[f]ederal power has more restrictions on it”); Ouellette, *supra* note 151, at 87 (the *NFIB* ruling “diminished the authority of Congress under the Commerce [Clause]”).

205. *United States v. Robbins*, 729 F.3d 131, 135 (2d Cir. 2013) (refusing, because the *NFIB* opinions were possibly dicta, to find that “*NFIB* alters [the] understanding of the Commerce Clause as to undermine the holding [of an earlier Commerce Clause case, *United States v. Guzman*, 591 F.3d 83 (2d Cir. 2010)]”).

206. *Roszkowski v. United States*, 700 F.3d 50, 57-59 (1st Cir. 2012) (*NFIB*'s Commerce Clause ruling did not apply to federal laws regulating the possession of firearms when those statutes do not “compel[] individuals to become active in commerce,” but instead “prohibit affirmative conduct that has an undeniable connection to interstate commerce”); *Nat'l Collegiate Athletic Ass'n v. Governor of New Jersey*, 730 F.3d 208, 244 (3d Cir. 2013) (*NFIB*'s Commerce Clause ruling did not apply to federal laws banning the transmission of sports bets because its “method of regulation” was “banning an activity altogether,” whereas, in *NFIB*, “the *method* chosen to regulate” was “forcing into economic activity individuals previously not in the market for health insurance”); *United States v. Howell*, 557 Fed. App'x. 579, 580 (7th Cir. 2014) (“[*NFIB*] concluded that the Commerce Clause does not afford much scope for the regulation of inactivity” and therefore did not apply to a defendant who was engaged in “interstate travel [which] lies at the core of the national power under the Commerce Clause.”); *Senne v. Village of Palatine, Ill.*, 695 F.3d 617, 620 (7th Cir. 2012) (*NFIB*'s Commerce Clause analysis did not apply where “there is no instance of the federal government forcing a state or an individual to participate in an interstate market.”); *United States v. Kiste*, 2013 U.S. Dist. LEXIS 19481, at *17 (N.D. Ind. Feb. 13, 2013) (*NFIB*'s Commerce Clause ruling did not apply to a law that “does not regulate inactivity, nor does it involve the regulation of commerce by compelling its existence.”); *United States v. Cabrera-Gutierrez*, 718 F.3d 873, 879 (9th Cir. 2013) (*NFIB* did not apply because of the act at issue, which “punish[ed] . . . inactivity”); *United States v. Henry*, 688 F.3d 637, 641 n.5 (9th Cir. 2012) (“[*NFIB*] involved a requirement that individuals take action” and therefore did not apply to the statutes at issue, which involved “a *prohibition* of conduct.”); *United States v.*

or have interpreted its Commerce Clause holding narrowly, as placing a precise limit on the use of the Clause to regulate *inactivity*.²⁰⁷ But federal telemedicine licensure, by definition, regulates activity: the practice of medicine.²⁰⁸ Further, it does not “compel individuals not engaged in commerce to purchase an unwanted product,”²⁰⁹ but instead compels physicians, who are willing participants in the stream of commerce, to secure licensure.²¹⁰ Lastly, federal telemedicine licensure would not be an “unprecedented” endeavor without “principled limits,”²¹¹ given the history of federal involvement in licensure²¹² and in health,²¹³ as well as such reform’s circumscribed focus on the licensure of those who practice telemedicine. For all these reasons, future courts are likely to continue to refuse to apply *NFIB*’s Commerce Clause ruling in order to constrain federal telemedicine licensure reform.

b. *NFIB*’s Narrow Commerce Clause Ruling Does Not Upset Existing Commerce Clause Jurisprudence, Which Grants Congress Broad Power to Regulate Telemedicine Licensure.

Because the *NFIB* ruling was so limited, it does not disturb existing Commerce Clause precedent, which is highly deferential to Congress and authorizes federal telemedicine licensure.²¹⁴ As

Spann, 2012 U.S. Dist. LEXIS 136282, at *13-15 (N.D. Tex. Oct. 9, 2012) (regardless of whether the Roberts opinion was valid precedent, it would not apply “where the statute in question does not *compel* individuals to act—let alone purchase a product—but rather *prohibits* individuals from acting.”); United States v. Sullivan, 753 F.3d 845, 854 (9th Cir. 2014) (*NFIB* did not apply to statutes that “do not compel commerce, but merely regulate an activity that Congress could rationally determine would affect interstate commerce, taken in the aggregate.”).

207. *E.g.*, Liberty Univ. v. Lew, 733 F.3d 72, 92-93 (4th Cir. 2013).

208. *Gonzales v. Oregon*, 546 U.S. 243, 243 (2006) (failing to challenge the CSA’s regulation of “the *activity* of physicians.”) (emphasis added).

209. *Id.*

210. *Id.* at 302 n.2, (Thomas, J., dissenting) (“[R]espondent-physicians are active participants in the interstate controlled substances market.”).

211. *Id.*

212. *See supra* Part II.B, Part III.B.

213. *See supra* Part III.A.

214. *See* United States v. Williams, 2012 U.S. Dist. LEXIS 110371, at *8 (“While, in [*NFIB*], the Court found Congress’s attempt to require everyone to buy health insurance exceeded its power under the commerce clause, the decision reaffirmed that “[t]he power of Congress over interstate commerce is not confined to the regulation of commerce among the states,’ but extends to activities that ‘have a substantial effect on interstate commerce,’” and, “moreover, is not limited to regulation of an activity that by itself substantially affects interstate commerce, but also extends to activities that do so only when aggregated with similar activities of others.”) (quoting *NFIB*, 132 S. Ct. at 2585-86).

Justice Ginsburg wrote in *NFIB*, presaging the views of courts and scholars,²¹⁵ “if history is any guide, today's *constriction* of the Commerce Clause will not endure.”²¹⁶ Indeed, this Clause “has been interpreted since 1937 as giving Congress virtually plenary authority.”²¹⁷ Since then, the Supreme Court “has sustained all major Commerce Clause legislation”²¹⁸ and “upheld every federal statute (with two trivial exceptions) after applying an extremely deferential standard of review”—specifically, whether there was a “rational basis for concluding that the activity regulated, taken in the aggregate nationwide, ‘substantially affects’ interstate commerce.”²¹⁹ This precedent is well-encapsulated in *NFIB* in the individual opinion of Ginsburg.²²⁰

The Commerce Clause analysis in that opinion, written for the minority of Justices who found that the Commerce Clause *did* support the mandate,²²¹ dovetails with precedent and thus reflects

215. United States v. Rose, 714 F.3d 362, 371 (6th Cir. 2013) (*NFIB* “did nothing to abrogate [the] holding in *Raich* that Congress has the power to regulate purely local activities that are part of an economic class of activities that have a substantial effect on interstate commerce”); Robert J. Pushaw Jr. & Grant S. Nelson, *The Likely Impact of National Federation on Commerce Clause Jurisprudence*, 40 PEPP. L. REV. 975, 979 (2013).

216. *NFIB*, 132 S. Ct. at 2652 (2012) (emphasis added).

217. Pushaw & Nelson, *supra* note 215, at 976; see also Lainie Rutkow & Jon S. Vernick, *The U.S. Constitution's Commerce Clause, the Supreme Court, and Public Health*, 126 PUB. HEALTH REP. 750, 750 (2011).

218. Pushaw & Nelson, *supra* note 215, at 979.

219. *Id.* at 976 (citing *Gonzales v. Raich*, 545 U.S. 1, 13-27 (2005)); see also Seth J. Safra, *The Amended Gun-Free School Zones Act: Doubt as to Its Constitutionality Remains*, 50 DUKE L. J. 2, 11 n.63 (2000) (listing cases). The “two trivial exceptions” were *Lopez* and *Morrison*. *Lopez* held that a federal law prohibiting the possession of a firearm near a school was beyond the Commerce Clause power because “possession of a gun in a local school zone is in no sense an economic activity that might . . . substantially affect any sort of interstate commerce.” *Lopez*, 514 U.S. at 567. *Morrison* held that a law creating a federal cause of action for victims of gender-motivated violence was also beyond the Commerce Clause power because “[g]ender-motivated crimes of violence are not, in any sense of the phrase, economic activity.” *United States v. Morrison*, 529 U.S. 598, 613 (2000). In *Raich*, the Court returned to a broad reading of the power. *Gobis*, *supra* note 112.

220. Robert J. Pushaw Jr., *The Paradox of the Obamacare Decision: How Can the Federal Government Have Limited Unlimited Power?*, 65 FLA. L. REV. 1993, 2011 (2013) (arguing that Ginsburg had the “better reading” of Commerce Clause case law).

221. *NFIB*, 132 S. Ct. at 2615-25 (Ginsburg, J., joined by Breyer, Sotomayor, Kagan, JJ., concurring in part, concurring in the judgment in part, and dissenting in part).

how courts will treat federal telemedicine licensure reform.²²² Ginsburg opens by stating that, with regard to the Commerce Clause, the Court “afford[s] Congress the leeway to solve national problems directly and realistically.”²²³ Its approach to judging whether Congress validly exercised its Commerce power is “guided by two familiar principles.”²²⁴ First, Congress may regulate activities “that substantially affect interstate commerce;”²²⁵ this “*capacious* power,” said Ginsburg, “extends even to local activities that, viewed in the aggregate, have a substantial impact on interstate commerce.”²²⁶

Second, the Court “owe[s] a large measure of respect to Congress when it opts to regulate an activity”;²²⁷ it asks “only (1) whether Congress had a ‘rational basis’ for concluding that the regulated activity substantially affects interstate commerce, and (2) whether there is a ‘reasonable connection between the regulatory means selected and the asserted ends.’”²²⁸ Further, in answering

222. Pushaw & Nelson, *supra* note 215, at 990.

223. *NFIB*, 132 S. Ct. at 2616 (citing *Am. Power & Light Co. v. SEC*, 329 U.S. 90, 103 (1946)).

224. *Id.*

225. *Id.* (internal quotations omitted) (quoting *Gonzales v. Raich*, 545 U.S. at 17 (2005)); see also *United States v. Lopez*, 514 U.S. 549, 557-59 (1995).

226. *NFIB*, 132 S. Ct. at 2616 (emphasis added) (citing *Raich*, 545 U.S. at 17; *Wickard v. Filburn*, 317 U.S. 111, 125 (1942); *NLRB v. Jones & Laughlin Steel Corp.*, 301 U.S. 1, 37 (1937)); see also *United States v. Downs*, 299 Fed. App’x 310 (5th Cir. 2008) (citing *NLRB*, 301 U.S. at 31; *United States v. Ho*, 311 F.3d 589, 599-602 (5th Cir. 2002); *United States v. Robinson*, 119 F.3d 1205, 1208 (5th Cir. 1997)). This rule is particularly important because, as critics of federal licensure have highlighted, telemedicine is not solely an interstate affair. *Ameringer*, *supra* note 21, at 64 (“Among the many problems with the concept of a national license for telemedicine is that such a license would purport to cover not just interstate, but also intrastate transactions”); Kathleen M. Vyborny, *Legal and Political Issues Facing Telemedicine*, 5 *ANNALS HEALTH L.* 61, 95-96 (1996) (“[T]he federal government may have no power to govern medical practice matters until they spill over state borders,” but telecommunications “create this interstate potential and invite federal involvement in this historically insular category of state regulation”); *Matak*, *supra* note 97, at 247 (asserting that federal telemedicine licensure legislation would be authorized by the Commerce Clause only if it regulated the interstate aspects of telemedicine and avoided the areas of health care administration which traditionally belong to the states).

227. *NFIB*, 132 S. Ct. at 2616 (citing *Raich*, 545 U.S. at 17; *Pension Benefit Guaranty Corp. v. R. A. Gray & Co.*, 467 U.S. 717, 729 (1984); *Hodel v. Indiana*, 452 U.S. 314, 326 (1981)).

228. *Id.* at 2616-2617 (citing *Hodel v. Indiana*, 452 U.S. 314, 323-324 (1981); *Raich*, 545 U.S. at 22; *Lopez*, 514 U.S. at 557; *Hodel v. Va. Surface Mining*, 452 U.S. 264, 277 (1981); *Katzenbach v. McClung*, 379 U.S. 294, 303 (1964); *Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241, 258 (1964); *United States v. Carolene Prods. Co.*, 304 U.S. 144, 152-53 (1938)).

these questions, a court presumes that the statute under review is constitutional and undoes it only if it is shown that Congress acted irrationally by passing it.²²⁹

Applying this framework to the facts of *NFIB*, Ginsburg concluded that Congress had a rational basis for finding that the uninsured, as a class, substantially affect interstate commerce.²³⁰ Her reasoning maps well onto telemedicine: “Those without insurance consume billions of dollars of health-care products and services each year. . . . Those goods are produced, sold, and delivered largely by national and regional companies who routinely transact business across state lines. The uninsured also cross state lines to receive care”²³¹ and their “inability to pay. . . drives up market prices, foists costs on other consumers, and reduces market efficiency and stability.”²³² Given these “far-reaching effects on interstate commerce” the decision not to buy insurance was one that Congress had Commerce Clause authority to address.²³³ Further, the mandate bore a “reasonable connection” to “Congress’ goal of protecting the health-care market from the disruption caused by individuals who fail to obtain insurance.”²³⁴ Requiring the uninsured to pay a toll gives them “a strong incentive to insure,” said Ginsburg, and there was “good reason to believe” that it would reduce the number of them and mitigate the adverse impact they have on the national health-care market.²³⁵

Applying the precedent cited by Ginsburg (which is the right precedent to apply since telemedicine does not involve regulating “inactivity”²³⁶) to telemedicine licensure, we reach the same outcome: it substantially affects interstate commerce and, thus, is within Congress’ power to regulate under the Commerce Clause.²³⁷ First, Congress has a “rational basis” for concluding that telemedicine licensure substantially affects interstate commerce.²³⁸

229. *Id.* (citing *United States v. Morrison*, 529 U.S. 598, 607 (2000)).

