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Expert Analysis

The Interstate Medical Licensure Compact

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One of the many powers reserved to the states in our system of government is the power to license and supervise the practice of the professions, including the practice of medicine. Historically, each state has set its own requirements for physicians to obtain a license to practice medicine within its borders. These requirements usually include graduation from an accredited medical school; completion of post-graduate residency or internship training in an accredited hospital training program; passing a licensing examination; completion of continuing medical education credits; and so on. The state may also investigate whether a physician applicant for a medical license has any criminal convictions, any past or pending disciplinary actions, any mental or physical impairment, or whether the applicant has caused any harm to patients.

This licensure process is regarded as a critical police power of the state that is intended to protect the health and safety of any patient who will receive medical treatment from the physician. Regulation of the practice of medicine in New York can be traced as far back as 1684, when it was a British colony.[1] New York's process for licensing physicians has traditionally been comprehensive and rigorous.[2]

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The continuing trend toward medical specialization, the developments in telecommunications and telemedicine,[3] the proliferating costs of health care services, the consolidation of hospitals and health care providers into large multistate systems, and the need to increase access to medical services in underserved and rural areas, among other factors, are driving the need for more and more physicians to be licensed in multiple states. Some states offer relatively simple reciprocity to physicians already licensed in another state. Others have more complex and time-consuming license requirements.

Unlike the licensing of lawyers, which involves familiarity with laws that differ from state to state, medicine is medicine, and even though the licensing requirements for physicians may be different in each state, the subject matter that is being practiced does not vary. That is one of the rationales behind what is known as the Interstate Medical Licensure Compact.[4]

Compact

The Compact was launched in 2013 by the Federation of State Medical Boards, a national not-for-profit organization that represents some 70 medical and osteopathic state licensing agencies. The goal of the

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Compact is to offer expedited licensure by states that join the Compact to physicians who meet the following qualifications:

1. Graduated from an accredited medical or osteopathic school;
2. Passed each component of the U.S. Medical Licensing Examination or Comprehensive Osteopathic Medical Licensing Examination;
3. Successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association;
4. Holds specialty Board certification;
5. Possesses a full and unrestricted license to practice medicine from the medical board of a state participating in the Compact;
6. Has never been convicted, received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;
7. Has never had a medical license subjected to discipline by a licensing agency in any federal, state or foreign jurisdiction (other than for non-payment of license fees);
8. Has never had a controlled substance license suspended or revoked by a state or by the U.S. Drug Enforcement Agency; and
9. Is not under active investigation by a licensing or law enforcement agency in any federal, state or foreign jurisdiction.

The Compact creates an "Interstate Medical Licensure Compact Commission" (commission), a private corporation that is a joint agency of the Compact's member states. Each member state appoints two individuals to serve as commissioners. The commission is charged with enforcing compliance with the Compact's provisions, the commission's bylaws, and rules promulgated by the commission, and is required to report annually to the governors and legislatures of the member states on the commission's activities and finances.

Significantly, the Compact states that rules made by the commission have "the force and effect of statutory law in a member state"; that all lawful actions of the commission, including all rules and bylaws promulgated by the commission, are binding upon the member states; and that all laws in a member state that are in conflict with the Compact are superseded to the extent of the conflict.

The commission sets the standards and requirements for multistate licensure.

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An eligible physician is required to designate one of the Compact's member states as a "State of Principal Licensure" where the physician has a full and unrestricted license to practice medicine. The State of Principal Licensure can be:

- the state of the physician's primary residence; or
- the state where at least 25 percent of the physician's practice occurs; or
- the location of the physician's employer.

The physician then designates the other member states in which the physician desires to obtain a license. Upon the commission's verification of credentials, the physician is issued a license to practice in the designated member states.

In order to become a member state of the Compact, the state legislature must enact the Compact as a law. Model legislation has been crafted for this purpose.[5]

Support

The Compact has the support of prominent organizations, including the American Medical Association; the American College of

Physicians; the American Academies of Dermatology, Family Physicians, Neurology, and Pediatrics; the American Osteopathic Association; the Accreditation Council for Continuing Medical Education; the National Board of Medical Examiners; a number of state medical and hospital associations; and major health care systems that operate in multiple states, including the Mayo Clinic, Ascension Health and Gunderson Health System. In addition, earlier this year, the Federation of State Medical Boards was awarded a three-year grant totaling $750,000 from the U.S. Health Resources and Services Administration to support the Compact's administration and expand the Federation's outreach to states that have not yet authorized the Compact.

The Compact thus far has been enacted in 18 states: Alabama, Montana, Arizona, Nevada, Colorado, New Hampshire, Idaho, Pennsylvania, Illinois, South Dakota, Iowa, Utah, Kansas, West Virginia, Minnesota, Wisconsin, Mississippi, Wyoming. Bills have been introduced in at least seven other states to adopt the Compact.

Support for the Compact is by no means universal. It is opposed by the Association of American Physicians and Surgeons (AAPS), which describes itself as an advocacy group of some 5,000 physicians in private medical practice. The AAPS objected[6] to the Compact's requirement that, besides being licensed by a state, a physician must also be Board-certified by a recognized specialty board organization. It also maintained that the Compact undermines a state's autonomy and control over the practice of medicine and that it places power in a private bureaucratic organization to define, intervene in and control the practice of medicine. It also objects that the Compact interferes with physicians' due process rights, pointing to provisions in the Compact that allow states to automatically suspend a physician's license if the physician's license in another member state is revoked, surrendered, relinquished in lieu of discipline, or suspended.

The Compact is also opposed by the American Legislative Exchange Council (ALEC) which identifies itself as a "non-partisan voluntary membership organization of state legislators dedicated to the principles of limited government, free markets and federalism" representing nearly one-quarter of state legislators. ALEC claims that the Compact:

- Supersedes a state's autonomy and control over the practice of medicine;
- Enables the commission to cause changes to states' medical practice licensing laws;
- Adds significant costs to member states to participate in the Compact;
- Makes it difficult and expensive for a state to withdraw from the Compact;
- Dramatically increases the costs of obtaining medical licenses; and
- Improperly defines a physician as a person who holds specialty board certification or a time-unlimited specialty certificate.[7]

New York

We have been unable to find any bills introduced in New York's Legislature that propose enactment of the Compact. As more states adopt the Compact and as telemedicine becomes more widespread, however, it is likely that at some point, such a bill will be introduced in New York. When that happens, it will almost certainly trigger a lively debate and intense lobbying by both proponents and opponents.

1. Bards, "A History of the Legal Regulation of Medical Practice in New York State," Bulletin of The New York Academy of Medicine, October 1967, pp. 924-40.
2. See, NY Education Law, Art. 131; 8 NYCRR Part 60.
3. See, e.g., Serbaroli, "Telemedicine: Legal and Practical Considerations", 251 NY Law Journal No. 100, May 27, 2014.
4. http://www.licenseportability.org/assets/pdf/Interstate-Medical-Licensure-Compact-(FINAL).pdf.
5. http://www.licenseportability.org/wp-content/uploads/2016/01/Interstate-Medical-Licensure-Compact-FINAL.pdf.
6. http://aapsonline.org/help-stop-the-moc-trojan-horse-the-interstate-medical-licensure-compact/.
7. https://www.alec.org/model-policy/resolution-opposing-federation-state-medical-boards-interstate-medical-licensing-compact/.