



Insight

# The Traveling Doctor: Medical Licensure Across State Lines

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In most other industries limiting access to a service is considered a bad thing, but when it comes to health care things get hazier. Becoming a Medical doctor is a challenging task, and gaining Medical licensure is one of the most difficult obstacles physicians may face. M.D.s need a license to practice medicine, and every state has a licensure procedure. However, states' regulations of health, safety, and welfare for their citizens are often overly burdensome and can limit the ability of physicians to reach many patients that need care the most. All 50 states have elected to regulate entry into medial practice in largely the same way, yet states continue to deny entry to qualified physicians licensed in other states to the physical and financial detriment of patients and physicians alike.

This paper explores medical licensing laws as they stand today, why reform is necessary, and why it has been so elusory. It concludes with a description of various reform approaches and attempts that have been made to implement them.

## Medical Licensing Today: A Long and Expensive Process

Depending on the state, processing an application for a medical license can take anywhere from 3 to 12 months, and can cost between \$110 and \$1,300. Despite the variation in the cost and time required to obtain a medical license, there is very little variation in the substantive requirements for medical licensing between the states.<sup>[1]</sup>

For starters, all 50 states require prospective physicians to pass the US Medical Licensing Exam (USMLE).<sup>[2]</sup> The USMLE is a three-part exam that medical students take over the course of their medical education. It requires a thorough understanding of a broad range of medical issues, laying the groundwork for a generalist.<sup>[3]</sup> In order for a candidate to sit for the USMLE, he or she must be enrolled in or have graduated from an American Medical Association approved medical school. In order to obtain a degree from an American medical school, candidates must have at least a Bachelor's degree and an additional 4 years of medical schooling.<sup>[4]</sup>

There are two minor variations between states. Some states limit how many attempts an M.D. may take at the USMLE before passing, capping attempts at 3; this limit has negligible effects though, since the passage rate for first-time test takers who have graduated from US medical schools is 96 percent for step one, 98 percent for step two, and between 96 and 100 percent for step three.<sup>[5]</sup> While this does mean a small percentage of test-takers will fail, what matters to medical students is their score- this will determine what area of medicine they will be eligible to study, and ultimately practice. The results of this exam will dictate where students will complete their residencies, and those who do poorly will not be eligible to practice in more competitive areas of medicine.

The remaining difference among different state medical licensing requirements is that some require up to three years of post-graduate training.<sup>[6]</sup> This may seem like a demanding standard, but it is standard practice within most programs and specialties for young doctors to continue to receive training for several years. States that have this type of requirement also look to years of post-graduate experience when considering an out-of-state applicant anyway.

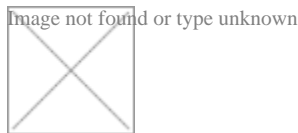
All states also require physicians that have been granted a license to maintain their knowledge by completing annual Continuing Medical Education credits. There is some variation here: some states require as little as 15 CME credits a year, while others require up to 50 per year.<sup>[7]</sup>

## Reform

### WHY WE NEED REFORM

It is indisputable that reform is necessary to make health care in America affordable and accessible. The Congressional Budget Office has estimated that there will be an additional 26 million insured individuals in America by 2024, and the Health Resources and Services Administration estimates that about 20 percent of them will live in areas with [physician shortages](#) – the Association of American Medical Colleges predicts that there will be a shortfall of around 90,000 physicians by 2020.<sup>[8]</sup>

Though there is much hand-wringing about the coming doctor shortage, an alternative theory is that the physician shortage is not necessarily a shortage, but a [mal-distribution of physicians](#). Currently the barriers to physicians attempting to provide services across-state-lines are significant enough to leave large portions of the country with a physician shortage, while other parts of the country have a large physician surplus.<sup>[9]</sup> This indicates that if there were fewer barriers to physicians moving among states, the laws of supply and demand would help to resolve the shortage naturally.



Another important reason for states to consider reform is the need to be able to tap into other states' physician resources and other medical providers on short notice during an emergency. During the immediate aftermath of Hurricane Katrina, there was one problem after another: there were not enough doctors to care for everyone seeking medical services; hospitals were overcrowded and later damaged by the storm, making the hospitals themselves unsafe; the Louisiana State Board of Medical Examiners, located in New Orleans was impacted by the hurricane and unable to respond to these problems expeditiously, resulting in confusing executive orders suspending licensing laws in the state almost a month after the hurricane hit.<sup>[10]</sup> During large-scale emergencies – whether they be natural or man-made disasters, terrorist attacks, or the outbreak of an infectious disease – communities affected by the situation will need a rapid response within minutes or hours, not days or weeks. Without easily navigable interstate licensing laws, however, a speedy response from the national medical community is next to impossible.

