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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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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

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.for-tune.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.american-telemed.org/about-telemedicine/what-is-telemedicine#.Vgqxm4_BzGc [<https://perma.cc/7P2J-AU9L>].

⁷ LEO BURNETT, *How UnitedHealthcare “Came in Hot” With Its Biggest Consumer Ad Push*, (Aug. 21, 2015), <http://leoburnett.com/articles/work/how-united-healthcare-came-in-hot-with-its-biggest-consumer-ad-push/> [<https://perma.cc/8JUC-VNFM>].

⁸ *Id.*

demonstrates the relevancy of telemedicine⁹ 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.¹⁰

This Note contributes to the scarce legal literature concerning telemedicine companies that provide online consultations between patients and physicians.¹¹ 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.¹² Those telemedicine companies typically contract with individuals, large companies, hospitals, or health insurers.¹³ 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.¹⁴

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].

¹³ *Id.*; see also Olga Kharif, *Telemedicine: Doctor Visits via Video Calls*, BLOOMBERG BUS. (Feb. 28, 2014), <http://www.bloomberg.com/bw/articles/2014-02-27/health-insurers-add-telemedicine-services-to-cut-costs> [https://perma.cc/H6T8-T7S4].

¹⁴ See Mary Delsener, *Telemedicine & The Courts: Teladoc v. Texas Medical Board as a Case Study*, B.C. INTELL. PROP. & TECH. F. 1 (2015).

However, some state prescription drug rules act as barriers that prohibit the increased use of online doctor visits.¹⁵ While those conferencing services provide several advantages,¹⁶ 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.¹⁷ Medical boards justify these rules as preserving the establishment of the patient-physician relationship, and for drug abuse and injury prevention purposes.¹⁸

Some state medical board rules are tailored to prevent “telemedicine abortions.”¹⁹ Other state rules, however, are broader and attempt to prevent physicians from writing any prescription without an in-person physical examination of the patient.²⁰ While the first category of rules may be unconstitutional as an undue burden on a woman’s right to seek an abortion,²¹ 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.²² State prescription rules are just one of

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,²³ 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.²⁴ 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.²⁵ 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.²⁶

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.²⁷ 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.

²³ See Brittney Bauerly, *Telemedicine in Rural Communities: Navigating the Legal Issues in this New Frontier of Health Care Delivery*, NETWORK FOR PUB. HEALTH L. (Dec. 8, 2015, 2:54 PM), https://www.networkforphl.org/the_network_blog/2015/12/08/726/telemedicine_in_rural_communities_navigating_the_legal_issues_in_this_new_frontier_of_health_care_delivery/?utm_source=Network+Report+12-10-15&utm_campaign=Network+Report+12-10-15&utm_medium=email&utm_content=184 [https://perma.cc/XFR4-T3QA] (noting that problems facing telemedicine companies include reimbursement, professional licensing, medical malpractice, data privacy, and FDA regulation concerns).

²⁴ *N.C. State Bd. of Dental Exam'rs v. FTC*, 135 S. Ct. 1101, 1108–11, 1114–17 (2015).

²⁵ *Id.* First articulated in the 1943 Supreme Court case *Parker v. Brown*, the state action doctrine provides state or local governments federal antitrust immunity. See *Parker v. Brown*, 317 U.S. 341, 351, 359, 361–63, 367–68 (1942). Today, the state action doctrine is synonymous with the phrase “*Parker* immunity.” See Jason Kornmehl, *State Action on Appeal: Parker Immunity and the Collateral Order Doctrine in Antitrust Litigation*, 39 SEATTLE UNIV. L. REV. 1, 6–7 (2015). For a complete discussion of the antitrust state action doctrine, see *infra* Part IV.A.

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* immunity²⁸ 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.³² 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.³³ However, most early telemedicine practices were not tremendously successful and interest dropped off in the mid-1980s, likely due to high transmission costs.³⁴ Yet, the Internet revolution in the 1990s prompted interest in renewing remote physician consultations through online services.³⁵

As recent as the early 2000s, independent telemedicine companies have sprung up across the United States.³⁶ Telemedicine companies that specifically provide online doctor visits arguably began to incorporate in 2002.³⁷ While it is hard to identify the “first” telemedicine company, MyDoc may have been the first company to provide online doctor consultations in 2002.³⁸ However, MyDoc quickly faced difficulties due to hostile state prescription rules and had to discontinue their online services for several years.³⁹

³² TELEMEDICINE: A GUIDE TO ASSESSING TELECOMMUNICATIONS IN HEALTH CARE 36 (Marilyn J. Field ed., 1996), http://www.ncbi.nlm.nih.gov/books/NBK45448/pdf/Bookshelf_NBK45448.pdf [<https://perma.cc/KJS8-E4TA>].

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.”).

