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The Future of Telehealth in Medical Licensing Regulations Post-Pandemic in the United States: A Comparison to the European Union and Australia

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I. Introduction

The use of telehealth has expanded rapidly in the United States since the outbreak of the COVID-19 pandemic, and with it so did the attention it received from regulatory bodies.[1] Waivers and changes to telehealth regulations during the public health emergency include expansions in applicable medical licensing, coverage, reimbursement, and federal funding initiatives, among others.[2] For example, the Centers for Medicare and Medicaid Services ("CMS") expanded coverage for telehealth services during the pandemic to allow physicians to provide remote care to patients across state lines and require those service to be reimbursed at the same rate as in-person medical services.[3]

Emergency provisions that relaxed telemedicine standards are currently being observed and evaluated.[4] Extra focus is being drawn to issues relating to physician's licensure compliance and the capacity for fraudulent behavior by healthcare providers.[5] Many people advocate for states to uphold many of the licensing practices adopted during the pandemic, so that patients can continue to utilize telehealth as a convenient method of addressing their healthcare needs.[6]

The focus of this paper pertains to telehealth regulations in the specific context of medical licensing. Physicians would be able to provide telehealth services more widely if policies are adopted that permanently allow licensed physicians to practice across state lines. This paper will discuss different avenues for achieving this in the United States and compare the

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[1] Deborah R. Farringer, *ARTICLE: A TELEHEALTH EXPLOSION: USING LESSONS FROM THE PANDEMIC TO SHAPE THE FUTURE OF TELEHEALTH REGULATION*, 9 Tex. A&M L. Rev. 1, 3 (2021).
[2] *See generally* Farringer, *supra* note 1 (discussing types of waivers and changes in regulations related to telehealth to be enacted during the COVID-19 pandemic).
[3] Farringer, *supra* note 1, at 25-26; *MEDICARE TELEMEDICINE HEALTH CARE PROVIDER FACT SHEET: Medicare coverage and payment of virtual services*, CMS (May 12, 2023), https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet.
[4] Farringer, *supra* note 1.
[5] *Id.*
[6] *Id.*

United States medical licensure system to those of the European Union and Australia. Policies advocating the use of medical licenses across state lines should be implemented that lay significant focus on the use of telehealth services. Different approaches to enabling medical licensing across states will be discussed. The best approach for the United States to take is to encourage all states to participate in the IMLC. Adopting this approach for licensure more widely across the United States would improve telehealth access by reducing some of the existing barriers to the widespread adoption and use of telehealth nationwide.

II. Background

A. What is Telehealth?

Telehealth is the provision of healthcare at a distance using communications technology.[7] Telehealth is a broad term encompassing remote clinical and non-clinical services.[8] While often used interchangeably, telemedicine sometimes refers more specifically to the provision of remote clinical services.[9]

Telehealth necessarily includes the digital transmission of medical data and information through both text and video.[10] There are significant regulatory interests in ensuring such private information is securely transmitted.[11]

B. History of Telehealth

Telehealth as it is thought of today has existed since the 1960s, through projects of the National Aeronautics and Space Administration ("NASA").[12] NASA used it to respond to the

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[7] Avery Schumacher, *NOTE: Telehealth: Current Barriers, Potential Progress*, 76 Ohio St. L.J. 409, 416 (2015).
[8] *Id.*
[9] *Id.*
[10] *Id.*
[11] Shilpa N. Gajarawala & Jessica N. Pelkowski, *Telehealth Benefits and Barriers*, NATIONAL LIBRARY OF MEDICINE: NATIONAL CENTER FOR BIOTECHNOLOGY INFORMATION (May 12, 2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7577680/.
[12] Farringer, *supra* note 1, at 9.

medical issues astronauts experienced while in space.[13] A lack of technology prevented significant growth of telehealth from occurring until the 1990s, when the internet was developed for widespread use.[14]

The concept of telehealth has been around for a long time, but before the COVID-19 pandemic there were significant barriers that prevented its widespread use.[15] Telehealth services are subject to state licensure laws, which vary widely and can make it difficult or impossible for physicians to practice across state lines.[16] Reimbursement policies regarding telehealth also serve as a barrier, since reimbursement rates also vary widely among different states and payers.[17] Telehealth services are also subject to a range of privacy laws, such as HIPAA, informed consent requirements, restrictions on prescribing medication, and other regulations that can be incredibly varied and complex across states.[18] There are a number of potential liability risks associated with telehealth, particularly in circumstances where care is being provided to patients across state lines.[19] Compliance with regulations can be time-consuming and costly, which deters physicians from providing telehealth services.[20] Patient factors also bar the widespread use of telehealth. Many patients lack access to the technology needed to utilize telehealth services.[21] Others lack the knowledge or ability to sufficiently use such technology.[22] Patients may simply prefer in-person care and may be hesitant to adopt new technology or change their established care

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[13] *Id.*
[14] *Id.* at 6.
[15] Gajarawala & Pelkowski, *supra* note 11.
[16] *Id.*
[17] *Id.*
[18] *Id.*
[19] *Id.*
[20] Peter Critikos III, *License to Screen: A Review of the Medical Licensure Schemes Impacting Telehealth Proliferation in the United States, the European Union, and Australia*, 32 Emory Int'l L. Rev. 317, 319 (2018).
[21] Laura C. Hoffman, *ARTICLE: RECONNECTING THE PATIENT: WHY TELEHEALTH POLICY SOLUTIONS MUST CONSIDER THE DEEPENING DIGITAL DIVIDE*, 19 Ind. Health L. Rev. 351, 360 (2022).
[22] *Id.* at 379.

routines as a result.[23] These barriers, among others, have slowed or prevented the incorporation of telehealth into the United States healthcare system for a long time.