### WHY WE HAVEN'T SEEN REFORM YET

Some physician groups, specifically the American Medical Association, have successfully set standards to participate in their profession that are so high only a select few are able to enter the market. These organizations have efficiently created numerous barriers to entry, which have helped to create scarcity in providers and drive up the cost of care. The AMA has used techniques such as collective fee setting schemes and prohibiting undercutting prices charged by other doctors; they have played a central role in continuously increasing the accreditation standards at American medical schools, and have worked hard to ensure that only traditional, allopathic providers from AMA approved schools are eligible for licensure.<sup>[11]</sup> They have also been the driving force behind creating medical licensure laws: in 1846 the AMA was first established with the explicit purpose of being the judge of which practitioners were true medical professionals and which were quacks.<sup>[12]</sup> The AMA lobbied hard for state licensure laws, which were ultimately upheld by the Supreme Court as a proper exercise of the state's police power.<sup>[13]</sup> Although the AMA does serve to raise quality of care and protect consumers from charlatans, its primary goal is to advance the interests of its members—including their financial interests.

Partly because of the strict hold the AMA has on medical licensing in the US, the advent of mid-level health professionals was an inevitable response to the lack of available and affordable physicians. Providers such as physicians' assistants, anesthesiologists, D.O.s, and chiropractors are or were once all beyond the reach of the AMA's guidelines. These providers are widely used; often at a lower cost than typical M.D. physicians. However, they create confusion when it comes to licensing laws: should they be treated like doctors or something else? States have provided varying answers to this question, and so have created another hurdle for those seeking to encourage interstate migration of physicians.

There are, of course, other smaller issues preventing a movement towards reform of medical licensing laws, this could include differences in CME requirements among states, or the reluctance of many states to release information about disciplinary proceedings of physicians in the state, at least until they have been resolved, which could take years and slow applications for licensure in other states.<sup>[14]</sup>

## Models of Reform – Options for the States

### FEDERAL LICENSURE AND REGULATION

One proposal that is a favorite of those who support giving the federal government greater control of medical licensing is to create a federal agency that could take on the responsibility for granting medical licenses in the United States. Similar to an agency like the Food and Drug Administration, a federal licensing agency could have the ability to create uniform standards and attempt to mandate that the states accept its regulations. Despite its popularity, however, this idea would be impracticable since it would involve state acquiescence, but the regulation of health, safety, and welfare are among the rights reserved to the states by the 10<sup>th</sup> Amendment, and it is therefore beyond the reach of a federal strong-arm.

Alternatively, a quasi-federal structure, similar to what Senator Tom Udall (D-NM) proposed in 2012, could create two forms of licensure.<sup>[15]</sup> In theory, all doctors would still be required to have a license in at least one state. Then doctors could apply for a national 'tandem' license that would work like a passport and would allow that physician to practice in any state.<sup>[16]</sup> The Udall bill avoided 10<sup>th</sup> Amendment issues by proposing that the bill would only apply to federal health care workers at first, and if it was successful could later be expanded to require all Medicare/ Medicaid providers to have a national tandem license. This would rely on federal preemption and would effectively expand Indian Health Service and VA-type national licensure to all medical services paid for by a federal program.

Though fraught with constitutional obstacles, these proposals would be relatively easy to implement as the

licensing laws among the states already require nearly uniform education and performance standards from all applicants. Furthermore, about 80-85 percent of American physicians voluntarily take a national exam that requires periodic requalification in order to become board-certified.<sup>[17]</sup> The existence and widespread adoption of board certification procedures could lay an easy path for nation-wide licensing boards to make a smooth transition to national licensure.

#### STATE-BY-STATE LICENSURE AND RECIPROCITY

A second approach to expanding medical licensing opportunities is for states to pass reciprocity laws whereby physicians that have been practicing for a given number of years, who have maintained certain standards such as a license in good standing, CME credits, or board certification, for example, will be eligible to practice in another state after giving the state medical licensing board notice of their intent to move. This type of approach would help to mitigate any fears state licensing boards may have about assuring the health and safety of their citizenry by requiring all transferring physicians to have enough practice experience and a clean record, which are both strong indicators of a doctor's capability. It would also lower the bar enough that experienced physicians would have an incentive to move among states, and in times of emergency, physicians from any state could easily and quickly come to the aid of those in neighboring states without fear of liability.

