More Than Just a Toothache? N.C. Dental Leaves Medical Boards Vulnerable: A Look at Telemedicine Companies and Antitrust Challenges to State Prescription Drug Rules

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MORE THAN JUST A TOOTHACHE? N.C. DENTAL LEAVES MEDICAL BOARDS VULNERABLE: A LOOK AT TELEMEDICINE COMPANIES AND ANTITRUST CHALLENGES TO STATE PRESCRIPTION DRUG RULES

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ABSTRACT

Encouraged by technological advancements and favorable provisions within the Affordable Care Act, telemedicine companies that offer online doctor visits are thriving in the health care industry. Online doctor visits are a relatively new and cost-efficient method to provide medical care over long distances that do not require patients to step outside their homes. However, many state medical board scope-of-practice rules prohibit physicians from prescribing medications without an in-person physical examination of the patient, which impedes telemedicine companies from offering their online services in those states. To circumvent this barrier, telemedicine companies may have a prima facie case under § 1 of the Sherman Act to strike down those professional regulations. After the Supreme Court’s 2015 decision in North Carolina State Board of Dental Examiners v. FTC, state medical boards composed of a majority of market participants likely do not enjoy Parker Immunity from the Sherman Act under the state action doctrine because they are active participants in the physician services market. That decision, along with the lessons learned from the district court proceedings in Teladoc v. Texas Medical Board, offers a framework for telemedicine companies to explore future Sherman Act challenges to restrictive state drug prescription rules.

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INTRODUCTION

In spring of 2015, UnitedHealthcare released a television commercial showcasing a couple dancing to the tune “(I’ve Had) The Time of My Life” of Dirty Dancing\(^1\) fame.\(^2\) While trying to recreate the climatic dance scene when Johnny held Baby in the air,\(^3\) the couple topples to the ground, breaks a table, and injures themselves.\(^4\) As the commercial ends, the couple consults with a physician, not through a traditional office visit, but through an Internet webcam.\(^5\) The commercial was an attempt by UnitedHealthcare to entice consumers to try their virtual clinic services (also known as online doctor visits).\(^6\) Advertising giant Leo Burnett claimed the commercial was part of the “biggest direct-to-consumer advertising campaign in the history of [UnitedHealthcare],” noting that the health insurance company previously advertised to employers, rather than consumers.\(^7\) In light of the Affordable Care Act (ACA) and creation of health care exchanges, the goal of the commercial was to advertise directly to consumers who did not have insurance through an employer.\(^8\) Importantly, that advertisement

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\(^1\) Dirty Dancing (Great American Films Ltd. P’ship 1987).
\(^2\) Our Song Commercial, UNITEDHEALTHCARE (March 15, 2015), https://www.youtube.com/watch?v=v9YiTIYO-2A [https://perma.cc/H2TA-98X5] [hereinafter UNITEDHEALTHCARE COMMERCIAL]. UnitedHealthcare is one of the largest health care companies in the United States. UnitedHealth Group, the parent company of UnitedHealthcare, ranked number 6 on the 2016 Fortune 500 list and is one of the most dominant industry players in the health insurance and Managed Care sectors. UnitedHealth Group, FORTUNE (2016), http://beta.fortune.com/fortune500/unitedhealth-group-6/ [https://perma.cc/4PVV-N7AY].
\(^3\) Dirty Dancing, supra note 1.
\(^4\) UNITEDHEALTHCARE COMMERCIAL, supra note 2.
\(^5\) Id.
\(^6\) Id. Online doctor visits are an application of telemedicine, which is formally defined as the “use of medical information exchanged from one site to another via electronic communications to improve a patient’s clinical health status.” What is Telemedicine, AM. TELEMEDICINE ASS’N, http://www.americanTelemed.org/about-telemedicine/what-is-telemedicine#.Vgqxm4_BzGc [https://perma.cc/7P2J-AU9L].
\(^8\) Id.
demonstrates the relevancy of telemedicine in the contemporary American health care system, and it implied that online doctor visits are a desirable service for many consumers in a digital age.

This Note contributes to the scarce legal literature concerning telemedicine companies that provide online consultations between patients and physicians. This includes companies such as Virtuwell, ConsultADoctor, Specialists On Call, LiveHealth Online, and HealthTap, as well as industry leaders Teladoc and MDLive, whose business models revolve around servicing online doctor visits. Those telemedicine companies typically contract with individuals, large companies, hospitals, or health insurers. Already, two major health care insurers, Aetna and UnitedHealthcare, have partnered with telemedicine companies to provide online physician services for their members, which demonstrates that the health care community is welcoming telemedicine with open arms.

9 It is important to distinguish between the terms “telemedicine” and “telehealth,” as they are mistakenly used interchangeably. For the purposes of this Note, “telemedicine” will refer to the actual delivery of remote clinical services, which mirrors the language of both the U.S. Department of Health and Human Services (HHS) and the American Telemedicine Association (ATA). See U.S. DEP’T OF HEALTH AND HUMAN SERVS., Telehealth: Glossary & Acronyms, http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Telehealth/glossary.html [https://perma.cc/5S78-T4TF]; What is Telemedicine?, AM. TELEMEDICINE ASS’N, http://www.americantelemed.org/about-telemedicine/what-is-telemedicine#.VgQURJNViko [https://perma.cc/7P2J-AU9L]. “Telehealth,” on the other hand, is a broader term that covers more than clinical health care delivery, and includes transmissions of health care information and educational programs such as WebMD. See U.S. DEP’T OF HEALTH AND HUMAN SERVS., Telehealth: Glossary & Acronyms, http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Telehealth/glossary.html [https://perma.cc/5S78-T4TF].

10 See UNITEDHEALTHCARE COMMERCIAL, supra note 2.

11 For convenience, this Note will use the broad term “telemedicine company” to refer only to private companies that service online doctor visits, even though that term also encompasses companies that engage in other forms of telemedicine such as remote patient monitoring.

12 See Online Doctor Consultation Services, VSEE, https://vsee.com/blog/online-doctor-consultation [https://perma.cc/5DU2-TUJQ] (describing payment plans and consultation costs for major telemedicine companies) [hereinafter VSEE].


However, some state prescription drug rules act as barriers that prohibit the increased use of online doctor visits. While those conferencing services provide several advantages, some state medical boards inhibit the further implementation of these programs because their rules require a physician to perform an in-person physical examination of a patient in order for the physician to prescribe medications. Medical boards justify these rules as preserving the establishment of the patient-physician relationship, and for drug abuse and injury prevention purposes.

Some state medical board rules are tailored to prevent “telemedicine abortions.” Other state rules, however, are broader and attempt to prevent physicians from writing any prescription without an in-person physical examination of the patient. While the first category of rules may be unconstitutional as an undue burden on a woman’s right to seek an abortion, the second category of rules are a direct threat to telemedicine companies in that they could very possibly limit the further expansion of online medical services. State prescription rules are just one of

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15 This Note discusses two of the most common types of state prescription rules that negatively impede telemedicine: (1) “telemedicine abortion” rules and (2) in-person physical examination requirement rules for prescriptions. See infra Parts II.A–B.

16 Advantages of online doctor consultations include lower travel costs, lower costs of physician visits, quicker access to medical care, and increased output of physician services. See infra Parts I.A.1–4.

17 According to the Centers for Disease Control (CDC), most states require a physical examination as the basis for prescribing and dispensing prescription drugs. See CDC, PRESCRIPTION DRUG PHYSICAL EXAMINATION REQUIREMENTS 1–2 (Jan. 29, 2015), http://www.cdc.gov/phlp/docs/pdpe-requirements.pdf [https://perma.cc/GQ9G-H386] (listing state prescription drug rules as enacted through December 4, 2013) [hereinafter CDC STUDY].

18 See infra notes 105–07 and accompanying text.

19 See Planned Parenthood of the Heartland, Inc., v. Iowa Bd. of Med., 865 N.W.2d 252, 264, 268–69 (Iowa 2015) (holding an Iowa rule that forbade medicated abortions without an in-person physical examination as unconstitutional because it placed an undue burden on a woman’s right to terminate her pregnancy).

20 See CDC STUDY, supra note 17, at 2.

21 See supra note 19.

22 Aware of that threat, Teladoc, one of the largest telemedicine companies, was successful in enjoining the Texas Medical Board when they promulgated an anticompetitive rule that required a “face-to-face visit or in-person
many roadblocks for telemedicine companies, yet telemedicine companies may be able to challenge state medical board rules requiring in-person examinations under federal antitrust law.