³⁶ See Tyler Chin, *Doctor-Founded Company a Phone-Only Practice*, AMED NEWS (May 23, 2005), <http://www.amednews.com/article/20050523/business/305239992/7/> [<https://perma.cc/L9ZB-7N74>].

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.⁴⁰ Recent studies demonstrate that 64 percent of Americans own smartphones.⁴¹ From that pool of smartphone owners, 62 percent have used their phone to look up information about a health condition.⁴² 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.⁴³ 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.⁴⁴ 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.⁴⁵ Decreased costs,

⁴⁰ Studies show 90 percent of American adults own a cell phone and 42 percent own a tablet computer. PEW RES. CTR., MOBILE TECHNOLOGY FACT SHEET (2014), <http://www.pewinternet.org/fact-sheets/mobile-technology-fact-sheet/> [https://perma.cc/5Q89-7NPA].

⁴¹ PEW RES. CTR., U.S. SMARTPHONE USE IN 2015, at 2 (April 1, 2015), http://www.pewinternet.org/files/2015/03/PI_Smartphones_0401151.pdf [https://perma.cc/EC7Z-UTX5].

⁴² *Id.* at 5.

⁴³ *New Trends in Telehealth Technology*, GLOBALMED, <http://www.globalmed.com/additional-resources/new-trends-in-telehealth-technology.php> [https://perma.cc/87WG-Q2ER].

⁴⁴ See Bruce Japsen, *With ACA, Telemedicine In 'Perfect Storm' for Coverage*, FORBES (Dec. 9, 2014, 8:21 AM), <http://www.forbes.com/sites/brucejapsen/2014/12/09/with-aca-telemedicine-in-perfect-storm-for-coverage/> [https://perma.cc/D7HY-KT55].

⁴⁵ *Technology, Media & Telecommunications Predictions*, DELOITTE, at 20 (2014), <http://www2.deloitte.com/content/dam/Deloitte/global/Documents/Technology-Media-Telecommunications/gx-tmt-predictions-2014.pdf> [https://perma.cc/HE26-KQEQ] [hereinafter *Technology, Media & Telecommunications Predictions*]. While video conferencing may be the first application of virtual doctor visits that comes to mind, Deloitte predicts that the vast majority of

increased output, and increased quality of care are the hallmarks of a procompetitive business practice relevant to an anti-trust analysis.⁴⁶ 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.⁴⁷ Those procompetitive advantages are discussed in the following subsections.⁴⁸

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.⁴⁹ 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

virtual doctor visits 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. *Id.* 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.

⁴⁶ *See* R. Preston McAfee, Hugo M. Mialon & Sue H. Mialon, Paper, *Private Antitrust Litigation: Procompetitive or Anticompetitive?*, U.S. DEP'T OF JUSTICE, ATR DIV., 1–2 (Dec. 1, 2005), <http://www.justice.gov/sites/default/files/atr/legacy/2006/12/27/220040.pdf> [<https://perma.cc/CN8A-YYJM>] (“The antitrust laws are intended to permit procompetitive actions by firms and deter anticompetitive actions.... Competition lowers prices and increases firms’ incentives to innovate, to the benefit of consumers.”).

⁴⁷ *See infra* Parts I.A.1–4.

⁴⁸ *See id.*

⁴⁹ 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 \$50.⁵⁰ A typical in-person primary care visit, on the other hand, costs uninsured patients \$150 on average and privately insured patients around \$49.⁵¹ Moreover, some private health insurers such as UnitedHealthcare and Anthem cover all the costs of online doctor visits provided by select telemedicine companies.⁵² Thus, patients enrolled in certain private insurance plans pay no out-of-pocket costs for online doctor visits.⁵³

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.⁵⁴ Industry leader, Teladoc, claims that physician response time was less than ten minutes on average.⁵⁵ 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.⁵⁶ Moreover, online clinics are typically open twenty-four hours, seven days a week.⁵⁷ In-person visits, on the other hand, may take days to weeks to occur after the patient calls to request an appointment.⁵⁸ Wait times for in-person doctor visits

⁵⁰ See VSEE, *supra* note 12.

⁵¹ See *Primary care visits available to most uninsured but at a high price*, JOHNS HOPKINS BLOOMBERG SCHOOL OF PUB. HEALTH (May 5, 2015), <http://www.jhsph.edu/news/news-releases/2015/primary-care-visits-available-to-most-uninsured-but-at-a-high-price.html> [<https://perma.cc/64XD-9SRH>].

⁵² Abby Goodnough, *Modern Doctors' House Calls: Skype Chat and Fast Diagnosis*, N.Y. TIMES (July 11, 2015), http://www.nytimes.com/2015/07/12/health/modern-doctors-house-calls-skype-chat-and-fast-diagnosis.html?_r=0 [<https://perma.cc/UK27-55BJ>].

