

Interstate Medical Licensure Compact: Pernicious Myths and Inescapable Facts

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For decades, states have authorized boards of physicians, members of the public, and sometimes other health care professionals, to license and regulate the practice of medicine. This licensing practice is consistent with the principles of the 10th Amendment of the US Constitution, which reserves powers that are not federally enumerated to state oversight. That said, with more participants in the health care marketplace today, new applications of technology in medical practice and changing consumer demands, the physician-patient relationship seems destined to evolve. Consequently, our regulatory framework must similarly adapt, preserving the longstanding practices and the authority of medical licensing boards while embracing new tools and a new mindset.

Detractors of this longstanding regulatory framework have, in recent years, suggested that the only recourse to address these forces is a radical shift toward federal regulation of physicians. Some have gone so far as to blame medical boards for being an “untenable barrier” to both physicians and patients.^{1,2} However, these arguments have been demonstrated not only to be a categorical misstatement of the important work of state medical boards and a deeply concerning stratagem to shift the federal and state balance of powers, they also seem to disregard the established infrastructure and vast expertise already in place in state medical licensing boards.³ It is perplexing, whether these actors seek to erode the existing framework in favor of a new, large, and wasteful federal regulatory body or simply prefer unfettered physician practice across state lines with little public accountability. Instead, state medical and licensing boards have themselves proposed a superior model, one uniting the benefits of the existing system with expedited licensing arrangements and enhanced data-sharing capabilities: an interstate compact.

An interstate compact is essentially a contract enacted as legislation, with exactly the same

language, passed by legislatures and signed by governors. As a legal construct, the interstate compact is specifically provided for in the US Constitution⁴ and has long been recognized by the courts as an effective tool for states to collectively resolve common problems without the intrusion of the federal government. More than 200 compacts exist in the United States, with 22 of them being truly national in scope.⁵ They are a fixture in virtually every sector of modern government, including boundary disputes, economic development, criminal justice, education, health care, insurance, resource management, taxes, and transit.

Since the proposed Interstate Medical Licensure Compact (IMLC) was finalized in September 2014, it has been met with broad support across the “house of medicine,” perhaps none more important than that of state medical boards themselves. Twenty-nine state medical boards have endorsed the IMLC and, since January 2015, 19 states have introduced legislation to join it. Seven states are needed to activate its provisions,⁶ and 11 states have adopted the necessary IMLC legislation to date (Alabama, Idaho, Illinois, Iowa, Minnesota, Montana, Nevada, South Dakota, Utah, West Virginia, and Wyoming).

Despite these successes, a few remaining skeptics⁷ whose political interests are not served by the IMLC have engaged in attacks on it using misinformation and intimidation, including the following arguments:

MYTH: The IMLC will supersede a state’s autonomy and control over the practice of medicine.

FACT: Physicians seeking entry into the IMLC will be evaluated by the board in their state of principal license against specific criteria as laid out in the IMLC’s definition of physician.⁸ In addition, Section 5 of the IMLC⁸ specifically details that it is the state board, not the Commission, that determines the eligibility of any physician to participate, which includes that board completing a federal and state criminal background check on the

applicant. Only state boards can issue licenses and discipline physicians under the IMLC, just as it is today. In reality, by employing the Compact Clause of the US Constitution, the IMLC protects states' rights and strengthens the ability of medical boards to protect the public.

MYTH: The Interstate Commission created by the IMLC will likely cause changes to state medical practice acts.

FACT: The IMLC's preamble clearly states that it creates another pathway for licensure but does not otherwise change any medical practice act. In addition, the IMLC clearly states that anyone licensed in a state through the IMLC must follow all laws and rules of that state to practice medicine there. The IMLC's Commission, like those created in other compacts, simply serves to administer the IMLC's provisions.

MYTH: There will be a large cost to each participating state who joins the IMLC.

FACT: Throughout the entirety of the IMLC's development, its drafters have clearly understood that it must not place economic burdens on boards or states. Although the IMLC contains language that holds states to ultimate fiduciary responsibility for the Commission, it has always been intended to be supported by transaction fees paid by participating physicians. Moreover, to aid in establishing the IMLC, the Commission will seek grant funding to offset implementation costs. Finally, a compelling example to rebut this assertion comes from Utah. In adopting the IMLC legislation, the state's official fiscal analysis found that enactment would have a positive fiscal impact on the state.⁹

MYTH: It will be difficult and expensive for a state to extricate itself from the IMLC.

FACT: If a state wishes to leave the IMLC, its legislature has only to repeal the compact statute it

enacted. The states themselves have the final decision-making authority on membership.

MYTH: The cost of obtaining medical licenses will be dramatically increased, and a state must protect its citizens from regulatory excesses.

FACT: States retain the ability to set their licensing fees, and physicians seeking licensure via the IMLC will also pay those fees just as any other applicant would. Thus, no board or state revenue is sacrificed. Moreover, the IMLC gives state boards the proper jurisdiction over physicians located outside its borders and practicing telemedicine in their states. This measure enhances public protection and reinforces the concept that medicine is practiced where the patient is located.

MYTH: The IMLC's definition of a physician is at variance with all other state medical boards, defining a physician as a person who holds specialty certification or a time-unlimited specialty certificate.

FACT: The definition of physician in the IMLC relates only to the initial eligibility to obtain a license via the IMLC. The IMLC does absolutely nothing to change the definition of physician in any medical practice act. It is worth noting that an estimated 80% of the US physician population will be eligible for expedited licensure under the IMLC.¹⁰

As with the practice of medicine in general, the debate over the framework of expedited interstate licensure of physicians should be grounded in logic and evidence. In so doing, the benefits of the IMLC become inescapably clear. The IMLC can productively respond to present and future forces that are challenging the status quo in medical regulation, without the disruptive effects of an unnecessary new bureaucracy. Using a compact is a well-tested approach, is widely supported, and sustains the provision of

high-quality care balanced with appropriate accountability to the public. For those who seek to discredit the IMLC, these facts lay bare their assertions as nothing more than pernicious scare tactics. (doi:10.7556/jaoa.2015.119)

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