The 2015 Supreme Court decision in *North Carolina State Board of Dental Examiners v. FTC* offers potential for future successful antitrust challenges to rules promulgated by state professional agencies. In *N.C. Dental*, a state dental board’s rule was scrutinized under § 1 of the Sherman Act, because the Court rejected the argument that rules promulgated by the dental board were protected under the antitrust state action doctrine. Around the same time as the *N.C. Dental* decision, a federal district court in Texas enjoined the Texas Medical Board from promulgating a rule that required a physician to conduct a face-to-face examination with the patient before prescribing controlled substances.

The lessons learned from the *Teladoc* case, along with the holding in *N.C. Dental*, provide the basis for future antitrust lawsuits challenging state medical board rules that require physicians to conduct an in-person physical examination of the patient before writing a prescription. This Note predicts that rules requiring evaluation before a physician can issue a prescription.” *Teladoc*, Inc. v. Tex. Med. Bd., 112 F. Supp. 3d 529, 534 (W.D. Tex. 2015). For an in-depth discussion of that case, see infra Part V.

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26 *Teladoc*, 112 F. Supp. 3d at 543–44.

27 See *N.C. Dental*, 135 S. Ct. at 1112–14; *Teladoc*, 112 F. Supp. 3d at 543–44.
in-person physical examinations for prescriptions will not be afforded *Parker* immunity\(^{28}\) under the state action doctrine if the state medical board is not actively supervised by the state. Thus, telemedicine companies may succeed in challenging those rules under § 1 because those rules can be considered concerted actions that unreasonably restrict telemedicine physicians from participating in the physician services market within a certain state. While state prescription rules vary from state to state, antitrust challenges to state medical board regulations will likely require a more detailed analysis than the per se framework.\(^{29}\) Instead, a court would likely apply the quick-look or rule of reason analysis.\(^{30}\) Under either the quick-look or rule of reason, a state prescription rule would probably only survive if the state medical board could advance the procompetitive justification of decreased health care costs stemming from drug injury and abuse prevention.\(^{31}\)

This Note is organized to address the issues previously mentioned in turn. Section I offers a brief history and insight on the relatively new business models of telemedicine companies that offer online doctor visits, and how employers, health care providers, and associated industries are posed to benefit. Section II notes the two most common types of state prescription drug rules that hinder further expansion of online doctor services: “telemedicine abortion” rules and in-person examination requirements. Section III describes § 1 of the Sherman Act and how it affects the health care industry. Section IV looks at the § 1 tests used to preempt state rules under the antitrust state action doctrine, and discusses the impact of the 2015 Supreme Court case *N.C. Dental* on *Parker* immunity and state medical boards. Section V uses the framework of the *Teladoc* district court case and hypothesizes potential § 1 challenges to state prescription drug rules that require in-person physical examinations.

\(^{28}\) *Parker* immunity grants a state actor immunity from federal antitrust suits only if the actor (1) manifests a clearly articulated policy to displace federal antitrust law; and (2) is actively supervised by public state officials. *See* PHILLIP AREEDA & HERBERT HOVENKAMP, 1 ANTITRUST LAW 386 (4th ed. 2013). For more on *Parker* immunity, *see infra* Part IV.A.

\(^{29}\) *See infra* Part V.C.

\(^{30}\) *See infra* Parts V.D.–E.

\(^{31}\) *See infra* Parts V.D.–E.
I. The Evolution and Expansion of Telemedicine and Online Doctor Visits

Remote physician consultations, a precursor to online doctor visits, began as early as the 1950s when health care providers began to explore new ways to tackle the “access to care” issue in rural areas. In 1959, a Nebraska hospital used a two-way television to transmit medical information, which prompted a few other hospitals around the country to use similar technologies. However, most early telemedicine practices were not tremendously successful and interest dropped off in the mid-1980s, likely due to high transmission costs. Yet, the Internet revolution in the 1990s prompted interest in renewing remote physician consultations through online services.

As recent as the early 2000s, independent telemedicine companies have sprung up across the United States. Telemedicine companies that specifically provide online doctor visits arguably began to incorporate in 2002. While it is hard to identify the “first” telemedicine company, MyDoc may have been the first company to provide online doctor consultations in 2002. However, MyDoc quickly faced difficulties due to hostile state prescription rules and had to discontinue their online services for several years.

33 Id. at 36–38.
34 Id. at 40. The most interesting failure in early telecommunications doctor consulting may be the STARPHAC project—a collaborative effort between the United States Indian Health Service, NASA, and the Lockheed Missiles and Space Company—that aimed to provide medical services through satellite-based communications to astronauts and rural Native American reservations. Id. at 39.
35 See Gunther Eysenbach, Towards the Millennium of Cybermedicine, J. MED. INTERNET RES. (Sept. 19, 1999), http://www.jmir.org/1999/suppl1/e2 [https://perma.cc/24SR-JPSA] (“The Internet and related new communication technologies enable health professionals to reach large populations with interactive applications, which in turn opens enormous opportunities and challenges.”).
37 Id.
38 See id.
39 See id. However, as of 2015, MyDoc offers online services again. See MYDOC, https://www.my-doc.com/patients [https://perma.cc/4RNC-QDLY].
In recent years, advancements in accessible, low-cost technology have contributed to the recent success of online doctor services as mobile technology such as smartphones, laptops, and tablets are now readily available to many Americans. Recent studies demonstrate that 64 percent of Americans own smartphones. From that pool of smartphone owners, 62 percent have used their phone to look up information about a health condition. Not surprisingly, telemedicine company GlobalMed claims mobile technology allows a patient to transmit vital sign information to their doctor, who can respond and treat the patient appropriately. As more and more Americans gain access to mobile technology, the greater the potential for companies that service products through that medium. Today, online doctor visits provide several procompetitive marketplace advantages relevant to an antitrust industry analysis.

A. Procompetitive Advantages of Online Doctor Visits

Online doctor visits may be one of the most promising applications of telecommunication technology in the health care industry. These visits can take the form of a video conference between the patient and the doctor, or they may involve no visual contact between patient and physician at all. Decreased costs,
increased output, and increased quality of care are the hallmarks of a procompetitive business practice relevant to an antitrust analysis. Recent data suggests that online doctor visits offer several procompetitive advantages—lower travel costs, lower health care expenditures, quicker access to medical care, and increased output of physician services. Those procompetitive advantages are discussed in the following subsections.

1. Lower Travel Costs

First, online doctor visits can greatly reduce the amount of time patients spend traveling and reduces travel-associated costs. Consulting with a physician from your mobile device or home computer cuts down on the patient’s travel time to the physician’s office. A 2006 research study noted that the distance to the physician’s office was directly proportional to the number of office visits. It is axiomatic that eliminating the need to travel to a doctor, especially for rural patients who live far from their medical providers, reduces travel costs.

2. Lower Health Care Expenditures

Second, online doctor visits are less expensive than typical in-person primary care visits. The cost of a single online doctor visit in the future will involve no visual contact. The patient would submit forms and photos documenting their medical condition and send it via Internet to the physician, who would respond with a diagnosis or prescription. However, twenty-five states currently prohibit a physician from prescribing medications solely on electronic patient questionnaires. See CDC STUDY, supra note 17, at 9–10.


See infra Parts I.A.1–4.

See id.

See W.T. Cecil, et al., Relationship of the Use and Costs of Physician Office Visits and Prescription Drugs to Travel Distances and Increases in Member Cost Share, 12 J. MANAGED CARE PHARM. 665, 673 (Oct. 2006), http://amcp.org/data/jmcp/Cecil%20article.pdf [https://perma.cc/7RBG-YLRH].
visit typically costs a patient between $40 to $50. A typical in-person primary care visit, on the other hand, costs uninsured patients $150 on average and privately insured patients around $49. Moreover, some private health insurers such as UnitedHealthcare and Anthem cover all the costs of online doctor visits provided by select telemedicine companies. Thus, patients enrolled in certain private insurance plans pay no out-of-pocket costs for online doctor visits.

3. Quicker Access to Medical Care

Third, telemedicine companies make an effort to promote how quick it is to access a doctor through their online consultation services. Industry leader, Teladoc, claims that physician response time was less than ten minutes on average. In other words, on average it takes less than ten minutes to contact and set up an immediate appointment with a physician using Teladoc’s services. Moreover, online clinics are typically open twenty-four hours, seven days a week. In-person visits, on the other hand, may take days to weeks to occur after the patient calls to request an appointment.