230. *Id.* at 2617.

231. *Id.*

232. *Id.*

233. *Id.* (internal quotations and citations omitted) (citing *Wickard v. Filburn*, 317 U.S. 111, 128 (1942) (“It is well established by decisions of this Court that the power to regulate commerce includes the power to regulate the prices at which commodities in that commerce are dealt in and practices affecting such prices.”)).

234. *Id.*

235. *Id.* (internal quotations omitted).

236. *See supra* Part III.B.1.a.

237. *NFIB*, 132 S. Ct. at 2617 (emphasis added) (citing *Gonzales v. Raich*, 545 U.S. 1, 17 (2005); *Wickard*, 317 U.S. at 125; *NLRB v. Jones & Laughlin Steel Corp.*, 301 U.S. 1, 37 (1937)).

238. *Id.* at 2616-17.

The market for physicians is now a national one.²³⁹ Seventeen percent of U.S. physicians have at least two state licenses (and six percent have three or more).²⁴⁰ Individual consumers, with the help of the Internet, commonly shop for doctors out of state.²⁴¹ Meanwhile, other major healthcare consumers include Medicaid, Medicare, the VA, and the “national and regional companies who routinely transact business across state lines” that Ginsburg highlighted in her analysis.²⁴²

Within this market, which is, “[b]y any measure...immense,”²⁴³ telemedicine is a growing force, expected to become a billion dollar industry by 2018.²⁴⁴ Therefore, this entire market is (positively) impacted by streamlined telemedicine licensure, which lets doctors more easily supply the entire market.²⁴⁵ Second, federal telemedicine licensure laws have a “reasonable connection” to the “asserted ends”—raising the level of quality and lowering the cost of healthcare.²⁴⁶ Streamlined licensure laws allow patients access to better doctors²⁴⁷ while easing the financial and administrative burden on doctors (savings that are passed onto

239. PETER R. KONGSTVEDT, *ESSENTIALS OF MANAGED HEALTH CARE* 231 (6th ed. 2012) (stating that the “local market for physician services is becoming increasingly national”).

240. Christine Vestal, *Expanding Telemedicine Beyond State Borders*, USA TODAY (Mar. 7, 2014, 9:44 AM), <http://www.usatoday.com/story/news/nation/2014/03/07/stateline-telemedicine-expansion/6159775/>.

241. KONGSTVEDT, *supra* note 239, at 231 (“Where once [medical] practitioners could rely on geographic isolation or blind loyalty from patients based on prior emotional experiences, the explosive growth of information enabled by the Internet has and will empower purchasers to shop for value beyond traditional geographic boundaries.”).

242. *NFIB*, 132 S. Ct. at 2617 (Ginsburg, J.); see Lisa Bernard-Kuhn, *The Doctor Will See You Now—Virtually*, CINCINNATI ENQUIRER (June 7, 2014, 4:36 PM), <http://www.usatoday.com/story/news/nation/2014/06/07/the-doctor-will-see-you-now-virtually/10171461>; Quil Lawrence, *For Ailing Vets in Rural Areas, Telemedicine Can Be the Cure*, NPR.ORG (May 29, 2013, 2:53 AM), <http://www.npr.org/2013/05/29/186483977/for-ailing-vets-in-rural-areas-tele-medicine-can-be-the-cure>; Graham, *supra* note 5 (“[M]uch of the dramatic growth in U.S. telehealth will be driven by Accountable Care Organizations . . . in both Medicare and among the privately insured.”).

243. *NFIB*, 132 S. Ct. at 2609 (Ginsburg, J.) (“Americans spent \$2.5 trillion on health care in 2009, accounting for 17.6% of our Nation’s economy. Within the next decade . . . spending on health care will nearly double.”).

244. Japsen, *supra* note 6.

245. ATA Practice Requirements, *supra* note 12.

246. *NFIB*, 132 S. Ct. at 2616-17.

247. ATA Practice Requirements, *supra* note 12.

consumers).²⁴⁸ Similarly, easing licensure laws fuels interstate competition in the health market, lowering costs nationally.²⁴⁹

2. *NFIB*'s Necessary and Proper Clause Holding Demonstrates that Federal Telemedicine Licensure Reform Will Find Support in This Clause.

In *NFIB*, a majority of Justices declined to find that the Necessary and Proper Clause could support the individual mandate.²⁵⁰ But it is clear that this ruling, like the Commerce Clause ruling, is a narrow one, constrained by the unusual facts of *NFIB*, which are, again, highlighted in the majority opinions of Roberts and Scalia.²⁵¹ Because this ruling is so narrow, *NFIB* preserves the broad reading of the Necessary and Proper Clause seen in 2010's *United States v. Comstock*.²⁵² Under that reading of the Clause, federal licensure reform will likely find support in the Necessary and Proper Clause, acting as an "extender" of the Commerce Clause (if it cannot find it in the Commerce Clause alone).²⁵³ Accordingly, the net effect of *NFIB*'s Necessary and Proper Clause ruling on such reform is positive.

a. *NFIB*'s Necessary and Proper Clause Holding, Limited by Its Unprecedented Facts, Will Not Be Applied to Hamper Federal Telemedicine Licensure Reform.

Although, in *NFIB*, a majority of Justices declined to find that the Necessary and Proper Clause could support the individual mandate, this ruling is too limited by its facts to hinder federal telemedicine licensure reform. The narrow scope of the holding is clear from the opinion of Roberts.²⁵⁴ His Necessary and Proper

248. Andis Robeznieks, *Proposed Patient-centered Telemedicine Policy Raises Licensing Questions*, MODERN HEALTHCARE (Mar. 20, 2014), <http://www.modernhealthcare.com/article/20140320/NEWS/303209952> ("Telemedicine barriers could add up to higher costs and poorer outcomes for patients.").

249. ATA Practice Requirements, *supra* note 12.

250. *NFIB*, 132 S. Ct. at 2591-93 (Roberts, C.J.); *id.* at 2646-48 (Scalia, J.); *cf.* Thomas More Law Ctr. v. Obama, 651 F.3d 529, 545-47 (6th Cir. 2011) (holding that the Necessary and Proper clause *did* grant Congress the power to enact the individual mandate); *see generally* Frederick Thide, *In Search of Limiting Principles: The Eleventh Circuit Invalidates the Individual Mandate in Florida v. U.S. Department of Health and Human Services*, 53 B.C. L. REV. 359 (2012).

251. *NFIB*, 132 S. Ct. at 2591-93 (Roberts, C.J.); *id.* at 2646-74 (Scalia, J.).

252. *See* *United States v. Comstock*, 560 U.S. 126, 133 (2010).

253. Hall, *supra* note 147, at 1847.

254. *NFIB*, 132 S. Ct. at 2592 (Roberts, C.J.).

Clause analysis, like his Commerce Clause analysis, rests on the fact that the mandate was “a regulation of inactivity” and “categorically different—basically more intrusive—from all other laws that Congress has passed.”²⁵⁵ Roberts began by stating that the Necessary and Proper Clause gives Congress the power to “‘make all Laws which shall be necessary and proper for carrying into Execution’ the powers enumerated in the Constitution” and “vests Congress with authority to enact provisions “‘incidental to the [enumerated] power, and conducive to its beneficial exercise.’”²⁵⁶ But, even though the Clause gives Congress the authority to “legislate on that vast mass of incidental powers which must be involved in the constitution,” it does not give Congress the authority to exercise any “great substantive and independent power[s]” beyond those specifically enumerated.²⁵⁷ Supreme Court Necessary and Proper Clause jurisprudence, said Roberts, has “been very deferential to Congress’ determination that a regulation is “necessary.”²⁵⁸ The Court has upheld laws that are “‘convenient, or useful’ or ‘conducive’ to the authority’s ‘beneficial exercise.’”²⁵⁹ But the Court has also declared unconstitutional those laws which are not “consist[ent] with the letter and spirit of the constitution,”²⁶⁰ because they are not “*proper* [means] for carrying into Execution” Congress’s enumerated powers. Rather, they are, “in the words of The Federalist, ‘merely acts of usurpation’ which ‘deserve to be treated as such.’”²⁶¹ Applying this framework, said Roberts, the individual mandate could not be sustained.²⁶² This was because prior cases upholding laws under this Clause involved “exercises of authority derivative of, and in service to, a granted power.”²⁶³ But the

255. Mark D. Rosen, *supra* note 187, at 126.

256. *NFIB*, 132 S. Ct. at 2591 (citing *McCulloch v. Maryland*, 17 U.S. 316, 418 (1819)).

257. *Id.* at 2591 (citing *McCulloch*, 17 U.S. at 411, 421).

258. *Id.* at 2591-92.

259. *Id.* at 2592 (citing *United States v. Comstock*, 560 U.S. 126, 133-34 (2010) (quoting *McCulloch*, 17 U.S. at 413, 418)).

260. *Id.* (citing *McCulloch*, 17 U.S. at 421) (emphasis original).

261. *Id.* (citing *Printz v. United States*, 521 U.S. 898, 924 (1997) (alterations omitted) (quoting THE FEDERALIST NO. 33, at 204 (A. Hamilton)); *New York*, 505 U.S. at 177; *Comstock*, 560 U.S. at 153, (Kennedy, J.) (“It is of fundamental importance to consider whether essential attributes of state sovereignty are compromised by the assertion of federal power under the Necessary and Proper Clause”)).

262. *Id.*; *NFIB*, 132 S. Ct. at 2592.

263. *Id.* (citing *Jinks v. Richland County*, 538 U.S. 456, 462 (2003); *Sabri v. United States*, 541 U.S. 600, 605 (2004); *Comstock*, 560 U.S. at 140).

individual mandate lacked this predicate.²⁶⁴ Instead, by forcing individuals to enter the stream of commerce by purchasing insurance, it gave Congress “the extraordinary ability to create the necessary predicate to the exercise of an enumerated power,” and was thus beyond the Clause’s reach.²⁶⁵ Further, said Roberts, it was not a proper means of effectuating reform because it was not “narrow in scope” or “incidental” to the exercise of the Commerce Clause power, the power it would extend.²⁶⁶ Rather, it was “a substantial expansion of federal authority.”²⁶⁷ By extending the Commerce Clause to cover individuals who did *not*, by some pre-existing activity, bring themselves into “the sphere of federal regulation,” it let Congress “reach beyond the natural limit of its authority.”²⁶⁸ This gave Congress the “extraordinary ability to create the necessary predicate to the exercise of an enumerated power” and “work a substantial expansion of federal authority.”²⁶⁹ This gave Congress the “extraordinary ability to create the necessary predicate to the exercise of an enumerated power” and “work a substantial expansion of federal authority.”²⁷⁰ Roberts refused to allow this and therefore concluded that this Clause could not support the mandate.²⁷¹

Scalia, the other majority Justice who explained why he declined to find that the Necessary and Proper Clause could support the individual mandate, also highlighted the unique facts that informed his decision.²⁷² Said Scalia, the ACA’s “mandating of economic activity” was an “expansion of the federal power to direct into a *broad new field*”²⁷³ “so limitless that it converts the Commerce Clause into a general authority to direct the economy.”²⁷⁴ That, said Scalia, was not “consist[ent] with the letter and spirit of the constitution.”²⁷⁵ Further, said Scalia, the individual mandate was not “the only practicable way” of achieving the regulatory goals at

264. *NFIB*, 132 S. Ct. at 2592.

265. *Id.*

266. *Id.* (citing *Comstock*, 560 U.S. at 148; *McCulloch v. Maryland*, 17 U.S. 316, 418 (1819)).

267. *Id.*

268. *Id.*

269. *Id.*

270. *Id.*

271. *Id.* at 2593.

272. *Id.* at 2646 (Scalia, J., dissenting).

273. *Id.* (emphasis added) (quoting *McCulloch*, 17 U.S. at 421).

274. *Id.* at 2646-47.

275. *Id.*

hand²⁷⁶ and suggested some ways which were not “unprecedented” but would achieve the ACA’s goals of reducing insurance premiums while ensuring the profitability of insurers (for example, denying an income tax credit to those who do not purchase insurance).²⁷⁷ Because of all this, Scalia said that allowing the Necessary and Proper Clause to support the individual mandate would mean that the Court would be “hard pressed to posit any activity by an individual that Congress is without power to regulate.”²⁷⁸ For that reason, the mandate could not stand.²⁷⁹

Because its unique facts played such a pivotal role, the Necessary and Proper Clause ruling in *NFIB* will not be applied to prevent federal telemedicine licensure reform from finding support in this Clause.²⁸⁰ The one lower court that has applied the Necessary and Proper ruling cited it only for the notion that Congress cannot use the Clause to regulate “those who by some preexisting activity bring themselves within the sphere of federal regulation” and provides no justification for laws effecting “a substantial expansion of federal authority.”²⁸¹ But federal telemedicine licensure regulates physicians engaged in commerce²⁸² rather than those who have not brought themselves, by some preexisting activity, into the sphere of regulation. Further, federal telemedicine licensure does not represent “a substantial expansion of federal authority.”²⁸³ Rather, Congress has acted in the realms of health and professional licensure.²⁸⁴ Accordingly, future courts will not apply *NFIB*’s Necessary and Proper Clause ruling to constrain federal telemedicine licensure reform.

276. *Id.* at 2647 (citing *Gonzales v. Raich*, 545 U.S. 1, 22 (2005)).

277. *Id.*

278. *Id.* (citing *United States v. Lopez*, 514 U.S. 549, 564 (1995)).

279. *Id.*

280. Ilya Somin, *The Individual Mandate and the Proper Meaning of ‘Proper’*, in *THE HEALTH CARE CASE: THE SUPREME COURT’S DECISION AND ITS IMPLICATIONS* 27 (Nathaniel Persily, Gillian E. Metzger & Trevor W. Morrison eds., 2013) (asserting that the only rules *NFIB* leaves lower courts are that “Congress would not have the power, under the Clause, to ‘regulate individuals precisely because they are doing nothing’” and that mandates which are not “predicated on some form of preexisting activity that brings individuals within the scope of federal authority” are prohibited).

