Weekly Checkup

Health Care Across State Lines

CHRISTOPHER HOLT | AUGUST 7, 2020

Several years ago, the American Action Forum published a paper entitled "The Traveling Doctor: Medical Licensure Across State Lines." It argued, among other things, that **state licensure requirements for medical professionals pose an unnecessary barrier to a more efficient distribution of health care professionals and—of particular relevance now—can complicate responses to public health emergencies.** Fast forward to this week when, in the midst of a public health crisis, Senators Chris Murphy and Roy Blunt introduced legislation, the Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act, that would allow any licensed medical provider in good standing to practice in any state or territory during a national public health emergency. **While federal action on this issue is complex and fraught, state licensure laws have long created problems, and policymakers need to find a solution.**

States' overuse of licensure requirements to protect established professional interests from competition has long been a concern for many conservatives. In the case of medical licensure laws, I've suspected for a while that part of the physician shortage we hear so much about is a maldistribution of health care professionals and not simply a shortage of them (another topic AAF experts explored, here). While licensure laws are unlikely to drive initial maldistribution, the fees and requirements state medical boards put in place can restrict physicians' ability to move between states. The irony is that—unlike state requirements for the practice of law—there isn't much variation between state medical licensure regimes. Instead, their primary purpose seems to be empowering state medical boards to collect dues.

Senators Murphy and Blunt aren't the first to tackle this issue, of course. Earlier this year, the Trump Administration waived rules requiring physicians to be licensed in the state where they provide services in order to bill Medicare and Medicaid during the COVID-19 public health emergency. But any federal response to licensure laws faces challenges.

The AAF paper explains that having the federal government simply seize control over medical licensing would run afoul of the 10th Amendment. Alternatively, the federal government could set up a second licensing regime required of all physicians who practice in federal health care programs and allow those providers to practice in any state, at least with regard to patients covered through federal programs, although this solution would be duplicative. This wouldn't be an unusual approach; the federal government regularly seeks to drive provider and state behavior by making participation in federal programs contingent on compliance. It also isn't too dissimilar to the Trump Administration's recent actions, though those were limited to the current crisis. More generally, **federal preemption runs counter to the general principles of federalism and isn't terribly appealing to small-government conservatives as a result.**

Of course, **states can and do enter into compacts and reciprocity agreements on their own** to allow doctors and other providers to practice across state lines. But during a public health crisis, particularly one national in scope, **these patchwork agreements can complicate the medical response and lead to delays**.

The TREAT Act attempts to thread the needle. Yes, it involves a degree of federal bigfooting on powers reserved for the states, but the legislation limits this preemption to public health emergencies. Effectively the