50 See VSEE, supra note 12.
53 See id.
54 See VSEE, supra note 12 (listing various telemedicine companies and their response times to patient requests for an online visit).
56 See id.
57 Telemedicine companies Virtuwell, ConsultADoctor, Specialists On Call, LiveHealth Online, HealthTap, MDLive, and Teladoc all claim to provide 24/7 access to doctors through their online consulting services. See VSEE, supra note 12.
vary wildly according to location in the United States. According to a 2014 survey, it may take only five days to schedule and see a doctor in Dallas, Texas, but up to sixty-six days in Boston, Massachusetts. One study demonstrated that online doctor visits resulted in quicker visits and, consequently, less follow-up visits, thereby reducing health care costs.

4. Increased Output of Physician Services

Fourth, physicians are able to consult more patients by using online consulting technologies. Sources are scarce to support that notion, however one telemedicine company successfully introduced evidence to support that fact in a recent antitrust case. In that case, physicians testified that online consultations allowed them to treat more patients and practice medicine on a more flexible schedule. While that testimony derived from affidavits, it is conceivable that a study of publishable quality could come to the same conclusion and offer more light on this procompetitive advantage.

B. Potential Business Impact on Other Industries

In the last two decades, health care and social assistance has replaced the manufacturing industry as the single most dominant industry in the vast majority of states. While other industries were hit hard by the 2008 recession, the health care sector has

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59 Id.
60 Lori Uscher-Pines & Ateev Mehrotra, Analysis of Teladoc use seems to indicate expanded access to care for patients without prior connection to a provider, 33 HEALTH AFFAIRS 258, 258 (Feb. 2014), http://content.healthaffairs.org/content/33/2/258 [https://perma.cc/4ABB-328G].
62 Id.
63 Id.
largely been resilient. In the near future, online doctor visits may become the preferred and easiest way to reach your doctor. Employers, health care companies, and associated industries may all benefit from the success of telemedicine companies.

1. Employers

Some of our country’s largest non-healthcare employers, such as PepsiCo and Bank of America, offer online doctor visits to their employees in order to cut health care costs and make physicians more accessible. A 2015 survey based on responses from large American companies illuminated that this trend is likely to continue because around 74 percent of respondents planned to offer telehealth to employees in states where it is legal.

The final phase of the Affordable Care Act’s Employer Shared Responsibility Mandate (“employer mandate”) may further encourage large employers to use online doctor visits. As of 2016, the employer mandate applies to employers with fifty or more full-time employees or full-time equivalents (FTEs), and requires those companies to offer affordable health insurance at a minimum value to their full-time employees or FTEs and their children up to the age of 26. If an applicable company fails to

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65 See Wright, supra note 64.
67 See Jayne O’Donnell & Benjamin Mitchell, Big telehealth firm to go public as remote doctor visits gain traction, USA TODAY (June 30, 2015), http://www.usatoday.com/story/money/business/2015/06/30/telehealth-ipo-teladoc-healthcare-costs/29482557/ [https://perma.cc/J7PB-B5HL] (stating that PepsiCo and Bank of America offer online doctor visits provided by Teladoc to their approximately 11 million employees).
69 26 U.S.C. § 4980H.
comply, the IRS will issue a penalty to them.\footnote{26 U.S.C. § 4980H(c)(4)(A). The penalty is calculated according to the gravity of the company's failure to provide affordable health insurance at a minimum value. See id. In other words, if more of a certain company's employees go elsewhere for coverage, or have to pay more than what is determined to be “affordable,” then the penalty will be larger (but still subject to a maximum amount). See Penalties for employers not offering coverage under the Affordable Care Act during 2016, HENRY J. KAISER FAMILY FOUND. (Oct. 2, 2015), http://kff.org/infographic/employer-responsibility-under-the-affordable-care-act/ [https://perma.cc/CMV5-ZY36].} In other words, employers with fifty or more employees are required to provide affordable health insurance at a minimum value to their employees and their children or face a fine. This could provide a major incentive for more companies to utilize health plans that honor online doctor visits, or include them in their own group plans, because they are a cheaper method of health care administration than in-person visits.\footnote{See supra notes 51–53 and accompanying text.}

2. Health Care Providers

Health care executives view telemedicine as an important component for the future of their companies.\footnote{A recent study found that 90 percent of health care executives have either begun to develop or implement a telemedicine program. FOLEY & LARDNER LLP, 2014 TELEMEDICINE SURVEY 1 (Nov. 11, 2014), http://www.foley.com/files/Publication/05855b1-1205-4be7-be5a-4e14602a4fac/Presentation/PublicationAttachment/39c25a9b-5f1-4ee8-b861-4ea2d71718ae/2014%20Telemedicine%20Survey%20Executive%20Summary.pdf [https://perma.cc/M4KT-EQL8] [hereinafter FOLEY & LARDNER SURVEY].} The ACA’s reimbursement guidelines may be one of the major factors in expanding telemedicine policies, as many hospitals are switching from their prior fee-for-service model to a pay-for-performance reimbursement model.\footnote{Id. at 2.} The pay-for-performance model reimburses federal health care funds according to (1) how well the health care provider performs in relation to other hospitals and (2) how much the provider improved their own performance.\footnote{Linking quality to payment, MEDICARE.GOV, https://www.medicare.gov/hospitalcompare/linking-quality-to-payment.html [https://perma.cc/W3R5-Z86D]. Changes to the health care reimbursement laws are generally found in Title III of the ACA. 124 Stat. 119.} Thus, health care companies bare a greater risk for keeping patients healthy,
and need to capitalize on innovative health care techniques such as video conferencing and other telemedicine practices.\textsuperscript{76} To sum up recent activity in the health care industry, Chief Executive Officer of telemedicine company MDLive, Randy Parker, observed that the ACA created “a perfect storm .... We are at a point where both technology and payers who are providing reimbursement have accepted the fact that there is an inflection point.”\textsuperscript{77}

3. \textit{Associated Industries}

Companies outside the health care industry are predicted to profit from telemedicine. At least one major technology company is testing the waters to join the health care industry because of the lucrative possibilities of telemedicine.\textsuperscript{78} In 2014, tech giant Google experimented with a trial telemedicine service.\textsuperscript{79} Consulting firm Deloitte predicted that the technology and telecommunications industries will profit in their response to the “growing demand for data volumes, quality of service data, high speed broadband ... and wireless networks.”\textsuperscript{80} Technology device manufacturers are also likely to benefit in expanding markets for mobile devices and mobile applications.\textsuperscript{81} With these predictions in mind, online doctor companies and associated industries may have a very profitable future. However, there are several potential roadblocks including reimbursement, professional licensing, medical malpractice, data privacy, U.S. Food and Drug Administration regulations, and fraud concerns.\textsuperscript{82} This Note does not discuss those hurdles; instead, it focuses on state prescription drug rules that prohibit prescriptions without an in-person visit.

\textsuperscript{76} See \textsc{Foley & Lardner Survey}, supra note 73, at 2.
\textsuperscript{77} See Japsen, supra note 44.
\textsuperscript{78} Amit Chowdhry, Google is testing a “Talk With a Doctor” feature within medical search results, \textsc{Forbes} (Oct. 15, 2014), http://www.forbes.com/sites/amitchowdhry/2014/10/15/google-is-testing-a-talk-with-a-doctor-feature-within-medical-search-results/ [http://perma.cc/ALF6-ZDYB].
\textsuperscript{79} Id. Google users have the option to set up a video chat session with a doctor if they searched for certain medical symptoms on the Google search engine. \textit{Id}.
\textsuperscript{80} See \textit{Technology, Media & Telecommunications Predictions}, supra note 45.
\textsuperscript{81} See \textit{id}.
\textsuperscript{82} See Bauerly, supra note 23.
II. STATE PRESCRIPTION DRUG RULE BARRIERS TO ONLINE DOCTOR VISITS

The U.S. Food and Drug Administration (FDA) approves drugs marketed for prescription use. However state laws and rules—not federal law—usually dictate the physical examination requirements for medication prescriptions. While FDA imposes labeling requirements on drugs, the agency cannot regulate the practice of medicine. Instead, states fill the void of regulating the practice of medicine and impose rules on prescribers.

Pursuant to a state’s police power, state legislatures generally create medical boards to regulate the practice of medicine. The state legislature dictates who is eligible to serve as a board member; physicians typically dominate the composition of the board, but some laypersons also serve as members. Through rules, medical boards generally regulate licensure, disciplinary procedures, and scope-of-practice. Scope-of-practice regulations aim to define the “spheres of activity within which various types of health-care providers ... are authorized to practice.”