281. *United States v. Elk Shoulder*, 696 F.3d 922, 939 (9th Cir. 2012) (citing *NFIB*, 132 S. Ct. at 2592).

282. *Gonzales v. Raich*, 545 U.S. 1, 22 (2005).

283. *Id.*

284. *Supra* Part II.A.

b. *NFIB*'s Necessary and Proper Clause Ruling Does Not Upset the “Rational Relation” Standard of *Comstock*, Which Grants Congress Broad Power to Regulate Telemedicine Licensure

Because *NFIB*'s Necessary and Proper Clause restrictions do not apply to federal telemedicine licensure, the governing precedent is the treatment of the Clause put forth in *Comstock*, the Necessary and Proper Clause case that preceded *NFIB*, which is highly deferential to Congress and authorizes federal telemedicine licensure reform. *Comstock*, cited by Roberts (and Ginsburg, in her dissent),²⁸⁵ “breathe[d] new life” into the Clause²⁸⁶ by finding that it grants Congress the authority to enact a statute so long as the statute is “rationally related” to the implementation of an enumerated constitutional power.²⁸⁷ Further, said the *Comstock* Court, in deciding if this “rational basis” exists, there is a “presumption of constitutionality”²⁸⁸; if “it can be seen that the means adopted are really calculated to attain the end,” then “the degree of their necessity, the extent to which they conduce to the end, [and] the closeness of the relationship between the means adopted and the end to be attained” are matters for Congress alone to decide.²⁸⁹ This metric, more “inflated”²⁹⁰ than the traditional one laid out in *McCulloch v. Maryland*,²⁹¹ echoes the “rational basis” test that, in other areas of constitutional law, is applied in a way that is “extremely deferential to the government.”²⁹² For this reason,

285. *NFIB v. Sebelius*, 132 S. Ct. 2566, at 2592 (2012); *id.* at 2627 (Ginsburg, J.); see also Alison L. LaCroix, *The Shadow Powers of Article I*, 123 YALE L.J. 2044, 2073 (2014) (stating that Roberts used *Comstock*'s approach to gauge the connection between a regulated activity and an enumerated power).

286. *United States v. Comstock*, 560 U.S. 126, 180 (2010) (Thomas, J., dissenting) (internal quotations omitted).

287. *Id.* at 135.

288. *Id.* (citing *United States v. Morrison*, 529 U.S. 598, 607 (2000)); see also *Champion v. Ames (Lottery Case)*, 188 U.S. 321, 355 (1903) (recognizing that the Constitution gives “Congress a large discretion as to the means that may be employed in executing a given power.”).

289. *Id.* (citing *Burroughs v. United States*, 290 U. S. 534, 547-48 (1934)).

290. Stephen E. Sachs, *The Uneasy Case for the Affordable Care Act*, 75 LAW & CONTEMP. PROBS. 17, 23 (2012).

291. *McCulloch v. Maryland*, 17 U.S. 316, 418-21 (1819) (stating that a law is within the Clause's reach if it is “incidental to [the] constitutional powers” as a means “plainly adapted” to executing an enumerated power); see generally Philip J. Levitz, *A Modern Fiduciary Theory of the Necessary & Proper Clause*, 3 (2012) (*Comstock* “presented a substantial rethinking of the Necessary and Proper Clause, for perhaps the first time since *McCulloch*.”).

292. Ilya Somin, *Taking Stock of Comstock: The Necessary and Proper Clause and the Limits of Federal Power*, 2009-10 CATO SUP. CT. REV. 239, 243

Comstock's rule has been called a “blank check” for Congress²⁹³ and “a difficult test to fail.”²⁹⁴ It has also led some “to wonder whether the Necessary and Proper Clause of the aughts would reprise the high-profile commerce power of the period between 1937 and 1995.”²⁹⁵ In fact, leading up to *NFIB*, “many commentators...assumed that the Court’s broad reading of the necessary and proper power in *Comstock* would lead it to uphold the individual mandate.”²⁹⁶

Applying this broad rule to federal telemedicine licensure reform, it is clear that such reform will find support in the Necessary and Proper Clause. Specifically, under *Comstock's* rule, there are “five considerations, taken together,” that help determine whether the Federal Government, exercising its enumerated powers, may constitutionally enact a statute.²⁹⁷ The five considerations are:

1. the breadth of the Necessary and Proper Clause;
2. a long history of federal involvement in the area of regulation at issue;
3. whether the statute reasonably extends longstanding policy;
4. the statute’s accommodation of state interests; and
5. the statute’s narrow scope.²⁹⁸

The *first* factor is important because it immediately tips the scales in favor of constitutionality by reiterating that Congress has “broad authority to enact federal legislation” under the Clause.²⁹⁹ This factor, because it weighs so heavily in favor of constitutionality and lacks “a clear limiting principle,” is an “automatic ‘plus’ for a

(2010). Perhaps to reinforce this point, the *Comstock* Court cited, as examples of rational basis scrutiny, certain Commerce Clause and Spending Clause decisions which were highly deferential to the government. *Id.* (citing *Comstock*, 560 U.S. at 132-33 (2010) (citing *Sabri v. United States*, 541 U.S. 600, 605 (2004); *Gonzales v. Raich*, 545 U.S. 1, 22 (2005))).

293. Ryan K. Melcher, *There Ain't No End for the 'Wicked': Implications of and Recommendations for § 4248 of the Adam Walsh Act after United States v. Comstock*, 97 IOWA L. REV. 629, 645 (2011).

294. Sachs, *supra* note 288, at 23.

295. LaCroix, *supra* note 283, at 2071.

296. *Id.* at 2073; *see also* Somin, *supra* note 290, at 240 (noting that it was augured, prior to *NFIB*, that *Comstock's* “broad interpretation of the Necessary and Proper Clause could be used to buttress the . . . constitutional justifications for the [ACA’s] ‘individual mandate.’”).

297. *United States v. Comstock*, 560 U.S. 126, 134 (2010).

298. *Id.* at 133-50.

299. *Id.* at 133.

whole category of laws.”³⁰⁰ Specifically, it says that, in determining whether the Clause supports a particular action, a court merely looks at whether the aforementioned “rational basis” exists and, that, as the court does so, there is a “presumption of constitutionality.”³⁰¹ If it can be seen that the means adopted are really calculated to attain the end, then the degree of the statute’s necessity, the extent to which it conduces the end, and the closeness of the relationship between the means adopted and the end to be attained, are matters for Congressional determination alone.³⁰² The *Comstock* Court gave examples of past authorizations under the Clause.³⁰³ For example, said the Court, although the Constitution, for the most part, does not create federal crimes, Congress had broad authority to create such crimes in furtherance of its enumerated powers to, for example, regulate interstate commerce or spend funds for the general welfare.³⁰⁴ By the same token, in order to enforce the federal crimes it creates, Congress can also “cause a prison to be erected at any place within the jurisdiction of the United States, and direct that all persons sentenced to imprisonment under the laws of the United States shall be confined there,” or having established a prison system, enact laws that ensure that system’s safe and responsible administration by, for example, requiring prisoners to receive medical care and educational training.³⁰⁵ Though the power to do these things is not “explicitly mentioned in the Constitution,”³⁰⁶ “Congress nonetheless possesses broad authority to do each of those things in the course of ‘carrying into Execution’ the enumerated powers ‘vested by’” the Necessary and Proper Clause.³⁰⁷ Federal telemedicine licensure is of the same mold. Pursuant to its Commerce Clause and Spending Powers, Congress has enacted many health initiatives, including Medicare and the ACA,³⁰⁸ all of which are jeopardized by rising healthcare costs and a physician

300. Margaret K. O’Leary, *Have No Fear (of “Piling Inference Upon Inference”): How United States v. Comstock Can Save the Matthew Shepard and James Byrd, Jr. Hate Crimes Prevention Act*, 97 CORNELL L. REV. 931, 952 (2012).

301. *Comstock*, 560 U.S. at 134-35 (citing *Sabri v. United States*, 541 U.S. 600, 605 (2004); *Gonzales v. Raich*, 545 U.S. 1, 22 (2005); *United States v. Lopez*, 514 U.S. 549, 577 (1995); *Hodel v. Virginia Surface Mining & Reclamation Ass’n*, 452 U.S. 264, 276 (1981)).

302. *Id.* at 135 (citing *Burroughs v. United States*, 290 U.S. 534, 547-48 (1934)).

303. *Id.* at 135-37.

304. *Id.* at 135-36 (citations omitted).

305. *Id.* at 136-37.

306. *Id.* at 137.

307. *Id.*

308. Health Care Quality Improvement Act, *supra* note 123.

shortage.³⁰⁹ Telemedicine can curb these problems³¹⁰ and help keep these programs viable, but only if the burden of fragmented licensure is lifted.³¹¹ Accordingly, there is a rational basis for Congress to conclude that federal telemedicine licensure is necessary for the implementation of *enumerated* constitutional powers.³¹²

The second *Comstock* factor asks if the federal statute at issue is a “modest addition” to “a longstanding history of related federal action”³¹³ in the area at issue. Such a history helps assess “the reasonableness of the relation between the new statute and pre-existing federal interests.”³¹⁴ In *Comstock*, for example, the statute at issue involved the civil commitment of mentally ill and sexually dangerous individuals already in federal custody.³¹⁵ It satisfied this factor because Congress had “been involved in the delivery of mental-health care to federal prisoners” and “provided for their civil commitment” since 1855, enacting at least ten statutes in this area.³¹⁶ Further, the statute at issue, because it had a “specific focus” (on persons who, due to a mental illness, were sexually dangerous), and was similar to statutes already in place, was a “modest addition” that “longstanding federal statutory framework.”³¹⁷ Telemedicine licensure satisfies this factor for the same reasons: Congress has been involved in health since at least 1798³¹⁸ and has enacting dozens of health statutes, including far-reaching programs like Medicare,

309. Lea Winerman, *Health Care Wrangling Picks Up Speed*, PBS NEWSHOUR (July 28, 2009, 5:35 PM), http://www.pbs.org/newshour/updates/health-july-dec09-reform_07-28/ (according to Pres. Barack Obama, “ballooning health care costs threaten Medicare,”); Ceslee D. Montgomery, *The Physician Shortage and the Future of the Affordable Care Act: The Coverage without Care Conundrum*, STANF. J. PUB. HEALTH 1 (2013) (the supply of care providers is an “imminent threat” to the ACA's reforms).

310. See Mathews, *supra* note 4; see also Gil Siegal, *Enabling Globalization of Health Care in the Information Technology Era: Telemedicine and the Medical World Wide Web*, 17 VA. J. L. & TECH. 1 (2012) (stating that the costs that telemedicine saves are typically borne by either individuals or federal health programs such as Medicaid) (citation omitted).

311. *Supra* note 15, 16.

312. *United States v. Comstock*, 560 U.S. 126, 135 (2010).

313. *Id.* at 137.

314. *Id.* (quoting *Gonzales v. Raich*, 545 U.S. 1, 21 (2005)).

315. *Id.*

316. *Id.* at 137-42.

317. *Id.* at 142.

318. See *supra* note 112; see also *United States v. Elk Shoulder*, 696 F.3d 922, 929 (9th Cir. 2012) (finding that eighteen years of regulation satisfied this factor of the test).

Medicaid, and the ACA.³¹⁹ It has also long regulated professional licensure.³²⁰ Federal telemedicine licensure reform is also precisely focused (on setting standards for doctors in telemedicine)³²¹ and echoes existing licensure review that Congress currently practices through the National Practitioner Data Bank.³²² Accordingly, telemedicine licensure is a “modest addition” to a “longstanding federal statutory framework.”³²³

The third *Comstock* factor asks if the statute at issue “reasonably extend[s]” that “longstanding...system” and is “reasonably adapted” to Congress’ power to act in this arena.³²⁴ In *Comstock*, for example, the statute at issue was deemed a reasonable extension of Congress’ involvement in the delivery of health care and providing civil commitment to those in custody because, as the custodian of such individuals, Congress had a duty to protect communities that could be harmed by them.³²⁵ Further, that statute was “reasonably adapted” to Congress’ power to act as a responsible custodian because sexually dangerous and mentally ill inmates posed threats to communities, especially since they would *not* be taken into custody by states (from which they had been removed when taken into federal custody in remote prisons).³²⁶ Likewise, telemedicine licensure reform “reasonably extend[s]” Congress’ existing health regulatory scheme.³²⁷ Whether that regulatory scheme rests on the Spending Clause Power to promote the “general welfare,”³²⁸ or the Commerce Clause power to regulate the health market,³²⁹ its stewardship is threatened by rising healthcare costs.³³⁰ Because telemedicine, freed of the burden of fragmented state licensure, will cut costs and improve care, federal

319. *See supra* note 113.

320. *See supra* notes 124-35 and accompanying text; *supra* Part III.A.

321. Andrew B. Coan, *Judicial Capacity and the Conditional Spending Paradox*, (Oct. 10, 2012); 2013 WISC. L. REV. 339, 346-47 (2012) (*NFIB* was preceded by “seven decades of uninterrupted judicial deference to Congress’s spending power”).

322. *See supra* note 121.

323. *United States v. Comstock*, 560 U.S. 126, 137 (2010).

324. *Id.* at 142-43.

325. *Id.* at 143-44.

326. *Id.* at 144.

327. *Id.* at 142-43.

328. *See supra* note 129, and accompanying text; U.S. CONST. art. § 8, cl. 1.

329. *Liberty Univ. v. Lew*, 733 F.3d 72, 91-94 (4th Cir. 2013).

