

ATA Policy Regarding State Medical Licensure¹

Although telemedicine utilization is increasing, it accounts for only a small fraction of all medical ‘encounters’ in the United States (including teleradiology). Despite that fact, during the last four years at least 14 states have passed legislation severely restricting the practice of telemedicine across state lines.

Most often this restriction takes the form of requiring full and unrestricted state licensure for any external physician providing services via telemedicine to residents of the State. Other states have similar statutes in various stages of the legislative process. Unless meaningful alternatives are developed, it is expected that many more states will follow the trend of restrictive legislation.

Background

The powers that are not granted to the federal government under the Constitution are reserved to the states as provided for by the Tenth Amendment of the United States Constitution. These activities are traditionally local in nature and most often pertain to health, safety, and welfare of a state’s citizenry. Under this authority physicians and other healthcare practitioners are required to obtain state licenses, comply with various state medical practice acts and are otherwise regulated by state medical boards whose members are usually appointed by state governors.

Although administrative practices might vary from state to state, in the past 30 years there has been a remarkable convergence in licensing requirements stipulated by states to license physicians. All states require the United States Medical Licensing Examination (USMLE). All recognize appropriate credentials from nationally accredited medical schools and residency programs regardless of location. All specialty board certification is conferred by national organizations and are based on national standards.

Today, state licensure requirements have substantially more similarities than differences. In fact, they only vary in terms of procedural and tangential issues, such as the number of times an applicant can take the USMLE (the range is from three to unlimited attempts) and the number of required postgraduate training years (the range is from zero to three years).

In fact there is little, if any data to support the claim that physicians of one state are more or less qualified than those of any other state.

The debate surrounding telemedicine and state medical licensure has focused on three approaches:

¹ Adopted by the ATA Board of Directors, May 21, 1999

² Full licensure has unfortunately been the most ‘successful’ approach to telemedicine licensure in recent years. It is rapidly becoming the de facto licensing approach for telemedicine today.

³ In 1996 the Federation of State Medical Boards (FSMB) produced a “A Model Act to Regulate Practice of Telemedicine or Medicine by Other Means Across State Lines” containing legislative language to create a

Full and Unrestricted Licensure²; Limited Licensure³, and National Licensure.⁴

Findings

1. The requirement for full and unrestricted licensure in each state can have a chilling effect on telemedicine practice. Moreover, it places excessive economic, administrative, and political burdens on current and future telemedicine providers.
2. Full and unrestricted state-based licensure requirements limit patient rights by denying easy access to remote medical expertise.
3. While reciprocity or other mechanisms of mutual recognition could solve interstate medical licensing issues, recent actions and positions taken at the state level and by a few medical organizations bring into question the political viability of these approaches. Recent attempts to change state laws have resulted in an increase rather than a decrease in licensure barriers.
4. A more flexible and permissive licensure environment is inexorably tied to reimbursement.
5. A new approach is required that provides a basis for legal challenge of the status quo. For any real movement to occur, state authority in this matter may have to be subordinated a legal instrument of an external authority.
6. The only external authorities are the US Congress or the Judicial system.

Interstate Commerce: Although the states rightfully hold the authority to regulate activities of legitimate local concern, this power is not absolute. The Commerce Clause of the US Constitution (Article 1) prohibits states from erecting barriers against activities that are inherently national in scope. In addition, barriers that transcend the traditional scope of state regulatory authority by protecting local economic interests, which restrict interstate commerce, have been treated as violations of the Commerce Clause.

Although the practice of medicine has traditionally been local in nature, telemedicine introduces a distance independent variable that is, by definition, neither local nor traditional.

secondary or limited license for telemedicine purposes. Only three states (Alabama, Tennessee, and Texas) have enacted legislation in any way consistent with FSMB's philosophy. The American Medical Association (AMA) opposed the act and called for a resolution requiring "full and unrestricted license" in each state for those "who wish to regularly practice telemedicine in that state."

² Full licensure has unfortunately been the most 'successful' approach to telemedicine licensure in recent years. It is rapidly becoming the de facto licensing approach for telemedicine today.

