COMMENTARY

The States' Hodgepodge of Physician Licensure Regulations

Tara Sklar[1] *and Christopher Robertson*[2]

1. UNIVERSITY OF ARIZONA, TUCSON, ARIZONA, USA. 2. BOSTON UNIVERSITY, BOSTON, MASSACHUSETTS, USA.

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The end of the federal COVID-19 public health emergency (PHE) on May 11, 2023, marked a pivotal shift in the landscape of telehealth regulation in the US. Kwan, Jolin, and Shachar analyze the implications of this transition by exposing inconsistencies in access to care. We agree that we now face a "convoluted patchwork of permanent and temporary changes to telehealth law and policy."[1]

While variations on insurance coverage and reimbursement rates are important, physician licensure is arguably the linchpin to practice medicine across state lines. Generally, physicians need a license in every state where their patients reside, regardless of where the physician is located. Federal telehealth expansion efforts post-PHE have not addressed licensing, even though Congress could create a permanent solution.[2] While members of Congress have introduced numerous bipartisan bills, none have gained significant traction outside of committees.[3]

This commentary explains how federal and interstate collaborations have largely failed to effectively address the interstate practice of telehealth and, as a result, states have been increasingly enacting unique telehealth registration pathways to allow out-of-state providers. Ultimately, a real national solution is required.

States have attempted to provide interstate practice pathways in four ways: 1) by participating in the Interstate Medical Licensure Compact (IMLC); 2) by enacting the Uniform Telehealth Act (UTA), which establishes a telehealth registration option; 3) by passing state legislation for telehealth registration; and 4) by allowing state licensure exceptions for interstate telehealth practice.

The IMLC was established in May 2015 to streamline the process and reduce the cost for physicians in good standing in one state to obtain a license in another. The IMLC has been enacted in 40 states, the District of Columbia, and the Territory of Guam.[4] The IMLC is not a national license or a state license that is recognized reciprocally in other states, but rather only a mechanism to gather multiple individual state licenses. The IMLC licenses are not tailored to the needs of telehealth; they are rather full licenses to open a practice in a state. As one clinician explains her experience using the IMLC to secure licenses in six states: "Doing this took months, cost thousands of dollars, and still leaves me unable to care virtually for patients in 43 states. The process is so cumbersome that less than 1% of physicians use it."[5]

In October of 2022, the Uniform Law Commission attempted to address the problems by promulgating the Uniform Telehealth Act (UTA).[6] The UTA establishes a telehealth registry where a provider could deliver telehealth services to a patient located in another state that has adopted the Act. To date, only one state, Washington, has passed the UTA,[7] Rhode

Tara Sklar, J.D., M.P.H., *is Faculty Director of the Health Law & Policy Program at the University of Arizona James E. Rogers College of Law, and Associate Director of the Telehealth Law & Policy Program at University of Arizona College of Medicine-Tucson.* **Christopher Robertson, J.D., Ph.D.,** *is the N. Neal Pike Scholar and Professor of Law at Boston University Schools of Law and Public Health.*

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Island and the District of Columbia legislatures have introduced it.

Other states are pursuing similar mechanisms. Currently, 13 states have enacted registration pathways for out-of-state physicians to provide limited telehealth services to patients within the state. These registration systems often require that physicians: not practice in-person care in the state which they are applying, show proof of liability insurance, maintain a current medical license in good standing in another state, and not be under current investigation. Each state requires continuing medical education. But no state requires specific training on how to deliver quality telehealth services, which would seem to be a gap in oversight.

Other requirements vary from state to state. For example, annual registration fees have a wide range. Florida charges no fee, and several states, including Delaware, Kansas, and West Virginia, charge only a fraction of their full license fees. In contrast, Arizona, Georgia, and Oregon charge as much as $500 per year, the cost of a full license.[8] States also have specific registration requirements. Utah requires out-of-state providers to have 10 years of prior experience. Vermont restricts out-of-state providers to a maximum of 10 patients in a 120-day period.[9]

In addition to these telehealth registries, more than 40 states have medical licensing exceptions that could allow for limited interstate telehealth practice.[10] The most frequent of these are for consultations (25 states) or indirect consultations (14 states), which are important to support specialty care. However, these exceptions often have restrictions such as prohibiting compensation or limiting the number of encounters to 10 per year. Other states have exceptions for infrequent care (15 states) or continuity of care (9 states).[11]

While these state efforts are laudable, they are still unduly restrictive. We believe that sheer protectionism and bureaucratic power-retention explain the slow pace of change in the face of patient demand and provider supply indifferent to state lines. While abuse of telehealth is clearly possible, mere insistence on local licensure is not tailored to solve any such problem.

The widely varying state regulation makes it difficult for providers to achieve economies of scale that could better serve disadvantaged populations or deliver care in areas with provider shortages. Investments in state-of-the-art technologies may be less financially attractive without the reassurances of being able to grow a telehealth practice across state lines. Unfortunately, the politics of abortion post-*Dobbs* have made it more difficult for states to collaborate over medical care.

We encourage states to consider the UTA more closely, rather than further fragmenting regulation of the profession. Even more, we look to the Federal government, which is the single largest payor of healthcare, whether directly or indirectly. In 2018, Congress gave the Veterans Administration power to allow interstate practice of medicine regardless of licensure, effectively preempting state laws.[12] The sky has not fallen. It is time for Congress to do likewise for all other patients.

During the PHE, physicians could provide care where needed across the country. Another pandemic should not be necessary to trigger a coordinated telehealth law and policy approach to address physician licensure.

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Note

The authors have no conflicts of interest to disclose.

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The Journal of Law, Medicine & Ethics, 52 (2024): 419-421.

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