330. SOC. SEC. ADVISORY BD., *THE UNSUSTAINABLE COST OF HEALTH CARE* (2009), available at http://www.ssab.gov/documents/TheUnsustainableCostofHealthCare_graphics.pdf (last visited Oct. 20, 2014).

telemedicine licensure reform is “reasonably adapted” to helping Congress satisfy its remit in this area.³³¹

The fourth *Comstock* factor asks if the statute “properly accounts for state interests” and does not “invade . . . state sovereignty in an area typically left to state control.”³³² E.g., the *Comstock* Court found that, though “States have traditionally exercised broad power to commit persons found to be mentally ill,”³³³ a federal law requiring the civil commitment of certain individuals in federal custody satisfied this factor because it accommodated state interests (by requiring that the state where the individual was domiciled be notified of the individual’s detention and allowing that state to take custody of the individual if it so desired).³³⁴ Although federal telemedicine licensure law would regulate an area that states often control,³³⁵ it satisfies this factor because it is limited to licensure of health professionals engaged in telemedicine.³³⁶ Past reform bills in this area have not sought to

331. Brian Heaton, *Will the Affordable Care Act Help Telehealth Flourish?*, GOV. TECH. (Sept. 12, 2012), <http://www.govtech.com/health/Will-the-Affordable-Care-Act-Help-Telehealth-Flourish.html>; GEORGE PANTOS, TELEHEALTH IN THE POST-ACA WORLD: A WHITE PAPER FOR COLLEGE AND UNIVERSITY ADMINISTRATORS (June 2013), available at [https://www.campusmd.net/news/Telehealth in the PostACA World.pdf](https://www.campusmd.net/news/Telehealth%20in%20the%20PostACA%20World.pdf) (last visited Mar. 17, 2015); Center for Telehealth & E-Health Law, *FSMB President Optimistic About Interstate Compact and Telemedicine*, CENTER FOR TELEHEALTH & E-HEALTH LAW (July 29, 2014), available at <http://ctel.org/2014/07/fsmb-president-optimistic-about-interstate-compact-and-telemedicine/> (“There is ‘a desire among physicians for multistate practice,’ he told audience members, noting that although currently only six percent of physicians hold licenses in three or more states, those numbers are continuously growing. Also fueling need are the current physician shortage and need to expand access to care, the latter of which partially stems from the Affordable Care Act.”); MD. DEP’T HEALTH & MENTAL HYGIENE, TELEMEDICINE RECOMMENDATIONS: A REPORT PREPARED FOR THE MARYLAND HEALTH QUALITY AND COST COUNCIL 2 (Dec. 2011) (“[T]he expansion of telemedicine will support the success of the ACA.”), available at http://mhcc.dhmh.maryland.gov/hit/Documents/md_telemedicine_report.pdf.

332. *Comstock*, 560 U.S. at 143-44 (internal quotations omitted).

333. *Id.* at 144 (quoting *Jackson v. Indiana*, 406 U.S. 715, 736 (1972)).

334. *Id.* at 143-45 (citing *New York v. United States*, 505 U.S. 144, 155 (1992)). Likewise, in *Elk Shoulder*, a federal sex offender registration statute satisfied this factor because it only applied to federal offenders and state offenders “who threaten the efficacy of the statutory scheme by traveling in interstate commerce.” *Elk Shoulder*, 696 F.3d at 21 (citing *Carr v. United States*, 560 U.S. 438, 451-53 (2010)).

335. See *supra* notes 10-22 and accompanying text; *supra* Part I.

336. Vyborny, *supra* note 220, at 95-96; Matak, *supra* note 97, at 247.

license physicians who are not practicing telemedicine and, additionally, have not tried to usurp the states' authority to initially license physicians.³³⁷ By maintaining this scope, federal telemedicine licensure reform “properly accounts for state interests” and does not “invade...state sovereignty in an area typically left to state control.”³³⁸

The fifth and last factor asks if the “links” between the statute in question and an enumerated Constitutional power are “too attenuated,”³³⁹ and whether the statute is “too sweeping in its scope.”³⁴⁰ Importantly, here “Congress'[] authority can be...more than one step removed from a specifically enumerated power.”³⁴¹ In *Comstock*, for example, it was held that the Constitution's enumerated powers (for example, regulate interstate commerce, enforce civil rights, or spend funds for the general welfare) engendered an implied power to criminalize conduct that might interfere with those enumerated powers, which engendered the power to imprison people who violated those (inferentially authorized) laws, which, lastly, engendered the additional powers to provide for the safe management of those prisons and to regulate the prisoners' behavior even after their release.³⁴² This was not too much “attenuation,” even though there was “more than a single step between an enumerated power and an Act of Congress.”³⁴³ Further, the Court found that deciding so did not confer on Congress a general “police power” because the statute at issue was narrow in scope, with discrete application (it only applied to small numbers of federal prisoners) and clear limits (it only applied to individuals already in federal custody).³⁴⁴ Accordingly, the statute, far from creating a “general police power,” was a “reasonably adapted and narrowly tailored means of pursuing the Government's legitimate interest as a federal custodian in the responsible administration of its prison system.”³⁴⁵ Federal telemedicine licensure reform satisfies this factor, too, because it is even more closely linked with an enumerated power than the statute at issue in *Comstock*. It rests either one step away from such a power, being directly in service of

337. See *infra*, note 388.

338. *Comstock*, 560 U.S. at 143-44 (internal quotations omitted).

339. *Id.* at 146 (emphasis added).

340. *Id.*

341. *Id.*

342. *Id.* at 147-48.

343. *Id.* at 148.

344. *Id.*

345. *Id.*

the Commerce Clause or Spending Power,³⁴⁶ or two steps away, being in service of Medicare, the ACA, or Congress' other health regulations³⁴⁷ (which are, in turn, directly in service of enumerated powers).³⁴⁸ Further, its enactment does not create a "general police power" for the same reasons the statute in *Comstock* did not: it is limited to the licensure of physicians engaged in the practice of telemedicine.³⁴⁹ Accordingly, federal telemedicine licensure reform satisfies this last factor, and the entire *Comstock* test and, thus, even in the wake of *NFIB*, remains a prime candidate for Necessary and Proper Clause support.

3. *NFIB*'s Spending Power Ruling Demonstrates That Conditional Spending-Based Federal Telemedicine Licensure Reform Will Find Support in This Clause.

The *NFIB* Court considered two provisions of the ACA in light of the Taxing and Spending Power³⁵⁰ and decided differently on each.³⁵¹ First, a majority of Justices agreed that Congress' Taxing Power supported the individual mandate.³⁵² Second, a majority of Justices agreed that the part of the ACA which threatened to reduce existing Medicaid grants to states that did not comply with its terms was unconstitutionally coercive and, thus, beyond Congress' Spending Power.³⁵³ Although the Taxing Power part of this ruling

346. See *supra* notes 177-252, 345-452 and accompanying text; *supra* Part III.A.

347. See *supra* notes 279-84, 295-99, 308-28 and accompanying text; *supra* Part III.A.

348. See *supra* note 129 and accompanying text; see also Eric Segall & Aaron E. Carroll, *Health Care and Constitutional Chaos: Why the Supreme Court Should Uphold the Affordable Care Act*, 64 STAN. L. REV. ONLINE 139 (May 29, 2012) (the Necessary and Proper Clause supported the ACA, generally, because Congress has the "enumerated authority to regulate commerce among the states," the "health care and health insurance industries are multibillion-dollar enterprises that affect our national economy," and "requiring people to buy health insurance is . . . [a] reasonable way for Congress to regulate commerce among the states, and thus . . . constitutional."), <http://www.stanfordlawreview.org/online/health-care-constitutional-chaos>.

349. See *supra* notes 327-28.

350. U.S. CONST. art. I, § 8, cl. 1.

351. *NFIB v. Sebelius*, 132 S. Ct. 2566, 2593-2609 (2014) (Roberts, C.J.); *Id.* at 2628-42 (Ginsburg, J., joined by Breyer, Sotomayor, and Kagan, JJ.).

352. *Id.* at 2593-2601, 2628-29.

353. *Id.* at 2601-09, 2629-42.

is a triumph for Congress,³⁵⁴ the Medicaid part of the ruling is more relevant to telemedicine licensure reform. This is because spending — specifically, conditional spending — is how Congress has pursued prior licensure³⁵⁵ and health³⁵⁶ reform, including Medicare,³⁵⁷ and tried to pursue telemedicine licensure reform.³⁵⁸ That said, this seemingly restrictive Medicaid ruling is, like *NFIB*'s Commerce Clause and Necessary and Proper Clause rulings, too limited by its precarious facts to hinder such conditional spending-based federal telemedicine licensure reform.³⁵⁹ If anything, *NFIB* benefits conditional spending-based federal telemedicine licensure reform by providing a roadmap for it to follow in order to maintain constitutionality.³⁶⁰ Lastly, *NFIB* does not upset existing Spending Power precedent, which is highly deferential to the Congress, and would support conditional spending-based federal telemedicine licensure reform (if, again, it stays within *NFIB*'s guidelines).³⁶¹

a. *NFIB*'s Medicaid Holding, Limited by Its Unprecedented Facts, Will Not Be Applied to Hamper Conditional Spending-Based Federal Telemedicine Licensure Reform

Although, in *NFIB*, a majority of Justices agreed that the ACA's threat to reduce existing Medicaid grants to states that did not comply with its terms was unconstitutional "coercing,"³⁶² this ruling is too limited by its facts to hinder federal telemedicine licensure reform (if such reform is built on conditional spending).³⁶³

354. Pasachoff, *supra* note 152; Matthew A. Melone, *The Pundits Doth Protest Too Much: National Federation of Independent Business v. Sebelius and the Future of the Taxing Power*, 2012 MICH. ST. L. REV. 1189, 1204 (2012).

355. See Commercial Motor Vehicle Safety Act of 1986, Pub. L. 99-570, 49 U.S.C. § 31102-03 (using conditional spending to achieve uniformity of drivers license standards).

356. See *supra* note 129.

357. *Id.*

358. See *infra* note 419.

359. *NFIB v. Sebelius*, 132 S. Ct. 2566, 2601-09 (2014).

360. See *infra* note 389.

361. See *infra* notes 402-441 and accompanying text; *infra* Part III.A.3.b.

362. *NFIB*, 132 S. Ct. at 2602.

363. *Id.* at 2601-09, 2629-42; Kenneth R. Thomas, Cong. Research Serv., R42367, *The Constitutionality of Federal Grant Conditions After National Federation of Independent Business v. Sebelius*, 141414 CONGRESSIONAL RESEARCH SERVICE 14 (July 17, 2012) ("[T]he factors that were important in [*NFIB*] are unlikely to occur in other legislative contexts" and, if they "mark the outer limits of Congress's power, then the case may have minimal impact on existing or future funding grant conditions."), <http://theincidentaleconomist.com/wordpress/wp-content/uploads/2012/07/CRS-Federal-Grants-R42367-clean.pdf>.

It is not, as some have said, an unprecedented limitation on conditional spending.³⁶⁴ It will not make the Spending power a “viable site for federalism-based attacks” on federal health programs like Medicaid and Medicare.³⁶⁵ Lower courts will not use it to limit conditional spending.³⁶⁶ Instead, it is “unlikely to apply much more broadly” and suggests “no problem with the . . . conclusion that Congress can impose conditions in exchange for funds.”³⁶⁷ The reason for this is evident in the “conspicuously fact specific” analyses³⁶⁸ on display in the opinions of the Justices.³⁶⁹

364. *E.g.*, Erin Ryan, *The Spending Power and Environmental Law After Sebelius*, 85 UNIV. COLO. L. REV. 1003, 1003 (2013) (*NFIB* “became the first Supreme Court decision ever to limit an act of Congress on spending power grounds” and “limits Congress’s ability to bargain with the states.”); Solum, *supra* note 187, at 55 (*NFIB* “opens the door to future challenges of Congress’s power to influence states through conditional spending.”); Nicole Huberfeld, Elizabeth W. Leonard & Kevin Outterson, *Plunging Into Endless Difficulties: Medicaid and Coercion in National Federation of Independent Businesses v. Sebelius*, 93 BOSTON UNIV. L. REV. 1, 46 (2013) (“*NFIB* was the first clear articulation of a federalism-based limit on Congress’s spending power.”).

365. Brietta R. Clark, *Safeguarding Federalism by Saving Health Reform: Implications of National Federation of Independent Business v. Sebelius*, 46 LOY. LA. L. REV. 541, 542 (2013).

366. *Direct Commc’ns Cedar Valley, LLC v. FCC*, 753 F.3d 1015, 1141 (10th Cir. 2014) (“[*NFIB*] involved federal funding to the states so they could implement a federal program” and therefore did not apply where “the federal government has assumed responsibility for financial support to third parties—not states—so the FCC can implement a federal program.”); *Texas v. EPA*, 726 F.3d 180, 197 (D.C. Cir. 2013) (finding that *NFIB*’s Medicaid ruling did not apply because a threatened construction delay of “up to twelve months” was not “of the same magnitude and nature as the Medicaid expansion provision that would strip “over 10 percent of a State’s overall budget”) (internal citations omitted).

367. Pasachoff, *supra* note 152, at 642, 662; *see also* Ellen K. Howard, *Student Symposium: Constitutional Law—Breaking Down the Supreme Court’s Spending Clause Ruling in NFIB v. Sebelius: A Huge Blow to the Federal Government or a Mere Bump in the Road?*, 35 U. ARK. LITTLE ROCK L. REV. 609, 633 (2013) (*NFIB*’s Spending Power holding “will remain limited to the uniquely large and entrenched Medicaid program” and will not be “be looked back on as D-Day for Congress’s spending power.”); Bruce G. Peabody & Peter J. Woolley, *The Public’s Constitutional Thinking and the Fate of Health Care Reform: PPACA as Case Study*, 81 FORDHAM L. REV. RES GESTAE 26, 26 (2012) (stating that the *NFIB* Spending Power was a “somewhat narrow ruling”).

368. Huberfeld, Leonard, & Outterson, *supra* note 356, at 8 (“[T]he Roberts plurality and the joint dissent offered slogans, suggesting that a federal condition is unconstitutionally coercive if it is a ‘gun to the head,’ ‘conscripts states,’ or is ‘economic dragooning.’ Those formulations are conspicuously fact specific and provide little guidance to future courts.”).

