

# Professional Licenses and Substantive Due Process: Can States Compel Physicians to Provide Their Services

Carolyn R. Cody

---

## Repository Citation

Carolyn R. Cody, *Professional Licenses and Substantive Due Process: Can States Compel Physicians to Provide Their Services*, 22 Wm. & Mary Bill Rts. J. 941 (2014), <https://scholarship.law.wm.edu/wmbrj/vol22/iss3/7>

**PROFESSIONAL LICENSES AND SUBSTANTIVE  
DUE PROCESS: CAN STATES COMPEL  
PHYSICIANS TO PROVIDE THEIR SERVICES?**

Carolyn R. Cody\*

INTRODUCTION .....	942
<i>A. The Professional License as a Property Right</i> .....	942
<i>B. The Expanding Power of the State to Revoke         Professional Licenses</i> .....	943
I. BACKGROUND .....	949
<i>A. Existing State Laws Revoking Professional Licenses and the         Standard of Review Used to Evaluate Them</i> .....	949
<i>B. Reaction to Massachusetts Health Care Reform and         Theoretical Implications on a National Scale</i> .....	951
<i>C. Efforts to Innovate Medical Care Delivery in the Face of         Constricting Insurance Networks</i> .....	956
II. DEVELOPING A STANDARD FOR SUBSTANTIVE DUE PROCESS EVALUATION OF PROFESSIONAL LICENSE REVOCATION ACTIONS .....	959
<i>A. Revisiting the Argument for Strict Review of Economic Substantive         Due Process and a Fundamental Right to Livelihood</i> .....	959
<i>B. Scope of the Physician's Legal Duty of Care and Why a Law         Structured like Massachusetts Bills H. 4452 and S. 2170         Should Fail Rational Basis Review</i> .....	964
III. A FURTHER COMPLICATION: STATE CONSTITUTIONALISM AND THEORETICAL POLICY IMPLICATIONS FOR NATIONWIDE MEDICAL CARE DELIVERY .....	970
IV. POLICY OPTIONS: HOW WE MIGHT MOVE FORWARD .....	973
CONCLUSION .....	976

---

\* J.D. Candidate, William & Mary Law, 2014. B.A., College of the Holy Cross, 2008. I am indebted to my father for inspiration, to the BORJ editorial staff for their diligence, and to my Note Editor for his patient guidance throughout the drafting process. Additionally, much love and many thanks to both of my long-suffering parents, to my sister, and especially Daniel, for their continuous, cheerful support and emotional devotion throughout this law school experience.

## INTRODUCTION

*A. The Professional License as a Property Right*

The English language defines a license as: “permission to act.”<sup>1</sup> By its legal definition, a license is “[t]he certificate or document evidencing such permission.”<sup>2</sup> The grant of a license is considered to be a vested property interest of the individual, which is protected by due process:

The kind of property interests that due process encompasses extends beyond the actual ownership of real estate, chattels, or money to include legitimate claims of entitlement to governmental benefits. . . . “Much of the existing wealth in this country takes the form of rights that do not fall within traditional common-law concepts of property. It has been aptly noted that ‘[s]ociety today is built around entitlement. The automobile dealer has his franchise, the doctor and lawyer their professional licenses, the worker his union membership, contract, and pension rights, the executive his contract and stock options; all are devices to aid security and independence.’”<sup>3</sup>

Because licenses are property rights,<sup>4</sup> the U.S. Supreme Court has thus recognized that due process protection applies to license revocation actions by the state.<sup>5</sup>

---

<sup>1</sup> *License Definition*, MERRIAM-WEBSTER.COM, <http://www.merriam-webster.com/dictionary/license> (last visited Mar. 2, 2014).

<sup>2</sup> BLACK’S LAW DICTIONARY 1002 (9th ed. 2009); *see also* 53 C.J.S. *Licenses* § 1 (2012) (“[F]ormal or official permit or permission to carry on some business or do some act which, without the license, would be unlawful . . .”).

<sup>3</sup> J. Bruce Bennett, *The Rights of Licensed Professionals to Notice and Hearing in Agency Enforcement Actions*, 7 TEX. TECH ADMIN. L.J. 205, 208 (2006) (quoting *Goldberg v. Kelly*, 397 U.S. 254, 262 n.8 (1970)) (footnote omitted); *see also* Mark R. Fondacaro & Dennis P. Stolle, *Revoking Motor Vehicle and Professional Licenses for Purposes of Child Support Enforcement: Constitutional Challenges and Policy Implications*, 5 CORNELL J.L. & PUB. POL’Y 355, 363 (1996) (“The United States Supreme Court has clearly recognized the issuance of both professional and motor vehicle licenses as creating important property or liberty interests requiring due process protection.” (citations omitted)).

<sup>4</sup> For the purposes of reviewing whether a license revocation law violates the Due Process Clause of the U.S. Constitution, the U.S. Supreme Court has not recognized a distinction between a license granting a right versus a privilege. *See* Bennett, *supra* note 3, at 209; *cf.* William W. Van Alstyne, *The Demise of the Right-Privilege Distinction in Constitutional Law*, 81 HARV. L. REV. 1439, 1439 (1968) (arguing that “the concept of ‘privilege’ is today no longer viable, and that the size and power of the governmental role in the public sector requires substantive due process control of the state in all its capacities”).

<sup>5</sup> *See* Bennett, *supra* note 3, at 211 (“A state . . . cannot deprive a person of an issued and outstanding license to practice a profession, or banish or exclude a person from the

In the American federalist system the authority to issue most licenses lies at the state level,<sup>6</sup> within the purview of each state's police power.<sup>7</sup> The U.S. Supreme Court has outlined the parameters of the state's police power regarding licensing broadly: "States have a compelling interest in the practice of professions within their boundaries, and . . . as part of their power to protect the public health, safety, and other valid interests they have broad power to establish standards for licensing practitioners and regulating the practice of professions."<sup>8</sup> This broadness is cited frequently in court decisions that affirm the validity of state regulation of licensees' operations.<sup>9</sup>

### *B. The Expanding Power of the State to Revoke Professional Licenses*

What is increasingly common in state regulation of professional licenses is the state actions revoking those licenses as a method of keeping the citizenry in check.<sup>10</sup>

---

practice of a profession, in a manner that contravenes due process of law."); Fondacaro & Stolle, *supra* note 3, at 363 (noting that the "Supreme Court has clearly recognized the issuance of both professional and motor vehicle licenses as creating important property or liberty interests requiring due process protection" (citations omitted)).

<sup>6</sup> However, there are some federal licenses. See *Federal Licenses & Permits*, U.S. SMALL BUS. ADMIN., <http://www.sba.gov/content/what-federal-licenses-and-permits-does-your-business-need> (last visited Mar. 2, 2014).

<sup>7</sup> See U.S. CONST. amend. X.

<sup>8</sup> Goldfarb v. Va. State Bar, 421 U.S. 773, 792 (1975); see also Marshall B. Kapp, *Conscripted Physician Services and the Public's Health*, 39 J.L. MED. & ETHICS 414, 418 (2011) ("The states' police power is not unlimited, but it is extremely broad."). Usually the power to issue a license and oversee licensee is through a state administrative agency. See, e.g., 243 MASS. CODE REGS. 1.00 (2012) ("Disciplinary Proceedings for Physicians"); VA. CODE ANN. § 46.2-391.2 (West 2012) ("Administrative suspension of license or privilege to operate a motor vehicle").

<sup>9</sup> See, e.g., Lambert v. Yellowley, 272 U.S. 581, 596 (1926) ("[T]here is no right to practice medicine which is not subordinate to the police power of the States."); Locke v. Shore, 634 F.3d 1185 (11th Cir. 2011), *cert. denied*, 132 S. Ct. 1004 (2012) (finding Florida license requirement for interior designers constitutional); Onyiuke v. N.J. State Superior Court, 435 F. Supp. 2d 394, 406 (D.N.J. 2006), *aff'd in part, vacated in part, sub nom.* Onyiuke v. New Jersey, 242 F. App'x 794 (3d Cir. 2007) (holding state rule requiring graduation from accredited law school as prerequisite to licensure rationally related to "legitimate interest in the high standards of qualification"); Walker v. Bd. of Prof'l Responsibility of Superior Court of Tenn., 38 S.W.3d 540 (Tenn. 2001) (finding regulation that required attorney's to disclose specialty certification in advertisements was valid); see also Bennett, *supra* note 3, at 210 ("State and federal courts have consistently upheld the licensing and regulation of professionals under the state's police power."); Kapp, *supra* note 8, at 418 ("This power has been specifically interpreted to include exclusive state authority to license health care professionals and to set and enforce the conditions that the regulated professionals must meet in order to obtain and retain licensure.").

<sup>10</sup> See, e.g., Wendte v. Bd. of Real Estate Appraisers, 70 P.3d 1089, 1092 (Alaska 2003) ("[A] licensing board need not establish that there is a nexus between a crime involving moral turpitude and one's ability to carry out the professional duties to issue sanctions."); Fondacaro & Stolle, *supra* note 3, at 383 ("[S]ome state courts have generally concluded that

As the complexities of an increasingly technological and mobile society have changed the way that people interact with each other, the application of legal duties that accompany certain of those interactions has also evolved. Modern American society is progressively more mobile, and thus more competitive within a larger pool of the population, with its citizens frequently commuting farther for employment<sup>11</sup> or developing specific expertise that narrows their professional options and aspirations for the sake of marketing specialized skills.<sup>12</sup>

Recognizing that in this modern society a significant portion of the population holds a government-issued license of some kind,<sup>13</sup> state governments have utilized the incentive power of license revocation laws in order to dissuade professional licensees from violating state laws or court orders completely unrelated to their qualifications to hold the license.<sup>14</sup>

---

license revocation may serve as a ‘deterrent to illegal drug distribution and use, and as a means of rehabilitation.’” (quoting *Rushworth v. Registrar of Motor Vehicles*, 596 N.E.2d 340, 344 (Mass. 1992))).

<sup>11</sup> “Indeed, without the ability to drive, many Americans would be forced to either relocate, switch employers, or switch careers altogether.” Fondacaro & Stolle, *supra* note 3, at 379; see Eric Jaffe, *Why American Commute Times Are Difficult to Compare to Other Countries*, ATLANTIC CITIES figs.3 & 7 (Oct. 18, 2011), <http://www.theatlanticcities.com/commute/2011/10/american-commute-times-so-difficult-to-measure/307/>; see also R.A., *How Long Are American Commutes?*, ECONOMIST (Oct. 16, 2011, 6:33 PM), <http://www.economist.com/blogs/freeexchange/2011/10/surveys>. However, recent studies suggest the number of American citizens with a driver’s license is decreasing. *More Women Have Driver’s License than Men in U.S.*, USA TODAY (Nov. 12, 2012, 1:58 PM), <http://www.usatoday.com/story/news/nation/2012/11/12/more-women-have-drivers-licenses-than-men-in-us/1700027/> (citing a study by the University of Michigan that showed the number of young Americans with a driver’s license has been shrinking over the past fifteen years). This could potentially force state laws to focus more intensely on professional licenses.

<sup>12</sup> See generally Marc T. Law & Sukkoo Kim, *Specialization and Regulation: The Rise of Professionals and the Emergence of Occupational Licensing Regulation*, 65 J. ECON. HIST. 723 (2005) (discussing the simultaneous uptick in both the market for professional services and state regulatory bodies of those professions in the twentieth century; includes a case study on the medical profession).

<sup>13</sup> See *id.* at 724–25 (“Between 1900 and 2000 the percentage of the labor force engaged in technical and professional occupations increased from 4 percent to over 20 percent. . . . By the mid-twentieth century, there were more than 1,200 state occupational licensing statutes. . . .”); see also Bob Ewing, *The Right to Earn a Living Under Attack*, 58 FREEMAN 18, 18 (2008), available at [http://www.fee.org/the\\_freeman/detail/the-right-to-earn-a-living-under-attack#axzz2Jr2dqdCF](http://www.fee.org/the_freeman/detail/the-right-to-earn-a-living-under-attack#axzz2Jr2dqdCF) (stating that between 1981 and 2008 the number of occupations with state licensing requirements had increased from eighty to one thousand).

<sup>14</sup> See, e.g., Fondacaro & Stolle, *supra* note 3, at 387–88 (“In the context of professional license revocation for the purpose of child support enforcement, the primary state objective is not regulation of professions . . . . Rather the state objective is to increase support collections.”); see also *id.* at 362, 358–59 n.10 (citing over forty state laws on the books regarding professional and motor vehicle license revocation for failure to pay child support). A few additional examples of state statutes curtailing the right to hold professional licenses are

To illustrate how this works, the following will use the example of Citizen A seeking a license to conduct Activity X. The state's analysis for whether Citizen A qualifies to hold a license to perform state-regulated Activity X has expanded beyond a review of whether Citizen A meets the qualifications necessary to conduct Activity X at a level acceptable to be a licensee in the state.<sup>15</sup> This expansion means that the review of Citizen A—who otherwise meets the licensing qualifications necessary to conduct Activity X—looks to see if Citizen A cannot have a license for other reasons, that is, actions that are unrelated to conducting licensed Activity X.<sup>16</sup> These “unrelated actions” are usually violations of the state's other laws. Some state statutes now even explicitly express that violations of certain laws lead to professional license revocation.<sup>17</sup> In operation, the license revocation laws assist the state in controlling these unrelated but disallowed behaviors because the licensing board can look beyond the licensee's qualifications to conduct the licensed activity to the licensee's personal actions. What is noteworthy—and until recently, unprecedented—about these professional license revocation statutes is that they widen the already broad scope of the state's jurisdiction under the police power to regulate licensees by controlling their personal lives.<sup>18</sup> However, a line must be drawn between which “unrelated actions” are appropriate within the state's broad police power.<sup>19</sup> “The established doctrine is that this liberty [guaranteed by the Due Process Clause] may not be interfered with, under the guise of protecting the public interest, by legislative

---

provided here: MASS. GEN. LAWS ANN. ch. 30A, § 13 (West 2012) (denying issuance “of a professional or occupational certificate, registration, license, or authority to any applicant . . . in . . . default” of a loan issued by the Massachusetts Education Financing Authority); N.J. STAT. ANN. § 18A:71C-19 (West 2012) (defining student loan default as professional misconduct qualifying the licensee for license suspension or revocation).