Advocates of telehealth have continued to push for more widespread use and availability, in part by trying to break down barriers from a law, policy, and ethics perspective.[24] These advocates believe that telehealth could provide valuable benefits to the United States healthcare system. Telehealth is said to enhance the provision of healthcare services to rural and medically underserved populations, foster more integrated care across platforms for providers treating the same patient, and bring greater convenience and efficiency for both patients and providers for the treatment of basic healthcare needs.[25]

The COVID-19 pandemic provided an unexpected opportunity to fully explore telehealth's advantages, as it created an ideal environment to see which concerns about and barriers to telehealth could potentially be overcome.[26] Federal and state restrictions implemented over the years to regulate telehealth were rapidly suspended as person-to-person contact needed to be extremely limited, and the use of telehealth exploded.[27] Instead of engaging in speculation, the United States had no choice but to witness the actual outcomes when exceptions were granted due to the extreme caution required for conducting in-person interactions.[28]

C. Benefits of Telehealth

[23] Racha Ftouni et al., *Challenges of Telemedicine during the COVID-19 pandemic: a systematic review*, NATIONAL LIBRARY OF MEDICINE: NATIONAL CENTER FOR BIOTECHNOLOGY INFORMATION (May 12, 2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9351100/.
[24] Farringer, *supra* note 1.
[25] *Id.*
[26] *Id.* at 4.
[27] *Id.*
[28] *Id.*

The United States has been experiencing a shortage of physicians, nurses, and other clinicians even prior to the COVID-19 pandemic.[29] Telemedicine programs, despite their increasing success, have not been able to keep pace with the shortage in specialist physicians as is.[30] The Association of American Medical Colleges has estimated that by 2025, the United States will lack as many as 90,000 physicians to cover the nation's healthcare needs.[31]

There is a significant disparity between available resources and services demanded, driven by two major factors.[32] First, the American population is increasingly aging and is therefore requiring greater medical attention.[33] Second, recent healthcare reform at the federal level has increased the number of people with health insurance, leading more people to seek healthcare they might not have been able to access in the past.[34]

As a result, when the pandemic began, an existing problem was made even worse.[35] Take a look at the demand for healthcare services since the pandemic, for example. The COVID-19 virus caused many more people to become sick, which increased the amount of people requiring medical attention.[36] The increase in demand due to people suffering from COVID-19 and the lingering symptoms related to it only put more strain on the healthcare system, highlighting the existing shortage of physicians across the United States.[37] In addition, the pandemic has had a

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[29] Paul J. Larkin, Jr., Marie Fishpaw & Lauren McCarthy, *ARTICLE: TELEMEDICINE AND OCCUPATIONAL LICENSING*, 73 ADMIN. L. REV. 747, 750 (2021).
[30] Critikos, *supra* note 20, at 324.
[31] *Id.*
[32] *Id.*
[33] *Id.*
[34] *Id.* at 324-25.
[35] Larkin, Fishpaw & McCarthy, *supra* note 29.
[36] *Impact of the COVID-19 Pandemic on the Hospital and Outpatient Clinician Workforce: Challenges and policy responses*, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION (May 12, 2023), https://aspe.hhs.gov/sites/default/files/documents/9cc72124abd9ea25d58a22c7692dccb6/aspe-covid-workforce-report.pdf.
[37] *Id.*

strong negative affect on the mental health and stamina of healthcare providers.[38] Many who were in the workforce prior to the pandemic have since left or reduced their working hours due to burnout or stress.[39] Many who were a few years away from retirement elected to retire early, further reducing the number of available physicians and increased the burden on those who remain.[40] For incoming physicians, the pandemic disrupted the education and training of medical students and residents.[41] Programs shifted to remote learning and restricted clinical learning experiences in-person trainings as much as possible, resulting in deferment of clinical experience and delays in the entry of new physicians into the workforce.[42] These factors will have long-term negative effects on the size of the physician workforce, exacerbating the shortage of physicians.[43]

Prior to the pandemic, Centers for Medicare and Medicaid Services ("CMS") and state guidance facilitated the use of telehealth for remote medical care in the United States.[44] Telemedicine was initially focused towards providing remote medical care when distance from in-person care made access difficult or impossible.[45] The Rural Health Care Pilot Program was established by the Federal Communications Commission in 2006 in order to provide funding for

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[38] Nishtha Gupta et al., *Impact of COVID-19 pandemic on healthcare workers*, NATIONAL LIBRARY OF MEDICINE: NATIONAL CENTER FOR BIOTECHNOLOGY INFORMATION (May 12, 2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8611576/.
[39] *Id.*
[40] Anish Bhardwaj, *COVID-19 Pandemic and Physician Burnout: Ramifications for Healthcare Workforce in the United States*, NATIONAL LIBRARY OF MEDICINE: NATIONAL CENTER FOR BIOTECHNOLOGY INFORMATION (May 12, 2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9206033/.
[41] Suzanne Rose, *Medical Student Education in the Time of COVID-19*, JAMA (May 12, 2023), https://jamanetwork.com/journals/jama/fullarticle/2764138.
[42] *Id.*
[43] Bhardwaj, *supra* note 40.
[44] Julia Shaver, *The State of Telehealth Before and After the COVID-19 Pandemic*, NATIONAL LIBRARY OF MEDICINE: NATIONAL CENTER FOR BIOTECHNOLOGY INFORMATION (May 12, 2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9035352/.
[45] Larkin, Fishpaw & McCarthy, *supra* note 29, at 751.

telehealth services in rural areas.[46] CMS established national guidelines for the use of telehealth services in Medicare programs, including the use of HIPAA-compliant videoconferencing technology.[47] It regulated what was federally permissible regarding who could perform and receive telehealth, where telehealth could be done, how telehealth services were reimbursed under Medicare, and what technology must be used for telehealth visits related to HIPAA compliance.[48] Many states established their own enabling statutes to regulate telehealth services within their jurisdictions.[49] These statutes varied in their requirements and guidelines, but they generally set standards for topics such as informed consent, licensure requirements, and reimbursement for telehealth services.[50]

Over time, telehealth has proved its value more broadly with a generally positive response from patients, physicians, and professional medical associations.[51] Significant players from these groups, such as the American Medical Association, have endorsed greater use of telemedicine, in part because of how it is capable of increasing the efficiency of healthcare amid provider shortages.[52]

1. Increase in Efficiency

Telemedicine provides both a mechanism for increasing the efficiency of available medical resources and a way to increase the effectiveness of available clinicians by allowing them to increase their treatment radius.[53] Treating patients remotely improves efficiency, as physicians can see more patients in a shorter amount of time and more patients are able to be