A recent attempt to put this type of reform into action crossed an important threshold last week with the passage of the Interstate Medical Licensure Compact in seven states, triggering the compact to go into effect.<sup>[18]</sup> The Interstate Medical Licensure Compact (Compact) is a pathway to licensure which affirms that the practice of medicine occurs in the state where the patient is located at the time care is provided, and puts physicians under the regulation of the state board of medicine in which they practice.<sup>[19]</sup> To participate, a physician must graduate from an accredited medical school, pass all portions of the USMLE (or the Osteopathic equivalent), successfully complete graduate medical education, hold specialty certification recognized by the American Board of Medical Specialties, hold an unrestricted license to practice medicine by a member board, have no convictions or adjudication against, have no suspensions or other discipline against a licensing agency in any jurisdiction, and other similar restrictions on character and fitness.<sup>[20]</sup>

Through this Compact a physician seeking a license in another Compact state may file an application for an expedited license.<sup>[21]</sup> The Interstate Compact Commission will then maintain a database of all physicians who have applied for licensure in member states. This Commission is also responsible for administering the Compact, creating rules for members, issue advisory opinions interpreting the language of the Compact, and provide for the payment of expenses related to the establishment and activities of the Commission, among other administrative duties.<sup>[22]</sup>

All 50 states are eligible to participate in this Compact, and to date, the necessary minimum of seven states have passed the model legislation, bringing the Compact into effect.<sup>[23]</sup> Eleven other states have introduced the model legislation in their states legislatures in 2015. The seven participating states are Montana, Idaho, Wyoming, South Dakota, Utah, West Virginia, and Alabama.<sup>[24]</sup> The participation of these particular states is indicative of the importance of the legislation, as these states all have significant rural populations experiencing physician shortages.

#### MUTUAL RECOGNITION AND PORTABILITY

The idea of state-by-state licensure is generally what comes to mind when most people contemplate expanding physicians' ability to practice across-state-lines. Similar to the way states recognize drivers' licenses, all care provided by a licensed physician could be treated as if the services had been performed in the state where the provider is licensed: for legal purposes, the provision of care would be treated as if the patient had traveled to

the physician, and not vice versa. States could, of course, require physicians to disclose to patients what state they are licensed in, but because of the nearly uniform requirements across states, this would likely have little effect on patients' decision making.

This approach would be particularly useful for telemedicine, emergency situations, and volunteer programs where doctors travel to underserved or particularly high-need areas to donate their services because it would require little to no cost or time between arrival in the state and legal practice. This reform could also be expanded to all licensed health care providers, including physicians' assistants, chiropractors, etc., if it proves to be successful.

Because attempts at programs similar to this have been unsuccessful in other professions, it may become necessary for national-level organization to engage all 50 states to agree to this type of recognition. The United States' Driver License Agreement was an interstate compact written with the support of the American Association of Motor Vehicle Administrators.<sup>[25]</sup> Similarly, it would likely be necessary to convene a meeting of state health commissioners to sign a reciprocity compact.

Another similar model of mutual recognition would be to mimic the Nursing Licensure Interstate Compact, which was an agreement among participating states to recognize licenses granted in other participating states.<sup>[26]</sup> This proposal is different from the one above, however, because it does not operate under the legal fiction that the services were provided in the state where the nurse was licensed. Instead, the compact has the effect of essentially granting out-of-state nurses licenses in multiple states, and requiring nurses to operate under the laws of the state in which they are actually practicing.<sup>[27]</sup>

It is interesting to note that the Nursing Licensure Interstate Compact has only been adopted by 24 states in the 14 years of its existence, which raises the question of whether physicians' lobbyists will be able to overcome support for these laws as ably as the nursing lobby apparently did.<sup>[28]</sup>

## Conclusion

Each reform option has strengths and weaknesses. Unfortunately because of the different costs and benefits associated with each approach, it has been impossible to build a national consensus. Despite nearly uniform requirements for licensure, the interests of those involved in granting licenses may be creating arbitrary and unnecessary barriers to practice that are hurting patients and physicians. Though it is important to recognize the right of states to protect the health, safety, and welfare of their citizens, mutual recognition and portability would still largely give states the ability to continue to monitor the care that is provided by physicians licensed in their state while creating incentives for states to build competitive regulatory systems that will attract physicians to those states.

The partial adoption of the Interstate Medical Licensure Compact is evidence that states can work together to protect the safety of all citizens while each having their own laws and requirements for licensure best suited to the needs of each state, even if that means that licensure laws are sometimes even at odds with one another. This reform approach, while not perfect, gives states the greater flexibility to protect their citizens while creating a competitive market that would increase access to and affordability of health care providers.

[1] [http://www.fsmb.org/policy/public-resources/state\\_specific](http://www.fsmb.org/policy/public-resources/state_specific).