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83 See 21 U.S.C. § 353(b) (codifying the Durham-Humphrey Amendment and requiring a prescription for drugs that are not safe for self-medication (i.e., over-the-counter) purposes).
84 See CDC STUDY, supra note 17, at 1 (“States have the primary responsibility to regulate and enforce prescription drug practice.”).
85 See 21 C.F.R. § 201.56 (defining the content and formatting requirements of prescription drug labels).
86 See CDC STUDY, supra note 17, at 1.
87 The police power allows a state legislature to enact or delegate to another administrative body “reasonable regulations established directly by legislative enactment as will protect the public health and the public safety.” Jacobson v. Mass., 197 U.S. 11, 25 (1905).
90 Sawicki, supra note 88, at 290.
91 Barbara J. Safriet, Closing the Gap Between Can and May in Health-Care Providers’ Scopes of Practice: A Primer for Policymakers, 19 YALE J. REG. 301, 302 (2002).
that regulations that define the circumstances and conditions that a physician must adhere to in order to prescribe prescription drugs are considered scope-of-practice regulations. The importance of state prescription drug rules as a scope-of-practice regulation comes into play later in this Note in the sections that cover the antitrust analysis and potential challenges to those rules.92

State rules that forbid medication prescriptions without an in-person physical examination of the patient prevent telemedicine companies from providing medication prescriptions through their online services.93 The following sections, A and B, discuss the two most common types of rules that prevent telemedicine companies from prescribing medications through their online services.

A. “Telemedicine Abortion” Rules

Restricting access to “telemedicine abortions” may be a proximate cause behind some restrictive prescription rules. The term “telemedicine abortion” refers to a medicated abortion capable of being induced within your own home, without ever consulting a gynecologist in-person.94 The first stage involves an in-person visit with a nurse who administers an ultrasound test and lab work with the woman seeking an abortion.95 Afterwards, the woman conducts a video conference with a gynecologist to determine if a medicated abortion is a proper option.96 If so, the gynecologist prescribes mifepristone and misoprostol, two prescription drugs that cause the lining of the uterus to break down and empty, effectively inducing a medicated abortion without the woman entering a surgical room or an in-person meeting with a

92 See infra Parts IV–V.
93 For example, a Texas rule previously required a physician to conduct a “face-to-face” physical examination in order for them to prescribe prescription drugs. 22 TEX. ADMIN. CODE § 190.8(L) (2015). Telemedicine company, Teladoc, filed an antitrust suit against the administrative agency and a federal court granted an injunction against enforcement of that rule. See Teladoc, Inc. v. Tex. Med. Bd., 112 F. Supp. 3d 529 (W.D. Tex. 2015).
95 Id.
96 Id.
physician. As many as eighteen states have placed restrictions on telemedicine abortions, and require a physician to perform an in-person physical examination of the woman. State rules that effectively eliminate telemedicine abortions may simply limit medication administration unless the physician is present at the time.

While there is little empirical evidence as to the outcomes of telemedicine abortions due to stringent state laws and regulations, researchers studied telemedicine abortions in Iowa and concluded that these forms of abortions improved access to abortions for women living in remote areas and reduced second-trimester abortions. Rules and laws that strictly target telemedicine abortions may be viewed as unconstitutional under the abortion doctrine’s “undue burden” analysis, therefore an antitrust suit may not be the proper remedy. However, telemedicine abortion rules are worth noting as an example of one common state prescription rule that impedes online doctor services.

B. In-Person Examination Requirements

Some state medical boards place blanket bans on all forms of medication prescriptions without an in-person physical examination.

98 See Semuels, supra note 94.
99 See GUTTMACHER INST., MEDICATION ABORTION (Feb. 1, 2016), http://www.guttmacher.org/statecenter/spibs/spib_MA.pdf [https://perma.cc/ZER3-JYG5] (noting that, in eighteen states, the “clinician providing a medication abortion [must] be physically present during the procedure, thereby prohibiting the use of telemedicine to prescribe medication for abortion remotely.”).
100 See, e.g., IOWA ADMIN. CODE r. 653-13.10(3) (2016), invalidated by Planned Parenthood of the Heartland, Inc. v. Iowa Bd. of Med., 865 N.W.2d 252 (Iowa 2015) (requiring a physician to be physically present with the woman at the time the abortion-inducing drug is provided).
101 See Semuels, supra note 94 (noting that fifteen states have banned telemedicine abortions).
103 See Planned Parenthood of the Heartland, 865 N.W.2d at 269 (holding the Iowa rule forbidding medicated abortions without an in-person physician present as unconstitutional because it placed an undue burden on a woman’s right to terminate her pregnancy).
of the patient. Proponents of these rules argue that forbidding online consultations that result in medication prescriptions is aimed at establishing and preserving a physician-patient relationship. That relationship has origins in contract law, but also involves fiduciary obligations on behalf of the physician. Injury and prescription drug abuse prevention is the more compelling argument behind rules that require an in-person physical examination. However, the Centers for Disease Control and Prevention—the federal agency charged with public health research—has noted that little identifiable information is available on the effectiveness of those statutes in preventing injury and drug abuse.

As of 2015, thirty-four states and the District of Columbia require a “physical examination” for prescribing a controlled substance. Some states will explicitly state that a patient-physician relationship is required. Indiana, for example, requires that “a physician shall not prescribe, dispense, or otherwise provide, or cause to be provided, any controlled substance to a person who the physician has never personally physically examined and diagnosed.”

Other states will reference the establishment of a patient-physician relationship that, as defined by state law, must include a physical examination. For example, South Carolina requires a “proper physician-patient relationship.” That relationship requires the physician to, “at a minimum ... personally perform and document an appropriate history and physical examination.”

104 See CDC Study, supra note 17.
105 Twenty-three states and the District of Columbia have laws requiring a physical examination of the patient related to the creation of a physician-patient relationship. See CDC Study, supra note 17, at 6 n.35.
106 Furrow, supra note 89, at 188 n.3.
107 See CDC Study, supra note 17, at 1.
108 Id.
109 Id. at 2 n.10.
110 Id. at 2.
112 CDC Study, supra note 17, at 6–7.
It is possible that broad rules that forbid prescriptions without in-person contact by the physician will be deemed as anti-competitive under § 1 of the Sherman Act if challenged by the appropriate telemedicine company, the FTC, or even a consumer.\footnote{See infra Part V.A.}

### III. The Sherman Act and the Health Care Industry

Section 1 of the Sherman Act prohibits “[e]very contract, combination, ... or conspiracy, in restraint of trade or commerce among the several States.”\footnote{15 U.S.C. § 1 (2015).} Taken literally, nearly every agreement between two or more parties can be considered a “restraint of trade;” thus the Supreme Court has limited the restrictions contained in § 1 to bar only “unreasonable restraints of trade.”\footnote{NCAA v. Bd. Regents Univ. of Okla., 468 U.S. 85, 98 (1984).} Yet, the Sherman Act is treated as a common law statute and the definition of an “unreasonable restraint of trade” evolves with economic theory and contemporary market conditions.\footnote{See Leegin Creative Leather Prods. v. PSKS, Inc., 551 U.S. 877, 888 (2007) (“Yet the Sherman Act’s use of ‘restraint of trade’ ‘invokes the common law itself, ... not merely the static content that the common law had assigned to the term in 1890.’”) (citing Bus. Elec. Corp. v. Sharp. Elec. Corp., 485 U.S. 717, 732 (1988)). Stare decisis is less influential in Sherman Act cases because the interpretation of the statute evolves to meet modern understandings and experiences, similar to the way the common law changes through time. See id.}

The Supreme Court interpreted the Sherman Act as a congressional effort to eliminate the “three evils” (“anticompétitive effects”) commonly produced by monopolies: (1) increased prices; (2) reduced output or a limitation on production; and (3) reduced quality.\footnote{Standard Oil Co. of N.J. v. United States, 221 U.S. 1, 52 (1911).} Plaintiffs can prove a prima facie case under § 1 by alleging that either (1) the defendant possesses market power;\footnote{See Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2, 27 n.46 (1984) (“As an economic matter, market power exists whenever prices can be raised above the levels that would be charged in a competitive market.”).} or (2) the anticompetitive agreement creates at least one of the three anticompetitive effects.\footnote{See United States v. Brown Univ., 5 F.3d 658, 668 (1993) (“The plaintiff may satisfy this burden by proving the existence of actual anticompetitive...”)} Moreover, the plaintiff’s claim
for relief is subject to a higher pleading standard and must be “plausible on its face” and require “more than a sheer possibility” that the defendant acted unlawfully. 122

The health care industry is not exempt from § 1. The Sherman Act was intended “to embrace the widest array of conduct possible.” 123 The Supreme Court found that restrictions on physician services have a substantial effect on interstate commerce, and are thus subject to the restrictions of the Sherman Act. 124 The Supreme Court made clear that it “refuse[s] to tolerate manifestly anticompetitive conduct simply because the health care industry is involved.” 125

When an anticompetitive agreement or concerted action 126 is challenged under § 1, courts use a sliding scale of analyses to determine whether the agreement or action violates the law, and each analysis requires a different level of proof. 127 At one end of

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122 Ashcroft v. Iqbal, 556 U.S. 662, 678–79 (2009). To demonstrate that burden, the plaintiff’s complaint needs to produce facts that “raise a right to relief above the speculative level ... [and] enough factual matter (taken as true) to suggest that an agreement was made.” Bell Atl. Corp. v. Twombly, 550 U.S. 544, 555–56 (2007).