369. *NFIB v. Sebelius*, 132 S. Ct. 2566, 2601-09, 2629-42 (2014).

Roberts' opinion, for example, shows that the holding is a fact-based and narrow one.³⁷⁰ At the outset, Roberts, writing for part of the majority, agreed with the idea that this case was "far from the typical" conditional spending case.³⁷¹ Normally, Congress may not only use its Spending Power "to grant federal funds to the States," but "may condition such a grant upon the States' taking certain actions" to ensure that the grants are used to provide for the "general welfare."³⁷² That said, in doing so, Congress can only "create *incentives* for States to act in accordance with federal policies."³⁷³ If "pressure turns into *compulsion*," Congress exceeds its power.³⁷⁴ In deciding which category the ACA's Medicaid provision fell into, Roberts focused on its particular details, which were as atypical as those surrounding the individual mandate.³⁷⁵

First, Roberts emphasized that the ACA's Medicaid provisions, unlike other conditional spending programs, took the form of "threats to terminate other significant independent grants" (that is, Medicaid's, rather than the ACA's).³⁷⁶ Although the Court had previously upheld conditional spending when the conditions were meant to ensure the funds were spent according to the "general welfare," conditions "that do not here govern the use of the funds" could not be justified on that basis and were instead "properly viewed as a means of pressuring the States to accept policy changes."³⁷⁷ Next, in determining whether such "pressure" reached the point of "compulsion," Roberts highlighted that "Medicaid spending accounts for over 20 percent of the average State's total budget, with federal funds covering 50 to 83 percent of those costs."³⁷⁸ In addition, he noted, "[t]he Federal Government estimates that it will pay out approximately \$3.3 trillion between

370. *Id.* at 2601-09.

371. *Id.* at 2603.

372. *Id.* at 2601-02 (citing *College Sav. Bank v. Fla. Prepaid Postsecondary Ed. Expense Bd.*, 527 U. S. 666, 686 (1999) (internal quotations omitted)).

373. *Id.* at 2602 (emphasis added).

374. *Id.* (quoting *Steward Mach. Co. v. Davis*, 301 U. S. 548, 590 (1937) (emphasis added); citing *Printz v. United States*, 521 U.S. 898, 933 (1997); *New York v. United States*, 505 U.S. 144, 174-75 (1992); see also Alex Kreit & Aaron Marcus, *Raich, Health Care, and the Commerce Clause*, 31 WM. MITCHELL L. REV. 957, 989 (2005) (stating that in structuring a conditional spending program, Congress is constrained "only by the rule that while [it] may encourage states to act, it cannot compel a state to carry out those acts.") (citing *New York*, 505 U.S. at 166)).

375. *NFIB*, 132 S. Ct. at 2601-09.

376. *Id.* at 2604.

377. *Id.* at 2603-04.

378. *Id.* at 2604.

2010 and 2019 in order to cover the costs of *pre-expansion* Medicaid.”³⁷⁹ Based on those figures, the ACA’s endangerment of Medicaid grants was “economic dragooning that leaves the States with no real option but to acquiesce” and therefore unconstitutional.³⁸⁰ Next, Roberts quashed the government’s argument that, because the Social Security Act, which includes the original Medicaid provisions, reserves “[t]he right to alter, amend, or repeal any provision” of the Act,³⁸¹ the states had consented to “modification[s]” of Medicaid when they first joined the program.³⁸² Even if the states had consented to “modification[s],” they had not consented to something like the ACA’s provisions, which “transformed” Medicaid from one type of program into another.³⁸³ Indeed, Medicaid was originally built to cover just four categories of people (the disabled, the blind, the elderly, and needy families with dependent children).³⁸⁴ But the ACA provision turned it “into a program to meet the health care needs of the entire nonelderly population with income below percent of the poverty level.”³⁸⁵ This was a “shift in kind, not merely degree” and thus beyond the consent of the states.³⁸⁶ Roberts concluded by limiting his own holding, noting that nothing in it precluded Congress from both offering funds under the ACA to expand health care and requiring that states that accept such funds comply with the conditions of their use.³⁸⁷ All that was precluded, said Roberts, was penalizing states that “choose not to participate in that new program by taking away their existing Medicaid funding.”³⁸⁸

Scalia, in an opinion written for the four justices that rounded out the majority on this issue, also harped on the situation’s outsized facts and figures.³⁸⁹ At the outset, Scalia called this, like the individual mandate, an issue of “first impression.”³⁹⁰ He confirmed, as Roberts had, that Congress could employ conditional spending³⁹¹,

379. *Id.*

380. *Id.* at 2605.

381. *Id.* (citing 42 U.S.C. § 1304).

382. *Id.*

383. *Id.*

384. *Id.* at 2605-06.

385. *Id.* at 2606.

386. *Id.* at 2605-06.

387. *Id.* at 2607.

388. *Id.*

389. *Id.* at 2658 (Scalia, J.).

390. *Id.* at 2642-43 (“[W]e have never found a law enacted under the spending power to be coercive.”).

391. *Id.* at 2658 (citing *Pennhurst St. Sch. and Hosp. v. Halderman*, 451 U.S. 1, 17 (1981); *South Dakota v. Dole*, 483 U.S. 203, 206 (1987); *Fullilove v. Klutznick*,

but with limitations³⁹²: specifically, that the conditions’ acceptance not be compulsive.³⁹³ In determining whether the ACA provision possessed that quality, Scalia also delved into the specific “dimensions of the Medicaid program,”³⁹⁴ citing facts: Medicaid was “the largest federal program of grants to the States” and, in 2010, the Federal Government directed more than \$552 billion in federal funds to the States, including \$233 billion went to pre-expansion Medicaid, representing “nearly 22% of all state expenditures combined.”³⁹⁵ Some states’ federal Medicaid outlays were equal to a third of their total state expenditures.³⁹⁶ Thus, said Scalia, “the offer that the ACA makes to the States—go along with a dramatic expansion of Medicaid or potentially lose all federal Medicaid funding—is quite unlike anything that we have seen in a prior spending-power case.”³⁹⁷ Further, if Congress had actually thought that states may actually refuse to abide by this condition, it would have devised a backup scheme such that society’s most vulnerable groups would not “be left out in the cold” once states’ Medicare funding was cut.³⁹⁸ But there was no such backup.³⁹⁹ Accordingly, said Scalia, it was clear that “the offer of the Medicaid Expansion was one that Congress understood no State could refuse” and therefore exceeded Congress’ Spending Power.⁴⁰⁰

Because the Medicaid ruling of *NFIB*, as shown by these opinions, was so fact-specific and narrow, it will not limit conditional

448 U.S. 448, 474 (1980) (opinion of Burger, C.J.); *Steward Mach. Co. v. Davis*, 301 U.S. 548, 593 (1937)).

392. *Id.* at 2659 (citing *Dole*, 483 U.S. at 207 (stating that spending power is “subject to several general restrictions articulated in our cases”); *Pennhurst*, 451 U.S. at 17 (stating that conditions must be unambiguous so state know what they are getting into); *Massachusetts v. United States*, 435 U.S. 444, 461 (1978) (stating that conditions must be related “to the federal interest in particular national projects or programs”); *Dole*, 483 U.S. at 210 (stating that conditions may not “induce the States to engage in activities that would themselves be unconstitutional”); *Lawrence Cnty. v. Lead-Deadwood Sch. Dist. No. 40-1*, 469 U.S. 256, 269-70 (1985)).

393. *Id.* at 2659 (citing *Steward Mach.*, 301 U.S. at 590; *College Sav. Bank v. Fla. Prepaid Postsecondary Educ. Expense Bd.*, 527 U.S. 666, 687 (1999); *Metro. Wash. Airports Auth. v. Citizens for A.B.A. Statement of Aircraft Noise, Inc.*, 501 U.S. 252, 285 (1991) (White, J., dissenting); *Dole*, 483 U.S. at 211).

394. *Id.* at 2659.

395. *Id.* at 2662-63 (citing Nat’l Ass’n of St. Budget Officers, *2010 State Expenditure Report: Examining Fiscal 2009-2011 State Spending*, 7 (2011)).

396. *Id.* at 2663.

397. *Id.* at 2664.

398. *Id.* at 2665.

399. *Id.*

400. *Id.* at 2666.

spending-based telemedicine licensure reform so long as such reform respects *NFIB*'s discrete boundaries. In this way, the ruling is a roadmap for such reform to follow in order to avoid being unconstitutionally coercive.⁴⁰¹ For example, both Roberts and Scalia were influenced by the amount of Medicaid spending at issue (\$552 billion) and the fact that it accounted for such a high percentage of states' total expenditures (as high as one third).⁴⁰² By contrast, in *South Dakota v. Dole*⁴⁰³, another conditional spending case where the Court held that no coercion existed, the federal statute at issue threatened (for states who did not adopt a uniform drinking age) just five percent of federal highway funds (or less than half of a percent of one plaintiff state's budget).⁴⁰⁴ Accordingly, conditional spending-based federal telemedicine licensure reform should keep the amount of funding that it threatens closer to the amount threatened by the law in *Dole* than to the amount threatened in *NFIB*.⁴⁰⁵ Second, Roberts said that "nothing in [his] opinion precludes Congress from offering funds under the [ACA] to expand the availability of health care, and requiring that States accepting such funds comply with any conditions on their use."⁴⁰⁶ His ruling was merely that Congress may not "penalize States that choose not to participate in [a] new program by taking away their existing Medicaid funding"⁴⁰⁷ and, more generally, that when "conditions take the form of threats to terminate other significant independent grants" they are an unconstitutional exercise of the Spending

401. Pasachoff, *supra* note 152, at 662 (stating that Congress should "take heed of *NFIB*'s lessons and pay close attention to the size and structure of . . . new . . . conditional spending programs").

402. *NFIB*, 132 S. Ct. at 2604-05, 2662-63; *see also* Huberfeld, Leonard, & Outterson *supra* note 356, at 62 (stating that "[a]ccording . . . to the Roberts plurality . . . offering a large sum of money is a permissible exercise of the spending power. But threatening to take away an equally large sum or a large percentage of already allotted money is potentially a prohibited exercise of the spending power.").

403. 483 U.S. 203 (1987).

404. *NFIB*, 132 S. Ct. at 2604 (quoting *Dole*, 483 U.S. at 211); *see also* Pace v. Bogalusa City Sch. Bd., 403 F.3d 272, 287 (5th Cir. 2005) (en banc) (stating that the threatened loss of an \$800 million federal spending program was not coercive because the state could have declined the funds).

405. Pasachoff, *supra* note 152, at 656-58.

406. *NFIB*, 132 S. Ct. at 2607.

407. *Id.*; *see also* Huberfeld, Leonard, & Outterson, *supra* note 356, at 88 (calling the decision "fractured," "obliquely reasoned," and "[s]elf-consciously avoiding any definable test"); Michael S. Greve, *Coercion, Conditions, and Commandeering: A Brief Note on the Medicaid Holding of NFIB v. Sebelius*, 37 HARV. J.L. & PUB. POL'Y 1 (2014).

Power.⁴⁰⁸ So conditional spending-based federal telemedicine licensure reform should avoid conditioning independent, unrelated grants (especially Medicaid's) on conformance with those laws.⁴⁰⁹ Instead of attaching telemedicine licensure reform to an existing program, drafters might position it as a "new program," attach a separate funding stream to it, and make applying for it wholly discretionary.⁴¹⁰ By following these guideposts, drafters of federal telemedicine licensure reform ensure that *NFIB*'s ruling does not apply to inhibit such reform.

b. *NFIB*'s Medicaid Ruling Does Not Upset Existing Conditional Spending Jurisprudence, Which Grants Congress Broad Power to Enact Conditional Spending-Based Telemedicine Licensure Reform.

NFIB's Medicare ruling, since it is so narrow, does not prevent existing conditional Spending Power jurisprudence, which is highly deferential to Congress, from being applied to—and authorizing—federal telemedicine licensure reform. In *NFIB*, Scalia said that the Spending Power is "obviously very broad" and gives Congress "wide leeway to decide whether an expenditure

408. *NFIB*, 132 S. Ct. at 2604.

409. Thomas, *supra* note 355, at 10-11 (stating that "Roberts' decision in *NFIB* appears to contemplate that when a court evaluates a grant condition, it must determine the relationship between that grant condition and the underlying grant program" and "if the grant condition is for a new and independent program, the government threatens the funding of an existing program, and the withholding of federal funding represents a significant portion of a state's budget, then the condition would be coercive under the Tenth Amendment.").

410. Pasachoff, *supra* note 152, at 657; *see also* Megan Ix, *National Federation of Independent Business v. Sebelius: The Misguided Application and Perpetuation of an Amorphous Coercion Theory*, 72 MD. L. REV. 1415, 1441-42 (2013) (stating that in *NFIB* "the Supreme Court found that the ACA did not simply expand the Medicaid program but . . . created a new program altogether. Thus, a possible new criterion for coercion emerged: A federal spending program may be coercive if it threatens to withhold funding from a separate program for refusal to participate in the new program.").

qualifies.”⁴¹¹ In fact, since 1936’s *United States v. Butler*,⁴¹² “the Court has never held that a federal expenditure was not for ‘the general welfare.’”⁴¹³ As Scalia also pointed out, one way that Congress can spend to promote the general welfare is by making grants to the States,⁴¹⁴ and the Supreme Court has “long held” that it may conditions those grants.⁴¹⁵ Such “conditional spending” has been the basis for much federal reform⁴¹⁶, including health reform.⁴¹⁷ In fact, “[t]he nation’s major public healthcare programs, such as Medicare, Medicaid, and CHIP, are all conditional spending programs.”⁴¹⁸ Courts have upheld such programs as a proper

411. *NFIB*, 132 S. Ct. at 2658 (citing *Helvering v. Davis*, 301 U.S. 619 (1937) (upholding, as an exercise of the Spending Power, the Social Security Act of 1935)); see also Kathleen S. Swendiman, CONG. RESEARCH SERV., *Health Care: Constitutional Rights and Legislative Powers*, 8 CONG. RESEARCH SERV. (July 9, 2012) (stating that the Spending Power is “one of the broadest grants of authority to Congress.”); Kreit, *supra* note 366, at 989 (Congress has “nearly unlimited discretion” as to how to spend tax dollars.); *Buckley v. Valeo*, 424 US 1, 90-91 (1975) (“[I]t is for Congress to decide which expenditures will promote the general welfare.”).