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[46] *Rural Health Care Program*, FEDERAL COMMUNICATIONS COMMISSION (May 12, 2023), https://www.fcc.gov/general/rural-health-care-program.
[47] Shaver, *supra* note 44.
[48] *Id.*
[49] *Id.*
[50] *Id.*
[51] Larkin, Fishpaw & McCarthy, *supra* note 29, at 751-52.
[52] *Id.* at 752.
[53] Critikos, *supra* note 20, at 325.

managed simultaneously.[54] This can reduce wait times for appointments and allow physicians to spend more time with each patient, which in turn can lead to better patient outcomes.[55] Also, expanding the treatment radius can facilitate collaboration of physicians with other healthcare professionals, such as specialists, nurses, and pharmacists.[56] This can lead to better coordination of care and improved patient outcomes.[57]

Physicians located across sparsely-populated areas who are being underutilized could lend a hand to regions that do not have enough providers to cover their populations without needing to leave their practice; likewise, they could receive assistance from surrounding areas when they are overbooked.[58] For example, allergists are busiest during Spring in the United States, when pollen levels rise and patients begin experiencing the first symptoms of seasonal allergies.[59] They are significantly less busy during Winter and at other times of the year when pollen levels are low and most allergy-afflicted individuals experience relief.[60] However, Texas is an exception to this pattern.[61] Their cedar trees are highly allergenic and peak in January.[62] As a result, there is a much higher need for allergists in Texas in January compared to other regions of the United States at the same time of year. With the use of telehealth across the United States, there could be increased flexibility for times of increased demand for appointments, without

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[54] Justin Greiwe, *Telemedicine in a Post-COVID World: How eConsults Can Be Used to Augment an Allergy Practice*, NATIONAL LIBRARY OF MEDICINE: NATIONAL CENTER FOR BIOTECHNOLOGY INFORMATION (May 12, 2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7211663/#bib5; Centaine L. Snoswell et al., *Determining if Telehealth Can Reduce Health System Costs: Scoping Review*, NATIONAL LIBRARY OF MEDICINE: NATIONAL CENTER FOR BIOTECHNOLOGY INFORMATION (May 12, 2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7605980/.
[55] Greiwe, *supra* note 54.
[56] *Id.*
[57] *Id.*
[58] *Id.*
[59] *Making the Most of Your Spring Allergy Visit*, AMERICAN ACADEMY OF ALLERGY ASTHMA & IMMUNOLOGY (May 12, 2023), https://www.aaaai.org/tools-for-the-public/conditions-library/allergies/spring-allergy.
[60] *Id.*
[61] *Id.*
[62] *Id.*

needing to allocate more physicians to a particular practice than is needed at other points of the year.

2. Reduction of Cost

The United States spends more per capita on healthcare than any other Organization for Economic Cooperation and Development (OECD) country.[63] As a result, many healthcare services are unaffordable for the majority of consumers.[64] Both public and private insurers have raised insurance premiums to offset high costs.[65] Moreover, the rate at which insurance premiums have increased has outpaced the more gradual growth of wages and the cost of living in the United States.[66]

In general, it is not clear how much telemedicine will reduce costs in the healthcare system itself.[67] Physicians will still require offices and medical and diagnostic equipment for the patients who choose to or need to conduct visits in person; however, they will be able to reduce the amount of office locations previously maintained in different regions that can be serviced remotely.[68] The most significant cost associated with seeing a physician is the cost of the physician's time, which remains largely the same between in-person and telemedicine visits.[69]

However, return to the shortage of specialist physicians in the United States that has been mentioned. Keeping specialist physicians on staff is a significant cost to hospitals and medical practices who need such services.[70] By allowing hospital-employed physicians to consult with specialists via telehealth when they are needed, instead of employing specialist physicians

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[63] Critikos, *supra* note 20, at 323.
[64] *Id.* at 323-24.
[65] *Id.* at 324.
[66] *Id.*
[67] Snoswell et al., *supra* note 54.
[68] *Id.*
[69] *Id.*
[70] Critikos, *supra* note 20, at 324.

directly, hospitals can cut costs in their staffing.[71] Areas with especially low saturations of specialist physicians can consult via telehealth with providers who would otherwise be inaccessible due to both high cost and scarcity of keeping specialists on staff.[72] That applies to areas with scarcities of general physicians as well.[73]

Transportation costs associated with attending in-person medical visits are another form of cost that is cut when telehealth services are utilized.[74] This includes the costs of vehicles and gas, or alternatively the cost of ticket prices for means of public transportation or ride-sharing.[75]

3. Reduction in Health Care Disparities

There are currently many individuals who lack access to healthcare because of geographic limitations, including those requiring home healthcare, those interned within correctional facilities, and those living in remote, rural areas.[76] Transportation, distance, and mobility are all factors that contribute to the significant racial and socioeconomic health disparities that divide the health of large populations of the United States.[77] They are not just barriers in their own right, but also barriers disproportionally affecting otherwise marginalized racial and socioeconomic groups.[78] Telehealth offers patients and healthcare providers the means to help close the gaps and combat these prevalent public health issues.[79]

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[71] *Id.*
[72] *Id.*
[73] *Id.*
[74] Samina T. Syed, Ben S. Gerber & Lisa K. Sharp, *Traveling Towards Disease: Transportation Barriers to Health Care Access*, NATIONAL LIBRARY OF MEDICINE: NATIONAL CENTER FOR BIOTECHNOLOGY INFORMATION (May 12, 2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4265215/.
[75] *Id.*
[76] Schumacher, *supra* note 7, at 418.
[77] *Id.*
[78] *Id.* at 417.
[79] *Id.* at 417-18.