<sup>15</sup> It is important to recognize that this form of government power is often an administrative method of enforcement “rather than [a] judicial” one. Fondacaro & Stolle, *supra* note 3, at 362 (discussing how, in an effort to prevent overburdening the state court systems, administrative procedures were used for license revocation proceedings for unpaid child support after the passage of the Family Support Act of 1988); *see also, e.g.*, 243 MASS. CODE REGS. 1.00 (2012) (“Disciplinary Proceedings for Physicians”).

<sup>16</sup> *See generally* Nadia N. Sawicki, *Character, Competence, and the Principles of Medical Discipline*, 13 J. HEALTH CARE L. & POL'Y 285 (2010) (arguing that quality of care problems in the American medical system can be helped by limiting the parameters of medical licensing board authority to misconduct related to professional competence rather than personal character).

<sup>17</sup> *See supra* note 14 and accompanying text.

<sup>18</sup> *Cf.* Van Alstyne, *supra* note 4, at 1462 (“[T]he expansion of government with its attendant influence on the individual [means] . . . the individual's alternatives to acceptance of arbitrary government action are practically nonexistent, and the potential control over his personal life is therefore practically absolute. This substantial influence which expanded governmental activity gives the government over the private lives of its citizenry makes the restraints of substantive due process necessary.”).

<sup>19</sup> *See* Sawicki, *supra* note 16, at 320 (noting that courts are “failing to provide a fuller analysis in substantive due process cases” to licensing boards).

action which is arbitrary or without reasonable relation to some purpose within the competency of the State to effect.”<sup>20</sup>

Historically, professional and other license revocation statutes were enacted to address both criminal and civil wrongs. But the civil examination was restricted to license-holder malpractice<sup>21</sup>—instances where a licensee failed to maintain her qualifications to hold the license—and revocation addressing actions outside the scope of the licensed activity was only initiated for criminal offenses threatening public safety.<sup>22</sup> Interestingly, some of these criminal convictions resulting in license revocation were not so related to the immediate public safety as they were to the “moral character” of the professional.<sup>23</sup> Arguably, it is this logic that has led to a recent expansion of state licensing boards’ investigatory power into the purview of licensees’ civil behavior beyond malpractice. For example, most states now allow for professional license revocation if the licensee has unpaid child support payments<sup>24</sup> or student loans in default.<sup>25</sup> This expansion of the state power to revoke licenses for

---

<sup>20</sup> Van Alstyne, *supra* note 4, at 1443 (quoting *Meyer v. Nebraska*, 262 U.S. 390, 399–400 (1923)).

<sup>21</sup> See Sawicki, *supra* note 16, at 292–93.

<sup>22</sup> See, e.g., *Pautsch v. Md. Real Estate Comm’n*, 31 A.3d 489 (Md. 2011) (finding revocation of a real estate broker’s license due to a child abuse conviction neither arbitrary nor capricious); *Morris v. Commonwealth*, 537 A.2d 93, 95 (Pa. 1988) (affirming suspension of a pharmacist’s professional license for conviction under the Drug Act). Specific to the medical industry, physicians have lost their licenses and even been jailed for violating the terms of the controlled substances laws. See Edward P. Richards, *The Police Power and the Regulation of Medical Practice: A Historical Review and Guide for Medical Licensing Board Regulation of Physicians in ERISA-Qualified Managed Care Organizations*, 8 ANNALS HEALTH L. 201, 220 & n.58 (1999) (citing examples of several state cases in which physicians have had their licenses rescinded for violation of controlled substances laws); see also Fondacaro & Stolle, *supra* note 3, at 383–84 (referencing controlled substance violations); Sawicki, *supra* note 16, at 293 (“[M]ost states authorize discipline . . . [for] criminal acts (typically felonies or crimes of ‘moral turpitude’).”).

<sup>23</sup> See Sawicki, *supra* note 16, at 291–92; Kurt W. Melchior, *Court of Appeal Chips Away at Constitutional Rights of Professional Licensees*, NOSSAMAN LLP (June 8, 2010), <http://www.nossaman.com/court-appeal-chips-away-constitutional-rights-professional?print=1> (noting the case of a California dentist who had his license revoked due to his substance abuse problems); see also *Kobrin v. Bd. of Registration in Med.*, 832 N.E.2d 628 (Mass. 2005) (upholding the administrative board’s decision to suspend a doctor’s license in response to his conviction of Medicare fraud); *Sedivy v. State ex rel. Stenberg*, 567 N.W.2d 784 (Neb. Ct. App. 1997) (upholding a veterinarian’s license revocation in response to conviction for federal tax evasion); Fondacaro & Stolle, *supra* note 3, at 387 (“Often courts will reason that such offenses involve moral turpitude bringing them within the scope of statutes providing for professional license revocation for acts involving moral turpitude.”). But see, e.g., *Brewer v. Dep’t of Motor Vehicles*, 155 Cal. Rptr. 643 (Cal. Ct. App. 1979) (“[N]o evidence . . . reasonably demonstrating that the evidence of [defendant’s] immoral character [in committing child molestation] relates to his fitness to engage in the vocation of selling automobiles.”).

<sup>24</sup> See Fondacaro & Stolle, *supra* note 3, at 390.

<sup>25</sup> See *infra* note 45 and accompanying text.

civil actions that are not related to the licensee's professional malpractice has led to an uptick in substantive due process challenges of such license revocation laws.<sup>26</sup>

Recently, a state explored expanding its police power even further into its analysis of a professional licensee's civil behavior. In the aftermath of its 2006 healthcare law,<sup>27</sup> the Commonwealth of Massachusetts's legislature introduced proposed amendments in 2009 and 2010<sup>28</sup>—hereinafter referred to as Massachusetts's mandatory medical service legislation—which compelled doctors, on threat of medical license revocation, to accept all presenting patients who were insured through certain insurance plans offered through the Commonwealth's new public insurance exchange.<sup>29</sup> The same legislation also commanded doctors to accept, as full payment for treating these patients they were mandated to treat, an amount set by the statute as an allowable charge for the service.<sup>30</sup> Although these amendments did not pass into law,<sup>31</sup> their introduction onto the Massachusetts Senate and House floors provides a good example of the fact that in some states, regulators are increasingly interested in going

---

<sup>26</sup> See Michael J. Phillips, *The Slow Return of Economic Substantive Due Process*, 49 SYRACUSE L. REV. 917, 918 (1999) (“[C]hallenges to economic regulation have been common events since at least the early 1980s, and their numbers have been steadily growing.”); *infra* Part I.A.

<sup>27</sup> See generally David A. Fahrenthold, *Mass. Marks Health-Care Milestone*, WASH. POST (Apr. 13, 2006), <http://www.washingtonpost.com/wp-dyn/content/article/2006/04/12/AR2006041202037.html>.

<sup>28</sup> S. 2170, 2009 Leg., 186th Sess. (Mass. 2009), available at <http://www.malegislature.gov/Bills/186/Senate/S2170>; H. 4452, 2009 Leg., 186th Sess. (Mass. 2009), available at <http://www.malegislature.gov/Bills/186/House/H4452>. These amendments were not passed. See Rob Tenery, *Medicine's 'Tipping Point': What's Next?*, ROB TENERY MD (June 10, 2011), <http://www.robtenerymd.com/blog/?p=87> (“Although the proposed legislation was reported out of committee favorably, it died as the session expired, without passing either the House or Senate.”). A reintroduction of the amendment in the House in 2011 also did not pass. H. 1470, 187th Leg. (Mass. 2011), available at <http://www.malegislature.gov/Bills/187/House/H1470> (follow “Bill History” tab; then “Accompanied a study order, see H4476” hyperlink; then note “No further action taken” on 1/1/2013 under that Bill History). For an overview from the point of view of opponents of S. 2710 and H. 4452, see Richard P. Gulla, *Massachusetts Medical Society Issues Strong Opposition to Proposed Legislation Linking Licensure to Participation in Health Plan*, MASS. MED. SOC'Y, Nov. 3, 2009 (archive copy on file with the *William & Mary Bill of Rights Journal* and author; note that Dr. Motta is no longer the spokesperson).

<sup>29</sup> This is referred to as the “Commonwealth Health Insurance Connector” which operates by “connect[ing] individuals to insurance by offering affordable, quality insurance products” and regulating what kinds of insurance products can be in the connector. *Massachusetts Health Care Reform Plan: An Update*, HENRY J. KAISER FAMILY FOUND. (June 2007), <http://www.kff.org/uninsured/upload/7494-02.pdf> [hereinafter *Massachusetts Health Care Reform*].

<sup>30</sup> The proposed amendments noted that this reimbursement rate would not be more than 110% of the Medicare rate set by the federal government through the U.S. Department of Health and Human Services. See *supra* note 28.

<sup>31</sup> See *supra* note 28.

beyond using license revocation power in response to licensee criminal acts or malpractice and actually utilizing them to control how professionals provide and collect for their services.

This Note will endeavor to examine the substantive due process arguments presented by any law structured like Massachusetts's mandatory medical services legislation, namely, mandating a professional service be at a set price and provided to a set population as a condition of licensure qualification. A listing of all potential constitutional issues of mandated medical services are highlighted in Marshall Kapp's *Conscripted Physician Services and the Public's Health*,<sup>32</sup> which notes that "[t]he use of state power to command physician labor is quite questionable in terms of physicians' rights,"<sup>33</sup> but here the analysis engages in an expanded and specific focus on substantive due process issues of license regulation by the states.<sup>34</sup> In particular, this Note will stress a key distinction between the licensee activity targeted by the proposed Massachusetts amendments and two other targets of past professional license revocation laws: delinquent child support and student loan payments. This Note puts forward that there is a key distinction between these activities; the latter two address a licensee's violation of a preexisting legal duty, which is absent in the activity targeted by the Massachusetts amendments.<sup>35</sup>

This distinction is the basis for the standard that this Note puts forth—that professional license revocation laws are constitutionally defensible only where the state must respond to the licensee's violation of a civil legal duty to another citizen or to protect the general public from crime; only these are non-arbitrary uses of the state's police power.<sup>36</sup> Even though unrelated to the licensee's professional activities, a legal duty has clearly been entered into where that licensee owes child support or student loan payments.<sup>37</sup> But a civil legal duty is not present between unconnected parties, for example where a professional licensee has not agreed to provide services

---

<sup>32</sup> See *supra* note 8. Kapp contemplates the effects of the new federal health care law. Kapp's highlighting of a version of Massachusetts's proposed legislation discussed in this Note as an example of this potential problem was the latter's inspiration. See Kapp, *supra* note 8.

<sup>33</sup> Kapp, *supra* note 8, at 419.

<sup>34</sup> Cf. Bennett, *supra* note 3, at 206–10 (discussing procedural due process); Fondacaro & Stolle, *supra* note 3, at 362–88 (analyzing—in the context of motor vehicle and professional license revocations for child support payment defaults—procedural due process, substantive due process, and equal protection).

<sup>35</sup> An analysis of the argument that the decision to enter the professional field is a voluntary one and thus rebuts this point is beyond the scope of this Note, but this Note does explain that the legal duty of a physician has never been held to start until the physician-patient relationship has been entered into consensually by both doctor and patient. See *infra* Part II.B.

<sup>36</sup> See *supra* note 20 and accompanying text; cf. *infra* Part II.B (highlighting why a law structured like Massachusetts's mandatory medical services legislation is an arbitrary use of the state's police power).

<sup>37</sup> See *infra* notes 158–59 and accompanying text (discussing the basis of legal duty for child support and student loans).

to a client, such as in the doctor-patient context that Massachusetts's mandatory medical services legislation addresses.<sup>38</sup> Therefore, there is a case to be made as to why substantive due process challenges to proposed legislation like Massachusetts's mandatory medical services legislation could prevent such a reality from coming to fruition on a larger scale.

In discussing the merits of the above, this Note will also explore the possibility of a higher scrutiny standard for substantive due process review of professional licenses and the policy issues surrounding medical care delivery. Part I.A of this Note examines the historical basis for reviewing professional license revocation laws under the deferential rational basis review. Parts I.B and I.C describe what is at stake by providing further background on Massachusetts's mandatory medical services legislation, national implications in light of the Federal Affordable Care Act, and how insurance networks affect this. Part II.A revisits whether the hypothetical fundamental right of livelihood might be appropriate to implement this in our twenty-first-century regulatory state. Part II.B puts forth that even without a fundamental right to livelihood, a law structured like Massachusetts's mandatory medical services legislation would still be unconstitutional under the rational basis review framework discussed in Part I.A. Part III notes the implications of greater due process protections under some state constitutions. Alternative approaches to fixing the policy issues are discussed in Part IV.

## I. BACKGROUND

### *A. Existing State Laws Revoking Professional Licenses and the Standard of Review Used to Evaluate Them*

Outside of malpractice actions, professional license revocation to combat delinquent parents owing child support was one of the first areas of civil behavior unrelated to licensee qualifications to affect a licensee's property right. Numerous state statutes were enacted starting in the early 1990s,<sup>39</sup> which allowed for the revocation of the defaulting payer's motor vehicle and/or professional license as a penalty.<sup>40</sup> Professional licenses were targeted mainly for the reason that some offending payers were "non-wage earners,"<sup>41</sup> and therefore payment could not be automatically withheld from their salaries.<sup>42</sup>

---

<sup>38</sup> See *infra* Part II.B (explaining the current accepted scope of a physician's duty to a potential patient).

<sup>39</sup> See Fondacaro & Stolle, *supra* note 3, at 357–60, 358 n.10, 389.

<sup>40</sup> See *id.* at 358. See generally, e.g., Pamela Forrestall Roper, Note, *Hitting Deadbeat Parents Where It Hurts: "Punitive" Mechanisms in Child Support Enforcement*, 14 ALASKA L. REV. 41 (1997) (discussing efforts to collect child support payments in the State of Alaska).

<sup>41</sup> Fondacaro & Stolle, *supra* note 3, at 358.

<sup>42</sup> See *id.* ("A significant share of the amount collected is directly attributable to federally required income withholding from noncustodial parents' wages.").