126 To determine what constitutes a concerted action the relevant inquiry is “whether there is a ‘contract, combination ... , or conspiracy’ amongst ‘separate economic actors pursuing separate economic interests,’ such that the agreement ‘deprives the marketplace of independent centers of decisionmaking,’ and therefore of ‘diversity of entrepreneurial interests,’ and thus of actual or potential competition.” Am. Needle, Inc. v. Nat’l Football League, 560 U.S. 183, 195 (2010) (citations omitted).

127 Cal. Dental Ass’n v. FTC, 526 U.S. 756, 780 (1999) (“There is always something of a sliding scale in appraising reasonableness, but the sliding
the scale, certain types of agreements are considered “per se unreasonable” if they are proven to nearly always or always have a “pernicious effect on competition and lack of any redeeming virtue.” At the other end, courts most commonly analyze potentially anticompetitive agreements under the “rule of reason,” which was well described by Justice Brandeis:

The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition. To determine that question the court must ordinarily consider the facts peculiar to the business to which the restraint is applied; its condition before and after the restraint was imposed; the nature of the restraint and its effect, actual or probable. The history of the restraint, the evil believed to exist, the reason for adopting the particular remedy, the purpose or end sought to be attained, are all relevant facts.

In between those analyses, a court may use the “quick-look” analysis when an observer with “even a rudimentary understanding of economics could conclude that the arrangements in question would have an anticompetitive effect on customers and markets.” The type of analysis is an important consideration in determining whether an in-person prescription requirement survives § 1 scrutiny.

IV. FEDERAL ANTITRUST PREEMPTION OF STATE LAWS AND REGULATIONS

Courts apply a two-stage inquiry in order to decide whether the Sherman Act preempts a state regulation. First, the scale formula deceptively suggests greater precision than we can hope for .... Nevertheless, the quality of proof required should vary with the circumstances.” (quoting PHILLIP AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW ¶ 1507, at 402 (1986)).

130 Cal. Dental, 526 U.S. at 770.
132 AREEDA & HOVENKAMP, supra note 28, ¶ 221a, at 46.
Sherman Act preempts a state statute if it “mandates or authorizes conduct that necessarily constitutes a violation of the antitrust laws in all cases, or if it places irresistible pressure on a private party to violate the antitrust laws in order to comply with the statute.” If in other words, a state law is preempted if that law constitutes a per se violation of § 1. If so, then the statute is preempted unless it is saved under the second inquiry: the state action doctrine. In less obvious cases where the state’s action doesn’t constitute a per se violation—but could be perceivably inconsistent with the Sherman Act—the state or state agency must qualify for the state action doctrine exemption, or else be subject to the restrictions of the Sherman Act.

A. State Action Doctrine (Parker Immunity)

The state action doctrine was first recognized in the 1943 Supreme Court decision *Parker v. Brown*, and the doctrine has become synonymous with the term “Parker immunity.” Over the years, the doctrine has been accepted as a judicially created exception to federal antitrust laws. In simple terms, Parker immunity is afforded to state or local government actions that have intentional or foreseeable anticompetitive effects. A state agency only enjoys Parker immunity if it (1) clearly articulates a

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133 Rice v. Norman Williams Co., 458 U.S. 654, 661 (1982). In devising the test, the Court applied similar principles to those used “in considering whether any state statute is preempted by a federal statute pursuant to the Supremacy Clause.” *Id.* at 659.


135 See AREEDA & HOVENKAMP, supra note 28, ¶ 221a, at 46.

136 See *id.*


139 See Kornmehl, *supra* note 25, at 2–3 (noting that *Parker* immunity strikes a balance between the principles of “federalism and state sovereignty”).
policy to displace federal antitrust law; and (2) is actively supervised by public state officials.\footnote{AREEDA & HOVENKAMP, supra note 28, ¶ 217, at 386.}

In \textit{Parker}, the Supreme Court “interpreted the antitrust laws to confer immunity on anticompetitive conduct by the States when acting in their sovereign capacity.”\footnote{N.C. St. Bd. of Dental Exam’rs v. FTC, 135 S. Ct. 1101, 1110 (2015) (citing \textit{Parker}, 317 U.S. at 350–51).} The plaintiff, a raisin producer and packager, sought to enjoin the state of California from enforcing a law that established state-run programs to market agricultural commodities produced within the state, and restricted competition among the growers by maintaining prices in the distribution of agricultural commodities.\footnote{\textit{Parker}, 317 U.S. at 344, 346.} The plaintiff argued that, because 90–95 percent of the raisins grown in California are ultimately shipped in interstate or foreign commerce,\footnote{\textit{Id.} at 345.} the California law was an unlawful contract in restraint of trade among the several states.\footnote{\textit{Id.} at 350.} The Supreme Court upheld the California law because they interpreted the Sherman Act to prohibit only “business combinations,” and not the state’s legislative authority.\footnote{\textit{Id.} at 351.}

Nearly forty years later, in \textit{California Retail Liquor Association v. Midcal Aluminum}, the Supreme Court established a two-part test to determine if a restraint of trade is a policy of the state and afforded \textit{Parker} immunity from federal antitrust laws.\footnote{Cal. Retail Liquor Ass’n v. Midcal Aluminum, 445 U.S. 97, 105 (1980).} To qualify for immunity, the restraint must be (1) “clearly articulated and affirmatively expressed as state policy” and (2) “actively supervised by the State itself.”\footnote{\textit{Id.}; AREEDA & HOVENKAMP, supra note 28, ¶ 217, at 386. The test from that case is often referred to as the “\textit{Midcal} test.” \textit{Id.}}

For the first prong of the \textit{Midcal} test, the Supreme Court’s holding in \textit{Hallie v. Eau Claire} remains the controlling precedent.\footnote{Hallie v. Eau Claire, 471 U.S. 34, 42–43 (1985).} The Court held that in order to pass the “clear articulation” factor, the state legislature need not “expressly state in a statute or its legislative history that the legislature intends for the delegated action to have anticompetitive effects” as long as...
the results of the anticompetitive effect were reasonably foreseeable.\footnote{Id.} As of 2015, the Court has not formulated a test to define the clear articulation factor any further.\footnote{See N.C. St. Bd. of Dental Exam’rs v. FTC, 135 S. Ct. 1101, 1112 (2015) (noting that the clear articulation factor was “yet still [to] be defined”).}

For the second prong of the \textit{Midcal} test, the Supreme Court recently adopted a new standard for state agencies to determine whether they are “actively supervised by the state,” and thus, subject to \textit{Parker} immunity.\footnote{Id. at 1114. The Court reasoned that active market participants “will pursue private interests in restraining trade” and “pose the very risk of self-dealing \textit{Midcal}’s supervision requirement was created to address.” \textit{Id.}} In \textit{N.C. Dental}, the Supreme Court addressed whether an agency empowered by the state to regulate the practice of dentistry could “exclude nondentists from the market for teeth whitening services in North Carolina.”\footnote{Id. at 1116.} The Court responded in the negative and ruled that this particular state agency was a non-sovereign entity controlled by active market participants that were not actively supervised by the state.\footnote{Id. at 1116.} The Court further held that any “state board on which a controlling number of decision makers are active market participants in the occupation the board regulates must satisfy \textit{Midcal}’s active supervision requirement.”\footnote{Id.}

The “active supervision” requirement for state professional boards is “flexible and context-dependent.”\footnote{Id. at 1116.} A court must determine whether the “[s]tate’s review mechanisms provide ‘realistic assurance’ that a nonsovereign actor’s anticompetitive conduct ‘promotes state policy, rather than merely the party’s individual interests.’”\footnote{Id. (quoting Patrick v. Burget, 486 U.S. 94, 100–01 (1988)).} The Court has identified “only a few constant requirements”\footnote{Id.} to determine active supervision:

(1) The supervisor must review the substance of the anticompetitive decision, not merely the procedure followed to produce it;
(2) The supervisor must have the power to veto or modify particular decisions to ensure they accord with state policy;

\begin{footnotes}
\item[\textsuperscript{149}] Id.
\item[\textsuperscript{150}] See N.C. St. Bd. of Dental Exam’rs v. FTC, 135 S. Ct. 1101, 1112 (2015) (noting that the clear articulation factor was “yet still [to] be defined”).
\item[\textsuperscript{151}] Id. at 1114.
\item[\textsuperscript{152}] Id. at 1109.
\item[\textsuperscript{153}] Id. at 1120.
\item[\textsuperscript{154}] Id. at 1114. The Court reasoned that active market participants “will pursue private interests in restraining trade” and “pose the very risk of self-dealing \textit{Midcal}’s supervision requirement was created to address.” \textit{Id.}
\item[\textsuperscript{155}] Id. at 1116.
\item[\textsuperscript{156}] Id. (quoting Patrick v. Burget, 486 U.S. 94, 100–01 (1988)).
\item[\textsuperscript{157}] Id.
\end{footnotes}
(3) The mere potential for state supervision is not an adequate substitute for a decision by the state;

(4) The state supervisor may not itself be an active market participant.  