Transportation is a substantial factor in healthcare disparities related to socioeconomic status.[80] At its simplest, poorer populations are less likely to own a car or have access to transportation to and from in-person medical visits.[81] Further, many who have access to public transportation or transportation of some other form are unable to afford the costs associated with such transportation.[82] This includes gas prices, ticket costs, and the cost of time not spent working when individuals have to take time off to travel to appointments.[83]

Separate from transportation, distance places a significant role in health care disparities. Populations living in remote, rural settings have to travel longer distances to access the same healthcare as populations living in urban, more densely populated regions.[84] Many have to travel dozens of miles to reach the nearest treating physician.[85] For specialized care, that distance can stretch to hundreds of miles.[86] This affects people with differing socioeconomic statuses to significantly disparate degrees.[87] For people of higher socioeconomic status, it is more likely to be feasible to take that time and travel those distances.[88]

People who live paycheck to paycheck are less likely to be able to take time off of work to travel any sort of distance, and significant distances are made impossible to travel both by cost of gas and cost of time needed to be taken off of work.[89] Some specialized healthcare services are far enough away that overnight travel is required, which is another cost that closes off access to many.[90] Elderly patients may no longer be able to drive, or may no longer have any means to

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[80] Syed, Gerber & Sharp, *supra* note 74.
[81] *Id.*
[82] *Id.*
[83] *Id.*
[84] *Id.*; Critikos, *supra* note 20, at 318.
[85] Critikos, *supra* note 20, at 318.
[86] *Id.*
[87] Syed, Gerber & Sharp, *supra* note 74.
[88] *Id.*
[89] *Id.*
[90] Critikos, *supra* note 20, at 318.

travel at all.[91] Limitations on mobility prevent populations of the elderly, the disabled, and the chronically ill from being able to physically transport themselves to in-person visits, or create a significant burden on their lives if they are able to do so with difficulty.[92] Proximity to care is a factor not just in poorer populations, but also for women and individuals who are responsible for raising children, foster parents, or any other form of caregiver.[93]

D. Risks of Telehealth

Telehealth offers many benefits, but there are also some potential risks and drawbacks that should be considered. In particular, many debate the quality and security of remote care compared to in-person visits.[94] First, telehealth visits often limit the ability to provide comprehensive physical examinations, which can limit physicians' ability to make accurate diagnoses and provide appropriate treatments.[95] Second, since telehealth visits require a reliable internet connection and access to relevant technology, such as a computer or smartphone with a camera and microphone, technical issues related to poor connectivity and device malfunctions are likely to result.[96] Such technical difficulties can limit the quality and effectiveness of telehealth visits. For some patients and physicians, interactions through a screen may lack a personal connection that is more present with in-person visits.[97] Patients may have trouble building a rapport with their physicians.[98] They may also feel more hesitant to discuss sensitive information through a screen, due to a lack of comfort or a heightened concern about privacy and security.[99] Telehealth services necessarily require the use of technology to transmit protected or

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[91] *Id.*
[92] *Id.*
[93] Syed, Gerber & Sharp, *supra* note 74.
[94] Ftouni et al., *supra* note 23.
[95] Gajarawala & Pelkowski, *supra* note 11.
[96] Ftouni et al., *supra* note 23.
[97] *Id.*
[98] *Id.*
[99] *Id.*

personal health information.[100] As a result, telehealth requires physicians to take increased measures to ensure that patient health information is protected and secure.[101] Greater use of technology involves greater risk for privacy and security breaches.[102] It is important to recognize these factors when discussing the use of telehealth so that attention can be placed on mitigating these risks and drawbacks as much as possible.

III. Licensure and Telehealth

A. Overview of Medical Licensing

The purpose of licensing at its most basic level is to allow governments to ensure that individuals that seek to practice a particular occupation satisfy minimum qualifications.[103] The substance of those qualifications differ in scope and strength depending on the agency setting them and the strength of the agency's interest in safeguarding the practice of the occupation.[104] In the medical field, licensing allows state medical boards to assert control over and restrict entry into the medical field for the purpose of protecting the interest of public health and safety.[105] The ultimate goal is to protect the public from fraudulent and incompetent healthcare professionals by ensuring that only those who are appropriately trained and sufficiently knowledgeable can provide healthcare services.[106]

From another perspective, medical licensure boards are seen as a way to limit market competition so that established physicians within the state, or other jurisdiction type, can maintain financial profit for their own benefit.[107] They do this by exercising control over

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[100] Gajarawala & Pelkowski, *supra* note 11.
[101] *Id.*
[102] *Id.*
[103] Critikos, *supra* note 20, at 327.
[104] *Id.*
[105] *Id.*
[106] *Id.*
[107] Critikos, *supra* note 20, at 327-28; Larkin, Fishpaw & McCarthy, *supra* note 29, at 771-72.

licensure to prevent new or competing physicians from entering the market.[108] The argument is that increased competition from physicians entering the market can lead to physicians being forced to lower their prices in order to remain competitive.[109] Limiting market competition can therefore protect established physicians from some of the negative effects of competition.[110] The other side to this argument focuses on the benefits of competition. Greater market competition can lead to increased efficiency, lower costs for services, and greater innovation in healthcare.[111] Increased competition often means improved access to care and lower costs for patients.[112] Ultimately, there are valid arguments on both sides regarding the role of medical licensure boards in regulating licensing requirements and market competition in healthcare.

No matter what the underlying motivations are on the agency level regarding the imposition of regulations and controls, a medical license indicates to the public that that a particular physician is qualified to practice medicine.[113] Licensure systems came to be out of the fundamental ideas that 1) the general public does not have the knowledge or expertise to safeguard their own interests here, and 2) reliance must be placed upon the assurance given by a physician's license, issued by an authority competent to judge in that respect, that they possess the requisite qualifications.[114]

The United States operates under a state-based medical licensure system.[115] States have authority to regulate the practice of medicine derived from the police powers granted by the

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[108] *Id.*
[109] *Id.*
[110] *Id.*
[111] *Competition in the Health Care Marketplace*, FEDERAL TRADE COMISSION (May 12, 2023), https://www.ftc.gov/advice-guidance/competition-guidance/industry-guidance/competition-health-care-marketplace#:~:text=Competition%20in%20health%20care%20markets,anticompetitive%20conduct%20that%20harms%20consumers.
[112] Larkin, Fishpaw & McCarthy, *supra* note 29, at 771-72.
[113] Critikos, *supra* note 20, at 327.
[114] Critikos, *supra* note 20, at 327-28; Larkin, Fishpaw & McCarthy, *supra* note 29, at 771-72.
[115] Critikos, *supra* note 20, at 328.