A number of these statutes have recently survived substantive due process challenges in state and federal courts.<sup>43</sup> And an analysis of the constitutionality of revocation actions for failure to pay child support reveals such laws are likely constitutional.<sup>44</sup> Similarly, revocation statutes in relation to unpaid student loans have recently been proposed and enacted in several states,<sup>45</sup> found appropriately analogous to the child support revocation laws,<sup>46</sup> and also are predicted to pass constitutional muster.<sup>47</sup> To date, the rational basis review tier<sup>48</sup> has been consistently applied to any sort of removal procedure for licenses as property rights.<sup>49</sup> The legal test for a law being scrutinized under this type of review is whether it is “rationally related to a legitimate government purpose.”<sup>50</sup> This test is very deferential to the government’s prerogative in enacting the law, and it is rare for this review to come out on the side of the plaintiff and against the imposition of the government’s law.<sup>51</sup> Although the

---

<sup>43</sup> See, e.g., *id.* at 372–73 n.104; *accord* Revocation of Prof. Licenses Due to Student Loan Arrears, Op. Tenn. Att’y Gen. No. 12-22, at 3 (Feb. 22, 2012) [hereinafter Op. Tenn. Att’y Gen.] (discussing *Amunrud v. Bd. of Appeals*, 143 P.3d 571 (Wash. 2006), *cert. denied*, 549 U.S. 1282 (2007) (suspending commercial driver’s license for failure to pay child support pursuant to state’s power under applicable license revocation statute) and *Thompson v. Ellenbecker*, 935 F. Supp. 1037 (D.S.D. 1995) (demonstrating that driver’s license suspension is effective to encourage child support payments)).

<sup>44</sup> See generally *Fondacaro & Stolle*, *supra* note 3, at 398–99 (concluding that it will be exceedingly difficult to find license revocation statutes for unpaid child support unconstitutional).

<sup>45</sup> See, e.g., Op. Tenn. Att’y Gen., *supra* note 43, at 1; see also Drew Fritton et al., *Student Loan Defaults and Professional Licenses*, UNIV. OF VT. LEGIS. RES. SHOP (Mar. 15, 2002), available at <http://www.uvm.edu/~vlrs/Education/studentloansprofessionallicenses.pdf> (discussing passage of license revocation laws for student loans defaults in Texas, New Jersey, and Georgia); Emily Bregel, *Loan Defaults Sting Tennessee Nurses*, CHATTANOOGA TIMES FREE PRESS (Jan. 18, 2011), <http://www.timesfreepress.com/news/2011/jan/18/loan-defaults-sting-nurses/?local>; *Consequences of Default*, STUDENT LOAN BORROWER ASSISTANCE, <http://www.studentloanborrowerassistance.org/collections/federal-loans/consequences-of-default-federal/> (last visited Mar. 2, 2014).

<sup>46</sup> See, e.g., Op. Tenn. Att’y Gen., *supra* note 43, at 3.

<sup>47</sup> See *id.*; see also Fritton et al., *supra* note 45, at 3–4 (finding constitutional issues with such a statute to be similar to those presented by the license revocation statutes already in place for child support payments).

<sup>48</sup> “The minimal level of review is the ‘rational basis test.’ All laws challenged under the due process clause . . . must meet at least rational basis review.” ERWIN CHEMERINSKY, *CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES* 540 (3d ed. 2006).

<sup>49</sup> “[T]he courts have held that professional licensure does not implicate the regulated party’s fundamental rights . . . [and so the law is] evaluated by the courts under the highly deferential rational relationship test.” Kapp, *supra* note 8, at 418 (citation omitted); see also *Fondacaro & Stolle*, *supra* note 3, at 372, 381; *Sawicki*, *supra* note 16, at 296.

<sup>50</sup> CHEMERINSKY, *supra* note 48, at 540.

<sup>51</sup> *Id.* (explaining that “any conceivable legitimate purpose is sufficient” in order to pass the rational basis test).

latter situation is not impossible,<sup>52</sup> it must be a “government[ ] action [that] is ‘clearly wrong, a display of arbitrary power, not an exercise of judgment.’”<sup>53</sup>

Given that professional (and other) licenses are issued under the state’s police power<sup>54</sup> and that power has been interpreted to be very broad,<sup>55</sup> it follows that it must be an extraordinary state use of the police power to be found unconstitutional using the rational basis review test—one that is so “wholly irrelevant”<sup>56</sup> that no “minimal[ ] rational relation” can be found.<sup>57</sup> In sum this extraordinary use of state police power must amount to an “arbitrary power” by the state.<sup>58</sup>

### *B. Reaction to Massachusetts Health Care Reform and Theoretical Implications on a National Scale*

The Commonwealth of Massachusetts enacted legislation in 2006 that mandated state residents purchase or otherwise obtain health insurance.<sup>59</sup> The law achieved this by creating both financial mandates and incentives, including requirements on employers to provide health insurance coverage for their workers or face a penalty cost per employee, an expansion of Medicaid,<sup>60</sup> a specialized consumer market for affordable insurance through a convergence of individual and small-group insurance markets via an intermediary agency, and a provision for government-funded subsidies to assist individuals in purchasing individual plans.<sup>61</sup>

---

<sup>52</sup> Sawicki, *supra* note 16, at 295 (“[T]he substantive due process requirement that the criteria for licensure and discipline be rationally related to the practice of medicine necessarily implies that there are at least some criteria that *do not* satisfy this standard.”).

<sup>53</sup> CHEMERINSKY, *supra* note 48, at 685 (quoting *Matthews v. DeCastro*, 429 U.S. 181, 185 (1976)); see also Ariel R. Schwartz, Note, *Doubtful Duty: Physicians’ Legal Obligation to Treat During an Epidemic*, 60 STAN. L. REV. 657, 689 (2007).

<sup>54</sup> See *supra* notes 7–8 and accompanying text.

<sup>55</sup> See *supra* notes 8–9 and accompanying text.

<sup>56</sup> CHEMERINSKY, *supra* note 48, at 677 (“The constitutional safeguard is offended [under rational basis review] only if a classification rests on grounds wholly irrelevant to the achievement of the State’s objective.”).

<sup>57</sup> Fondacaro & Stolle, *supra* note 3, at 372 (citation omitted). An argument is made that this standard is met in the case of Massachusetts’s proposed legislation regarding physician licenses later in this Note. See *infra* Part II.B.

<sup>58</sup> See *supra* note 20 and accompanying text.

<sup>59</sup> 2006 Mass. Legis. Serv. 111 (West); see also *Massachusetts Health Care Reform*, *supra* note 29.

<sup>60</sup> For an overview of this program, see *What Is Medicare/Medicaid?*, MED. NEWS TODAY, <http://www.medicalnewstoday.com/info/medicare-medicaid/> (last visited Mar. 2, 2014). This is known as the “MassHealth” program in Massachusetts. See *Massachusetts Health Care Reform*, *supra* note 29.

<sup>61</sup> See *Massachusetts Health Care Reform*, *supra* note 29.

As a result, thousands of previously uninsured Commonwealth residents attained coverage for their health care expenses.<sup>62</sup> However, the nearly half-million<sup>63</sup> of the newly covered patients exacerbated a shortage of primary care doctors that Massachusetts was experiencing even before the health care reform legislation of 2006.<sup>64</sup> The Commonwealth therefore found itself in a situation where it had successfully insured previously uninsured residents, yet those residents were unable to access the primary care physician market, due to medical practices not taking on any more patients or limiting those they did take.<sup>65</sup> Partially in response to this situation, the two aforementioned amendments were proposed in both the Massachusetts House of Representatives and Senate in 2009.<sup>66</sup> Each contained language that compelled physicians to accept certain “affordable health plan[s]”<sup>67</sup> as full payment for services rendered or face revocation of their medical licenses.<sup>68</sup> The language of the Senate version of the proposed law reads:

Every health care provider licensed in the commonwealth which provides covered services to a person covered under “Affordable Health Plans” must provide such service to any such person, as a condition of their licensure, and must accept payment at [110% of the Medicare reimbursement rate for those services as if they were rendered to a Medicare beneficiary], an amount equal to

---

<sup>62</sup> See *infra* Part I.B.

<sup>63</sup> See William C. Symonds, *In Massachusetts, Health Care for All?*, BLOOMBERG BUSINESSWEEK (Apr. 3, 2006), <http://www.businessweek.com/stories/2006-04-03/in-massachusetts-health-care-for-all-businessweek-business-news-stock-market-and-financial-advice>.

<sup>64</sup> See Kapp, *supra* note 8, at 416 & n.34; Tanya Albert Henry, *Physician Shortage in Massachusetts Continues to Squeeze Primary Care*, AM. MED. NEWS (Oct. 12, 2011), <http://www.ama-assn.org/amednews/2011/10/10/prsc1012.htm>. See generally MASS. MED. SOC’Y, PHYSICIAN WORKFORCE STUDY (Sept. 2009) (reporting on a study of physician labor market conditions from 2002 to 2009 that revealed chronic physician shortages in the Commonwealth) (on file with author).

<sup>65</sup> See, e.g., MASS. MED. SOC’Y, *supra* note 64, at 3 (finding for Internal Medicine alone, “[l]ess than half (44%) of internal medicine physicians are accepting new patients”).

<sup>66</sup> See *supra* notes 28–29 and accompanying text.

<sup>67</sup> This term refers to health insurance plans sold within the State Connector that are targeted towards small employers. See MASS. MED. SOC’Y, PHYSICIAN GUIDE TO COMMONWEALTH CARE/CHOICE 8 (2007), available at <http://tinyurl.com/o7vsyva> (“The Connector will provide affordable health plan products to small groups/businesses and individuals. The Connector granted its Seal of Approval to seven health plans . . .”).

<sup>68</sup> See Gulla, *supra* note 28; see also *supra* notes 27–31 and accompanying text. Compare also the Model State Emergency Health Powers Act (MSEHPA), which aimed to do the same thing for physicians who did not treat patients during an epidemic. MODEL STATE EMERGENCY HEALTH POWERS ACT § 401 (2001); see Schwartz, *supra* note 53, at 686. Schwartz’s due process analysis focuses on the procedural due process failings of the MSEHPA specifically but does not consider mandates for routine care. See *id.* at 688–89.

the actuarial equivalent [to that] rate, or the applicable contract rate with the carrier for the carrier's product offering with the lowest level benefit plan available to the general public within the Connector . . . .<sup>69</sup>

Essentially, the Massachusetts legislature attempted to solve its physician shortage problem by mandating that doctors accept patients insured through the specialty Affordable Health Plans cited to in the statute and provided through the government-regulated health insurance exchange.<sup>70</sup> What made this regulatory control attempt distinctive from a previous, yet similar, medical license revocation law in the Commonwealth<sup>71</sup> (and also present in other states<sup>72</sup>) was the fact that it *mandated* physician participation in the insurance program.<sup>73</sup>

The potential for replication of Massachusetts's mandatory medical services legislation by other states in the wake of the recent federal health care reform shows there may be implications on a national scale for the future of medical licensure regulation.<sup>74</sup> The physician shortage in Massachusetts is not limited to that state,<sup>75</sup>

---

<sup>69</sup> S. 2170, 2009 Leg., 186th Sess. (Mass. 2009), *available at* <http://www.malegislature.gov/Bills/186/Senate/S2170>. Identical language is also present in the accompanying House bill. *See* H. 4452, 2009 Leg., 186th Sess. (Mass. 2009), *available at* <http://www.malegislature.gov/Bills/186/House/H4452>; *see also* Gulla, *supra* note 28.

<sup>70</sup> *See* Gulla, *supra* note 28.

<sup>71</sup> This was in regards to balance billing. *See* *Mass. Med. Soc'y v. Dukakis*, 815 F.2d 790 (1st Cir. 1987) (upholding state statute prohibiting balance billing as a condition of medical licensure). For a definition of balance billing, *see infra* note 79.

<sup>72</sup> *See, e.g., infra* note 82.

<sup>73</sup> In comparison, balance billing was a voluntary decision on the doctor's part. *See Dukakis*, 815 F.2d at 792–93; *see also infra* notes 79–82 and accompanying text.

<sup>74</sup> *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (codified as amended in scattered sections of 25, 26, 29, and 42 U.S.C. (2012)); *see also* Kapp, *supra* note 8, at 415.

<sup>75</sup> *See* CTR. FOR WORKFORCE STUDIES, ASS'N OF AM. MED. COLLS., RECENT STUDIES AND REPORTS ON PHYSICIAN SHORTAGES IN THE U.S. 1 (2009) *available at* <http://www.aacom.org/Documents/bodu/2009-05/Recent%20Studies%20Physician%20Workforce%20Shortages-%20April%202009%20-%20AAMC%20Salsberg%20%282%29.pdf> (“Over the past several years, a growing number of national and state or specialty specific studies indicate that the U.S. physician workforce is facing current or future shortages.”); Suzanne Sataline & Shirley S. Wang, *Medical Schools Can't Keep Up*, WALL ST. J. (Apr. 12, 2010), <http://online.wsj.com/article/SB10001424052702304506904575180331528424238.html> (listing 954,000 as the current number of doctors, and estimating that this country will have a general shortage of 150,000 doctors in the next fifteen years based on medical school enrollment and spots for mandatory residency training programs, which are restricted because teaching hospitals rely heavily on federal funds from Medicare to pay the resident doctors); *see also* Kapp, *supra* note 8, at 414–16. *But see* David C. Goodman & Elliott S. Fisher, *Physician Workforce Crisis? Wrong Diagnosis, Wrong Prescription*, 358 NEW ENG. J. MED. 1658, 1658–61 (2008), *available at* <http://www.nejm.org/doi/pdf/10.1056/NEJMp0800319> (questioning whether

and the nation as a whole is seeing declining membership of medical providers in the Medicare and Medicaid networks generally,<sup>76</sup> especially among family providers. Forty-five percent of those physicians stating that they are unlikely or unwilling to take on publicly insured patients are family practitioners.<sup>77</sup> One reason proffered for these declining numbers within the networks were government cuts to reimbursement rates,<sup>78</sup> and although physicians are not barred from balance billing<sup>79</sup> or charging their full rate over and above the insurance contribution for patients holding most insurance plans,<sup>80</sup> there are regulatory bars to the practice for Medicare and Medicaid patients at both the federal<sup>81</sup> and state<sup>82</sup> level.