⁵³ See *id.*

⁵⁴ See VSEE, *supra* note 12 (listing various telemedicine companies and their response times to patient requests for an online visit).

⁵⁵ *How does it work?*, TELADOC, <http://www.teladoc.com/how-does-it-work/> [<https://perma.cc/5PN5-98BP>].

⁵⁶ See *id.*

⁵⁷ Telemedicine companies Virtuwel, 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.

⁵⁸ *Physician Appointment Wait Times and Medicaid and Medicare Acceptance Rates*, MERRITT HAWKINS (2014), <http://www.merrithawkins.com/uploadedFilesMerrittHawkings/Surveys/mha2014waitsurvPDF.pdf> [<https://perma>

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.⁵⁹ One study demonstrated that online doctor visits resulted in quicker visits and, consequently, less follow-up visits, thereby reducing health care costs.⁶⁰

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.⁶¹ In that case, physicians testified that online consultations allowed them to treat more patients and practice medicine on a more flexible schedule.⁶² While that testimony derived from affidavits,⁶³ 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.⁶⁴ While other industries were hit hard by the 2008 recession, the health care sector has

.cc/DCP6-3N3A] (providing the average scheduling times for in-person doctor visits in different cities of the United States).

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>].

⁶¹ See *Teladoc, Inc. v. Tex. Med. Bd.*, 112 F. Supp. 3d 529, 537 (W.D. Tex. 2015).

⁶² *Id.*

⁶³ *Id.*

⁶⁴ See BUREAU OF LABOR STATISTICS, LARGEST INDUSTRIES BY STATE, 1990–2013 (July 28, 2014), http://www.bls.gov/opub/ted/2014/ted_20140728.htm [<https://perma.cc/895L-2QJK>]; see also Joshua Wright, *Health care's unrivaled job gains and where it matters most*, FORBES (Oct. 13, 2013), <http://www.forbes.com/sites/emsj/2013/10/07/health-cares-unrivaled-job-gains-and-where-it-matters-most/#57f1a93b14a7> [<https://perma.cc/7R39-LEDT>].

largely been resilient.⁶⁵ In the near future, online doctor visits may become the preferred and easiest way to reach your doctor.⁶⁶ 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.⁶⁷ 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.⁶⁸

The final phase of the Affordable Care Act's Employer Shared Responsibility Mandate ("employer mandate")⁶⁹ 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 26.⁷⁰ If an applicable company fails to

⁶⁵ See Wright, *supra* note 64.

⁶⁶ Eric Topol, *The future of medicine is in your smartphone*, WALL ST. J. (Jan. 9, 2015), <http://www.wsj.com/articles/the-future-of-medicine-is-in-your-smartphone-1420828632> [<https://perma.cc/A9UF-WY2H>] (noting that consulting firms Deloitte and PricewaterhouseCoopers forecasted "that virtual physician visits (replacing in-office visits) will soon become the norm").

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).

⁶⁸ *Health care benefits cost increases to hold steady in 2016, National Business Group on Health Survey Finds*, NAT'L BUS. GROUP ON HEALTH (Aug. 12, 2015), <https://www.businessgrouphealth.org/pressroom/pressRelease.cfm?ID=263> [<https://perma.cc/B85W-4T3R>].

⁶⁹ 26 U.S.C. § 4980H.

⁷⁰ See *id.*; *Employer Mandate Fact Sheet*, CIGNA (May 2015), <http://www.cigna.com/assets/docs/about-cigna/informed-on-reform/employer-mandate-fact-sheet.pdf> [<https://perma.cc/DT4B-NTQE>].

comply, the IRS will issue a penalty to them.⁷¹ 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.⁷²

2. Health Care Providers

Health care executives view telemedicine as an important component for the future of their companies.⁷³ 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.⁷⁴ 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.⁷⁵ Thus, health care companies bare a greater risk for keeping patients healthy,

⁷¹ 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>].

⁷² *See supra* notes 51–53 and accompanying text.

⁷³ 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/0585f5b1-1205-4be7-be5a-4e14602a4fac/Presentation/PublicationAttachment/39c25a9b-5ff1-4ee8-b861-4ea2d71718ae/2014%20Telemedicine%20Survey%20Executive%20Summary.pdf> [<https://perma.cc/M4KT-EQL8>] [hereinafter FOLEY & LARDNER SURVEY].

⁷⁴ *Id.* at 2.

⁷⁵ *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.

and need to capitalize on innovative health care techniques such as video conferencing and other telemedicine practices.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.”⁷⁷

3. *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.⁷⁸ In 2014, tech giant Google experimented with a trial telemedicine service.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.”⁸⁰ Technology device manufacturers are also likely to benefit in expanding markets for mobile devices and mobile applications.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.⁸² This Note does not discuss those hurdles; instead, it focuses on state prescription drug rules that prohibit prescriptions without an in-person visit.