Tenth Amendment of the United States Constitution.[116] The Supreme Court has held that the state interest in protecting its citizens extends to the regulation of medical licensing.[117] In *Dent v. West Virginia*, the Supreme Court upheld a state medical licensing requirement and held that a state has the authority to limit a profession to a small number of individuals who have demonstrated the necessary qualifications of learning and skill to safely perform the profession.[118] Thus, each state has the power through its own medical practice act to regulate the physicians and medical professionals that seek to practice in its territory.[119] Authority is given to the state medical board to regulate licensing, including measures for granting medical licenses, renewing medical licenses, and regulating the ethical practice of medicine.[120]

B. Licensure as a Barrier to Providing Telehealth Services

State licensing regulations typically prevent out-of-state physicians from rendering medical services of any sort to a state's residents where the physician is not licensed to practice in that state.[121] The medical licensure system therefore requires physicians to obtain separate licenses for each state they wish to practice in.[122] This applies generally, regardless of whether the services are rendered remotely or not.[123] The concept reflects concerns about economic loss from licensing fees and revenues, market saturation, and a general desire to have authority over the quality and safety standards of the medical profession.[124] Many states maintain this strict position for the practice of telehealth, and states that have elected to create licensure exceptions

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[116] U.S. Const. amend. X.
[117] Larkin, Fishpaw & McCarthy, *supra* note 29, at 773-74.
[118] Larkin, Fishpaw & McCarthy, *supra* note 29, at 773 (citing *Dent v. West Virginia*, 129 U.S. 114, 9 S. Ct. 231 (1889)).
[119] Larkin, Fishpaw & McCarthy, *supra* note 29, at 773-74.
[120] *Id.*
[121] Farringer, *supra* note 1, at 9.
[122] *Id.*
[123] *Id.*
[124] *Id.*

or special licenses for telehealth are often limited to situations in which telehealth services are delivered infrequently.[125]

Physician practices often face substantial expenses due to the complexity of state laws.[126] Obtaining each license separately and maintaining compliance with differing and complex state laws can result in significant business expenses for physicians, imposing costs that many physicians cannot or do not wish to take on for the sake of providing telehealth services across state lines.[127] State medical practice acts contain significant variations in such things as what defines the practice of medicine, what conduct constitutes the unlawful practice of medicine, and other general licensure requirements for obtaining, renewing, and otherwise maintaining a license once granted.[128]

For many physicians, the cost of licensing fees and the effort required to comply with complex licensing regulations is an insurmountable obstacle or has offered too little benefit to justify the investment of time and resources.[129] State-specific requirements impose significant burdens on physicians who wish to incorporate the use of telehealth into their practices.[130] This makes licensure regulations one of the most formidable barriers to the growth and widespread use of telehealth services in the United States.[131] But with the rise of telehealth, many states have been compelled to reconsider their approaches to medical licensure.[132]

C. The Interstate Medical Licensure Compact

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[125] *Id.*
[126] Critikos, *supra* note 20.
[127] *Id.*
[128] *Id.*
[129] Farringer, *supra* note 1, at 9.
[130] *Id.*
[131] *Id.*
[132] *Id.*

Since 2017, the Federation of State Medical Boards ("FSMB") introduced a model compact which states adopted to create the Interstate Medical Licensure Compact ("IMLC"), an agreement among participating states to streamline the medical licensing process for qualifying physicians who seek to practice in multiple states.[133] The FSMB is a national non-profit organization that represents the medical boards within the United States and its territories.[134] It introduced the IMLC as a means of facilitating the process of obtaining medical licensure across state lines.[135]

The goal of the IMLC was to extend the general reach of physicians, improve access to specialist physicians, and capitalize on the use of new medical technologies for things like telehealth.[136] Eligible physicians can complete one application with the IMLC and leverage it to receive a separate license from each state in which they seek to practice, provided that each of those states is also a participant in the IMLC.[137] This has important implications for telehealth, as it allows physicians to provide telehealth service to patients across state lines without the need to obtain separate licenses in each state.[138]

However, the IMLC as it stands now is not a full solution for the challenges related to telehealth regulations in medical licensing. The eligibility requirements for this program are fairly strict and the application process is still burdensome enough to physicians such that it

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[133] *GENERAL FAQs ABOUT THE COMPACT*, INTERSTATE MEDICAL LICENSURE COMPACT (May 12, 2023), https://www.imlcc.org/faqs/#:~:text=In%20an%20effort%20to%20maximize,traditional%20medical%2Dlicense%20application%20processes.

[134] *Federal Grant Awarded to Expand Interstate Medical Licensure Compact; Support License Portability for PAs*, FEDERATION OF STATE MEDICAL BOARDS (May 12, 2023), https://www.fsmb.org/advocacy/news-releases/federal-grant-awarded-to-expand-interstate-medical-licensure-compact.

[135] *Id.*

[136] *About The Compact*, INTERSTATE MEDICAL LICENSURE COMPACT (May 12, 2023), https://www.imlcc.org/a-faster-pathway-to-physician-licensure/.

[137] *Id.*

[138] *Id.*

limits the rate at which telehealth could be expanding under this program.[139] Since not all states have joined the IMLC, in many states physicians still need to obtain separate licenses even if they are located in a participating state. But with pressure increasing recently to provide more flexibility and improved access to necessary healthcare services, thirty-seven states, the District of Columbia, and the Territory of Guam currently participate in some capacity.[140] More states are currently in discussions to introduce legislation to join the IMLC.[141] The IMLC may be able to help facilitate change in the expanding practice of telehealth by easing some of the difficulty caused by the state medical licensing system.[142]

D. Waivers and Regulatory Changes to Medical Licensing and Telehealth in Response to COVID-19

The Secretary of Health and Human Services ("HHS") declared a public health emergency in January 2020 in response to confirmed cases of COVID-19.[143] This led to drastic changes in the delivery of healthcare services in a short period of time to accommodate the heightened need to keep patients and physicians safe as well as the government orders for individuals to stay at home or in isolation from others.[144] The declaration has been renewed more than ten times since then, most recently as of February 9, 2023, so the federal public health emergency remains ongoing at this time.[145] It has been announced, however, that the state of emergency will officially end on May 11, 2023.[146] States who tied licensure policies to the end of