---

having more physicians will translate into better care for Americans); Sarah Kliff, *Doctor Shortage? What Doctor Shortage?*, WASH. POST (Jan. 15, 2013), <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/01/15/doctor-shortage-what-doctor-shortage/> (reporting on a new Health Affairs study that suggests the statistics predicting a shortage of doctors for newly insured patients seeking medical care are overblown due to changes in how medical practices operate).

<sup>76</sup> See Kapp, *supra* note 8, at 415 (“Doctors are threatening to drop out of Medicare because cuts in Medicare reimbursement rates mean they can’t even cover their costs.”) (quoting Grace-Marie Turner, *Nine Danger Signs in Obamacare*, HEARTLAND (July 2010), available at <http://www.heartland.org/healthpolicy-news.org/article/27718>); Avik Roy, *‘Health Affairs’ Study: One-Third of Doctors Won’t Accept New Medicaid Patients*, FORBES (Aug. 7, 2012), <http://www.forbes.com/sites/aroy/2012/08/07/health-affairs-study-one-third-of-doctors-wont-accept-new-medicaid-patients/>. But cf. Kliff, *supra* note 75.

<sup>77</sup> Julia Brown, *More Primary Care Physicians Turning Away Medicaid Patients*, MANAGED HEALTHCARE EXEC. (July 1, 2012), <http://managedhealthcareexecutive.modernmedicine.com/mhe/article/articleDetail.jsp?id=780037>.

<sup>78</sup> See Kapp, *supra* note 8, at 420; Brown, *supra* note 77; Roy, *supra* note 76; cf. Gulla, *supra* note 28 (“Insurers are raising premiums without additional reimbursements to physicians.”).

<sup>79</sup> “Balance billing is the practice by which a doctor bills a patient for the balance of the doctor’s fee over and above the amount that the [insurance] program has determined to be a ‘reasonable charge.’” *Mass. Med. Soc’y v. Dukakis*, 815 F.2d 790, 790 (1st Cir. 1987); see also *Med. Soc’y of State of N.Y. v. Cuomo*, 777 F. Supp. 1157, 1159 (S.D.N.Y. 1991), *aff’d*, 976 F.2d 812 (2d Cir. 1992) (“Balance billing ‘provides a “safety valve” for physicians who believe that the fee schedule does not adequately reflect the quality of services they provide.’” (citation omitted)).

<sup>80</sup> See *infra* Part I.C.

<sup>81</sup> Physicians are barred under federal law from balance billing qualified Medicare beneficiaries. See *CTRS. FOR MEDICARE & MEDICAID SERVS.*, U.S. DEP’T OF HEALTH & HUMAN SERVS., PROHIBITION ON BALANCE BILLING QUALIFIED MEDICARE BENEFICIARIES (QMBS) (revised Aug. 28, 2012), available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1128.pdf>; Trina Cuppett, *Medicaid Billing Guidelines*, AAPC (Mar. 29, 2010), <http://news.aapc.com/index.php/2010/03/medicaid-billing-guidelines/> (citing 42 C.F.R. § 447.15 and stating that “a provider is not to bill the difference between the amount paid by the state Medicaid plan and the provider’s customary charge to the patient, the patient’s family or a power of attorney for the patient”).

<sup>82</sup> See, e.g., *Dukakis*, 815 F.2d 790 (upholding state statute prohibiting balance billing as a condition of medical licensure); *Cuomo*, 777 F. Supp. 1157; *Pa. Med. Soc’y v. Marconis*, 755 F. Supp. 1305 (W.D. Pa. 1991), *aff’d*, 942 F.2d 842 (3d Cir. 1991).

Family medical providers in particular cite these regulatory limits on reimbursement as problematic for operating small, private practices, and therefore are unable to keep up with the spiraling costs of patient care and maintaining an office while absorbing lower reimbursement rates from patients using government-funded policies with depressed rates.<sup>83</sup> Interest groups have been “sounding the alarm” since 2007 regarding cuts to Medicare reimbursement under the Sustainable Growth Rate (SGR) formula,<sup>84</sup> which is a congressional tool used to determine Medicare reimbursement rates.<sup>85</sup> The SGR has been notoriously unreliable and described as “broken,”<sup>86</sup> with Congress blocking last minute pay cuts of over twenty percent to physicians for the last several years at the expiration of each tax year.<sup>87</sup> This is an action the medical community points to as a major reason why doctors are reluctant to participate in the program: the uncertainty surrounding payment has the potential to seriously affect operating costs if a large percentage of the physician’s patients use Medicare to cover their medical bills.<sup>88</sup> If multiple states were to successfully pass laws like Massachusetts’s proposed mandatory medical services legislation to

---

<sup>83</sup> See Scott W. Atlas, *How to Save America’s Health Care Safety Net*, FORBES (Aug. 20, 2012, 9:15 PM), <http://www.forbes.com/sites/scottatlas/2012/08/20/how-to-save-americas-health-care-safety-net> (declaring fifteen percent of medical facilities will lose money by 2019); Parija Kavilanz, *Doctors Going Broke*, CNN (Jan. 6, 2012, 9:39 AM), [http://money.cnn.com/2012/01/05/smallbusiness/doctors\\_broke/index.htm](http://money.cnn.com/2012/01/05/smallbusiness/doctors_broke/index.htm); James Rickert, *Do Medicare and Medicaid Payment Rates Really Threaten Physicians with Bankruptcy?*, HEALTH AFFAIRS BLOG (Oct. 2, 2012, 10:23 AM), <http://healthaffairs.org/blog/2012/10/02/do-medicare-and-medicaid-payment-rates-really-threaten-physicians-with-bankruptcy>.

<sup>84</sup> See Cheryl Clark, *Medical Groups Sound Alarm on SGR ‘Crisis,’* HEALTHLEADERS MEDIA (Sept. 30, 2010), <http://www.healthleadersmedia.com/content/PHY-257135/Medical-Groups-Sound-Alarm-on-SGR-Crisis###>.

<sup>85</sup> See Paul N. Van de Water, *The Sustainable Growth Rate Formula and Health Reform*, CTR. ON BUDGET & POLICY PRIORITIES (Apr. 21, 2010), <http://www.cbpp.org/cms/?fa=view&id=3166> (“[T]he sustainable growth rate [(SGR)] formula determines how much Medicare pays for services that physicians provide. . . . If spending in a given year exceeds the SGR target for that year, then the amounts paid to physicians . . . are supposed to be reduced in the following year to move total spending back towards the target path.”); see also Kapp, *supra* note 8, at 415 & n.10.

<sup>86</sup> Gulla, *supra* note 28.

<sup>87</sup> See Clark, *supra* note 84 (discussing a planned “23% cut in physician fees Dec. 1, . . . followed by another 6.5% cut Jan. 1” in 2010); Gulla, *supra* note 28 (“The current [SGR] formula calls for a 21 percent cut in physician reimbursements as of January 1. Each year for the last several years, Congress has used a last-minute fix to erase planned cuts in physician payments called for by the SGR formula.”); *Medicare Program Extensions and Cuts in ‘Fiscal Cliff’ Legislation*, MASS. MED. SOC’Y (Jan. 1, 2013), <http://www.massmed.org/Advocacy/Key-Issues/Medicare/Medicare-Program-Extensions-and-Cuts-in--Fiscal-Cliff--Legislation/#.UoPIPF14xnA> (noting the SGR was “fix[ed]” through 2013 preventing “Medicare physician payment rates . . . scheduled to be reduced by 26.5 percent on December 31, 2012 . . . [were avoided] through December 31, 2013”).

<sup>88</sup> See Kavilanz, *supra* note 83.

address the shortage of doctors available to their citizens, physicians and medical groups could potentially become bankrupt.<sup>89</sup>

*C. Efforts to Innovate Medical Care Delivery in the Face of Constricting Insurance Networks*

The rise of private and public “managed care organizations” (MCOs)<sup>90</sup> within the healthcare insurance industry inserted third parties into the contractual relationship between patient and doctor<sup>91</sup> and dramatically changed the process of healthcare delivery for Americans.<sup>92</sup> MCOs largely accomplished this by creating contractual networks of doctors.<sup>93</sup> The insurance company could often control the type of care that the doctor provided by mandating compliance with evidence-based medicine best practices<sup>94</sup> to qualify for reimbursement, essentially removing the ability of the

---

<sup>89</sup> Parija Kavilanz, *Doctors Driven to Bankruptcy*, CNN (Apr. 8 2013, 11:20 AM), <http://money.cnn.com/2013/04/08/smallbusiness/doctors-bankruptcy/> (“Doctors . . . blame shrinking insurance reimbursements, changing regulations, and . . . rising costs . . . for making it harder to keep their practices afloat.”).

<sup>90</sup> See, e.g., *Managed Care*, MEDICAID.GOV, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Managed-Care/Managed-Care.html> (last visited Mar. 2, 2014); see also Nan D. Hunter, *Managed Process, Due Care: Structures of Accountability in Health Care*, 6 YALE J. HEALTH POL’Y L. & ETHICS 93, 98 (2006) (noting that “pre-authorization has the greatest impact on cost containment”).

<sup>91</sup> See Richard Dolinar & S. Luke Leininger, *Pay for Performance or Compliance? A Second Opinion on Medicare Reimbursement*, 3 IND. HEALTH L. REV. 391, 403 (2006); Russell Korobkin, *The Efficiency of Managed Care “Patient Protection” Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1, 10–14 (1999).

<sup>92</sup> See Hunter, *supra* note 90, at 121 (noting a fifty-percent increase in the number of private-insurance policyholders under an MCO from 1992 to 1998).

<sup>93</sup> See generally, e.g., PHYSICIAN AND OTHER HEALTH CARE PROVIDER CONTRACTING TOOLKIT, AM. MED. ASS’N & AM. ASS’N OF PREFERRED PROVIDER ORGS. (2009), available at <http://www.ama-assn.org/resources/doc/psa/aappo-toolkit.pdf>. In exchange for a rate set by the insurance plan (usually lower than the doctor might charge as a market rate), the doctors theoretically received a steady supply of patients who used the insurance plan and were bound to use the plan’s network of providers.

<sup>94</sup> Insurance companies use “[c]linical practice guidelines” to dictate, in some cases, the type of care patients receive from a networked doctor. Dolinar & Leininger, *supra* note 91, at 403 (“[C]ompensat[ing] health care providers according to their compliance with the ‘best practices . . . .’”); Korobkin, *supra* note 91, at 12–14 (reimbursing for predefined resource use targets). One of the most consistent efforts to force networked doctors to conform with EBM guidelines has come from Medicare. See Elise Viebeck, *Study: Most Medicare Docs Set to Face Performance Penalties*, HILL (Jan. 8, 2013, 2:32 AM), <http://thehill.com/blogs/healthwatch/medicare/275987-study-most-medicare-docs-set-to-pay-performance-penalties>; see also Kapp, *supra* note 8, at 420 (“The terms and conditions of physician payment are set exclusively by the government, with the program beneficiaries enjoying no control over those or most other aspects of their coverage.”).

medical provider to decide independently what care to provide.<sup>95</sup> Many private insurance groups as well as Medicare and Medicaid operate like MCOs.

In response, there have been some efforts by physicians to cut out the insurance middlemen and deal directly with patients in both (1) deciding what services to provide and when and (2) receiving payment.<sup>96</sup> This is often referred to as “concierge medicine.”<sup>97</sup> The potential for concierge medicine practice-styles to draw doctors away from the MCO insurance network structure has been such that it has drawn the attention of Congress,<sup>98</sup> due to a fear that it may further decrease the pool of providers participating in the Medicaid/Medicare insurance programs.<sup>99</sup> As previously noted, the latter has already been dropping markedly in recent years.<sup>100</sup> A law structured like Massachusetts’s mandatory medical services legislation would essentially bar physicians from exclusively using alternative service delivery methods like concierge care.<sup>101</sup> There is also the additional concern that insurance companies working with

---

<sup>95</sup> See Cynthia A. Smith, *A Legislative Solution to the Problem of Concierge Care*, 30 SETON HALL LEGIS. J. 145, 146–48 (2005) (discussing problems with managed care).

<sup>96</sup> Steve Hargreaves, *Cash-Only Doctors Abandon the Insurance System*, CNN (June 11, 2013, 1:44 PM), <http://money.cnn.com/2013/06/11/news/economy/cash-only-doctors/>.

<sup>97</sup> See Sandra J. Carnahan, *Law, Medicine, and Wealth: Does Concierge Medicine Promote Health Care Choice, or Is It a Barrier to Access?*, 17 STAN. L. & POL’Y REV. 121, 121 (2006) (“[A] . . . growing number of physicians have distanced themselves from the constraints of cost-conscious managed care and reduced their patient loads . . . to a select number of patients able and willing to pay for a more personalized method of health care . . .”); Kapp, *supra* note 8, at 415 & n.8; Smith, *supra* note 95, at 149–50 (discussing a variety of concierge care-style arrangements).

<sup>98</sup> See U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-05-929, PHYSICIAN SERVICES: CONCIERGE CARE CHARACTERISTICS AND CONSIDERATIONS FOR MEDICARE 1 (2005), *available at* <http://www.gao.gov/new.items/d05929.pdf>; Robert M. Portman & Kate Romanow, *Concierge Medicine: Legal Issues, Ethical Dilemmas, and Policy Challenges*, 1 J. HEALTH & LIFE SCI. L. 1, 9 (2008) (“Almost from their inception, concierge practices have grabbed the attention of federal lawmakers and regulators.”).

<sup>99</sup> See Smith, *supra* note 95, at 150–51; *see also* Kapp, *supra* note 8, at 415 (“Medicare beneficiaries could effectively be pushed into a separate (and unequal) health care system with reduced access to physician services.”); Ricardo Alonso-Zaldivar, *Spread of Concierge Medicine Prompts Medicare Worries*, HUFFINGTON POST (Apr. 2, 2011, 11:14 AM), [http://www.huffingtonpost.com/2011/04/02/concierge-medicine-medicare-health-care\\_n\\_844042.html](http://www.huffingtonpost.com/2011/04/02/concierge-medicine-medicare-health-care_n_844042.html) (“[Medicare’s] financial troubles are causing doctors to reassess their participation . . . . [T]he impact [of concierge practices] could be broader because primary care doctors are in short supply and [PPACA] will bring in more than 30 million newly insured patients. If concierge medicine goes beyond just a thriving niche, it could lead to a kind of insurance caste system . . . .”).