412. 297 U.S. 1 (1936).

413. *NFIB*, 132 S. Ct. at 2658; Andrew B. Coan, *Judicial Capacity and the Conditional Spending Paradox*, (Oct. 10, 2012); 2013 WISC. L. REV. 339, 346-47 (2012) (*NFIB* was preceded by “seven decades of uninterrupted judicial deference to Congress’s spending power”).

414. *NFIB*, 132 S. Ct. at 2658.

415. *Id.* at 2602 (Roberts, C.J.) (citing *College Sav. Bank v. Fla. Prepaid Postsecondary Educ. Expense Bd.*, 527 U.S. 666, 686 (1999)).

416. *South Dakota v. Dole*, 483 U. S. 203, 206-7 (1987) (Congress has “repeatedly employed” conditional spending “to further broad policy objectives.”).

417. See Kreit, *supra* note 403, at 989-90 (listing The Mental Health Act of 1946, the Mental Retardation Facilities & Community Mental Health Service Act of 1963, and Medicare and Medicaid in 1966 as examples); Emergency Medical Treatment and Active Labor Act, Pub. L. No. 99-272, § 1921 (1991); see also Tammy R. Murray, *State Innovation in Health Care: Congress’ Broad Spending Power Under a National Health Care System will Stifle State Laboratories of Democracy*, 3 INDIANA HEALTH L. REV. 1, 1 (2006) (“[T]he spending power of the federal government is nearly limitless, allowing it to influence or control state government regulation of health care.”); see also FRANK P. GRAD, *THE PUBLIC HEALTH LAW MANUAL*, 14 (2d ed. 1990) (“Through . . . categorical grant-in-aid programs, the federal government influences the manner in which public health is administered and the methods of service delivery. The taxing and spending power clearly has as much impact on public health as does the more direct exercise of power under the interstate commerce clause.”).

418. Nicole Huberfeld, *Conditional Spending and Compulsory Maternity*, 2010 U. ILL. L. REV. 751, 753 (2010) (citing Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, 9 J. HEALTH CARE L. & POL’Y 5, 10 (2006)); see also *Coleman v. Glynn*, 983 F.2d 737, 740-41 (6th Cir.1993) (“Medicaid . . . is an example of Congress legislating through use

exercise of the Spending Power, even over Tenth Amendment objections.⁴¹⁹ For this reason, conditional spending is a viable path for federal regulation of the medical profession,⁴²⁰ including telemedicine licensure reform.⁴²¹

That said, as pointed out by Ginsburg in her opinion, conditions on the states' use of the federal funds⁴²² do have "federalism-based limits" on these conditions.⁴²³ One is the "coercion" limitation discussed above,⁴²⁴ which federal telemedicine licensure clears; the other four are laid out in *South Dakota v. Dole*,⁴²⁵ the "leading decision in this area."⁴²⁶ Specifically, the *Dole* Court said the conditions placed on federal grants to States are that those conditions must (a) promote the "general welfare," (b) "unambiguously" inform States what is demanded of them, (c) be germane "to the federal interest in particular national projects or

of its spending power."); *Gonzaga Univ. v. Doe*, 536 U.S. 273, 280 (2002) (stating that Medicaid is spending power legislation).

419. *E.g.*, *Halderman v. Pennhurst St. Sch. & Hosp.*, 612 F.2d 84, 98 (3d Cir. 1979), *rev'd on other grounds*, 101 S. Ct. 1531 (1981) (upholding federal funds conditioned on states adopting standards for the treatment and habilitation of the developmentally disabled, despite the argument that such conditions "transgress the bounds of federal law making competence, inasmuch as mental health policies have always been within the states' traditional police power authority."); *North Carolina v. Califano*, 445 F. Supp. 532, 533 (E.D.N.C. 1977), *aff'd mem.*, 435 U.S. 962 (1978) (upholding federal health grants conditioned on states establishing a health planning and development agency, despite the argument that such conditions were "an unconstitutional interference with the State's legislative and constitutional processes violative of the principles of federalism and state sovereignty, as guaranteed under . . . the Tenth Amendment.").

420. Lars Noah, *Ambivalent Commitments to Federalism in Controlling the Practice of Medicine*, 53 U. KAN. L. REV. 149, 169 (2004) ("[B]ecause the Supreme Court has not yet imposed any meaningful limitations on the spending power, Congress could regulate health care professionals without ever having to invoke the Commerce Clause.").

421. *See* McCann, *supra* note 18 (stating that two Congressional bills tried to use Medicaid or Medicare funding to incent states to liberalize their telemedicine licensure policies: (1) The Telemedicine for Medicare Act (H.R. 3077), introduced in the House in September 2013, which would have let Medicare providers treat patients electronically in any state so long as they were licensed in one state, and (2) The Telehealth Promotion Act (H.R. 6719), introduced in the House in January 2013, which would have decreed that care providers on *all* federal plans could practice in all states if they were licensed in their physical location).

422. *See* *NFIB v. Sebelius*, 132 S. Ct. 2566, 2633 (2012).

423. *See id.* at 2634.

424. *See id.* (citing *South Dakota v. Dole*, 483 U.S. 203, 211 (1987)).

425. *See Dole*, 483 U.S. at 203.

426. *See NFIB*, 132 S. Ct. at 2634.

programs,” and (d) not “induce the States to engage in activities that would themselves be unconstitutional.”⁴²⁷

Conditional-based federal telemedicine licensure reform satisfies (or can easily satisfy) each of *Dole*'s conditions. First, such reform promotes the “general welfare.”⁴²⁸ Like the conditional spending upheld in *Dole*, which sought to curb underage drinking and driving, and like other Court-upheld health-related conditional spending,⁴²⁹ federal telemedicine licensure reform aims to solve an “interstate problem require[ing] a national solution.”⁴³⁰ Specifically, it aims to protect the welfare of Americans by improving the quality of medical care and curbing its costs.⁴³¹ Second, like the one at issue in *Dole*, a federal telemedicine licensure reform statute can “clearly state[]” the “conditions upon which States receive the funds.”⁴³² It can do this, for example, by unambiguously referring to the funding programs it targets and unambiguously addressing the specific actions (e.g., mutual reciprocity of licensure) required.⁴³³ Third, like the statute in *Dole*, federal telemedicine licensure reform is germane to a federal interest in a national program.⁴³⁴ The statute upheld in *Dole*, for example, “directly related to one of the main purposes for which highway funds are expended — safe interstate travel” which was “frustrated” by “the lack of uniformity in the States’ drinking ages,” which had created “an incentive to drink and drive” because “young persons commut[e] to border States where the drinking age is lower.”⁴³⁵ By instituting uniformity of laws, the statute at issue “conditioned the receipt of federal funds in a way reasonably calculated to address this particular impediment to a purpose for which the funds are expended.”⁴³⁶ Likewise, federal telemedicine licensure reform aimed squarely at curbing the “lack of uniformity” of telemedicine licensure laws.⁴³⁷ This fragmentation hinders

427. *Id.* (citing *Dole*, 483 U.S. at 207-8, 210).

428. *See Dole*, 483 U.S. at 208.

429. *See Helvering v. Davis*, 301 U.S. 619 (1937) (Medicare); *NFIB*, 132 S. Ct. at 2593-2601, 2628-29 (ACA).

430. *See Dole*, 483 U.S. at 208.

431. *See supra* Part III.A.

432. *See Dole*, 483 U.S. at 208.

433. *See Curtis Summers, Porn Impacts the Spending Power? The Children's Internet Protection Act and Dole's Need for Practical "Bite,"* 53 U. KAN. L. REV. 509, 521 (2005).

434. *See Dole*, 483 U.S. at 208.

435. *Id.* at 209 (citing the Presidential Commission on Drunk Driving, Final Report 11 (1983)).

436. *Id.*

437. *See supra* note 421.

telemedicine,⁴³⁸ a proven way to cut the costs of healthcare,⁴³⁹ which threaten federal expenditures aimed at improving American healthcare.⁴⁴⁰ Accordingly, licensure conditions tied to such expenditures, are “reasonably calculated” to address that “particular impediment for which the funds are expended.”⁴⁴¹ Fourth, a federal telemedicine licensure reform statute would not “induce the States to engage in activities that would themselves be unconstitutional.”⁴⁴² As an example, said the *Dole* Court, a grant of federal funds conditioned on invidiously discriminatory state action or the infliction of cruel and unusual punishment would be an illegitimate exercise of the Congress’ broad Spending Power.⁴⁴³ But no such claim about telemedicine licensure has or can be made; indeed, conditional spending-based federal telemedicine licensure reform would not force states to engage in any activities they do not already engage in and whose constitutionality has previously been upheld.⁴⁴⁴ Thus, conditional spending-based federal telemedicine licensure reform satisfies all the conditions set forth in *Dole* and should be upheld as a constitutional exercise of Congress’ power to spend on the general welfare.

B. Liberty Proves That NFIB’s Commerce Clause Ruling Will Not Be Applied Broadly to Prevent Federal Telemedicine Licensure Reform from Finding Support in This Clause.

Shortly after *NFIB*, in *Liberty*,⁴⁴⁵ the Fourth Circuit took its turn to weigh the constitutionality of certain provisions of the ACA. Among the lower courts that have tackled this topic,⁴⁴⁶ *Liberty* stands out. This is because *Liberty* shows, convincingly, that the Commerce Clause ruling of *NFIB* will not apply broadly to restrict the Commerce Clause power.⁴⁴⁷ Instead, *Liberty* indicates that the limits that *NFIB* placed on the Commerce Clause power are circumscribed and that pre-*NFIB* Commerce Clause precedent, which is highly deferential to Congress, applies as it always did.⁴⁴⁸ Because the Commerce Clause is still the most potent source of

438. See *supra* note 16.

439. See *supra* note 4.

440. See *supra* note 301.

441. *Dole*, 483 U.S. at 209.

442. *Id.* at 210.

443. *Id.* at 210-11.

444. See Appendix I; *supra* note 124.

445. See *Liberty Univ. v. Lew*, 733 F.3d 72, 91-96 (4th Cir. 2013).

446. *Supra* note 128.

447. See *Liberty Univ.*, 733 F.3d at 91-94.

448. See *id.*

support for federal telemedicine licensure reform,⁴⁴⁹ *Liberty* is a positive omen for such reform.

The plaintiffs in *Liberty* challenged the “employer mandate,” the provision of the ACA that requires some employers to provide health coverage for employees and their dependents.⁴⁵⁰ Initially, the U.S. District Court for the Western District of Virginia dismissed the action, upholding the employer mandate.⁴⁵¹ On appeal, the Fourth Circuit held that the Anti-Injunction Act (“AIA”) barred the case from consideration and remanded it with instructions to dismiss.⁴⁵² The plaintiffs then petitioned for writ of certiorari with the Supreme Court, who vacated the Fourth Circuit’s judgment and remanded it for reconsideration in light of *NFIB*’s AIA ruling.⁴⁵³ On remand, the Fourth Circuit considered whether the employer mandate was within Commerce Clause authority.⁴⁵⁴

In the end, the Fourth Circuit found that the employer mandate was within Congress’ Commerce Clause authority, confirming that *NFIB*’s ruling was a narrow one that will not crimp the Clause’s broad ability to support federal telemedicine licensure.⁴⁵⁵ The Fourth Circuit began by citing Roberts’ *NFIB* opinion to say that the Commerce Clause power is a broad one.⁴⁵⁶ The symbolic value of this cite cannot be ignored; it shows that, in the eyes of the Fourth Circuit, *NFIB* affirmed, rather than peeled back, the decades of Commerce Clause expansion that preceded it.⁴⁵⁷ As if to double down on that notion, the Fourth Circuit then cited *NLRB*, the catalyst of the Clause’s modern expansion, to say that its authority includes “the power to enact *all* appropriate legislation for its protection or advancement; to adopt measures to promote its growth and insure its safety; to foster, protect, control, and restrain.”⁴⁵⁸ This means it gives Congress the authority to regulate activities that substantially affect interstate

449. See *supra* Part III.B.1.b.

450. *Liberty Univ.*, 733 F.3d at 83. The *Liberty* plaintiffs also, like the plaintiffs in *NFIB*, challenged the ACA’s individual mandate. *Id.* But that aspect of the case was discontinued in the wake of *NFIB*. *Id.* at 95.

451. *Id.*

452. *Id.*; see *Liberty Univ. v. Geithner*, 671 F.3d 391 (4th Cir. 2011).

453. *Liberty Univ.*, 733 F.3d at 83; *Liberty Univ. Inc. v. Geithner*, 133 S. Ct. 679 (2012).

454. *Liberty Univ.*, 733 F.3d at 91-94.

455. *Id.*

456. *Id.* at 91-92 (citing *NFIB v. Sebelius*, 132 S. Ct. 2566, 2585 (2012)).

457. *Supra* note 147.