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[139] *Id.*
[140] *Id.*
[141] *Id.*
[142] *Id.*
[143] *Declarations of a Public Health Emergency*, HHS (ASPR) (May 12, 2023), https://aspr.hhs.gov/legal/PHE/Pages/default.aspx.
[144] Farringer, *supra* note 1, at 47.
[145] *Declarations of a Public Health Emergency*, *supra* note 143.
[146] *Fact Sheet: End of the COVID-19 Public Health Emergency*, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (May 12, 2023), https://www.hhs.gov/about/news/2023/05/09/fact-sheet-end-of-the-covid-19-public-health-

the federal public health emergency are about to experience the end of such policies, unless those states elect to alter their policies or otherwise adopt them permanently.[147]

These changes included widespread and broad waivers of the existing telehealth restrictions and limitations in place at that time.[148] Federal agencies, state agencies, and private payors all implemented changes to their telehealth standards and regulations, in some cases effectuating complete waivers of existing regulations and in others cases creating more targeted exceptions to existing laws for the practice of telehealth.[149] For medical licensing exceptions, the primary focus was on waivers and regulatory exceptions that went into effect on the state level in response to the COVID-19 public health emergency. Federal waivers geared towards enabling increased use of telehealth services during the public health emergency did not supersede state laws and regulations.[150] It was up to each state to make changes and provide waivers to the extent they wished to ease restrictions on medical licensing for the use of telehealth services.[151] Almost all the states temporarily waived medical licensing restrictions to allow physicians with equivalent out-of-state medical licenses to provide telehealth services within their state.[152]

On the federal level, CMS waived the Medicare program's requirement that a provider be licensed in the state in which telehealth services are delivered.[153] However, this waiver only applies to medical licensure within the context of Medicare coverage and reimbursement.[154]

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emergency.html#:~:text=At%20the%20end%20of%20the%20COVID%2D19%20PHE%20on%20May,19%20Vaccination%20Program%20Provider%20Agreement.

[147] Cynthia Cox et al., *The End of the COVID-19 Public Health Emergency: Details on Health Coverage and Access*, KFF (May 12, 2023), https://www.kff.org/policy-watch/the-end-of-the-covid-19-public-health-emergency-details-on-health-coverage-and-access/.

[148] Farringer, *supra* note 1, at 22.

[149] *Id.*

[150] *Id.* at 32.

[151] *Id.*

[152] *Id.*

[153] *Id.* at 26.

[154] *Id.*

CMS's licensing waiver does not supersede state medical licensure laws, which are ultimately responsible for determinations of medical licensing standards state by state.[155]

The declaration of a public health emergency by HHS did not necessarily require states to issue waivers or otherwise take action in regard to their telehealth restrictions.[156] However, many states made changes during this time that mirrored the federal changes implemented in the Medicare program, expanding reimbursement and coverage for telehealth services on the state level under their Medicaid programs.[157] Differing state approaches to telehealth prevented widespread uniformity in state Medicaid waivers for telehealth services.[158] However, all the states and the District of Columbia effectuated waivers to the restrictions preventing licensed physicians from providing telehealth services to Medicaid beneficiaries across state lines.[159] In this way, licensing changes were consistent across the states.[160] Just as with the Medicare program, these state Medicaid waivers only ease licensing restrictions for the purpose of Medicaid coverage and reimbursement.[161]

As of Fall 2021, at least two states have adopted their telehealth waivers permanently in order to increase use of and access to telehealth services beyond the pandemic.[162] Idaho cited the pandemic as proving they could advance healthcare through telehealth and make licensing easier without compromising patient safety.[163]

IV. A Comparison of the United States to the European Union and Australia

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[155] *Id.*
[156] *Id.* at 29.
[157] *Id.*
[158] *Id.* at 30.
[159] *Id.*
[160] *Id.*
[161] *Id.*
[162] *Id.* at 33.
[163] *Id.*

The scope of medical licenses granted in the United States are generally limited by state boundaries, but there are different medical licensing systems and telehealth practices outside the United States that are not limited by this type of barrier.[164] Other nations and supranational entities can be observed for their strengths, so that they can serve as models of how to implement more progressive systems for regulating medical licensure in telehealth in the United States.[165] This section examines the European Union and Australia.

Just like in the United States, telehealth provides an important means of improving access to healthcare services and reducing the costs associated with traveling for visits and employing specialist physicians in the European Union and Australia.[166] Both the European Union and Australia have similar problems as the United States related to specialist physician shortages in rural areas, as well as a scarcity of general availability of services due to increasing demand from aging populations.[167] Telehealth provides a modern avenue for reducing these issues both in the United States and abroad in the European Union and Australia.[168]

The European Union has a medical licensure system based around its Member States, each a sovereign nation in its own right, compared to the state-based system the United States has within a single federal republic.[169] However, the European Union allows for the cross-border delivery of telehealth medical services at no additional burden to physicians fully licensed in a member state.[170] Australia, on the other hand, possesses a federal medical licensure system,

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[164] Critikos, *supra* note 20, at 319-20.
[165] *Id.* at 320.
[166] *Id.* at 337.
[167] *Id.* at 332, 338.
[168] *Id.* at 337.
[169] *Id.* at 320.
[170] *Id.*

where federal registration for a medical license affords physicians the ability to practice medicine in every state and territory.[171]

A. European Union

In the European Union, member states have seen success in expanding access to telehealth services during the pandemic.[172] This is due at least in part to their regulations on medical licensure.[173] The European Union's licensing system is set up similarly to the United States, where each individual member state sets their own licensing standards and requirements.[174] However, the European Union adopts a different licensing policy for providing treatment across borders for purposes such as telehealth.[175] They adhere to what is known as the "country-of-origin principle."[176]