<sup>100</sup> See *supra* notes 76–78 and accompanying text.

<sup>101</sup> Cf. Kapp, *supra* note 8, at 415 (“Without major changes in health care delivery systems . . . Congress would have to intervene to prevent the withdrawal of providers from the Medicare market and the severe problems with beneficiary access to care that would result.”)

state-funded programs could potentially have greater authority to further depress market payment reimbursement rates due to the loss of bargaining power for physicians and hospitals. In general, the battle over whether physicians must accept reimbursement via insurance has yet to be fought but demonstrates an interesting area of potential conflict between professional licensees choosing how to conduct their business and the state regulatory authority.

The Massachusetts Legislature's attempt to constrain a physician's choice of doing business with an insurance provider through threat of license revocation was an unprecedented attempt to expand the state police power<sup>102</sup> in regulating professional licenses. This theoretical step threatens to control substantially how physicians practice and could be replicated nationally. What made this legislation different from past laws proposing punitive medical license revocation for malpractice<sup>103</sup> is that there the doctor had the *option* to engage in that behavior in the first place; those other revocation actions reflected judgment based on a violation of something the doctor had agreed to conform to in a contractual relationship.<sup>104</sup>

The *choice* by a physician to accept an insurance company's reimbursement rates and become a medical provider in that insurer's network is a simple contractual choice. To decide against such a contract is behavior that is not professional malpractice, nor is it related to a criminal or civil dispute to which the licensee is a party.<sup>105</sup> Should any law structured like Massachusetts's mandatory medical services legislation, in any profession requiring a license, succeed in any state, such laws will amount to a significant reduction of a licensed professional's autonomy in deciding how he or she practices within the profession vis-à-vis how and when the professional provides services.<sup>106</sup>

---

(quoting 2010 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS, APPENDIX: STATEMENT OF ACTUARIAL OPINION 281–82 (Aug. 5, 2010)).

<sup>102</sup> See *supra* Introduction.

<sup>103</sup> See *supra* notes 81–83.

<sup>104</sup> See *infra* note 187 and accompanying text; see also Kapp, *supra* note 8, at 416–17 (noting that the doctrine of informed consent applies to both the patient and the physician's decision to enter into a treatment relationship); AMA Op. on Code of Med. Ethics, Op. 9.12–Patient-Physician Relationship: Respect for the Law and Human Rights (2007), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion912.page> (“Generally, both the physician and the patient are free to enter into or decline the relationship.”).

<sup>105</sup> Compare the typical triggers for state license revocation laws discussed in *supra* Introduction.B and Part I.A.

<sup>106</sup> For example, these include the ability to engage in concierge-care arrangements, require payment directly from the patient without dealing with insurance company reimbursement processes, or even pick and choose when to accept new patients into the practice. See *supra* Part I.C.

## II. DEVELOPING A STANDARD FOR SUBSTANTIVE DUE PROCESS EVALUATION OF PROFESSIONAL LICENSE REVOCATION ACTIONS

This Part will begin with a pitch for professional licenses to be viewed as fundamental rights and then moves on to the crux of this Note, which is that the lack of a preexisting duty in the situation premised in Massachusetts's mandatory medical services legislation bars laws like that from passing the low bar of substantive due process scrutiny under rational basis review.

### *A. Revisiting the Argument for Strict Review of Economic Substantive Due Process and a Fundamental Right to Livelihood*

It has been firmly established that medical licenses are subject to state regulation, and some hold this decision as barring a finding that such a license could be a fundamental right.<sup>107</sup> Furthermore, a fundamental right to livelihood has been dismissed by the U.S. Supreme Court.<sup>108</sup> It is not currently recognized by any of the state courts.<sup>109</sup> However, some commentators predict economic substantive due process's "slow but steady comeback,"<sup>110</sup> and for the purposes of this Note it is worth reiterating how the significant investment modern Americans made in their livelihoods,<sup>111</sup> coupled with the change in professional licensing regulatory initiatives,<sup>112</sup> might accelerate such a comeback.<sup>113</sup> Indeed, "today the federal and state governments directly or indirectly control a great proportion of the nation's employment"<sup>114</sup> through such regulation.<sup>115</sup> Furthermore, *Lambert*, concerning medical licenses, derives its

---

<sup>107</sup> See, e.g., *Lambert v. Yellowley*, 272 U.S. 581, 596 (1926) ("[T]here is no right to practice medicine which is not subordinate to the police power of the states.").

<sup>108</sup> See *id.*; Fondacaro & Stolle, *supra* note 3, at 386–87, 386 n.212 (presenting the argument of Wayne McCormack, *Economic Substantive Due Process and the Right of Livelihood*, 82 KY. L.J. 397, 450 (1994), for the fundamental right of livelihood, but concluding that it is not likely to be successful).

<sup>109</sup> See Fondacaro & Stolle, *supra* note 3, at 386–87.

<sup>110</sup> Phillips, *supra* note 26, at 919. See generally TIMOTHY SANDEFUR, *THE RIGHT TO EARN A LIVING: ECONOMIC FREEDOM AND THE LAW* (2010) (discussing recent efforts to revive the fundamental right to livelihood in the face of increasing trade regulations).

<sup>111</sup> See *supra* notes 11–13.

<sup>112</sup> See *supra* Introduction.B.

<sup>113</sup> See *supra* note 13 and accompanying text (noting the rapid expansion of state professional licensing schemes in the late twentieth century); see also McCormack, *supra* note 108, at 450 ("Licensing and regulation, . . . restrict activities that perform many of the social functions formerly served by property. In the post-industrial state, economic productivity, labor, and personality functions merge in many aspects of our business lives.").

<sup>114</sup> Van Alstyne, *supra* note 4, at 1461; see also *supra* notes 10–11 and accompanying text.

<sup>115</sup> See *supra* note 14.

holding from authority only speaking to the state's power to regulate *entry* into the profession, not the acts of the licensees themselves.<sup>116</sup>

The modern question is thus whether this massive intrusion into the regulation of citizens via government-issued licenses needed for their careers violates due process to the extent that the “government action . . . deprive[s] the claimant of occupational liberty . . . not merely prevent[s] her from occupying a particular job.”<sup>117</sup> Fundamental rights are “liberties . . . so important that”<sup>118</sup> rational basis review<sup>119</sup> is inappropriate for reviewing a law for substantive due process violations, so strict scrutiny review is applied.<sup>120</sup> For such fundamental rights, “generally the government cannot infringe upon them.”<sup>121</sup> In a past era, economic substantive due process was recognized as triggering strict scrutiny.<sup>122</sup> But today, such concepts of liberty have only been extended by the U.S. Supreme Court to rights related to personal privacy and autonomy, travel, voting, and access to the courts.<sup>123</sup> These are considered “essential to the orderly pursuit of happiness by free men.”<sup>124</sup>

This Note postulates that given that “the protection afforded occupational freedom depends on the degree to which it has been infringed,”<sup>125</sup> since professional licenses are integral to career and social standing,<sup>126</sup> it should amount to a fundamental right to livelihood because investment in such a career and license is on par with the essential freedom to pursue happiness<sup>127</sup> recognized in other fundamental rights. Thus

---

<sup>116</sup> *Lambert v. Yellowley*, 272 U.S. 581, 596 (1926), cites four cases for its proposition regarding medical licenses and the state police power: *Dent v. West Virginia*, 129 U.S. 114 (1888) (requiring certification); *Collins v. Texas*, 233 U.S. 288 (1911) (finding merit in an action for practicing without a license); *Crane v. Johnson*, 242 U.S. 339 (1917) (requiring medical school as a prerequisite); *Graves v. Minnesota*, 272 U.S. 425 (1926) (finding merit in an action for practicing without a license); see also Schwartz, *supra* note 53, at 688–89 (addressing the *Lambert* case); *supra* Introduction.B.

<sup>117</sup> Phillips, *supra* note 26, at 938.

<sup>118</sup> CHEMERINSKY, *supra* note 48, at 792.

<sup>119</sup> For an overview of this tier of scrutiny, see *supra* Part I.A.

<sup>120</sup> See *supra* note 48 and accompanying text.

<sup>121</sup> CHEMERINSKY, *supra* note 48, at 792.

<sup>122</sup> Prior to World War II and the New Deal Era, the Supreme Court recognized economic rights and liberties as protected classes of fundamental rights based on the Supreme Court reading in the Constitution that a person possesses natural rights to own and keep property. See CHEMERINSKY, *supra* note 48, at 608–11; Fondacaro & Stolle, *supra* note 3, at 371; Phillips, *supra* note 26, at 917–24.

<sup>123</sup> SANDEFUR, *supra* note 110, at 1–2; McCormack, *supra* note 108, at 401–16; Phillips, *supra* note 26, at 925, 936.

<sup>124</sup> Phillips, *supra* note 26, at 936.

<sup>125</sup> *Id.* at 938.

<sup>126</sup> See *supra* notes 12–13 and accompanying text.

<sup>127</sup> Phillips, *supra* note 26, at 936.

the Supreme Court should consider reviewing a case like *Lambert* and more fully explaining the parameters of the states' police power for professional licenses.<sup>128</sup>

In their review of the fundamental right to livelihood in application to license revocation due to unpaid child support, Mark Fondacaro and Dennis Stolle note that creation of a fundamental right is difficult and it must be applied to behaviors historically beyond the reach of government.<sup>129</sup> Due to such a standard they conclude an effort to create a fundamental right to livelihood would not be successful.<sup>130</sup> But this overlooks a narrow yet existent area where economic substantive due process is applied to attack overly "general social and economic regulations."<sup>131</sup>

Applying Fondacaro and Stolle's standard to the health care industry, it is unlikely that any Supreme Court Justice would find that healthcare professionals are beyond the reach of some government regulation.<sup>132</sup> Additionally, federal funds provide salaries for training newly minted doctors.<sup>133</sup> However, an argument can be made that a line might be drawn in the sand between an acceptable regulation within the confines of historical precedent<sup>134</sup> and one that is too general in its social and economic ramifications. Indeed,

[t]he U.S. Supreme Court has also recognized that the right to follow a chosen profession, free from unreasonable governmental interference, is within the liberty concepts of due process of law. These holdings rest on the severity of the consequences that typically result when a professional's license is suspended or revoked.<sup>135</sup>

---

<sup>128</sup> *Lambert v. Yellowley*, 272 U.S. 581 (1926). Although reviewing *Lambert* might seriously affect a large extent of case law, consider that state constitutions may grant varying protections to professional licenses in the future. See *infra* Part IV. Indeed, it is not clear that the *Lambert* proposition regarding medical licenses subject to the state police power discussed in the opinion is controlling in state courts: only fifteen states cite to it, and only eleven of those were before the highest court. *Lambert*, 272 U.S. at 596.

<sup>129</sup> See Fondacaro & Stolle, *supra* note 3, at 379–80.

<sup>130</sup> See *supra* note 108 and accompanying text.

<sup>131</sup> Phillips, *supra* note 26, at 926.

<sup>132</sup> Cf. Smith, *supra* note 95, at 153–54.

<sup>133</sup> See Sataline & Wang, *supra* note 75 (noting that spots for mandatory residency training programs for newly graduated medical doctors are restricted because teaching hospitals rely heavily on federal funds from Medicare to pay the resident doctors); cf. Goodman & Fisher, *supra* note 75; Kliff, *supra* note 75.

<sup>134</sup> McCormack, *supra* note 108, at 399, 449–53 (arguing for the U.S. Supreme Court to recognize a protected right of livelihood limited by "narrowly circumscribed uses"); see also CHEMERINSKY, *supra* note 48, at 792.

<sup>135</sup> Bennett, *supra* note 3, at 211–12 (footnotes omitted); see also *Cleveland Bd. of Educ. v. Loudermill*, 470 U.S. 532, 543 (1985) ("[T]he significance of the private interest in retaining employment cannot be gainsaid. We have frequently recognized the severity of depriving a person of the means of livelihood."); McCormack, *supra* note 108, at 452 ("The interest in

With this standard in mind, this Note puts forth that in light of the expanding and unprecedented regulatory power of the states over professional occupations,<sup>136</sup> the U.S. Supreme Court should “identify elements that, at this stage in our history, will trigger special solicitude under the Due Process Clause.”<sup>137</sup> Some of these elements may be the level of proficiency required to attain entry into the profession,<sup>138</sup> the average market expenditures<sup>139</sup> required to attain entry into the profession, and the social implications of entering and exiting certain professions.<sup>140</sup> Due to such increasing economic costs on professionals, laws that constrain their autonomy in practicing their trade may serve as a deterrent for their entry into the market in the first place.<sup>141</sup> In line with this theory, consider the example of how Massachusetts is trying to combat this mentality among medical students, by attracting them into the less lucrative medical specialty of primary care through tax-free grants for loan repayments up to \$50,000 in exchange for a promise of practicing in primary care.<sup>142</sup>

---

pursuing a lawful trade or occupation has been extolled by any number of writers, both on the Supreme Court and elsewhere.”); Van Alstyne, *supra* note 4, at 1462 (“[T]he expansion of government with its attendant influence on the individual [means] . . . alternatives to acceptance of arbitrary government action are practically nonexistent, and the potential control over his personal life is therefore practically absolute.”).

<sup>136</sup> See *supra* Introduction.B.

<sup>137</sup> McCormack, *supra* note 108, at 449; see also Fondacaro & Stolle, *supra* note 3, at 386 (noting McCormack’s argument); *supra* notes 12–13 and accompanying text (discussing the increasing numbers of people pursuing professional careers).

<sup>138</sup> Waller v. State, 68 S.W.2d 601, 605 (Tex. App. 1934) (“To obtain a license and proficiency requires the expenditure of money and years of preparation, attended by toil and self-denial.”); McCormack, *supra* note 108, at 452 (“In the post-industrial state, this [lawful trade or occupation] interest takes on even more significance. The high-tech world emphasizes mental labor. Success in the modern economic world, whether viewed individually or collectively, requires development of personality traits because skills will be the most marketable commodities we will have.”).

<sup>139</sup> Also consider lost wage revenue from leaving the market and attending school and the student loan debt crisis currently engulfing the United States. See Martha C. White, *Is the Student-Loan Debt Crisis Worse than We Thought?*, TIME (Nov. 29, 2012), <http://business.time.com/2012/11/29/is-the-student-loan-debt-crisis-worse-than-we-thought/>.