⁷⁶ See FOLEY & LARDNER SURVEY, *supra* note 73, at 2.

⁷⁷ See Japsen, *supra* note 44.

⁷⁸ Amit Chowdhry, *Google is testing a “Talk With a Doctor” feature within medical search results*, 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].

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. *Id.*

⁸⁰ See *Technology, Media & Telecommunications Predictions*, *supra* note 45.

⁸¹ See *id.*

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.⁸³ However state laws and rules—not federal law—usually dictate the physical examination requirements for medication prescriptions.⁸⁴ While FDA imposes labeling requirements on drugs,⁸⁵ the agency cannot regulate the practice of medicine. Instead, states fill the void of regulating the practice of medicine and impose rules on prescribers.⁸⁶

Pursuant to a state's police power,⁸⁷ state legislatures generally create medical boards to regulate the practice of medicine.⁸⁸ 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.⁸⁹ Through rules, medical boards generally regulate licensure, disciplinary procedures, and scope-of-practice.⁹⁰ Scope-of-practice regulations aim to define the “spheres of activity within which various types of health-care providers ... are authorized to practice.”⁹¹ It follows

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).

⁸⁸ Nadia N. Sawicki, *Character, Competence, and the Principles of Medical Discipline*, 13 J. HEALTH CARE L. & POL'Y 285, 289 (2010). Some state medical boards are independent bodies, while others are part of a larger administration, such as a department of health. See *Frequently Asked Questions About State Medical Boards*, FED'N OF ST. MED. BDS., <http://www.fsmb.org/policy/consumer-resources/frequently-questions> [<https://perma.cc/TX4G-PMDN>].

⁸⁹ See Sawicki, *supra* note 88, at 291–92; BARRY R. FURROW, *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* 87 (7th ed. 2013).

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 visits.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).

⁹⁴ See Alana Semuels, *The Safer, More Affordable Abortion Only Available in Two States*, ATLANTIC (Oct. 10, 2014), <http://www.theatlantic.com/business/archive/2014/10/the-safer-more-affordable-abortion-only-available-in-two-states/381321/> [https://perma.cc/4JUH-TUY6].

⁹⁵ *Id.*

⁹⁶ *Id.*

physician.⁹⁷ As many as eighteen states have placed restrictions on telemedicine abortions,⁹⁸ and require a physician to perform an in-person physical examination of the woman.⁹⁹ State rules that effectively eliminate telemedicine abortions may simply limit medication administration unless the physician is present at the time.¹⁰⁰

While there is little empirical evidence as to the outcomes of telemedicine abortions due to stringent state laws and regulations,¹⁰¹ 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.¹⁰² Rules and laws that strictly target telemedicine abortions may be viewed as unconstitutional under the abortion doctrine's "undue burden" analysis,¹⁰³ 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

⁹⁷ See *The Abortion Pill*, PLANNED PARENTHOOD, <http://www.plannedparenthood.org/learn/abortion/the-abortion-pill> [<https://perma.cc/23M9-GE9R>].

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).

¹⁰² See Daniel Grossman et al., *Changes in service delivery patterns after introduction of telemedicine provision of medical abortion in Iowa*, 103 AM. J. PUB. HEALTH 73 (2013).

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.¹⁰⁴ Proponents of these rules argue that forbidding online consultations that result in medication prescriptions is aimed at establishing and preserving a physician-patient relationship.¹⁰⁵ That relationship has origins in contract law, but also involves fiduciary obligations on behalf of the physician.¹⁰⁶ Injury and prescription drug abuse prevention is the more compelling argument behind rules that require an in-person physical examination.¹⁰⁷ 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.¹⁰⁸

As of 2015, thirty-four states and the District of Columbia require a “physical examination” for prescribing a controlled substance.¹⁰⁹ Some states will explicitly state that a patient-physician relationship is required.¹¹⁰ 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.”¹¹¹

Other states will reference the establishment of a patient-physician relationship that, as defined by state law, must include a physical examination.¹¹² For example, South Carolina requires a “proper physician-patient relationship.”¹¹³ That relationship requires the physician to, “at a minimum ... personally perform and document an appropriate history and physical examination.”¹¹⁴

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.

¹¹¹ 844 IND. ADMIN. CODE 5-4-1 (2003).

¹¹² CDC STUDY, *supra* note 17, at 6–7.

¹¹³ S.C. CODE ANN. § 40-47-113(A) (2015).

¹¹⁴ *Id.* § 40-47-113(A)(1) (2015).