458. *Liberty Univ.*, 733 F.3d at 92 (citing *NLRB v. Jones & Laughlin Steel Corp.*, 301 U.S. 1, 36-37) (emphasis added).

commerce,⁴⁵⁹ and the power to regulate, without a showing that they have “any specific effect upon interstate commerce,” activities in which “in the aggregate, the activity ‘would represent a general practice . . . subject to federal control.’”⁴⁶⁰ Moreover, said the Fourth Circuit (borrowing language from Ginsburg’s *NFIB* opinion), Congress need not show that the activity “taken in the aggregate, substantially affect[s] interstate commerce in fact, but only that a *rational basis* exists for so concluding.”⁴⁶¹

The Fourth Circuit next acknowledged that *NFIB* had shown that the Commerce Clause power was not without limits.⁴⁶² But the Court marginalized those limits, saying that *NFIB*’s ruling was merely that the Clause does not give Congress authority to “compel” or “mandate” an individual to enter commerce by purchasing a good or service and “permits Congress to regulate only *existing activity*.”⁴⁶³ In fact, said the Court, *NFIB*’s ruling was so limited it did not even apply to the employer mandate.⁴⁶⁴ This was because the employer mandate “does not seek to create commerce in order to regulate it.”⁴⁶⁵ Unlike the individuals who were the focus of the individual mandate in *NFIB*, employers are, by their nature, “engaged in economic activity” and “in the market for labor.”⁴⁶⁶ So, said the Court, the employer mandate does not compel them to “become active in commerce”⁴⁶⁷ and regulates only “existing commercial activity, i.e., the compensation of employees.”⁴⁶⁸ Further, the employer mandate does not require employers to purchase an unwanted product.⁴⁶⁹ Some employers would have to

459. *Id.* at 92 (citing *United States v. Morrison*, 529 U.S. 598, 609 (2000)).

460. *Id.* (citing *Citizens Bank v. Alafabco, Inc.*, 539 U.S. 52, 56-57 (2003)) (ellipsis in original).

461. *Id.* (citing *Gonzales v. Raich*, 545 U.S. 1, 22 (2005)) (emphasis added); *see also id.* at 91 (“[T]he *determinative test* of the exercise of power by the Congress under the Commerce Clause is simply whether the activity sought to be regulated is commerce which concerns more States than one and has a real and substantial relation to the national interest.”) (quoting *Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241, 255 (1964)) (internal quotations omitted) (emphasis added).

462. *Id.* (citing *NFIB v. Sebelius*, 132 S. Ct. 2566, 2585-93 (Roberts, C.J.); *id.* at 2644-50 (Scalia, J., dissenting)).

463. *Id.* (citing *NFIB*, 132 S. Ct. at 2587 (Roberts, C.J.); *id.* at 2646-47 (Scalia, J., dissenting)) (emphasis added).

464. *Id.* at 93.

465. *Id.*

466. *Id.*

467. *Id.* (citing *NFIB*, 132 S. Ct. at 2587 (Roberts, C.J.)) (emphasis in original).

468. *Id.* (internal quotations omitted).

469. *Id.*

increase employee compensation (by offering new or modified health insurance coverage), but they remained free to self-insure.⁴⁷⁰ For these reasons, the employer mandate “stands on quite a different footing from the individual mandate” and was not affected by the ruling of *NFIB*.⁴⁷¹

Having decided that, the *Liberty* Court then concluded that the employer mandate was a valid exercise of Congress’ authority under the Commerce Clause, using reasoning that transfers easily to federal telemedicine licensure reform.⁴⁷² Specifically, the Fourth Circuit found that the employer mandate was within the Commerce Clause power because Congress, for three reasons,⁴⁷³ had a “rational basis” for concluding that the activity it regulated “substantially affect[s] interstate commerce.”⁴⁷⁴ First, the employer mandate regulates a term of employment (compensation) that substantially affects interstate commerce⁴⁷⁵ because health insurance that is provided as part of employee compensation “is the primary source of coverage for the nonelderly,” and “[h]ealth insurance and health care services are a significant part of the national economy.”⁴⁷⁶ Second, employers who do not offer health insurance to employees gain an unfair economic advantage over those who do, perpetuating a “vicious cycle:” uninsured workers turn to emergency rooms for care that they cannot afford, and care providers pass the cost (of their uncompensated care) on to private insurers, who, in turn, pass the cost on to the insured through premium increases, thus making it more expensive for employers to insure employees.⁴⁷⁷ These costs were a large drag on the economy.⁴⁷⁸ Thus, employer-provided health insurance has a substantial impact on interstate commerce.⁴⁷⁹ Third, recognizing Congress’ authority to enact the

470. *Id.* at 93-94.

471. *Id.* at 94.

472. *Id.* at 94-95.

473. *Id.*

474. *Id.* at 94.

475. *Id.*

476. *Id.* (citing CONG. BUDGET OFFICE, KEY ISSUES IN ANALYZING MAJOR HEALTH INSURANCE PROPOSALS 4 (Dec. 2008); 42 U.S.C. § 18091(2)(B) (2012)) (“National health spending is projected to increase from [\$2.5 trillion], or 17.6 percent of the economy, in 2009 to [\$4.7 trillion] in 2019. Private health insurance spending is projected to be [\$854 billion] in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce.”).

477. *Id.* (citing H.R. Rep. No. 111-443(II), at 985 (2010); § 18091(2)(F)).

478. *Id.* (citing § 18091(2)(E)-(F)) (“[T]he cost of providing uncompensated care to the uninsured was \$43 billion in 2008 and the economy loses up to \$207 billion a year because of the poorer health and shorter lifespan of the uninsured.”).

479. *Id.* at 95.

employer mandate would not, as *NFIB* prohibited, “open a new and potentially vast domain to congressional authority” or “enable the Federal Government to regulate all private conduct.”⁴⁸⁰ Requiring employers to offer employees a certain level of compensation through health insurance coverage is akin to requiring them to pay workers a minimum wage or time and a half for overtime.⁴⁸¹ Thus, the Court said its conclusion that “Congress had a rational basis for finding that employers’ provision of health insurance coverage substantially affects interstate commerce” fit squarely within the existing Supreme Court jurisprudence, including *NFIB*.⁴⁸²

This analysis and ruling, preserved when the Supreme Court declined to grant certiorari in 2013,⁴⁸³ maps well with federal telemedicine licensure reform. Like the employer mandate, federal telemedicine licensure reform is not affected by *NFIB*’s limitations because it regulates “only existing activity;”⁴⁸⁴ like *Liberty*’s employers, physicians are, by their nature, “engaged in economic activity.”⁴⁸⁵ Further, telemedicine satisfies the “rational basis”⁴⁸⁶ test for the same three reasons that the *Liberty* Court decided the employer mandate did. It regulates an activity (the licensure of telemedicine practitioners) that, because it dictates who may practice across state lines, substantially affects the interstate market for care.⁴⁸⁷ Second, like the employer-sponsored health plans in *Liberty*, telemedicine licensure has a broader impact on interstate commerce.⁴⁸⁸ State telemedicine licensure laws still “present the most formidable hurdle for the interstate practice of medicine.”⁴⁸⁹ Just as the absence of employer-sponsored health plans create a drag on the entire health market and economy, so do any barriers that block telemedicine practitioners from competing (and cutting costs⁴⁹⁰) in

480. *Id.* (citing *NFIB v. Sebelius*, 132 S. Ct. 2566, 2587, 2643 (2012)).

481. *Id.* (citing *United States v. Darby*, 312 U.S. 100, 115 (1941); *Overnight Motor Transp. Co. v. Missel*, 316 U.S. 572, 577 (1942)).

482. *Id.*

483. *Liberty Univ. v. Lew*, 733 F.3d 72 (4th Cir.), *cert. denied*, 134 S. Ct. 683 (2013).

484. *Id.* at 92 (citing *NFIB*, 132 S. Ct. at 2587, 2646-47); *see supra* Part III.B.3.b.

485. *Id.* at 93.

486. *Id.* at 92.

487. *See supra* Part III.B.1.b.

488. *Liberty Univ.*, 733 F.3d. at 94.

489. *See Spradley*, *supra* note 106, at 317.

490. *See supra* Part III.B.1.b.

new markets.⁴⁹¹ Lastly, recognizing Congress' authority to enact federal telemedicine licensure will not "open a new and potentially vast domain to congressional authority."⁴⁹² Congress already broadly regulates health⁴⁹³ and licenses professions.⁴⁹⁴ Accordingly, federal telemedicine licensure reform is a valid exercise under existing precedent, as applied by *Liberty*, which provides yet another buttress for such reform.

V. CONCLUSION

Telemedicine, along with its promise to improve the quality and reduce the cost of care, has been hindered by a fragmented system of state licensure of telemedicine practitioners. A federally-directed reform effort, because it is most likely to achieve uniformity (and to do so swiftly), is the most effective cure for this problem. But it has not always been clear that such an effort would survive constitutional scrutiny. Luckily, the ACA's legal aftermath has resolved some of this ambiguity. While *NFIB's* Commerce Clause, Necessary and Proper Clause, and Medicaid Spending Power rulings placed limits on those powers, the fact is that those limits (as demonstrated, with regard to the Commerce Clause, in *Liberty*) are very narrow. They will not hamper federal telemedicine licensure reform. Further, each of *NFIB's* holdings preserves the Supreme Court jurisprudence which preceded *NFIB* and which is highly deferential to Congress. Based on that jurisprudence, Congress can confidently pursue telemedicine licensure reform knowing that it will overcome any constitutional challenges and find secure support in the Commerce Clause, Necessary and Proper Clause, or Congress' power to spend conditionally on the general welfare.

491. *See id.*; *see also Connecting America: The National Broadband Plan*, 206 (2010) ("State-by-state licensing . . . hinders access to care, especially for residents of states that do not have needed expertise in-state.").

492. *See id.* (citing *NFIB v. Sebelius*, 132 S. Ct. 2566, 2587, 2643 (2012)).

493. *See supra* note 19.

494. *See supra* Part I.B.

TABLE 1⁴⁹⁵

Alabama	To practice telemedicine in Alabama, out-of-state ⁴⁹⁶ doctors need not have a full license to practice medicine in Alabama but must obtain a telemedicine-specific license. ⁴⁹⁷
Alaska	To practice telemedicine in Alaska, out-of-state doctors must have a full license to practice medicine in Alaska and must have a “(licensed) health care provider [with the patient] to assist the [out-of-state] physician with their examination.” ⁴⁹⁸
Arizona	To practice telemedicine in Arizona, out-of-state doctors need not have a full license to practice medicine in Arizona, but may only engage in single or infrequent consultations with Arizona-licensed physicians. ⁴⁹⁹
Arkansas	To practice telemedicine in Arkansas, out-of-state doctors must have a full license to practice medicine in Arkansas unless they merely “consult” on an “irregular basis” with an in-state, Arkansas-licensed doctor. ⁵⁰⁰

495. The authors of this article independently researched the state guidelines and statutes reflected in this chart. However, similar articles and projects have created charts with the identical purpose. For further reference, those charts can be found at the following sources. *The State of Licensure in the U.S.*, Law and Policy in Telemedicine, TELEMEDICINE INFORMATION EXCHANGE (2007), https://web.archive.org/web/20070816053326/http://tie.telemed.org/legal/state_data.asp?type=licensure; Telemedicine Licensure Report, Center for Telemedicine Law, OFFICE FOR THE ADVANCEMENT OF TELEHEALTH (June 2003), *available at* <http://www.hrsa.gov/ruralhealth/about/telehealth/licenserpt03.pdf>.

496. For the purposes of this Table, “out-of-state” doctor refers to a doctor who is physically present as well as licensed to practice medicine in another state. Further, unless otherwise specified, “license” refers to a full medical (or “M.D.”) license (and not, for example, a telemedicine-specific license).

497. ALA. CODE § 34-24-502-507 (2012).

498. ALASKA STATE MED. BRD. ISSUED GUIDELINES § 6 (2014).

499. ARIZ. REV. STAT. § 32-1421 (2012).

500. ARK. STATE MED. BD. REG. 20 (1997) (discussing practice of medicine by a non-resident).

California	To practice telemedicine in California, out-of-state doctors must have a full license to practice medicine in California and must “provide an appropriate [in-person] prior exam to diagnose and/or treat the patient.” ⁵⁰¹
Colorado	To practice telemedicine in Colorado, out-of-state doctors must have a full license to practice medicine in Colorado unless they (a) are providing emergency care; (b) are providing “occasional” care, and keep no staff or office in Colorado; or (c) are providing care in certain select areas (e.g., podiatry). ⁵⁰²
Connecticut	To practice telemedicine in Connecticut, out-of-state doctors must have a full license to practice medicine in Connecticut unless they are (a) providing care on an “irregular basis” with a doctor who is licensed in the state or (b) work for an educational institution. ⁵⁰³
Delaware	No specific licensure laws or policies pertaining to telemedicine licensure. However, Delaware prohibits internet prescribing by a physician who has not established a prior physician-patient relationship ⁵⁰⁴ as well as treating patients solely by “correspondence”, which includes “telecommunications.” ⁵⁰⁵
District of Columbia	No specific licensure laws or policies pertaining to telemedicine licensure.
Florida	To practice telemedicine in Florida, out-of-state doctors must have a full license to practice medicine in Florida and must have previously given the patient a physical examination. ⁵⁰⁶

501. CAL. BUS. & PROF. CODE § 2290.5 (West 2014).

502. COLO. REV. STAT. 12-36-106 (2014).

503. CONN. GEN. STAT. § 20-9(21)(b) (2012).

504. DEL. CODE. tit. 16, § 4744 (c)(1) (2008).

505. DEL. CODE. tit. 24, § 9.2.1.4.

506. FLA. ADMIN. CODE ANN. r. 64B8-9.014 (2004).

Georgia	To practice telemedicine in Georgia, out-of-state doctors must have a full license to practice medicine in Georgia and “shall not have ultimate authority over the care or primary diagnosis of a patient...in Georgia.” ⁵⁰⁷
Hawaii	No specific licensure laws or policies pertaining to telemedicine licensure. However, out-of-state radiologists do not need to be licensed to practice medicine in Hawaii. Further, commissioned medical officers or psychologists employed by the US DOD and credentialed by the Tripler Army Medical Center do not need to be licensed to practice medicine in Hawaii in order to treat neighbor island beneficiaries within a Hawaii national guard armory. ⁵⁰⁸
Idaho	No specific licensure laws or policies pertaining to telemedicine licensure. ⁵⁰⁹
Illinois	To practice telemedicine in Illinois, out-of-state doctors must have a full license to practice medicine in Illinois unless they are providing “periodic consultations [with] a person licensed [in Illinois]” or “a second opinion provided to a person licensed [in Illinois]” or “services provided to a patient in Illinois following care or treatment originally provided to the patient in the state in which the provider is licensed to practice.” ⁵¹⁰
Indiana	To practice telemedicine in Indiana, out-of-state doctors need not have a full license to practice medicine in Indiana so long as they do not practice telemedicine on a “regular, routine, and nonepisodic basis or under an oral or written agreement” or if they are “called in for consultation by an individual licensed to practice medicine ...in Indiana.” ⁵¹¹

507. GA. CODE ANN. § 43-34-31 (2014).

508. HAW. REV. STAT. §§ 453-2(3), 453-2(b)(6) (2014).

509. IDAHO CODE ANN. § 54-1804(2) (2014).

510. 225 ILL. COMP. STAT. 60/49.5 (West 2014).