<sup>140</sup> Bennett, *supra* note 3, at 212 (“Such right is the capital stock of its possessor from which dividends are expected sufficient to protect him from the infirmity of old age . . . . To cancel a professional license is to take the entire capital stock of its possessor and to leave him in most instances the equivalent of a bankrupt. But it does much more than this; it takes from him his professional standing and in a manner whatever good name he has, which leaves him ‘poor indeed.’” (quoting Waller, 68 S.W.2d. at 605)); see also Schwartz, *supra* note 53, at 690 (“At issue are physicians’ livelihoods, reputations . . .”).

<sup>141</sup> See McCormack, *supra* note 108, at 452; see also, e.g., MASS. MED. SOC’Y, PHYSICIAN WORKFORCE STUDY 4–5 (Sept. 2009) (summarizing “Recruitment Issues”); *supra* Parts I.B–C.

<sup>142</sup> See generally UMASS AHEC NETWORK, PRIMARY CARE PHYSICIAN RECRUITMENT AND RETENTION PROGRAMS IN MASSACHUSETTS (updated Apr. 2011), available at <http://www.mass.gov/eohhs/docs/dph/com-health/primary-care/primary-care-physician-recruitment.pdf>.

Building on this economic cost theory, it follows that it may actually be in the public interest, for the sake of our economy as a whole, to allow the fundamental right protection to careers requiring professional licensure, based on the requirement of significant investment of time, resources, and licensure application.<sup>143</sup> Harm to consumers and third parties affected by the bad actions of licensed professionals are the predominant reason offered for not finding a fundamental right to livelihood for fear of offering licensees too much protection.<sup>144</sup> Today such expanded regulation of licensed professionals is perhaps detrimental to consumers and third parties,<sup>145</sup> so it may be reasoned that a heightened degree of substantive due process protection is warranted for professional licenses.<sup>146</sup>

Of course, “[b]alanced against these concerns is the need for protection of the public interest through prevention of inept practice of a profession that is so complicated that the marketplace cannot be expected to exert any sensible control on competence.”<sup>147</sup> Understandably, the scope of how insurance networks operate to reimburse physicians<sup>148</sup> has made it difficult for consumers to find physicians on their own using market reputation or even understand reasonable pricing schemes, which are arguably the two issues the Massachusetts mandatory medical service legislation sought to address.<sup>149</sup> However, it is debatable whether either of these things relate to the ineptitude concerns of licensing a professional.<sup>150</sup> Furthermore, it seems that Massachusetts’s mandatory medical services legislation would have dissuaded people from joining the Massachusetts medical community,<sup>151</sup> or caused

---

<sup>143</sup> See McCormack, *supra* note 108, at 452; see also Phillips, *supra* note 26, at 943 (discussing a plaintiff who prevailed under rational basis review because “the ordinance [was] more detrimental than beneficial to the public” (citation omitted)).

<sup>144</sup> See McCormack, *supra* note 108, at 450 (“Government regulates these activities precisely because they do affect persons other than the regulated.”); see also Law & Kim, *supra* note 12, at 754 (“[S]tate licensing powers [are] used . . . as an instrument to ‘protect the safety and welfare’ of consumers.”).

<sup>145</sup> Such a license revocation law may actually further limit the number of physicians available to citizens through revoking licenses for non-conformers, thereby further exacerbating the dearth of primary care providers and doctors in general. See *supra* Part I.B.

<sup>146</sup> See McCormack, *supra* note 108, at 450; cf. *supra* note 18.

<sup>147</sup> McCormack, *supra* note 108, at 452.

<sup>148</sup> See *supra* Part I.C.

<sup>149</sup> Cf. Law & Kim, *supra* note 12, at 724 (“The sale and purchase of professional services are often subject to problems of asymmetric information.”).

<sup>150</sup> See *supra* Introduction.B; *infra* Part II.B.

<sup>151</sup> Loss of choice, it can be argued, creates “social problems [that] tend to drive out individual ethics, which are essential to the creation and cultivation of optimal physician-patient relationships.” Kapp, *supra* note 8, at 418–19. The personal drive to take on the enormous amount of sacrifice to attain the skill to enter the profession may be lost to the detriment of society as a whole. See *supra* notes 138–41 and accompanying text. Consider this effect in conglomeration with the national physician shortage already present. See *supra* Part I.C.

them to leave the state to practice elsewhere, which would not have served the public interest.<sup>152</sup> The loss of choice to the professional, and the possible harms to the consumer seem to outweigh the proposed benefits of such legislation.

For these primary economic and social reasons, heightened due process protections should be granted to the professional license as a property right. This prevents laws like the Massachusetts mandatory medical services legislation that could create such social and economic ramifications without appropriately addressing the specialized elements of investing in a professional career and those professionals' impact on the public's well-being at large.

*B. Scope of the Physician's Legal Duty of Care and Why a Law Structured like Massachusetts Bills H. 4452 and S. 2170 Should Fail Rational Basis Review*

Should the creation of a fundamental right to livelihood fail, we are left with rational basis review, which historically has been the standard for substantive due process challenges of professional license revocations.<sup>153</sup> Even without a fundamental right, there is some weight that might still be given to the public welfare argument discussed above, where some cases have prevailed under rational basis review due to the law's potential harm to the public.<sup>154</sup> Additionally, there is a strong argument to be made that a law structured like the Massachusetts mandatory medical services legislation is "economic protectionism in its most glaring form, and this goal is not legitimate . . . [because it amounts] to favoritism [by] only restrict[ing] [doctors] and fail[ing] to restrict similarly-situated [professionals] such as [nurses, physicians assistants, pharmacists, etc.]."<sup>155</sup> Due to such line drawing, it follows that the legislation is a "government[ ] action [that] is 'clearly wrong, a display of arbitrary power, and not an exercise of [rational] judgment.'"<sup>156</sup>

But this Note argues that there are stronger grounds to find laws structured like the Massachusetts mandatory medical services legislation arbitrary. That legislation was distinct from past professional license revocation laws: no legal duty of care exists between a doctor and patient until both consent for the patient to be examined.<sup>157</sup> Compare this to the preexisting duty of parenthood present in the case of child support

---

<sup>152</sup> See *infra* Part IV.

<sup>153</sup> See *supra* Part I.A.

<sup>154</sup> See Phillips, *supra* note 26, at 943 (discussing a plaintiff who prevailed under rational basis review because "the ordinance [was] more detrimental than beneficial to the public" (citation omitted)).

<sup>155</sup> *Id.* (citations omitted).

<sup>156</sup> CHEMERINSKY, *supra* note 48, at 685 (citation omitted); see also *supra* note 20 and accompanying text.

<sup>157</sup> See *infra* notes 183–96 and accompanying text.

payment defaults<sup>158</sup> or a legal financial contract creating a preexisting duty to pay that has actively been entered into in the case of defaulted upon student loans.<sup>159</sup>

The core purpose of the state licensing authority is to ensure the potential licensee is qualified to conduct the act regulated by the license.<sup>160</sup> Indeed, although it was demonstrated earlier that this qualification process can broadly examine the personal actions of the licensee,<sup>161</sup> and “[a] State can require high standards of qualification, such as good moral character or proficiency in its law,” before it grants an applicant a license to practice,<sup>162</sup> the U.S. Supreme Court has held that these qualification requirements “must [also] have a *rational* connection with the applicant’s fitness or capacity” to engage in the licensed activity.<sup>163</sup>

This Note suggests that the distinction the preexisting legal duty lends in this analysis is evidenced by the fact that courts have used it as the nexus between previously enacted license revocation statutes and the role of the state as a licensing authority. For example, “it might appear to be a strained argument to suggest that failure to pay child support is related to one’s professional capacity”;<sup>164</sup> however, the connection lies in the fact that one aspect of professional competency qualifying one to hold a professional license is fulfilling legal obligations.<sup>165</sup> Arguably, the insinuation is that delinquency in one legal relationship is evidence of one’s potential lack of competency in others. Thus it could be that the licensee will act to the detriment of the profession as a whole.<sup>166</sup> This suggests that in cases involving child support and student loan payment defaults, the court’s unspoken impetus to uphold the state laws were because the laws helped protect legal relationships *already in place*, and the social policy interests of financial security for raising children in the state and ensuring the solvency of loan providers were legitimate state concerns considering the

---

<sup>158</sup> See Francis C. Amendola et al., 67A C.J.S. *Parent and Child* § 156 (2013) (“It is generally the rule that the parents of minor children have a fundamental duty to support them.”).

<sup>159</sup> This would be by way of the promissory note the student loan defaulter originally signed to receive the loans.

<sup>160</sup> See Fondacaro & Stolle, *supra* note 3, at 387–88; *supra* Introduction.

<sup>161</sup> See *supra* Introduction.B.

<sup>162</sup> *Schwartz v. Bd. of Bar Exam’rs of N.M.*, 353 U.S. 232, 239 (1957); see also Sawicki, *supra* note 16, at 293–94 (discussing constraints imposed on licensing boards by *Schwartz*).

<sup>163</sup> *Schwartz*, 353 U.S. at 239 (emphasis added).

<sup>164</sup> Fondacaro & Stolle, *supra* note 3, at 387–88.

<sup>165</sup> See *id.* (“[C]ourts have recognized that failure to pay child support may be related to professional competency . . . [due to] a lack of appropriate character and fitness of the subject professional.” (citation omitted)).

<sup>166</sup> *Cf., e.g., Lusskin v. State of Fla. Agency for Health Care Admin., Bd. of Med.*, 731 So. 2d 67, 67 (Fla. Dist. Ct. App. 1999) (discussing an administrative complaint seeking suspension of a medical license for “noncompliance with the Physician’s Recovery Network’s (‘PRN’) contract as a basis for his inability to practice with skill and safety”).

effect on the state market should either of those areas become crises.<sup>167</sup> Furthermore, where a preexisting legal duty is evidenced, there is a rational relation to the legitimate concern about whether such licensees are fit to hold professional licenses when they openly disregard other legal duties.<sup>168</sup> It is this connection that makes such a law reaching the professional license a “government[ ] action [that] is [not] ‘clearly wrong, [nor] a display of arbitrary power, [but rather] an exercise of judgment.’”<sup>169</sup> In other words, the act of revoking the license was an appropriate method of achieving the ends to incentivize licensees, as citizens carried out their other legal relationships.

In comparison, the objective of the Massachusetts medical services legislation was to ensure newly insured patients had access to physicians.<sup>170</sup> Obviously this is not an ignoble goal. But which insurance network a physician chooses to do business with,<sup>171</sup> or which patients they decide to take on,<sup>172</sup> is wholly beyond the scope of their qualification to practice medicine and therefore it is entirely inappropriate to predicate a forced doctor-patient relationship using a state licensing scheme. Unless the doctor and patient have already entered into a treatment relationship there is no preexisting legal duty that the doctor owes to the patient.<sup>173</sup> The lack of a preexisting legal duty to be violated does not bring into question a physician’s competency of character the way that delinquent child support and student loan payments do. This is why a law like Massachusetts’s mandatory medical services legislation is nothing more than “a display of arbitrary power, not an exercise of judgment.”<sup>174</sup>

---

<sup>167</sup> Namely, for the other license revocation examples discussed, by increasing demands on the public welfare system, *see* Fondacaro & Stolle, *supra* note 3, at 360, or on loan providers who, faced with increasing defaults, might decline to offer future student loans making it impossible for some citizens to attain a professional degree.

<sup>168</sup> *Cf.* CHEMERINSKY, *supra* note 48, at 677 (noting rational basis review is only offended if the law is based on “grounds wholly irrelevant to the achievement of the State’s objective”).

<sup>169</sup> *Id.* at 685 (citation omitted); *see also supra* note 20 and accompanying text.

<sup>170</sup> *See Massachusetts Health Care Reform, supra* note 29.

<sup>171</sup> *See supra* Part I.C.

<sup>172</sup> *See* Kapp, *supra* note 8, at 414 & nn.3–4; *see also* Megan Willett, *Doctor Refuses to Treat 200-Pound Woman Because of Her Weight*, BUS. INSIDER (Aug. 28, 2012, 11:48 AM), <http://www.businessinsider.com/woman-denied-medical-treatment-due-to-her-weight-2012-8> (noting doctor was completely within her rights to turn away an obese patient for fear of injury to staff and equipment).

<sup>173</sup> *See infra* notes 183–96. Arguably, the Emergency Medical Treatment & Labor Act, which requires presenting patients be cared for by hospital emergency rooms even with no payment received was a previous attempt to force a doctor-patient relationship, which drove up rates of care for everyone. *EMTALA*, AM. COLL. OF EMERGENCY PHYSICIANS, <http://www.acep.org/content.aspx?id=25936> (last visited Mar. 2, 2014); *see also* Emergency Medical Treatment & Labor Act (EMTALA), 42 U.S.C.A. § 1395dd (2012). However, there are two important distinctions: the first being that the Massachusetts mandatory medical services legislation addressed non-emergency doctor-patient interactions. *See* Kapp, *supra* note 8, at 419. Secondly, the EMTALA does not require hospitals to have an emergency room and some hospitals are closing their emergency departments. *EMTALA, supra*.

<sup>174</sup> CHEMERINSKY, *supra* note 48, at 685 (citation omitted).

A great illustration of this concept is the idea that the incentive power of a license revocation law is no more than “a system similar to civil contempt in which *the obligor* holds the key to the jailhouse door.”<sup>175</sup> In other words, the decision to violate a legal duty *lies with the licensee entirely*. This does not exist between a physician and a member of the public with whom they have not entered into a doctor-patient relationship. Furthermore, because there is no legal duty present that can be enforced, there is no reason for the physician (or any other theoretical professional without a legal duty to act) to continue to be a physician.<sup>176</sup> For child support or student loan default the licensee does not have the choice of avoiding his payment obligations.<sup>177</sup> License revocation is designed to incentivize them to comply with those obligations, whereas the physician can opt to pursue a different career that does not require medical licensure or practice in another state where such a condition of medical licensure does not exist in response to a law like the Massachusetts mandatory medical services legislation.<sup>178</sup>

To avoid falling into that category of arbitrary use of power, a state or federal law generally mandating a physician’s legal duty to the public would need to be passed. Outside of that extreme option, a connection to the medical licensing scheme that is akin to the default of legal duties of child support and student loans could lie in industry ethical custom, perhaps with the American Medical Association’s (AMA) Code of Ethics,<sup>179</sup> which asserts certain professional ethical standards, including a mandate against “invidious discrimination” that could arguably be applied to accepting certain insurances.<sup>180</sup> If the licensing agency in a state finds that membership with the AMA is connected to the licensee’s character and fitness qualification requirement then perhaps a nexus can be found between the license qualification and the act of refusing to accept certain insurance networks or patients.<sup>181</sup> However, given the AMA’s voluntary membership of doctors,<sup>182</sup> this seems highly unlikely.