The Supreme Court’s articulation of the active supervision requirement is aimed to reduce the “risks licensing boards dominated by market participants may pose to the free market.” Market participants may “confuse[ their] own interests with the State’s policy goals.” The Court likened agencies controlled by market participants to private trade associations with regulatory power, which “often have economic incentives to restrain competition ... [that may] have a serious potential to [cause] anticompetitive harm.”

With these requirements and policies in mind, state medical boards with a controlling majority of market participants are likely subject to the active supervision requirement and, if not actively supervised, will not enjoy Parker immunity. It is important to note that, if an actor does not enjoy Parker immunity, that determination will not ultimately confer liability; it simply means that an antitrust suit may proceed. Whether or not the antitrust suit would be successful is up to the litigants and the governing courts.

B. The Impact of N.C. Dental on State Medical Boards

As a result of the N.C. Dental decision, anti-competitive rules promulgated by state medical boards as they stand will likely not be afforded Parker immunity. Shortly after the N.C. Dental decision, commentators expressed interest that the ruling in N.C. Dental can be expanded to state medical boards if they are proven to be run by active market participants. Scope-of-practice rules are

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158 Id. at 1116–17.
159 Id. at 1116.
160 Id. at 1114.
161 Id.
162 See infra Part V.B. and accompanying text.
164 Eric M. Fraser, Argument Analysis: Court wary of immunity for licensing boards, but what about doctors?, SCOTUSBLOG (Oct. 15, 2014), http://www
of special importance because the holding in *N.C. Dental* is directly applicable to scope-of-practice determinations made by medical boards. The rules that determine under what circumstance a physician can prescribe a drug are considered scope-of-practice regulations. It follows that those types of rules promulgated by medical boards composed of a majority of active market participants fall within the holding of *N.C. Dental*.

After *N.C. Dental*, the FTC issued a report for states to guide them in efforts to insulate their professional boards. However, it is still unclear as to what state mechanisms provide “realistic assurance” that a state professional board is promoting state policy. As of early 2016, some states have begun to take steps to insulate their professional boards from the decision, and antitrust attorneys expect all states to enact some kind of legislation to address the holding in *N.C. Dental*. For example, Connecticut passed a law that adds an active state supervision provision over actions of licensing boards that operate under the Connecticut Department of Public Health. Oklahoma took a different

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165 *See* Kathleen Foote, *Immune No Longer: State Professional Boards Consider Their Options*, 30 ANTITRUST MAG. 55, 56 (Fall 2015) (on file with author) (“Scope of practice determinations are the most obvious action to which *NC Dental* is applicable .... [B]ecause the Board’s action regarding teeth whitening was such a determination.”) (quotations omitted).

166 *See supra* notes 90–91 and accompanying text.

167 *See supra* notes 164–66 and accompanying text.


170 *See Foote, supra* note 165, at 56 (discussing the various paths that different states have taken to protect the rulemaking ability of their professional boards); *see also* Alexandra W. Jabs, Note, *North Carolina State Board of Dental Examiners v. FTC: When Will Enough Active State Supervision Be Enough*, 75 MD. L. REV. ENDNOTES 44, 73 (2016) (highlighting the efforts of the state of California which created an independent review commission to satisfy the active supervision requirement).

171 *CONN. GEN. STAT.* § 19a-14(f) (2015); *see also* Foote, *supra* note 165, at 56 n.11.
route—the governor issued an executive order that requires the state Attorney General to review all non-rulemaking decisions by licensing boards.\textsuperscript{172} It is unclear how courts will react to these measures.\textsuperscript{173} The rules promulgated by un-insulated medical boards dominated by market participants, however, will likely not enjoy \textit{Parker} immunity.\textsuperscript{174}

While the FTC issued a guidance document covering what they view to be sufficient to insulate a state medical board, that does not necessarily mean that a board will receive \textit{Parker} immunity.\textsuperscript{175} It is up to the judiciary to interpret the scope of the holding in \textit{N.C. Dental}.\textsuperscript{176} Moreover, the FTC may or may not decide to file suit if a medical board follows their guidance.\textsuperscript{177} However, a private party with standing is not bound by a guidance document and has the option to file suit.\textsuperscript{178} The following section highlights a recent case that may open the door for telemedicine companies to challenge anticompetitive state prescription rules, and speculates further challenges.

\section*{V. Strategies for $\S$ 1 Challenges to State Medical Board Prescription Rules}

A recent case in the U.S. District Court for the Western District of Texas illustrates that telemedicine companies may succeed in

\begin{quotation}
\textsuperscript{173} Kathleen Foote, the Senior Assistant Attorney General and Antitrust Chief in the California Department of Justice, noted that, in response to the \textit{N.C. Dental} holding, “there is increasing recognition that it will take litigation—maybe a lot of it—to set the goalposts on the new playing field.” Foote, supra note 165, at 57.
\textsuperscript{174} See \textit{N.C. Dental}, 135 S. Ct. at 1110.
\textsuperscript{175} See FTC Guidance supra note 168 n.* (“The Federal Trade Commission is not bound by this Staff guidance and reserves the right to rescind it at a later date.”).
\textsuperscript{176} \textit{N.C. Dental}, 135 S. Ct. at 1123.
\textsuperscript{177} See supra note 175.
\textsuperscript{178} See Fed. Trade Comm'n, Operating Manual Ch. 8: Industry Guidance 2, https://www.ftc.gov/sites/default/files/attachments/ftc-administrative-staff-manuals/ch08industryguidance.pdf [https://perma.cc/J67C-2FT2] (“Unlike a trade regulation rule (TRR) (see OM Ch. 7, ‘Rulemaking’), a guide does not have the force or effect of law and is not legally binding on the Commission or on the public in an enforcement action.”).
\end{quotation}
challenging state rules that require in-person physical examinations for prescriptions under § 1 of the Sherman Act. In *Teladoc v. Texas Medical Board*, the nation’s largest telehealth provider was successful in enjoining the Texas Medical Board from promulgating a new rule that required a “face-to-face examination prior to prescription of a dangerous drug or controlled substance.” The crux of Teladoc’s argument was that the Texas rule would eliminate Teladoc physicians from providing health care, which would negatively impact “not just the competitor physicians, but consumers, [creating] a classic antitrust injury.”

That court held that, under either a quick-look analysis or rule of reason analysis, Teladoc’s claim succeeded in proving the necessary elements for a preliminary injunction. Teladoc met its burden of proving that the Texas rule had an anti-competitive effect by producing higher premiums and decreased choices. In response, the Texas Medical Board offered a single justification that the anticompetitive rule would lead to improved quality of medical care. The Teladoc case provides the framework for a potential lawsuit against rules promulgated by state medical boards that restrict a physician’s ability to prescribe medications without an in-person examination of the patient. A hypothetical challenge to that type of law is discussed in the following sections.

A. Standing

In any § 1 case, plaintiffs must “prove injury of the type that the antitrust laws were intended to prevent and that flows from

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181 See Teladoc, 112 F. Supp. 3d at 534 (internal quotation marks omitted). That case was procedurally unique because the merits of the antitrust issues were analyzed because the defendant declined to assert the affirmative defense of *Parker* immunity in the early pleading stages. Id. at 535. This Note, however, argues that future antitrust challenges would be successful in similar circumstances even if immunity is pleaded by the medical board, because state medical boards will not likely be afforded *Parker* immunity.
182 Id. at 536–37.
183 Id. at 537.
184 Id.
185 Id. at 538.
that which makes the defendants’ acts unlawful. Telemedicine companies who provide online doctor consultations are potential plaintiffs because they are being excluded from the market for physician services of medication prescriptions. While this Note focuses on telemedicine companies, there may be additional potential plaintiffs. Prescription medication consumers are harmed because they are directly affected by the higher prices of in-person visits, thus they could possibly bring a suit seeking redress. Additionally the FTC could file suit because they have jurisdiction over antitrust suits concerning “professional services” within the health care industry.

