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Occupational Licensing in Health Care: Sorting the Wheat from the Chaff

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[1] The views expressed in these remarks are my own and do not necessarily reflect the views of the Federal Trade Commission or any other Commissioner. Thanks to my Attorney Advisor, Pallavi Guniganti, for assisting in the preparation of these remarks.

want to sell cut flowers without arranging them, you can do so under a dealer's permit, but not within three hundred feet of a retail florist's place of business.[5]

Today I'd like to focus on occupational licensing in health care, a sector where we cannot easily assess a professional's competence based on how easily pleasing we think the product is. Most health care consumers are subject to an information asymmetry[6]—they do not understand medicine as well as the providers do. This market failure therefore calls for some regulation of providers. Still, it's not a coincidence that regulated healthcare jobs frequently face staffing shortages.[7]

These shortages became particularly dire this year due to the Covid-19 pandemic. Even parts of the country such as New York City that have a large number of medical facilities suddenly needed additional doctors and nurses to care for an upsurge in patients who require ventilators and other critical care.[8]

State-based licensing can restrict the geographic mobility of medical personnel to provide care where it is needed the most. Physicians and registered nurses take exams based on national certification standards, yet meeting the national standards does not automatically enable successful exam-takers to practice across the nation.

spouses and partners of military service members, who frequently must move from one state to another and may face prohibitive costs and difficulties in obtaining a license in each state.

Several states have eased the rules specifically for military spouses, by mandating the issuance of a state occupational license if the spouse is licensed in another state with substantially equal or h

The FTC has advocated for greater reciprocity of occupational licensing among states. In September 2018, our Economic Liberty Task Force issued a report that highlighted steps that states could take to improve the portability of occupational licenses.[12] The report warned that "Multistate licensing requirements can also limit consumers' access to services. For example, licensure requirements can prevent qualified service providers from addressing time-sensitive emergency situations across a nearby state line or block qualified health care providers from providing telehealth services to consumers in rural and underserved locations

to practice – but the states also share information about these practitioners to ensure that moving across state lines doesn't become a way for bad doctors and nurses to keep practicing

For example, the Interstate Medical Licensure Compact became operational in April 2017. It is an agreement among participating states to cooperate in streamlining the licensing process for qualifying physicians who want to practice in multiple states, in part by enhancing states' ability to share investigative and disciplinary information about physicians. It now includes 29 states, the District of Columbia, and Guam – although several of those places have not yet fully implemented the compact.

Similarly, the Nursing Licensure Compact enables nurses to be licensed in one state and then practice in other states that are part of the voluntary agreement. In 2018, 25 states implemented the Enhanced Nursing Licensure Compact with additional requirements, such as state and federal fingerprint-based criminal background checks. Nurses who are first licensed in any Compact state can practice in all Compact states without delay, reducing costs on application fees and license renewals.

However, the nurse licensing compact still does not establish a single standard for the scope of practice. Depending on their level of education and experience, nurses may be independently competent to provide care and write prescriptions, but they often are required to work under a doctor's supervision.[17]

IV. During the pandemic

During the Covid-19 pandemic, the federal government and nearly every state has waived or suspended some limitations on the provision of health care, to reduce delays or restrictions on the availability of care.

[17] See supra note 14.

The Department of Health and Human Services announced that it temporarily will refrain from enforcing its requirement that "physicians or other health care professionals hold licenses in the State in which they provide services, [so long as] they have an equivalent license from another State."[18] The Centers for Medicare & Medicaid are issuing temporary waivers so that hospitals can use medical professionals such as physician assistants and nurse practitioners more fully – but relevant state law constraints still apply.

Several states have relaxed their limitations on what nurses can do during the pandemic. For example, Louisiana has expanded the scope of practice for APRNs and Certified Registered Nurse1 (y

professionals” so those who are l

spouses and partners of military service members, they can expand it to encompass all residentsLegislators and regulators should consider which laws and rules are truly necessary for patients' safety, and which ones create unnecessary barriers to market entry.