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.¹¹⁵

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.”¹¹⁶ 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.”¹¹⁷ 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.¹¹⁸

The Supreme Court interpreted the Sherman Act as a congressional effort to eliminate the “three evils” (“anticompetitive effects”) commonly produced by monopolies: (1) increased prices; (2) reduced output or a limitation on production; and (3) reduced quality.¹¹⁹ Plaintiffs can prove a prima facie case under § 1 by alleging that either (1) the defendant possesses market power;¹²⁰ or (2) the anticompetitive agreement creates at least one of the three anticompetitive effects.¹²¹ Moreover, the plaintiff’s claim

¹¹⁵ See *infra* Part V.A.

¹¹⁶ 15 U.S.C. § 1 (2015).

¹¹⁷ *NCAA v. Bd. Regents Univ. of Okla.*, 468 U.S. 85, 98 (1984).

¹¹⁸ 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.*

¹¹⁹ *Standard Oil Co. of N.J. v. United States*, 221 U.S. 1, 52 (1911).

¹²⁰ 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.”).

¹²¹ 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

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 action¹²⁶ 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

effects, such as reduction of output, increase in price, or deterioration in quality of goods or services [C]ourts typically allow proof of the defendant’s ‘market power’ instead. Market power ... is essentially a ‘surrogate for detrimental effects.’”) (quotations omitted).

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).

¹²³ *United States v. Brown Univ.*, 5 F.3d 658, 665 (1993) (citing *Goldfarb v. Va. St. Bar*, 421 U.S. 773, 787–88 (1975)).

¹²⁴ *Hosp. Bldg. Co. v. Trs. of Rex Hosp.*, 425 U.S. 738, 739–40 (1976) (holding that an unlawful conspiracy to restrain trade and commerce in the furnishing of medical services in Raleigh, North Carolina, substantially impacted interstate commerce).

¹²⁵ *Jefferson Parish*, 466 U.S. at 25 n.42 (citing *Ariz. v. Maricopa Med. Soc’y*, 457 U.S. 332, 348–51 (1982)). See, e.g., *Nat’l Gerimedical Hosp. v. Blue Cross*, 452 U.S. 378 (1981); *Am. Med. Ass’n v. United States*, 317 U.S. 519, 528–29 (1943).

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.”¹²⁸ 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.¹²⁹

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.”¹³⁰ The type of analysis is an important consideration in determining whether an in-person prescription requirement survives § 1 scrutiny.¹³¹

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.¹³² 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)).

¹²⁸ *N. Pac. Ry. Co. v. United States*, 356 U.S. 1, 5 (1958).

¹²⁹ *Chi. Bd. Trade v. United States*, 246 U.S. 231, 238 (1918).

¹³⁰ *Cal. Dental*, 526 U.S. at 770.

¹³¹ See, e.g., Michael A. Carrier, *The Rule of Reason: An Empirical Update for the 21st Century*, 16 *GEO. MASON L. REV.* 827, 830 (2009) (finding that “[p]laintiffs almost never win under the rule of reason” when surveying all the rule of reason cases between 1999–2009).

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.”¹³³ In other words, a state law is preempted if that law constitutes a per se violation of § 1.¹³⁴ If so, then the statute is preempted unless it is saved under the second inquiry: the state action doctrine.¹³⁵ 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.¹³⁶

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.”¹³⁷ Over the years, the doctrine has been accepted as a judicially created exception to federal antitrust laws.¹³⁸ In simple terms, *Parker* immunity is afforded to state or local government actions that have intentional or foreseeable anticompetitive effects.¹³⁹ A state agency only enjoys *Parker* immunity if it (1) clearly articulates a

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.

¹³⁴ See Matthew McDonald, Note, *Antitrust Immunity Up in Smoke: Preemption, State Action, and the Master Settlement Agreement*, 113 COLUM. L. REV. 97, 98 (2013).

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

¹³⁶ See *id.*

¹³⁷ *Parker v. Brown*, 317 U.S. 341, 351 (1943); Kornmehl, *supra* note 25, at 6–7.

¹³⁸ Kornmehl, *supra* note 25, at 7. Both the Judiciary and Congress have provided federal antitrust immunity to certain industries through statute and case law respectively. See, e.g., McCarran-Ferguson Act, 15 U.S.C. §§ 1011–1015 (providing the insurance industry is immune to antitrust suits); *Fed. Baseball Club v. Nat’l League*, 259 U.S. 200, 209 (1922) (deciding to grant Major League Baseball immunity to antitrust suits).

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.¹⁴⁰

In *Parker*, the Supreme Court “interpreted the antitrust laws to confer immunity on anticompetitive conduct by the States when acting in their sovereign capacity.”¹⁴¹ 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.¹⁴² The plaintiff argued that, because 90–95 percent of the raisins grown in California are ultimately shipped in interstate or foreign commerce,¹⁴³ the California law was an unlawful contract in restraint of trade among the several states.¹⁴⁴ 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.¹⁴⁵

Nearly forty years later, in *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 *Parker* immunity from federal antitrust laws.¹⁴⁶ 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.”¹⁴⁷

For the first prong of the *Midcal* test, the Supreme Court’s holding in *Hallie v. Eau Claire* remains the controlling precedent.¹⁴⁸ 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

¹⁴⁰ AREEDA & HOVENKAMP, *supra* note 28, ¶ 217, at 386.