B. Pleading Challenges and Proving a Prima Facie Case

Potential plaintiffs will bear the burden of production to establish a prima facie case that the rule resulted in anti-competitive effects. A plaintiff will have to prove that a defendant state medical board possesses market power, or that the rule creates (1) increased prices for physicians’ services for prescriptions; (2) decreased output in the market for physicians’ services for prescriptions; or (3) reduced quality of medical care. As evidenced by the Teladoc lawsuit, state rules that prohibit physicians from prescribing medication without an in-person examination of the

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187 See Teladoc, 112 F. Supp. 3d at 537 (Elimination of physicians providing healthcare would thus negatively impact ..., consumers, a classic antitrust injury.

188 Although the FTC and Antitrust Division of the United States Department of Justice (DOJ) both have jurisdiction to enforce federal antitrust law, both agencies have agreed to separately pursue certain industries and practices. See Fed. Trade Comm’n & Antitrust Div. U.S. Dep’t Justice, Memorandum of Agreement Between the Fed. Trade Comm’n and the Antitrust Div. of the U.S. Dep’t of Justice Concerning Clearance Procedures for Investigations 8 (Mar. 2002), http://www.justice.gov/sites/default/files/atr/legacy/2007/07/17/10170.pdf [https://perma.cc/RS4B-V8YS]. The FTC has jurisdiction over antitrust suits concerning professional services within the health care industry. See id.

189 PHILLIP AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW, ¶ 1504b, at 358 (2d ed. 2003).
190 See supra notes 119–21 and accompanying text.
patient likely increase overall costs for physician services.\textsuperscript{191} Potential plaintiffs will have to provide evidence that online doctor services are cheaper than regular physician visits.\textsuperscript{192} Moreover, those rules are likely to reduce output of physician services.\textsuperscript{193} To sustain their burden, plaintiffs will have to provide evidence, likely in the form of affidavits or research studies, that physicians who conduct online visits with patients treat more patients than without those services.\textsuperscript{194} Lastly, it will be difficult for a plaintiff to prove that online doctor services result in increased quality of care.\textsuperscript{195}

To prevent scrutiny under § 1, a state medical board will have to assert \textit{Parker} immunity and must prove that they (1) manifested a clearly articulated policy to displace federal antitrust law and (2) are actively supervised by public state officials.\textsuperscript{196} It is likely that the clear articulation element is met because it is reasonably foreseeable that a law requiring an in-person examination of a patient for prescriptions would be anticompetitive and exclude online services from the market of prescription services.\textsuperscript{197} Prescription drugs can only be prescribed by certain qualified people (such as physicians).\textsuperscript{198} Thus, they are inherently anticompetitive because they exclude other people from the prescribing market.

\textsuperscript{191} \textit{Teladoc}, 112 F. Supp. 3d at 537 (finding that Teladoc submitted evidence that their remote doctor consultations typically cost $40, whereas the average cost to the physician or emergency room was $145 or $1957 respectively). Thus, restricting Teladoc’s telemedicine services would result in increased prices. \textit{Id.}

\textsuperscript{192} \textit{Id.}

\textsuperscript{193} \textit{Id.} (stating Teladoc submitted physician affidavits declaring that their remote doctor consulting services allowed certain doctors to treat more patients).

\textsuperscript{194} AREEDA & HOVENKAMP, supra note 189, ¶ 1504b at 358.

\textsuperscript{195} Plaintiffs will need to introduce evidence that online doctor visits increase the quality of health care services and are superior in that regard to in-person visits. Although online visits have advantages, no identifiable credible information supports the proposition that they increase the quality of health care services.

\textsuperscript{196} \textit{See supra} note 147 and accompanying text.

\textsuperscript{197} \textit{See} N.C. St. Bd. of Dental Exam’rs v. FTC, 135 S. Ct. 1101, 1112 (2015) (“[A] policy may satisfy this test yet still to be defined at so high level of generality as to leave open critical questions about how and to what extent the market should be regulated.”).

The active supervision element, however, will be highly fact-dependent and require litigators to test their skills. The best litigation route for a plaintiff would be to frame their argument against active supervision by using the factors identified by the Supreme Court in *N.C. Dental*.

C. Per Se Analysis

In any § 1 challenge to an anticompetitive practice, a court must decide which analysis should govern the case. It is unlikely that a per se analysis would be used in potential challenges to state prescription rules, because courts are generally hesitant to apply a per se analysis to rules adopted by professional associations. It is not impossible, however, for a court to apply a per se analysis to a defendant in the health care industry.

A potential plaintiff would benefit from this analysis because it is the most plaintiff-friendly. The most plausible argument to make would be that rules requiring in-person physical examinations constitute horizontal price fixing. That type of rule may

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200 See *supra* note 158 and accompanying text.

201 See *supra* notes 127–31 and accompanying text.

202 See *FTC v. Ind. Fed’n of Dentists*, 476 U.S. 447, 458 (1986) (“We have been slow to condemn rules adopted by professional associations as unreasonable *per se*”); *Nat’l Soc’y of Prof’l Eng’rs v. United States*, 435 U.S. 679, 695 (1978) (holding that an engineering society’s ethical canon that prohibited competitive bidding was analyzed under the rule of reason, not under the per se analysis).


205 Courts differentiate between two types of restraints: horizontal and vertical. A horizontal restraint is “an agreement between competitors at the
be considered a concerted action to maintain the price of physician services for medication prescriptions at the current level required by in-person hospital visits, whereas online doctor visits would greatly reduce that amount if they were allowed to compete in the market. Thus, there is an agreement between competitors (physicians) at the same level of the market structure to keep doctor visit costs high, constituting horizontal price fixing.

However, a court would likely reject this argument because a potential defendant could raise the procompetitive justifications of either (1) increased quality of care or (2) drug abuse and injury prevention. The medical board would need to offer evidence which demonstrates that either of those two justifications would result in market efficiencies, thus precluding the use of the per se analysis.

The first justification, increased quality of care, would likely be hard to prove or impossible to categorize as a justification, because public safety is generally not considered a redeeming cognizable justification in Sherman Act cases. In the Teladoc case, the state medical board offered that same procompetitive

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206 See supra notes 50–53.

207 See supra note 205.

208 Once the defendant identifies a procompetitive justification, also called a “redeeming virtue,” then the per se rule is inapplicable because it only applies to agreements that have a “pernicious effect” on competition and “lack of any redeeming virtue.” N. Pac. Ry. Co. v. United States, 356 U.S. 1, 5 (1958) (emphasis added).

209 See Nat’l Soc’y of Prof’l Eng’rs v. United States, 435 U.S. 679, 692 (1978) (“The purpose of the analysis is to form a judgment about the competitive significance of the restraint; it is not to decide whether a policy favoring competition is in the public interest, or in the interest of the members of an industry.”).
However, the court cited a string of Supreme Court decisions and held that public safety is not a sufficient justification in § 1 cases. Thus, any public safety justification, including improved quality of medical care, will likely not be sufficient as a procompetitive justification.

The second justification of injury and drug abuse is compelling because some prescription drugs, such as opioid pain relievers (OPRs) and other narcotics, are dangerous drugs that need to be regulated tightly. OPRs are highly addictive and commonly abused; examples include oxycodone, hydrocodone, and methadone. According to the CDC, three-quarters of prescription drug overdose deaths in 2011 were attributed to OPRs. A recent study demonstrates that OPR abuse has a serious economic strain on the health care industry, due to the excess medical costs associated with substance abuse treatment programs, prevention programs, and research. In total, annual health care costs of OPR abuse accounted for approximately 55.7 billion dollars in the United States. Thus, it is conceivable that there could be cost savings associated with rules that require an in-person examination.