Under the country-of-origin principle, a physician in the European Union is able to practice medicine legally so long as they 1) comply with the licensure requirements of their own member state and 2) treat the patient or patients from within their own member state.[177] It supersedes the requirements in any of the other member states, regardless of which member state the patient is located in. [178] In other words, physicians properly licensed in one member state are authorized to provide telehealth services to patients in any other member state. They are operating under what is called a mutual recognition program, rather than a uniform licensing system or a completely disjointed state-based system.[179] The term is derived from the member

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[171] *Id.* at 339-40.
[172] Dana Pirvu & Rachel Snyder, *E.U. Way Ahead of the Game on Telehealth*, EPSTEIN BECKER GREEN (May 12, 2023), https://www.healthlawadvisor.com/2013/03/21/e-u-way-ahead-of-the-game-on-telehealth/.
[173] *Id.*
[174] *Id.*
[175] *Id.*
[176] *Id.*
[177] *Id.*
[178] *Id.*
[179] Critikos, *supra* note 20, at 334.

states' recognition of the professional qualifications of physicians as established through the licenses granted by other Member States.[180] The mutual recognition program was first adopted by the European Union in 2005, but at the time it did not include telehealth and applied only to situations where a licensed physician physically moved from one member state to another to provide medical services.[181] In 2011, the scope expanded to include telehealth through an adjustment of definitions, in part for the purpose of providing legal certainty for businesses and consumers.[182]

The European Union mutual recognition model demonstrates a starkly opposite treatment of cross-border licensing for telehealth from within a system similar to the United States system, where the physician in general must be licensed in the state in which the patient is located. It is a much less complex and less burdensome solution than even the IMLC provides, as there is no separate application needed to able to leverage an individual's medical license in a cross-border capacity. It is not a uniform licensure system, but rather a legal right that is awarded automatically upon receipt of a proper medical license.[183] Thus, while other barriers remain in the way of telehealth growth, the European Union did not need to adopt waivers or changes to their licensing regulations to allow for the use of telehealth to expand.[184]

The European Union therefore stood in a much better position for the rapid adoption and expansion of telehealth at the beginning of the COVID-19 pandemic, since medical licensing did not stand as a barrier to the provision of telehealth services widely across the member states.

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[180] *Id.*
[181] *Id.*
[182] *Id.*
[183] *Id.*
[184] *Id.*

Patients were not restricted to physicians within their member state when seeking access to medical services remotely became necessary.

B. Australia

Australia has a federal system model for general medical registration, governed by the Medical Board of Australia.[185] It follows that physicians registered with the Medical Board of Australia can practice medicine in every Australian state and territory. Australia's system of a single national agency allows it to single-handedly enforce registration and renewal for all medical professionals in the country.[186]

The laws, regulations, and regulatory agencies governing the practice of medicine in Australia do not distinguish between the in-person practice of medicine and the practice of medicine through telehealth.[187] Guidance was later issued by the Medical Board of Australia which established that physicians registered under the federal licensing system can engage in technology-based patient consultations across jurisdictional borders within the country.[188] As a result, the same standards that apply to traditional healthcare delivery apply to telehealth services and technologies, which allows for very portable registration of physicians.[189]

Prior to adopting their current federal system, the Australian system of medical licensing had a similar state-based approach as the United States and the European Union.[190] Recent legislative reform, adopted in 2010, implemented the system governed by the Medical Board of Australia, in response to similar difficulties as the ones at the forefront of discussion in the United States today.[191] Physicians experienced similar problems when they sought to practice

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[185] *Id.* at 320.
[186] *Id.* at 339-40.
[187] *Id.* at 340.
[188] *Id.*
[189] *Id.*
[190] *Id.* at 341, 343.
[191] *Id.* at 341.

medicine across state or territorial lines, and regulatory barriers related to this prevented physicians who wished to expand their practices across jurisdictional boundaries from doing so.[192] Each state and territory legislature had to separately enact the same legislative framework for this concept to come to fruition.[193] The adoption of this system has not eliminated other existing barriers to the expansion of telehealth, but medical licensing in particular has not stood in the way of the growth of telehealth.[194]

An attempt to adopt a federal system would be a large undertaking for the United States, as the state power to regulate the practice of medicine stems from both the Supreme Court and the United States Constitution.[195] However, Congress has the authority to enact legislation to regulate interstate commerce, and in case of a conflict between federal and state laws, federal law prevails under the Supremacy Clause.[196] There is something to be learned about the Australian system for medical registration. It has in common with the European Union that physicians do not have to face additional expenses and burden to leverage a proper medical license for the provision of telehealth services across state lines. It is the most straightforward option, in stark contrast to the United States, in that there is only one set of uniform requirements for qualification, training, renewal, and overall maintenance of the medical license once earned.

The United States is in need of both unity and simplicity in its system for medical licensing. Perhaps the unified system Australia is showing is something the United States can strive for in some form through the IMLC, through encouragement of state participation and streamlining of the eligibility requirements and application process. By working to ease the

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[192] *Id.*
[193] *Id.* at 343
[194] *Id.* at 343-44.
[195] *Id.* at 328.
[196] U.S. Const. art. 1, § 8, cl. 3.; U.S. Const. art. 6, cl. 2.

strictness of the standards required for participation in the IMLC it would encourage physicians to incorporate telehealth technologies into their practices for the provision of medical services across IMLC-participating state lines.

V. Going Forward: Rethinking Regulations and the Future of Telehealth

Overall, the state and federal actions during the COVID-19 pandemic related to medical licensing restrictions in telehealth have enabled greater access to healthcare services and increased capacity for physicians to leverage their state medical licenses for the provision of telehealth services across state lines.[197] Telehealth services have helped to promote efficiency in the healthcare system and minimize the spread of infectious diseases in healthcare settings.[198] Telehealth is a valuable tool for reducing barriers to accessing healthcare and helping to reduce racial, socioeconomic, and other entwined health disparities related to transportation, distance, and mobility.[199]

The COVID-19 pandemic has been a powerful driving force for discourse and discussion on the topic of telehealth, with it being forced to the forefront by imposed periods of isolation and a continued need for healthcare services during the public health emergency.[200] It has encouraged many physicians, hospitals, and healthcare systems to incorporate telehealth into their practices for the first time or to expand the services which they provide in remote form.[201] Patients are able to receive care from the comfort and security of their own homes. Both patients and providers were forced to learn how to use telehealth technologies quickly and out of necessity.[202] This will have a lasting impact on the use of telehealth in the delivery of healthcare,