¹⁴¹ N.C. St. Bd. of Dental Exam’rs v. FTC, 135 S. Ct. 1101, 1110 (2015) (citing *Parker*, 317 U.S. at 350–51).

¹⁴² *Parker*, 317 U.S. at 344, 346.

¹⁴³ *Id.* at 345.

¹⁴⁴ *Id.* at 350.

¹⁴⁵ *Id.* at 351.

¹⁴⁶ Cal. Retail Liquor Ass’n v. Midcal Aluminum, 445 U.S. 97, 105 (1980).

¹⁴⁷ *Id.*; AREEDA & HOVENKAMP, *supra* note 28, ¶ 217, at 386. The test from that case is often referred to as the “*Midcal* test.” *Id.*

¹⁴⁸ *Hallie v. Eau Claire*, 471 U.S. 34, 42–43 (1985).

the results of the anticompetitive effect were reasonably foreseeable.¹⁴⁹ As of 2015, the Court has not formulated a test to define the clear articulation factor any further.¹⁵⁰

For the second prong of the *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 *Parker* immunity.¹⁵¹ In *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.”¹⁵² 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.¹⁵³ 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 *Midcal*’s active supervision requirement.”¹⁵⁴

The “active supervision” requirement for state professional boards is “flexible and context-dependent.”¹⁵⁵ 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.’”¹⁵⁶ The Court has identified “only a few constant requirements”¹⁵⁷ 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;

¹⁴⁹ *Id.*

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”).

¹⁵¹ *Id.* at 1121.

¹⁵² *Id.* at 1109.

¹⁵³ *Id.* at 1120.

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 *Midcal*’s supervision requirement was created to address.” *Id.*

¹⁵⁵ *Id.* at 1116.

¹⁵⁶ *Id.* (quoting *Patrick v. Burget*, 486 U.S. 94, 100–01 (1988)).

¹⁵⁷ *Id.*

- (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.¹⁵⁸

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."¹⁵⁹ Market participants may "confus[e] their own interests with the State's policy goals."¹⁶⁰ 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."¹⁶¹

With these requirements and policies in mind, state medical boards with a controlling majority of market participants are likely subject to the active supervision requirement¹⁶² 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.¹⁶³ 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.¹⁶⁴ Scope-of-practice rules are

¹⁵⁸ *Id.* at 1116–17.

¹⁵⁹ *Id.* at 1116.

¹⁶⁰ *Id.* at 1114.

¹⁶¹ *Id.*

¹⁶² See *infra* Part V.B. and accompanying text.

¹⁶³ See Robert Eisig Bienstock, *Municipal Antitrust Liability: Beyond Immunity*, 73 CALIF. L. REV. 1829, 1837 (1985).

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.¹⁶⁵ The rules that determine under what circumstance a physician can prescribe a drug are considered scope-of-practice regulations.¹⁶⁶ 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*.¹⁶⁷

After *N.C. Dental*, the FTC issued a report for states to guide them in efforts to insulate their professional boards.¹⁶⁸ However, it is still unclear as to what state mechanisms provide “realistic assurance” that a state professional board is promoting state policy.¹⁶⁹ As of early 2016, some states have begun to take steps to insulate their professional boards from the decision, and anti-trust attorneys expect all states to enact some kind of legislation to address the holding in *N.C. Dental*.¹⁷⁰ 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.¹⁷¹ Oklahoma took a different

.scotusblog.com/2014/10/argument-analysis-court-wary-of-immunity-for-licensing-boards-but-what-about-doctors/ [https://perma.cc/96RT-MS6A].

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.

¹⁶⁸ FED. TRADE COMM’N, FTC STAFF GUIDANCE ON ACTIVE SUPERVISION OF STATE REGULATORY BOARDS CONTROLLED BY MARKET PARTICIPANTS (Oct. 2015), https://www.ftc.gov/system/files/attachments/competition-policy-guidance/active_supervision_of_state_boards.pdf [https://perma.cc/75F9-DF7A] [hereinafter FTC GUIDANCE].

¹⁶⁹ *N.C. St. Bd. of Dental Exam’rs v. FTC*, 135 S. Ct. 1101, 1116 (2015).

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.¹⁷² It is unclear how courts will react to these measures.¹⁷³ The rules promulgated by un-insulated medical boards dominated by market participants, however, will likely not enjoy *Parker* immunity.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 *Parker* immunity.¹⁷⁵ It is up to the judiciary to interpret the scope of the holding in *N.C. Dental*.¹⁷⁶ Moreover, the FTC may or may not decide to file suit if a medical board follows their guidance.¹⁷⁷ However, a private party with standing is not bound by a guidance document and has the option to file suit.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.