211 Id. at 540 (citing Nat’l Soc’y of Prof’l Eng’rs, 435 U.S. at 695; FTC v. Ind. Fed’n of Dentists, 476 U.S. 447, 463 (1986)).
212 There is ample evidence that those drugs are more commonly abused and, consequently, more dangerous than other prescription drugs. See CDC STUDY, supra note 17, at 1; Howard G. Birnbaum, et al., Societal Costs of Prescription Opioid Abuse, Dependence, and Misuse in the United States, 12 PAIN MED. 657, 657 (2011), http://painmedicine.oxfordjournals.org/content/painmedicine/12/4/657.full.pdf [https://perma.cc/MSW2-W57Q].
213 Several federal agencies regulate OPRs. The Drug Enforcement Administration (DEA) is the lead federal agency that deals with controlled substances and narcotics. Drug Enforcement Administration, FED. REG., https://www.federalregister.gov/agencies/drug-enforcement-administration [https://perma.cc/L855-LQXQ]. The Food and Drug Administration (FDA) is also beginning to explore and assess new policies to further regulate OPRs. See Califf, FDA top officials call for sweeping review of agency opioid policies, FOOD AND DRUG ADMIN. (Feb. 4, 2016), http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm484765.htm [https://perma.cc/2TWS-RWVE].
214 See CDC STUDY, supra note 17, at 1.
215 Id.
216 See Birnbaum, supra note 212, at 660.
217 Id. at 661.
Injury and drug abuse is a compelling justification, and the per se analysis will likely not apply because the Supreme Court only applies the “demanding” per se rule in obvious cases.\(^{218}\) Once the defendant introduces some justification for the anti-competitive conduct, the court will not use a per se analysis.\(^{219}\) If the argument for a per se analysis fails, then a court will look at the case under a quick-look or rule of reason analysis.

**D. Quick-Look Analysis**

Potential plaintiffs could argue that a court should apply a quick-look analysis.\(^{220}\) A court will use the quick-look analysis when “an observer with even a rudimentary understanding of economics could conclude that the arrangements in question would have an anticompetitive effect on customers and markets.”\(^{221}\) The burden-shifting framework of the quick-look analysis involves several steps. First, the court determines if the restraint is “inherently suspect.”\(^{222}\) Second, if the restraint is inherently suspect, then the defendant is charged with the burden of articulating a “legally cognizable competitive justification.”\(^{223}\) Third, the plaintiff has to address that justification, which they can easily do by either (a) simply showing the restraint harmed consumers (without having to adduce evidence), or (b) demonstrating that the restraint had likely anticompetitive effects.\(^{224}\) Fourth, the

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\(^{219}\) Id. at 36 (parentheses omitted).


\(^{221}\) Cal. Dental Ass’n v. FTC, 526 U.S. 756, 770 (1999).

\(^{222}\) Polygram Holdings, Inc. v. FTC, 416 F.3d 29, 35–36 (D.C. Cir. 2005).

\(^{223}\) Id. at 36 (parentheses omitted).

\(^{224}\) Id.
hefty evidentiary burden switches to the defendant to show that the restraint did not harm consumers or the procompetitive justification outweighs the effects on consumers.\textsuperscript{225}

A court could apply the quick-look analysis, as they did with the agreement in \textit{National Society of Professional Engineers v. United States}, where the Supreme Court held that a professional association’s agreement was not price fixing, but appeared to be so similar that “no elaborate industry analysis [was] required to demonstrate the anticompetitive character of such an agreement.”\textsuperscript{226} However, it is unclear if a court will deem an in-person prescription rule as inherently suspect, because this area of antitrust litigation is novel and the legal standard behind the quick-look analysis is cloudy and rarely applied.\textsuperscript{227} The defense attorneys’ resources and the availability of reliable evidence would likely determine whether quick-look analysis is used.

\textit{E. Rule of Reason Analysis}

Under a rule of reason analysis, a potential plaintiff would incur a costly legal battle.\textsuperscript{228} A plaintiff’s success under the rule of reason is possible,\textsuperscript{229} but will most likely not occur.\textsuperscript{230} The rule of reason is the preferred standard for § 1 cases, requiring the judge to weigh the harms and benefits of the anticompetitive act.\textsuperscript{231} To establish a prima facie case, plaintiffs would have to allege the defendant medical board possessed sufficient market power or

\textsuperscript{225} Id.
\textsuperscript{227} Maurice E. Stucke, \textit{Does the Rule of Reason Violate the Rule of Law?}, 42 U.C. DAVIS. L. REV. 1375, 1413 (2009) (“Not surprisingly, the quick-look standard is rarely applied and has fallen into disuse in actually resolving cases.”).
\textsuperscript{228} See id. at 1460–66 (noting that a rule of reason case is costlier than a per se case due to the extensive scope of discovery necessitating huge litigation teams).
\textsuperscript{229} See, e.g., \textit{Teladoc}, 112 F. Supp. 3d 529, 536–37 (2015) (holding that Teladoc's § 1 claims succeeded under both the quick-look and Rule of Reason analyses).
\textsuperscript{230} See Carrier, \textit{supra} note 131, at 830.
\textsuperscript{231} See \textit{supra} note 127. Perhaps “[c]ontrary to its name, the Rule [of Reason] does not open the field of antitrust inquiry to any argument in favor of a challenged restraint that may fall within the realm of reason. Instead, it focuses directly on the challenged restraint’s impact on competitive conditions.” Nat'l Soc'y of Prof'l Eng'rs v. United States, 435 U.S. 679, 688 (1978).
the rule in contention resulted in increased prices, lower output, or lower quality of care for the product of physicians’ services.232

A plaintiff’s easiest method would be to prove that the state medical board’s rulemaking abilities confer total control over the physician’s services market in a given state. To do so, a plaintiff would have to define the relevant market, which includes (1) the relevant geographic market and (2) the relevant product market.233 In any potential case, the relevant geographic market is defined as the state where the rule was in effect.234 The relevant product market would be physician services because telemedicine physicians compete with urgent care physicians, hospital-based physicians, and private physicians.235

Alternatively, a possibly more difficult route for a plaintiff would be to prove that the contested rule resulted in higher prices, lower output, or reduced quality of care for physicians’ services.236 This claim would be difficult to assess because a potential plaintiff would need statistical evidence about online doctor services in that particular market before the rule was adopted, or possibly use evidence from other jurisdictions where it is available.

If the plaintiff introduces a prima facie case, a defendant could rebut by producing evidence that the rule creates benefits that outweigh the harms produced by the plaintiff’s case.237 As stated earlier, the defendant’s best option would be to prove the rule aims to reduce drug abuse and promote injury prevention, thereby reducing medical costs associated with those problems.238

Even if a court was willing to accept that justification in defense of a state prescription rule, the plaintiff would still have the opportunity to prove that the alleged benefits of the rule are not necessary to achieve its goals.239 That inquiry has two parts:

232 See supra note 119.
233 AREEDA & HOVENKAMP, supra note 189, ¶ 1503, at 348.
235 See, e.g., id. ¶ 42(b) (pleading the relevant product market as physician services).
236 See supra note 119 and accompanying text.
237 AREEDA & HOVENKAMP, supra note 189, ¶ 1504b, at 358.
238 See supra notes 212–18 and accompanying text.
239 The rule of reason’s last step “involves determining whether the challenged agreement is necessary to achieve its purported goals.” United States
(1) whether the restraint actually promotes the legitimate interests; and (2) whether that restraint can be pursued in a manner to restrain competition less.\textsuperscript{240}

If the in-person prescription rules are promulgated to reduce drug abuse and injury prevention, then that justification is likely a legitimate interest under the state’s police power authority.\textsuperscript{241} However, it is possible that the rule could be viewed as overly restrictive if it forbids all prescriptions resulting from an online consultation. A less restrictive rule could, in effect, place a physical examination requirement on only truly dangerous prescriptions. A less restrictive law could require physical examinations for only OPRs,\textsuperscript{242} and allow for online consultations for other prescriptions. This type of law would, in effect, be a less restrictive method for a state to enforce physical examination rules if those rules were adopted to prevent injury and drug abuse.

CONCLUSION

Telecommunication technologies and patient-care models have advanced to the point where online doctor services provide a cost effective method of health care. Although some medical professionals may advocate against online consultation services for prescription drugs in favor of the old system of in-person visits, a dogmatic reliance on the traditional health care delivery system will not stand up to a § 1 challenge unless proven to promote an efficient market. The Sherman Act, like the common law, “evolves to meet the dynamics of present economic conditions.”\textsuperscript{243} Although online doctor visits are a novel form of medical care, they should not be ignored. Online doctor visits have promising benefits for competition and health outcomes because they are cheaper than in-person visits, easier to schedule, and reduce travel times.\textsuperscript{244} Telemedicine companies have standing to sue state medical boards over rules that require in-person physical

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\textsuperscript{240} Areeda & Hovenkamp, supra note 189, ¶ 1505, at 370.

\textsuperscript{241} See supra notes 86–92 and accompanying text.

\textsuperscript{242} See supra note 212.


\textsuperscript{244} See supra Part I.A.
examinations and should strongly consider taking that action if it would allow them to expand their services. Although state level legislation requiring more active supervision could affect the antitrust analysis, legislative change is often slow to develop. Furthermore, it is questionable if states will adopt a truly active model of supervision, the definition of which is amorphous and currently undefined. The possibilities of this form of “impact litigation” in the health care field could be advantageous to providers, consumers, and the market at large.