---

<sup>175</sup> Fondacaro & Stolle, *supra* note 3, at 388 (emphasis added).

<sup>176</sup> *Cf. supra* Part II.A (discussing the economics and social policy implications of not recognizing a fundamental right in modern livelihood).

<sup>177</sup> It should be noted that bankruptcy proceedings do not discharge child support obligations nor federally subsidized student loans. *See* 11 U.S.C.A. § 523 (2012).

<sup>178</sup> For a more in-depth analysis of this possibility, see *infra* Part IV.

<sup>179</sup> *See generally* AMA’S CODE OF MED. ETHICS (2001), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. For a description of the origins of the AMA Code of Ethics, see Schwartz, *supra* note 53, at 661–62.

<sup>180</sup> *See, e.g.,* AMA Op. on Code of Med. Ethics, Op. 9.12–Patient-Physician Relationship: Respect for Law and Human Rights (2007), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion912.page> (“The creation of the patient-physician relationship is contractual in nature. . . . However physicians who offer their services to the public may not decline to accept patients . . . [on a] basis that would constitute invidious discrimination.”).

<sup>181</sup> Consider that some commentators have found there has been a “pattern of the Court looking to the AMA for guidance.” Schwartz, *supra* note 53, at 666.

<sup>182</sup> *See id.* at 662 (“[O]nly a quarter of physicians are members of the [AMA] . . .”).

This is because in general, the scope of the legal duty of a treating physician has never been purported to go beyond the treatment relationship that he or she freely agrees to.<sup>183</sup> This is reflected in medical malpractice case law at both the state and federal level. These decisions generally hold that a physician's legal duty is limited to patients treated.<sup>184</sup> This includes the Massachusetts courts.<sup>185</sup> The crucial point is that courts treat physician-patient interactions as contracts, and "[w]hether a physician-patient relationship is created is a question of fact, turning upon a determination [about] whether the patient entrusted his treatment to the physician *and the physician accepted the case*."<sup>186</sup> This is the key: a contractual foundation has defined how medical services are provided in the doctor-patient relationship in this country and other key provisions relating to patient rights rely on it.<sup>187</sup> It follows that if a law

---

<sup>183</sup> See Kapp, *supra* note 8, at 414 ("Historically, the physician-patient relationship has been one into which each party enters voluntarily. According to the American Medical Association, 'A patient-physician relationship exists when a physician serves a patient's medical needs, generally by mutual consent between physician and patient (or surrogate).'" (citing the AMA Op. on Code of Med. Ethics, Op. 10.015—The Physician-Patient Relationship (2011))).

<sup>184</sup> See, e.g., *Wolf v. Fauquier Cnty. Bd. of Supervisors*, 555 F.3d 311, 320 (4th Cir. 2009) (stating that "liability for malpractice is predicated upon an initial finding [of] a consensual agreement" (citation omitted)); *Gaulden v. Green*, 733 S.E.2d 802, 804 (Ga. Ct. App. 2012) (stating that in order to succeed on the merits "plaintiff must come forward with evidence of a physician-patient relationship"); *Cromer v. Children's Hosp. Med. Ctr. of Akron*, 985 N.E.2d 548, 553 (Ohio Ct. App. 2012) ("[T]he duty of the physician is established simply by the existence of a physician-patient relationship, not by questions of foreseeability." (citation omitted)); *Jennings v. Badgett*, 230 P.3d 861, 865 (Okla. 2010) ("[A] physician is not under a general duty to provide professional services to others, [so] the physician must consent to provide the services. The agreement of the physician to treat and the patient to receive treatment is the basis of the employment contract." (citation omitted)); *Mead v. Legacy Health Sys.*, 283 P.3d 904, 909 (Or. 2012) (en banc) (establishing that "physician-patient relationship is a necessary predicate").

<sup>185</sup> *Calhoun v. United States*, 539 F. Supp. 2d 500, 508 (D. Mass. 2008) ("[Plaintiff] must first establish the existence of a physician-patient relationship."). This apparent conflict with the failed legislation discussed *supra* in Part I.B is likely something that would have been hotly contested in Massachusetts malpractice actions. However, it is doubtful that if the law had succeeded a non-patient could successfully sue for professional malpractice, unless of course the doctor illegally refused to treat them. However, if Massachusetts had needed to declare a general duty of care to the public in order to make their mandatory medical service legislation legal given the contractual standard mentioned above, such a requisite legal foundation might open medical doctors to malpractice actions from patients they had not actively treated. The policy implications of this issue are beyond the scope of this Note, but are important to recognize in the context of this Note's discussion.

<sup>186</sup> *Wolf*, 555 F.3d at 320 (emphasis added) (quoting *Lyons v. Grether*, 239 S.E.2d 103, 105 (Va. 1977)).

<sup>187</sup> For example, the doctrine of informed consent protects patients from unwanted medical treatment and gives them the right to refuse care or procedures that are even against the advice of the doctor's expertise. See Kapp, *supra* note 8, at 416–17 (citing Rachel Reibman,

like the Massachusetts mandatory medical services legislation can be held constitutional, the implications of controlling the autonomy of one party to the physician-patient relationship means that it may open the door for the other side to also be controlled through receipt of mandatory medical procedures.<sup>188</sup> A good example of the latter is the brewing debate over mandatory vaccines.<sup>189</sup>

Connected to this debate are religious and moral objections to entering into a contract to provide medical services.<sup>190</sup> For example, a law drafted like the Massachusetts mandatory medical service legislation could come into conflict with federal or state conscience and refusal clauses, which allow providers to refuse to conduct services inapposite to their personal moral convictions.<sup>191</sup> It could also affect a physician's direct threat defense and right to refer if they feel they do not possess the appropriate expertise to treat.<sup>192</sup> These other legal doctrines are highly suggestive of the importance of the medical provider's personal autonomy in deciding which physician-patient relationships they will enter into in the first place.<sup>193</sup> Similarly, language in the AMA suggests it "recognizes a physician can ethically refuse to provide a treatment because he objects to the nature of the treatment, but a physician

---

Comment, *The Patient Wanted the Doctor to Treat Her in the Closet, but the Janitor Wouldn't Open the Door: Healthcare Provider Rights of Refusal Versus LGB Rights to Reproductive and Elder Healthcare*, 28 TEMP. J. SCI. TECH. & ENVTL. L. 65, 91 (2009)). Furthermore, the seriousness of the doctor-patient legal duty is exemplified in patient rights under the tort doctrine of abandonment liability, should the doctor inappropriately terminate treatment for whatever reason, including payment. See Schwartz, *supra* note 53, at 677–78 (noting that "states [can] require physicians to provide care once they have begun treating a patient"); cf. AMA Op. on Code of Med. Ethics, Op. 8.115–Termination of the Patient-Physician Relationship (1996), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8115.page>.

<sup>188</sup> See generally Marshall B. Kapp, *If We Can Force People to Purchase Health Insurance, Then Let's Force Them to Be Treated Too*, 38 AM. J.L. & MED. 397, 398 (2012) (addressing "the possibility of government-mandated medical treatment as a logical sequel" to the expanded governmental role in health care delivery following the U.S. Supreme Court's upholding of PPACA).

<sup>189</sup> See generally Kyra R. Wagoner, Note, *Mandating the Gardasil Vaccine: A Constitutional Analysis*, 5 IND. HEALTH L. REV. 403 (2008) (examining mandatory state vaccination programs for children); Jed Lipinski, *Endangering the Herd*, SLATE MAG. (Aug. 13, 2013, 10:58 AM), [http://www.slate.com/articles/news\\_and\\_politics/jurisprudence/2013/08/anti\\_vaxxers\\_why\\_parents\\_who\\_don\\_t\\_vaccinate\\_their\\_kids\\_should\\_be\\_sued\\_or.html](http://www.slate.com/articles/news_and_politics/jurisprudence/2013/08/anti_vaxxers_why_parents_who_don_t_vaccinate_their_kids_should_be_sued_or.html) (explaining the case for suing parents who refuse to vaccinate their children against formerly eradicated diseases, thereby endangering other children when the former catch the disease).

<sup>190</sup> See Reibman, *supra* note 187, at 66.

<sup>191</sup> *Id.* at 66–67, 66 nn.3–4, 71 n.27.

<sup>192</sup> See Schwartz, *supra* note 53, at 671–74.

<sup>193</sup> However, it should also be noted that these laws are somewhat tempered by laws governing civil rights, which doctors are not permitted to violate in deciding whether or not to treat a patient. See *id.* at 668 (discussing the ADA); Kapp, *supra* note 8, at 417. However, exclusions exist, most notably for sexual orientation. See Reibman, *supra* note 187, at 67.

cannot ethically refuse to treat a specific patient because he objects to a characteristic of the patient.”<sup>194</sup> Whether a decision not to accept a particular insurance network can be considered actively objecting to a “characteristic of the patient,”<sup>195</sup> such an analysis would likely fail if the doctor could argue they were willing to treat the patient and in denying the patient’s insurance only sought to set their own price for the services. The AMA also discusses the restraint on this in defining a “reasonable fee.”<sup>196</sup>

In summary, it follows that the argument for upholding a law like Massachusetts’s mandatory medical services legislation, which predicates mandatory service for a set payment on threat of license revocation, is much weaker under rational basis review than other license revocation laws. In those other instances, the professional has previously committed some act that violates an already-existing legal duty; this is not the case with physicians who have not yet entered into a physician-patient relationship.

### III. A FURTHER COMPLICATION: STATE CONSTITUTIONALISM AND THEORETICAL POLICY IMPLICATIONS FOR NATIONWIDE MEDICAL CARE DELIVERY

An interesting variable in the debate is the effect of state constitutions granting varying levels of due process protections. In some state courts a fundamental right does not need to be triggered in order for a state law to be reviewed under strict scrutiny.<sup>197</sup> This is because some states interpret their constitution’s contract clauses stricter than that of the Federal Constitution.<sup>198</sup> This enables the state to find that

---

<sup>194</sup> Reibman, *supra* note 187, at 91.

<sup>195</sup> *Id.*

<sup>196</sup> AMA Op. on Code of Med. Ethics, Op. 6.05—Fees for Medical Services (1994), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion605.page> (“A physician should not charge or collect an illegal or excessive fee. . . . A fee is excessive when after a review of the facts a person knowledgeable as to current charges made by physicians would be left with a definite and firm conviction that the fee is in excess of a reasonable fee.”). This opinion goes on to list certain factors that can be indicative of calculating a reasonable fee. *Id.* However, without numerical data, this is surely a broad standard that could be manipulated to support either side of this debate.

<sup>197</sup> Generally, a state court may interpret its state constitution as providing its citizens with more, but not less, constitutional protection than the United States Constitution. For example, a state court may strike down a state statute for a violation of state equal protection doctrine even though the state’s interpretation of its own equal protection clause is more expansive than the Supreme Court’s interpretation of the federal equal protection clause. In such a case, the state constitutional provision will be regarded as an adequate and independent ground for judicial review.

Fondacaro & Stolle, *supra* note 3, at 376 (citations omitted).

<sup>198</sup> *See id.* at 377 (“State courts considering the constitutionality of such programs would therefore have the authority to strike down the state statutes that implement the program based on state constitutional interpretation, independent of federal constitutional concerns.”).

some state laws are unconstitutional where they would otherwise be upheld under the Federal Constitution, “[a]s long as the state has never previously held the provision of their state constitution in question to hold essentially the same meaning as the Federal Constitution’s parallel provision.”<sup>199</sup> Additionally, the state constitution must also provide more individual protection than the Federal Constitution.<sup>200</sup> In these cases, the U.S. Supreme Court has no jurisdiction to review because it is considered a state issue.<sup>201</sup> This presents an interesting implication for health care delivery nationwide.<sup>202</sup>

Although exploring each state’s constitution in regard to whether the protections afforded their citizens go beyond the Federal Constitution is beyond the scope of this Note,<sup>203</sup> it is worth highlighting the policy implications of such a situation should laws like Massachusetts’s mandatory medical services legislation succeed in some states. Should these arguments become more prevalent,<sup>204</sup> as the state regulatory structure imposes more restrictions on licensees—including any laws structured like Massachusetts’s mandatory medical services legislation—the discussion on the varying scope of state constitutional protection of substantive due process may become a hot topic for health care delivery.

If some courts find that states have the authority to revoke licenses through statutory mandate, as proposed in Massachusetts’s mandatory medical services legislation, the potential negative policy implications for our federalist system would be legion. Where state constitutions offer more protections for the property rights of the license-holder, there exists the possibility that statutorily authorized license revocation laws will be struck down as unconstitutional in some states and not others. This could lead to a patchwork of state regulatory systems where, in some

---

<sup>199</sup> *Id.*

<sup>200</sup> *Id.* at 376–77; *see also* Schwartz, *supra* note 53, at 676 (“[S]ome states have defined ‘disability’ more broadly than the [federal] ADA.”).

<sup>201</sup> Fondacaro & Stolle, *supra* note 3, at 377.

<sup>202</sup> *Id.*

<sup>203</sup> State constitutionalism is a tricky area to analyze and is problematic for predicting when a state might grant their citizens more individual due process protection than a federal court. *See id.* (describing state constitutional law as a “wasteland of confusing, conflicting . . . pronouncements[,] [and] [s]eldom is it clear when a state supreme court will interpret their state constitution in a manner that provides their citizens with more protection”).