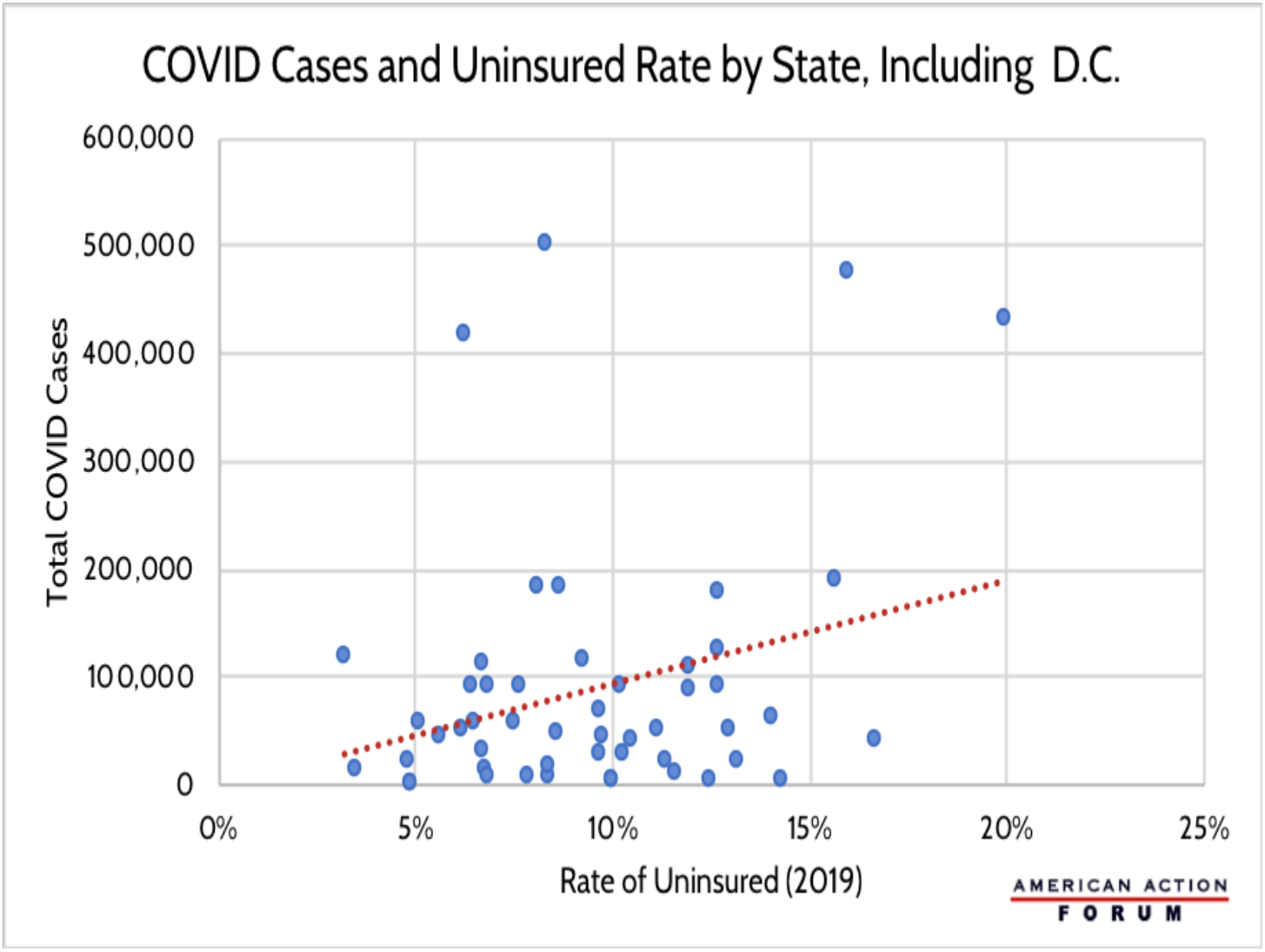
legislation would take the Trump Administration's actions and apply it beyond federal programs, regardless of state regulations, for the duration of a public health emergency.

Competing state licensure regimes for health care providers are an inefficiency in the health care system that is both unnecessary and potentially harmful. While the issue is a thorny one without easy federal solutions, it needs to be addressed. Whether the TREAT Act is the best solution can be debated, but **federal and state policymakers should work to address the problems of competing, duplicative licensure regimes, particularly in the context of public health crises such as the current pandemic.**

CHART REVIEW: UNINSURANCE RATES AND COVID-19 OUTBREAKS

Serena Gillian, Human Welfare Policy Fellow

The current COVID pandemic and its resulting economic downturn have led to one of the largest-ever losses of health insurance among Americans-—5.4 million laid-off workers have become uninsured—but a lack of insurance before the pandemic is also correlated with higher outbreaks of the coronavirus. As the chart below indicates, states with higher uninsured rates in 2019 show higher COVID-19 case numbers now. This correlation could be due to multiple factors. For one, people without health insurance are less likely to seek testing or, if tested, to pursue medical treatment after receiving a positive test result. As a result, they may spread the disease. Additionally, a lack of health insurance often serves as an indicator of income, and low-income earners could have higher exposure to the virus due to their participation in low-wage, essential jobs that require close contact with others as well as their denser living conditions. Finally, people without health insurance, in general, are more likely to have underlying conditions that make them more vulnerable to the virus.



Data from the Centers for Disease Control and Prevention and the U.S. Census Bureau

WORTH A LOOK

Kaiser Health News: America's Obesity Epidemic Threatens Effectiveness of Any COVID Vaccine

New York Times: It's Kitchen Sink Time': Fast, Less-Accurate Coronavirus Tests May Be Good Enough