V. STRATEGIES FOR § 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

¹⁷² OKLA. EXEC. DEP'T, EXEC. ORDER NO. 2015–33 (2015), <http://www.sos.ok.gov/documents/executive/993.pdf> [<https://perma.cc/ZC7L-AKSK>]; see also Foote, *supra* note 165, at 56 n.13.

¹⁷³ Kathleen Foote, the Senior Assistant Attorney General and Antitrust Chief in the California Department of Justice, noted that, in response to the *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.

¹⁷⁴ See *N.C. Dental*, 135 S. Ct. at 1110.

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.”).

¹⁷⁶ *N.C. Dental*, 135 S. Ct. at 1123.

¹⁷⁷ See *supra* note 175.

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.”).

challenging state rules that require in-person physical examinations for prescriptions under § 1 of the Sherman Act.¹⁷⁹ In *Teladoc v. Texas Medical Board*, the nation's largest telehealth provider¹⁸⁰ 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."¹⁸¹ 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."¹⁸²

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.¹⁸³ Teladoc met its burden of proving that the Texas rule had an anti-competitive effect by producing higher premiums and decreased choices.¹⁸⁴ In response, the Texas Medical Board offered a single justification that the anticompetitive rule would lead to improved quality of medical care.¹⁸⁵ 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

¹⁷⁹ *Teladoc, Inc. v. Tex. Med. Bd.*, 112 F. Supp. 3d 529 (W.D. Tex. 2015).

¹⁸⁰ *What is Teladoc?*, TELADOC, <https://www.teladoc.com/> [<https://perma.cc/3JGC-RS28>] (providing that Teladoc is the largest and first telehealth provider in the United States).

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."¹⁸⁶ 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.¹⁸⁷ Additionally the FTC could file suit because they have jurisdiction over antitrust suits concerning "professional services" within the health care industry.¹⁸⁸

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.¹⁸⁹ 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.¹⁹⁰ As evidenced by the *Teladoc* lawsuit, state rules that prohibit physicians from prescribing medication without an in-person examination of the

¹⁸⁶ *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 492 U.S. 489 (1977).

¹⁸⁷ *See Teladoc*, 112 F. Supp. 3d at 537 (Elimination of physicians providing healthcare would thus negatively impact consumers, a classic anti-trust injury."). Thus, any person seeking a prescription may have a viable cause of action.

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.¹⁹¹ Potential plaintiffs will have to provide evidence that online doctor services are cheaper than regular physician visits.¹⁹² Moreover, those rules are likely to reduce output of physician services.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.¹⁹⁴ Lastly, it will be difficult for a plaintiff to prove that online doctor services result in increased quality of care.¹⁹⁵

To prevent scrutiny under § 1, a state medical board will have to assert *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.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.¹⁹⁷ Prescription drugs can only be prescribed by certain qualified people (such as physicians).¹⁹⁸ Thus, they are inherently anticompetitive because they exclude other people from the prescribing market.

¹⁹¹ *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. *Id.*

¹⁹² *Id.*

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

¹⁹⁴ AREEDA & HOVENKAMP, *supra* note 189, ¶ 1504b at 358.

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.

¹⁹⁶ See *supra* note 147 and accompanying text.

¹⁹⁷ 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.”).

¹⁹⁸ See 21 U.S.C. § 353(b) (2015).

The active supervision element, however, will be highly fact-dependent and require litigators to test their skills.¹⁹⁹ 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*.²⁰⁰

C. Per Se Analysis

In any § 1 challenge to an anticompetitive practice, a court must decide which analysis should govern the case.²⁰¹ 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.²⁰² It is not impossible, however, for a court to apply a per se analysis to a defendant in the health care industry.²⁰³

A potential plaintiff would benefit from this analysis because it is the most plaintiff-friendly.²⁰⁴ The most plausible argument to make would be that rules requiring in-person physical examinations constitute horizontal price fixing.²⁰⁵ That type of rule may

¹⁹⁹ See *N.C. St. Bd. of Dental Exam'rs v. FTC*, 135 S. Ct. 1101, 1116–17 (2015) (providing a vague set of factors to determine what actions constitute “active supervision”).

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).

²⁰³ *Ariz. v. Maricopa Cty. Med. Soc'y*, 457 U.S. 332, 335–36 (1982) (applying the per se rule to a group of competing physicians who set maximum fees they could claim in payment for health services provided to policyholders of certain insurance plans).