<sup>204</sup> Arguably, this attitude is presented most clearly through our country’s federalist stance. For example, there has been strong resistance by states to founding or expansion of state programs driven by federal order and funding, most recently over the expansion of Medicaid contained in the PPACA, which the Supreme Court found unconstitutional, *see Nat’l Fed. of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012), and the refusal of some states to run the state health exchanges mandated by the PPACA, *see, e.g., Robert Pear, Most Governors Refuse to Set Up Health Exchanges*, N.Y. TIMES (Dec. 14, 2012), <http://www.nytimes.com/2012/12/15/us/most-states-miss-deadline-to-set-up-health-exchanges.html>.

states physicians practice under a mandate to treat all patients who seek care from them and/or at a set rate of reimbursement, and in other states physicians would have more freedom in their choice of how many patients to accept and how to receive payment—that is running the business side of their practice. This could be exacerbated if insurance companies in the states mandating physician service through medical license revocation achieve greater bargaining power over physicians in those states.<sup>205</sup> If such a situation were to occur, this would also potentially create an uneven patchwork of *quality* of medical care in this country, as physicians potentially could migrate from the state markets that strictly regulate their freedom to practice, into states that offer more freedom and flexibility to determine how to deliver and how much to charge for the services they provide.<sup>206</sup>

In the alternative, however, Congress could make these issues moot through a massive redistribution of power between the federal government and the states regarding the power to issue professional licenses.<sup>207</sup> This redistribution of regulatory power is not altogether improbable. The federal government has intervened in state licensing regulatory schemes in the past by actually requiring “license restriction programs” for child support delinquency,<sup>208</sup> establishing minimum standards that states must meet when issuing commercial drivers’ licenses,<sup>209</sup> and standardizing state motor vehicle license identification cards.<sup>210</sup> Compared to these other federal initiatives, the PPACA vastly changed the power structure of the insurance regulatory process in the United States by superseding many of the regulatory functions that had traditionally been reserved for the states through their individual insurance

---

<sup>205</sup> See *supra* Part I.C (discussing bargaining between physicians and insurance companies for reimbursement rates).

<sup>206</sup> Of course, it should be noted that this effect alone might deter states from enacting a law like Massachusetts’s mandatory medical services legislation. But this also depends on the amount of future federal involvement in the licensing of medical doctors. See *infra* notes 209–11 and accompanying text.

<sup>207</sup> It is likely that licenses for non-professional activities like driving would not be able to come under federal control based on the state power protections of the Tenth Amendment. See Wesley M. Oliver, *A Round Peg in a Square Hole: Federal Forfeiture of State Professional Licenses*, 28 AM. J. CRIM. L. 179, 195 & n.95 (2001) (examining the federal government’s ability to revoke state-issued licenses due to the licensee’s criminal activity); cf. Kapp, *supra* note 8, at 417 (comparing the idea of medical services to that of a public utility).

<sup>208</sup> Fondacaro & Stolle, *supra* note 3, at 358 & n.9.

<sup>209</sup> 49 U.S.C. § 31131 (2006); see also *Commercial Driver’s License Program*, FED. MOTOR CARRIER SAFETY ADMIN., U.S DEP’T OF TRANSP., <http://www.fmcsa.dot.gov/registration-licensing/cdl/cdl.htm> (last visited Mar. 2, 2014). But note that the same statute also gave states the authority to create exemptions for some drivers. See, e.g., N.J. STAT. ANN. § 39:3-10j (2013).

<sup>210</sup> Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Tsunami Relief, 2005, Pub. L. No. 109-13, § 3, 119 Stat. 231 (2005) (issuing federal minimum standards that states must meet in issuing drivers license identification cards).

departments.<sup>211</sup> Beyond that, the industry is a huge part of the national GDP,<sup>212</sup> which arguably creates policy grounds for federal government regulation.

In summary, if challenges to state laws structured like Massachusetts's mandatory medical services legislation are upheld in some state courts and denied in others, it could create significant variations in quality and delivery of medical care between states, because those state issues are not within the jurisdiction of federal courts. Perhaps allowing the federal government to supersede state regulation of some industries that have traditionally been within the powers left to the states<sup>213</sup> is one way of ameliorating this theoretical problem but not likely to occur under the PPACA's current structure. If it were to occur, it would certainly be a slow evolution.

#### IV. POLICY OPTIONS: HOW WE MIGHT MOVE FORWARD

Moving beyond the discussion on substantive due process for professional licenses, we must also consider the factors that inspired bills like the Massachusetts mandatory medical services legislation in the first place—namely the longstanding national health care delivery crisis. There have been various suggestions about how

---

<sup>211</sup> See *State Health Insurance Mandates and the ACA Essential Benefits Provisions*, NAT'L CONFERENCE OF STATE LEGISLATURES (updated Dec. 31, 2013), <http://www.ncsl.org/issues-research/health/state-ins-mandates-and-aca-essential-benefits.aspx> (“To prevent Federal dollars going to state benefit mandates, the health reform law requires states to defray the cost of benefits required by state law in excess of essential health benefits.”). However, it should be noted that the law heavily utilized the state regulatory structures already in place. For example, the PPACA's mandate for an independent, external review of insurance claims denial seeks to take advantage of the fact that these processes are already in place in forty states. It does this by generally requiring all healthcare plans to be bound by existing state external review processes on the condition that they meet the minimum requirements of the federal external review process. EMP. BENEFITS SEC. ADMIN., U.S. DEP'T OF LABOR, TECHNICAL RELEASE 2010-01, INTERIM PROCEDURES FOR FEDERAL EXTERNAL REVIEW RELATING TO INTERNAL CLAIMS AND APPEALS AND EXTERNAL REVIEW UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 1–2 (Aug. 23, 2010), available at <http://www.dol.gov/ebsa/pdf/ACATEchnicalRelease2010-01.pdf>. The state external review process must be preapproved. *Affordable Care Act: Working with States to Protect Consumers*, CTR. FOR CONSUMER INFO. & OVERSIGHT, CTRS. FOR MEDICAID & MEDICARE SERVS., [http://cms.gov/CCIIO/Resources/Files/external\\_appeals.html](http://cms.gov/CCIIO/Resources/Files/external_appeals.html) (last visited Mar. 2, 2014).

<sup>212</sup> E.g., *Health Expenditure, Total (% of GDP)*, WORLD BANK, <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS> (last visited Mar. 2, 2014) (listing the expenses of the U.S. healthcare system as 17.9% of the total national GDP between 2009 and 2013). Also note that the Social Security Act created national health insurance programs that are federally funded, so healthcare is already arguably something that falls under the federal government's jurisdiction to regulate through the Commerce Clause.

<sup>213</sup> See *supra* Introduction.A (discussing the state police power under the Tenth Amendment).

to solve the problems with access to doctors.<sup>214</sup> Letting market forces solve the price issue with an influx of new doctors into the market is a valid one,<sup>215</sup> but increasing the number of doctors in this country is complicated given the residency requirements for practice and the way those residency programs are funded.<sup>216</sup> Alternatively, bringing more doctors into the U.S. market is an expensive endeavor and not necessarily a sound investment should trainees choose to leave the practice of medicine in another country or altogether.<sup>217</sup>

In his article, Marshall Kapp argues for an option placed before the consumer rather than force the service provider to conform to “command and control forms of regulation.”<sup>218</sup> His primary suggestion is that the success of tax-free “health care savings accounts,”<sup>219</sup> which allow employees to deduct pre-tax some of their paycheck into an account exclusively used for health care expenses, could be adapted to cover larger expenses than they currently do.<sup>220</sup> This Note proposes this concept could also be bolstered by the success of some dental programs that give “discounts” based on partnerships with some insurance groups but do not otherwise provide dental benefits.<sup>221</sup> Arguably this is the kind of market economics present in physicians competing among concierge services discussed earlier, and so those types of medical practices removing the insurance middleman should be encouraged rather than maligned or barred.<sup>222</sup>

---

<sup>214</sup> See, e.g., Smith, *supra* note 95, at 158–60 (suggesting legislating a maximum workload for primary care practitioners to combat the incentive for doctors to see as many patients a day as possible to meet insurance network reimbursement quota requirements).

<sup>215</sup> See Kapp, *supra* note 8.

<sup>216</sup> See *supra* note 133.

<sup>217</sup> E.g., Sarah Rainey, *The New Brain Drain (and Who Can Blame Them?)*, TELEGRAPH (Nov. 10, 2012, 7:30 AM), <http://www.telegraph.co.uk/expat/9667069/The-new-brain-drain-and-who-can-blame-them.html> (discussing the larger number of British doctors, among other professionals, who have trained in and then left the United Kingdom to pursue better salaries elsewhere).

<sup>218</sup> Kapp, *supra* note 8, at 420.

<sup>219</sup> See *Health Savings Accounts: Is an HSA Right for You?*, MAYO CLINIC, <http://www.mayoclinic.com/health/health-savings-accounts/GA00053> (last visited Mar. 2, 2014).

<sup>220</sup> Kapp, *supra* note 8, at 420.

<sup>221</sup> See Ashlea Ebeling, *Dental Discount Plans Beat Insurance*, FORBES (Oct. 29, 2009, 3:00 PM), <http://www.forbes.com/forbes/2009/1116/investing-dentist-medicare-dental-discount-plans-beat-insurance.html> (“For about \$100 a year you get access to a network of dentists who have agreed to work for the sort of reduced fees they accept when they sign up for an insurance plan’s preferred provider network.”); see also, e.g., *AETNA Dental Discount Program*, AETNA, <http://www.aetna.com/plans-services-health-insurance/detail/dental-insurance/dental-discount.html> (last visited Mar. 2, 2014) (describing the program as an “alternative to dental insurance”); cf. Kapp, *supra* note 8, at 240 (imagining a voucher program akin to “Food Stamp recipients [who] do not have a problem in finding food merchants who are willing to sell them their goods”).

<sup>222</sup> See *supra* Part I.C.

However, a major problem for some small practices are burgeoning administrative costs, as previously discussed. Thus, what actually may be far more productive is encouragement of *service provider* choice by encouraging new structures of medical practice delivery.<sup>223</sup> This might be better able to solve some of the physician shortage issues consumers face, especially for primary care services, because physicians are in a better position to understand elements of medical practice more efficiently than the average patient.<sup>224</sup> Perhaps it is not necessarily a negative thing that some doctors are selling their practices to hospitals or equivalent administrative entities who might be able to save more on administrative costs and better insulate themselves from risks.<sup>225</sup> However, this removes the element of autonomy that a physician has over his or her practice, which should not go unacknowledged, and working in such a situation may be hardly better than working under the Massachusetts legislation that this Note discusses. The taxing power of government has historically been used to persuade citizens to make personal choices of their own accord based on the incentive power of saving money.<sup>226</sup> A tax credit scheme might be used to encourage licensed medical practitioners to establish medical practices that are more efficiently structured and cost less to deliver care,<sup>227</sup> which could offset the varying insurance reimbursement rates the practice might encounter and be otherwise forced to pick and choose between.<sup>228</sup> These methods of addressing the

---

<sup>223</sup> See Debra A. Draper et al., *High-Performance Health Plan Networks: Early Experiences*, CTR. FOR STUDYING HEALTH SYS. CHANGE (May 2007), available at [http://www.massmed.org/advocacy/key-issues/health-care-reform/high-performance-health-plan-networks--early-experiences-\(pdf\)](http://www.massmed.org/advocacy/key-issues/health-care-reform/high-performance-health-plan-networks--early-experiences-(pdf)) (“At the market level, if these networks influence enough enrollees to shift to high-performing providers, physicians losing market share might be motivated to improve efficiency and quality to better compete.”); Kliff, *supra* note 75.

<sup>224</sup> Consider merely the impetus of agreements between medical personnel:

From a contractual standpoint, a physician’s refusal to treat patients . . . would be likely to jeopardize her staff privileges at a given hospital. Without staff privileges, she might be unable to practice medicine in that region . . . . This contractual relationship between physicians and hospitals creates strong professional, financial, and social pressures to ensure [treatment].

Schwartz, *supra* note 53, at 679.

<sup>225</sup> See Parija Kavilanz, *Doctors Bail Out on Their Practices*, CNN (July 16, 2013, 9:18 AM), <http://money.cnn.com/2013/07/16/smallbusiness/doctors-selling-practices/index.html>. Of course, this also means doctors would become employees or contractors of said hospitals, which could restrict professional autonomy in other ways.

<sup>226</sup> See, e.g., *Federal Incentives for Wind Power Deployment*, U.S. DEP’T OF ENERGY, <http://www1.eere.energy.gov/wind/pdfs/51452.pdf> (last visited Mar. 2, 2014) (“The federal government uses several tax-based policy incentives to stimulate the deployment of wind power.”).

<sup>227</sup> See Goodman & Fisher, *supra* note 75, at 1660–61.

<sup>228</sup> This Note presents this as an example of Kapp’s call for “other supply side policy interventions that economically empower, and hence make more desirable to physicians, individuals who otherwise would be unattractive additions to a physician’s practice roster because

health care delivery problem are potentially constructive ways of tackling the access problem without hamstringing the significant property rights in professional medical licenses that are protected by due process.

#### CONCLUSION

Licenses are property rights historically subject to substantive due process review. Their revocation, however, is usually upheld under rational basis review. Laws structured like Massachusetts's mandatory medical services legislation bring into focus the question of whether this standard is still acceptable in the modern world, where licensed professionals are much more common and a career is much closer to an intangible piece of property with significant investment of resources into that property than ever before.

Unlike the license revocation laws passed in response to defaults on child-support or student loans payments, a preexisting legal duty is not present where doctors have not yet entered into a contract to provide their services. Furthermore, unless state governments—or the federal government—are willing to expand radically the scope of the fiduciary duty of doctors from a mutually voluntary physician-patient relationship at the beginning of treatment<sup>229</sup> to the entire general public at large (as potential patients), a license revocation law structured like Massachusetts's mandatory medical service legislation cannot pass constitutional muster. Some regulation of medical care delivery is appropriate, but government regulatory efforts cannot undermine the validity of a professional's property interests in a license protected by due process in the civil context without the licensee's violation of a legal duty to another member of the public.

---

those individuals are victims of the negative financial incentives permeating the Medicare and Medicaid programs." Kapp, *supra* note 8, at 420.

<sup>229</sup> AMA Op. on Code of Med. Ethics, Op. 10.05—Potential Patients (2008), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion1005.page>.