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[197] Farringer, *supra* note 1, at 35.
[198] *Id.*
[199] Schumacher, *supra* note 7, at 418.
[200] Farringer, *supra* note 1.
[201] *Id.*
[202] Farringer, *supra* note 1, at 35-36.

as both patients and physicians have experienced the capabilities of telehealth technologies and grown accustomed to the widespread availability of telehealth services.[203] The increased ability to use telehealth during the COVID-19 pandemic, as well as the waivers and changes to law effectuated in this time, will pave the way for future use of telehealth services and developing trends in the adoption of less restrictive telehealth laws and regulations.[204]

After examining the European Union and Australian models, policies that facilitate the use of medical licenses across state lines should be prioritized in order to facilitate the widespread use of telehealth services. The European Union is the better model to try and emulate in the United States, as the member state-based system for medical licensing is more comparable to the state-based system of the United States than the federal medical licensing system in Australia. It can best be adopted through encouraging all states to participate in the IMLC.

Congress has the authority to establish a federal medical licensing system for provision of cross-state medical services, including telehealth services, under the Commerce Clause of the United States Constitution.[205] It could enact legislation for a system similar to EU's mutual recognition program, and federal legislation would preempt any conflicting state laws. However, legislation to that effect would need to comply with other constitutional provisions, such as the Due Process Clause, and would likely face significant political and legal challenges.

The Due Process Clause requires that individuals be afforded certain procedural and substantive protections before being deprived of their rights or property by the government.[206] Any legislation enacted by Congress, in this case a federal licensing system to enable the provision of medical services across state lines, would need to comply with the requirements of

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[203] *Id.*
[204] *Id.*
[205] U.S. Const. art. 1, § 8, cl. 3.
[206] U.S. Const. amend. XIV, § 2.

due process, which can include notice and an opportunity to be heard, fair treatment under the law, and protection of individual rights.[207] Depending on the specific details of the legislation and the rights and interests it would affect, compliance with due process could be a point of heavy political or legal contention. Stakeholders may argue that the proposed system is overly burdensome or violates individual rights.[208] In such circumstances, challenges to the legislation may arise in the form of lawsuits or other forms of opposition, which could significantly delay or potentially derail its implementation.[209] Political opposition could arise from concerns over federal encroachment on states' rights or the potential impact on established medical licensing boards.[210] Moreover, the establishment of a federal licensing system would require a new federal agency to enforce the rules that are set, adding additional administration and costs to the federal government.[211]

Another approach to implementing a system modeled after the EU would be for all states to adopt changes to their policies in order to allow for medical licensing across state lines. State medical boards have already begun to shift towards encouraging the implementation of telehealth services. State by state there has been a visible shift since the COVID-19 pandemic towards letting go of some of the fear of fraud and desire for market control that dominated legislative thought for the past few decades.[212] Like Australia did, many of these states could and should

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[207] U.S. Const. amend. XIV, § 2.
[208] *Telemedicine: A Guide to Assessing Telecommunications in Health Care*, *The Policy Context of Telemedicine*, NATIONAL LIBRARY OF MEDICINE: NATIONAL CENTER FOR BIOTECHNOLOGY INFORMATION (May 12, 2023), https://www.ncbi.nlm.nih.gov/books/NBK45446/.
[209] *Id.*
[210] *Id.*
[211] Shirley Svorny, *Liberating Telemedicine: Options to Eliminate the State-Licensing Roadblock*, CATO INSTITUTE (May 12, 2023), https://www.cato.org/policy-analysis/liberating-telemedicine-options-eliminate-state-licensing-roadblock.
[212] Farringer, *supra* note 1, at 35-36.

adopt the waivers and changes enacted during the public health emergency to relax the burden licensing regulations play on the growth of telehealth in the United States.

Another path and the best one for adopting a system similar to the EU's mutual recognition program would be to push for participation of all states in the IMLC. The IMLC provides a strong route for states to take, whereby they might utilize a more uniform set of requirements to be implemented to make a qualifying medical license obtained in one IMLC state valid for use in telehealth across all other IMLC states. This approach is favorable because it involves asking states to adopt an already established set of uniform standards, rather than relying on each state to draft and implement changes individually that may continue to vary wildly in scope and requirements. Each approach to enabling medical licensure across state lines would encounter resistance from state medical boards and related stakeholders, who may view such changes as an encroachment on their authority. But the IMLC has continued to expand in its reach throughout the pandemic, and it provides the best route to enabling physicians to provide telehealth services across state lines without having to obtain individual licenses from each state, promoting the widespread use of telehealth as a result.

VI. Conclusion

Medical licenses in the United States are not traditionally portable across state lines, unlike the broader portability of licenses that is permitted in the European Union and Australian licensure systems. The necessity of telehealth during the COVID-19 pandemic has compelled many states in the United States to reconsider their approaches to medical licensing. State regulations vary wildly, and each state differs in its licensing process and requirements, making it particularly costly and burdensome for physicians to be required to apply separately for a medical license in each state they wish to practice in.

Patients are largely limited to seeking telehealth services from physicians within their state, and this as well as a general scarcity of available physicians and other barriers to accessing healthcare stand in the way of allowing telehealth to be widely available for the many people that wish to use it. Waivers and changes to regulations adopted during the public health emergency to allow the practice of telemedicine across state lines are being considered for permanent adoption, which is an important step towards allowing the United States to experience the full benefits of widespread incorporation and use of telehealth across the nation.

Policies that enable the use of medical licenses across state lines should be prioritized in order to facilitate greater use of telehealth services. By implementing permanent policies that allow licensed physicians to practice across state lines without needing to obtain separate licenses for each state, physicians would be able to provide telehealth services on an increased scale and to a broader patient base to cover the gaps currently existing from a scarcity of physicians. The best avenue for achieving this is to encourage states to participate in the IMLC. Relaxing jurisdictional limitations and introducing a uniform standard for licensure in this way would improve telehealth access in the United States and reduce some of the existing barriers to the widespread adoption and use of telehealth nationwide.