²⁰⁴ See Thomas B. Leary, Paper, *A Structured Outline for the Analysis of Horizontal Agreements*, FED. TRADE COMM'N (Mar. 3–4, 2004), https://www.ftc.gov/sites/default/files/documents/public_statements/structured-outline-analysis-horizontal-agreements/chairsshowcasetalk.pdf [<https://perma.cc/MUB9-ZX93>] (“Experienced antitrust counselors recognize that the method of analysis is often outcome-determinative; plaintiffs tend to win *per se* cases and defendants tend to win rule-of-reason cases.”).

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.²⁰⁶ 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.²⁰⁷

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.²⁰⁸

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.²⁰⁹ In the *Teladoc* case, the state medical board offered that same procompetitive

same level of the market structure,” while a vertical restraint refers to “combinations of persons at different levels of the market structure.” *United States v. Topco Assoc., Inc.*, 405 U.S. 596, 608 (1972). Horizontal price fixing is typically considered per se unreasonable. *See FTC v. Super. Ct. Trial Lawyers Ass’n*, 493 U.S. 411, 436 n.19 (1990) (“[H]orizontal price-fixing ... has been considered a per se violation for many decades.”). But horizontal price fixing is not always considered per se unreasonable, especially if an industry requires horizontal restraints to produce the product at all. *See NCAA v. Bd. Regents Univ. of Okla.*, 468 U.S. 85, 100–01 (1984) (refusing to apply a per se analysis to horizontal price fixing on college football television contracts because the live college football industry required horizontal restraints in order to produce the product of live college football).

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) (“[T]he 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.”).

justification.²¹⁰ However, the court cited a string of Supreme Court decisions and held that public safety is not a sufficient justification in § 1 cases.²¹¹ 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 drugs²¹² that need to be regulated tightly.²¹³ OPRs are highly addictive and commonly abused; examples include oxycodone, hydrocodone, and methadone.²¹⁴ According to the CDC, three-quarters of prescription drug overdose deaths in 2011 were attributed to OPRs.²¹⁵ 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.²¹⁶ In total, annual health care costs of OPR abuse accounted for approximately 55.7 billion dollars in the United States.²¹⁷ Thus, it is conceivable that there could be cost savings associated with rules that require an in-person examination.

²¹⁰ *Teladoc, Inc. v. Tex. Med. Bd.*, 112 F. Supp. 3d 529, 538 (2015) (“The sole justification the [Texas Medical Board] offers is that the New Rule 190.8 will lead to improved quality of medical care.”).

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

²¹⁸ See *Cont'l T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36, 50 (1977).

[A] *per se* rule is confined to restraints that would always or almost always tend to restrict competition and decrease output. Thus, a *per se* rule is appropriate only after courts have had considerable experience with the type of restraint at issue, and only if they can predict with confidence that the restraint would be invalidated in all or almost all instances under the rule of reason.

Leegin Creative Leather Prods. v. PSKS, Inc., 551 U.S. 877, 877–78 (2007) (internal citation omitted).

²¹⁹ See *supra* note 208.

²²⁰ In their challenge to the Texas Medical Board, plaintiff Teladoc argued for a quick-look analysis. *Teladoc, Inc. v. Tex. Med. Bd.*, 112 F. Supp. 3d 529, 536–37 (2015).

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.²²⁵

A court could apply the quick-look analysis, as they did with the agreement in *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."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.²²⁷ The defense attorneys' resources and the availability of reliable evidence would likely determine whether quick-look analysis is used.

E. Rule of Reason Analysis

Under a rule of reason analysis, a potential plaintiff would incur a costly legal battle.²²⁸ A plaintiff's success under the rule of reason is possible,²²⁹ but will most likely not occur.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.²³¹ To establish a prima facie case, plaintiffs would have to allege the defendant medical board possessed sufficient market power or

²²⁵ *Id.*

²²⁶ 435 U.S. 679, 692 (1978).

²²⁷ Maurice E. Stucke, *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.").

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).

²²⁹ *See, e.g., 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).

²³⁰ *See Carrier*, *supra* note 131, at 830.

²³¹ *See 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.

²³⁴ See, e.g., Amended Complaint at ¶ 43, *Teladoc v. Tex. Med. Bd.*, 112 F. Supp. 3d 529 (2015) (No. 1:15-cv-00343-RP), 2015 WL 487362 (pleading the relevant geographic market as the state where the rule was in effect).

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.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.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,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."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.²⁴⁴ Telemedicine companies have standing to sue state medical boards over rules that require in-person physical

v. Brown Univ., 5 F.3d 658, 678 (1993); AREEDA & HOVENKAMP, *supra* note 189, ¶ 1505, at 370.

²⁴⁰ AREEDA & HOVENKAMP, *supra* note 189, ¶ 1505, at 370.

²⁴¹ See *supra* notes 86–92 and accompanying text.

²⁴² See *supra* note 212.

²⁴³ *Leegin Creative Leather Prods. v. PSKS, Inc.*, 551 U.S. 877, 879 (2007).

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.