511. IND. CODE §§ 25-22.5-1-1.1 (4)(b), 25-22.5-1-2(5) (2014).

Iowa	To practice telemedicine in Iowa, out-of-state doctors must have a full license to practice medicine in Iowa unless consultation and services are "incidental" to the care of patients. (Note that medical reports used for "primary diagnostic purposes" are not considered incidental under this provision.). ⁵¹²
Kansas	To practice telemedicine in Kansas, out-of-state doctors must have a full license to practice medicine in Kansas, with an exception made for second readings by a radiologist consulting with a Kansas-licensed radiologist. ⁵¹³
Kentucky	To practice telemedicine in Kentucky, out-of-state doctors must have a full license to practice medicine in Kentucky unless they practice medicine "infrequently" or "when called to see or attend to particular patients in consultation and association with a Kentucky-licensed physician." ⁵¹⁴
Louisiana	To practice telemedicine in Louisiana, out-of-state doctors need not have a full license to practice medicine in Louisiana but need a telemedicine-specific license and cannot open an office or meet with patients or receive calls from patients within Louisiana. ⁵¹⁵
Maine	No specific licensure laws or policies pertaining to telemedicine licensure.
Maryland	To practice telemedicine in Maryland, out-of-state doctors must have a full license to practice medicine in Maryland ⁵¹⁶ unless they (1) are students; (2) are merely "engaging in consultation with a physician licensed in" Maryland; (3) work for the federal government;

512. IOWA BD. OF MED., A POLICY STATEMENT ON TELEMEDICINE APPROVED BY THE IOWA BOARD (1996), *available at* <http://www.medicalboard.iowa.gov/policies/telemedicine.html>.

513. KAN. ADMIN. REGS. § 100-26-1 (2006).

514. KY. REV. STAT. ANN. § 311.560 (West 2014).

515. LA. REV. STAT. ANN. § 37:1276.1 (2008).

516. MD. CODE REGS. 10.32.05.03 (2013).

	(4) are (a) authorized to practice medicine by any state adjoining Maryland which grants the same privilege to Maryland licensees and (b) do not keep an office in Maryland; or (5) are psychiatrists supervised by licensed psychiatrists. ⁵¹⁷
Massachusetts	No specific licensure laws or policies pertaining to telemedicine licensure. ⁵¹⁸
Michigan	No specific licensure laws or policies pertaining to telemedicine licensure.
Minnesota	To practice telemedicine in Minnesota, out-of-state doctors need not have a full license to practice medicine in Minnesota if they (1) receive a telemedicine-specific license, register with the Board of Medical Practice, and promise not to open an office, receive phone calls, or meet with patients in Minnesota (2) provide only emergency treatment (3) provide treatment only on an “irregular or infrequent” basis or (4) provide treatment “in consultation with a physician licensed in this state and the Minnesota physician [who] retains ultimate authority over the diagnosis and care of the patient.” ⁵¹⁹
Mississippi	To practice telemedicine in Mississippi, out-of-state doctors need not have a full license to practice medicine in Mississippi if treatment is “requested by” a physician licensed to practice in Mississippi who has established a doctor-patient relationship and given a physical examination to the patient. ⁵²⁰

517. MD. CODE ANN., HEALTH OCC. § 14-302 (West 2013).

518. Notably, Massachusetts is taking steps to address this ambiguity. Chapter 224 of the Acts of 2012 § 249, effective on Nov. 5, 2012, ordered a report on the licensing of telemedicine professionals.

519. MINN. STAT. § 147.032 (2007).

520. 73 - 25 MISS. CODE R. § 34 (LexisNexis 2013); 50-13 MISS. CODE R. § 2635 (2012).

Missouri	To practice telemedicine in Missouri, out-of-state doctors must have a full license to practice medicine in Missouri unless (1) treating a patient “in consultation with a physician licensed to practice in” Missouri and that physician retains “ultimate authority” over the care of the patient or (2) rendering an opinion for a judicial matter. ⁵²¹
Montana	To practice telemedicine in Montana, out-of-state doctors need not have a full license to practice medicine in Montana but must obtain a telemedicine-specific license, must practice in their own specialty, and may not be physically present in Montana. ⁵²²
Nebraska	To practice telemedicine in Nebraska, out-of-state doctors must have a full license to practice medicine in Nebraska. ⁵²³
Nevada	To practice telemedicine in Nevada, out-of-state doctors must have a full license to practice medicine in Nevada, unless they obtain a telemedicine-specific license, are licensed in another state, do not have any disciplinary actions against them, and are certified by the American Board of Medical Specialties. ⁵²⁴
New Hampshire	To practice telemedicine in New Hampshire, out-of-state doctors must have a full license to practice medicine in New Hampshire unless they are merely consulting a licensed doctor and that doctor retains the ultimate authority and responsibility over the patient’s care. ⁵²⁵

521. MO. REV. STAT. § 334.010 (2014).

522. MONT. ADMIN. R. 24.156.803 (2014); MONT. CODE ANN. § 37-3-343 (2011).

523. NEB. REV. STAT. § 38-2024 (2014).

524. NEV. REV. STAT. § 630.261(E) (2014).

525. N.H. REV. STAT. § 329:1-b (1996); N.H. BD. OF MED., GUIDELINES FOR PHYSICIAN INTERNET AND TELEPHONE PRESCRIBING (2004) *available at* <http://www.nh.gov/medicine/aboutus/prescribing.htm> (stating that telephone prescribing is approved).

New Jersey	To practice telemedicine in New Jersey, out-of-state doctors must have a full license to practice medicine in New Jersey unless they are merely “taking charge temporarily, on written permission of the board, of the practice of a [licensed doctor] during his absence from the State.” ⁵²⁶
New Mexico	To practice telemedicine in New Mexico, out-of-state doctors need not have a full license to practice medicine in New Mexico, but must obtain a telemedicine-specific license. ⁵²⁷
New York	To practice telemedicine in New York, out-of-state doctors must have a full license to practice medicine in New York unless (a) they are providing only “occasional consultations”; or (b) are providing care that does not rise to the level of a doctor-patient relationship. ⁵²⁸
North Carolina	To practice telemedicine in North Carolina, out-of-state doctors must have a full license to practice medicine in North Carolina unless consulting with a licensed doctor on an “irregular basis.” ⁵²⁹
North Dakota	To practice telemedicine in North Dakota, out-of-state doctors must have a full license to practice medicine in North Dakota. ⁵³⁰

526. N.J. STAT. ANN. § 45:9-21(b) (West 2006).

527. N.M. STAT. ANN. § 61-6-11.1 (2014).

528. N.Y. EDUC. § 6526(3) (McKinney 1979); N.Y. DEPT. OF HEALTH, STATEMENTS ON TELEMEDICINE, available at <https://www.health.ny.gov/professionals/doctors/conduct/telemedicine.htm>.

529. N.C. GEN. STAT. § 90-18(c)(11) (2011); see also N.C. MED. BD., POSITION STATEMENTS: TELEMEDICINE (2010) available at http://www.ncmedboard.org/position_statements/detail/telemedicine.

530. N.D. CENT. CODE § 43-17-02 (2014); N.D. STATE BD. OF MED. EXAMINERS, BOARD MEETING MINUTES, (2013) (“The board discussed the fact that we always require licenses for telemedicine. Dr. Martin noted that in the practice of telemedicine, one loses the benefit of seeing the patient first-hand.”).

Ohio	To practice telemedicine in Ohio, out-of-state doctors need not have a full license to practice medicine in Ohio, but need a telemedicine-specific certificate. ⁵³¹
Oklahoma	To practice telemedicine in Oklahoma, out-of-state doctors must have a full license to practice medicine in Oklahoma unless care involves “brief consultations” with Oklahoma-licensed doctors. ⁵³²
Oregon	To practice telemedicine in Oregon, out-of-state doctors need not have a full license to practice medicine in Oregon if they (1) obtain a specific license to practice medicine across state lines; or (2) give only emergency care; or (3) merely consult with an Oregon- licensed physician and do not undertake the primary responsibility for diagnosing or rendering treatment to the patient. ⁵³³
Pennsylvania	To practice telemedicine in Pennsylvania, out-of-state doctors need not have a full license to practice medicine in Pennsylvania but must (1) be in an adjoining state and (2) obtain a special extraterritorial license, the granting of which depends on (a) the availability of medical care in that area and (b) whether the doctor’s resident state reciprocates. ⁵³⁴
Rhode Island	To practice telemedicine in Rhode Island, out-of-state doctors must have a full license to practice medicine in Rhode Island. ⁵³⁵
South Carolina	No specific licensure laws or policies pertaining to telemedicine licensure.

531. OHIO REV. CODE § 4731.296(C) (West 2008).

532. OKLA. STAT. tit. 59, § 492(a) (2009); OKLA. STAT. tit. 36, § 6802(a) (2009).

533. OR. REV. STAT. § 677.135, 137- 39 (2014).

534. 63 PA. STAT. ANN. § 422.34(a)(c)(2) (West 1986).

535. R.I. BD. OF MED. LICENSURE AND DISCIPLINE, GUIDELINES FOR THE APPROPRIATE USE OF TELEMEDICINE AND THE INTERNET IN MEDICAL PRACTICE, available at <http://www.health.ri.gov/publications/guidelines/provider/AppropriateUseOfTelemedicineAndTheInternetInMedicalPractice.pdf>.

South Dakota	To practice telemedicine in South Dakota, out-of-state doctors must have a full license to practice medicine in South Dakota unless “in actual consultation” with a South Dakota-licensed “practitioner of the healing arts.” ⁵³⁶
Tennessee	To practice telemedicine in Tennessee, out-of-state doctors need not have a full physician license to practice medicine in Tennessee if (1) they obtain a special-purpose telemedicine license; or (2) the care involved “occurs less than once a month or involves fewer than ten patients on an annual basis or comprises less than one percent (1%) of the physician's diagnostic or therapeutic practice” or is “in consultation” with a Tennessee-licensed physician. ⁵³⁷
Texas	To practice telemedicine in Texas, out-of-state doctors need not have a full license to practice medicine in Texas but must (1) obtain a telemedicine-specific license and (2) be a medical specialist located in another jurisdiction who provides only episodic consultation services on request to a physician licensed in this state who practices in the same medical specialty. ⁵³⁸
Utah	To practice telemedicine in Utah, out-of-state doctors must have a full license to practice medicine in Utah unless they are (1) licensed elsewhere with ten years of experience and no disciplinary action pending; (2) rendering services non-commercially; (3) charging no fee beyond expenses; and (4) not engaging in unlawful or unprofessional conduct. ⁵³⁹

536. S.D. CODIFIED LAWS § 36-4-41, 36-2-9 (2002).

537. TENN. COMP. R. & REGS. 0880-02-16 (2010).

538. 22 TEX. ADMIN. CODE § 172.12 (2015); TEX. OCC. CODE ANN. § 151.056 (West 2001).

539. UTAH CODE ANN. § 58-67-305 (West 2013).

Vermont	To practice telemedicine in Vermont, out-of-state doctors must have a full license to practice medicine in Vermont unless “using telecommunications to consult with a duly licensed practitioner herein.” ⁵⁴⁰
Virginia	To practice telemedicine in Virginia, out-of-state doctors must have a full license to practice medicine in Virginia unless “rendering . . . medical advice or information through telecommunications from a physician licensed to practice medicine in . . . an adjoining state . . . to emergency medical personnel acting in an emergency situation.” ⁵⁴¹
Washington	To practice telemedicine in Washington, out-of-state doctors need not have a full license to practice medicine in Washington unless they open an office or appoint a place to meet patients or receive calls in Washington. ⁵⁴²
West Virginia	To practice telemedicine in West Virginia, out-of-state doctors must have a full license to practice medicine in West Virginia unless they are: (1) acting in a consulting capacity with a West Virginia-licensed doctor for a period of not more than three months (note: this exemption is applicable on a one-time only basis; (2) engaged in the practice of telemedicine and consulting or rendering second opinions concerning diagnosis; (3) providing care in an emergency or without compensation; or (4) providing care on an irregular or infrequent (less than once a month or less than twelve times in a calendar year). ⁵⁴³
Wisconsin	No specific licensure laws or policies pertaining to telemedicine licensure.

540. VT. STAT. ANN., tit. 26, § 1313 (2014).

541. VA. CODE ANN. § 54.1-2901(a)(7) (2015).

542. WASH. REV. CODE §§ 18.71.030(6), 18.57.040(6) (2015).

543. W.VA. CODE R. §30-3-13 (2)(3) (2009).

Wyoming	To practice telemedicine in Wyoming, out-of-state doctors must have a full license to practice medicine in medicine Wyoming unless said physician merely “consults by telephone, electronic or any other means” with a physician licensed in Wyoming. ⁵⁴⁴
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544. WY. BD. OF MED RULES AND REGS. CH. 1 § 4(e); WYO. STAT. ANN. § 33-26-103 (2009).