⁴ There are at least three potential forms of creating a more uniform national licensure system: Federal Certification or Licensure; Federal Preemption of certain restrictive state laws; and Mutual Recognition between states. Federal Certification would actually grant licensure at the federal level. An example is aviation. All civilian pilots (including airline transport pilots) are licensed at the federal level. The Federal Aviation Administration (FAA) manages pilot certification in the US. Preemption grants functional licensure in certain circumstances by superceding state statutes. The Wyden Amendment (a 1995 attempt to preempt state law in cases in which a physician conducts a consultation using telecommunications) is an example of an attempt to restrain overreaching state laws through limited federal action. Mutual Recognition of licensure between states is based on the concept of reciprocity. The drivers license in an example of automatic reciprocity in which the holder of a license in one state can legally drive in any other state. The Nursing Licensure Interstate Compact, currently being finalized by the nursing community, grants nursing licensure privileges in all participating states provided the nurse already has a valid license in at least one state.

In a legal challenge, courts would balance the objective and purpose of state law against the burden on interstate commerce. If benefits of state law outweigh the burden of interstate commerce, state regulation will generally be upheld. If regulation imposes a substantial burden on interstate commerce, it will likely be held unconstitutional. Industries with legal and/or legislative precedents for transitioning from local to national regulation includes trucking, food, telecommunication, banking, railroad, and automotive. The hallmark of industries making the transition is financial viability. Sustained economic growth for telemedicine may be essential prior to a successful legal challenge.

If the nature of activity being regulated requires uniform national regulation, then no state regulation is permissible. This is why pilots are certified at the national rather than state level.

Traditionally, the courts have had little tolerance of interference in interstate commerce, especially interference that protect local economic interests, even when state's rights issues are in the forefront. In the majority of cases, state regulations are struck down if it can be shown state laws are designed to protect local interests at the expense of out of state competitors.

ATA Position:

The ATA state licensure policy position offers a compromise between full national licensure and state-imposed unreasonable barriers that meets the following guidelines:

- Preserves the right of each state to regulate medicine in traditional face-to-face (FTF) physical setting
 - Preserves licensure authority at the state level
 - Avoids unnecessary restraints on interstate commerce
 - Ensures that all patients have access to health care expertise necessary to protect and promote their health regardless of the location of the provider
 - Advances telemedicine as a valuable service delivery strategy that can play a critical role in overcoming time and distance barriers that often limit access to quality health care
1. The medical event should be defined as occurring where the physician is located. No medical event can occur in the absence of a either patient or physician (or other medical provider). Both are essential.
 2. A physical face-to-face (FTF) encounter between physician (or other medical provider) and patient within state borders remains the purview of the state.
 3. If the encounter is virtual (i.e. non-physical FTF) and a physician is located in another state, the encounter is neither traditional nor local and is therefore outside the purview or jurisdiction of the state.
 4. States should not restrict physical travel by patients to seek medical advice outside the state and should not be permitted to restrict 'virtual' travel as well.

5. States should not restrict a duly licensed physician or other medical provider from seeking consulting medical expertise from a physician or other medical provider licensed in another state.
6. The ATA should support and define the Interstate Telemedicine Encounter (ITE) within the following specific guidelines:
 - Telemedicine request originates from a provider who is fully licensed in the patient's state
 - The patient and requesting physician must have a real physician-patient relationship
 - The patient and requesting physician must have a real (i.e. physical) FTF encounter
 - The out-of-state consulting physician using telemedicine must be fully licensed in the state in which the physician is located
 - [Optional] The out-of-state physician must register his/her intent to provide telemedicine services to patients residing in that state. This is for information purposes only. No action by the state is required except confirmation of receipt of the letter of intent
 - The responsibility of medical care for the patient must remain with the requesting physician. Care never transfers to the out-of-state physician in this telemedicine model. The requesting physician is the attending physician.
7. The ATA recognizes that these jurisdictional and licensure issues also effect a wide variety of individuals within, as well as outside, the health care community. The ATA should utilize the state licensure issues to expand the constituency of telemedicine by formal and informal outreach to the 'digital community' (hardware, software, and telecom vendors; electronic commerce industry), managed care, and patient advocacy groups.
8. Strategies for creating a more favorable licensure environment and for securing expanded reimbursement should be synergistic. They must be implemented in parallel over time with long term commitment.

Implementation: ATA will assume a proactive position on state licensure and ATA will make every effort to provide input reflecting these policy statements to legislative and/or regulatory organizations.