Legislative Analysis

HOUSE FISCAL AGENCY

Phone: (517) 373-8080
http://www.house.mi.gov/hfa

Analysis available at
http://www.legislature.mi.gov

JOIN INTERSTATE MEDICAL LICENSURE COMPACT

House Bill 4066 as reported from committee w/o amendment
House Bill 4067 (H-1) as reported from committee
Sponsor: Rep. Jim Tedder
Committee: Health Policy
Complete to 10-4-17

BRIEF SUMMARY:

The bills would create a new section of the Michigan Public Health Code to enact into law the "Interstate Medical Licensure Compact."

FISCAL IMPACT:

House Bill 4066 would have a significant fiscal impact–of undetermined magnitude–on the Department of Licensing and Regulatory Affairs (LARA). The bill would not likely have any fiscal impacts on other units of state or local government. A full analysis follows in ***Fiscal Information***, below.

House Bill 4067 does not appear to have any fiscal impact on any units of state or local government.

THE APPARENT PROBLEM:

Telemedicine technologies—including video-conferencing, internet-based applications, store-and-forward imaging, streaming media, and phone and wireless communications—make it easier for physicians to practice medicine without regard to state boundaries, allowing patients access to care wherever they are.

However, physicians are licensed to practice medicine by professional state licensing boards in each of the fifty states. They work within their scopes of practice only within the states in which they are licensed.

A written document—the Interstate Medical Licensure Compact—has been drafted as 'model legislation' by state medical board representatives, with assistance from the Federation of State Medical Boards and the Council of State Governments. More information about the model legislation being advanced by the Federation of State Medical Boards can be found at (http://www.fsmb.org/).

The interstate compact will allow physicians to be licensed in many states simultaneously and promptly, after the respective state legislatures enact the 'model language' of the compact into state law. For additional information, see ***Background Information*** below.

Legislation has been introduced in Michigan that constitutes the proposed Interstate Medical Licensure Compact. It is based upon 'model legislation', enacted in 22 states and under consideration in three more and the District of Columbia.[1]

THE CONTENT OF THE BILL:

House Bill 4066 is the main bill, while House Bill 4067 is complementary legislation. The bills are tie-barred, so that neither could go into effect unless the other were also enacted into law. Both bills would take effect 90 days after enacted, with the Compact in HB 4066 taking effect 180 days after the bill is enacted. Further, House Bill 4066 would be repealed three years after its enactment into law.

A detailed description of each bill follows.

House Bill 4066

Purpose. In order to strengthen access to health care, and in recognition of the advances in the delivery of health care (such as mobile physician teams and telemedicine to allow physicians to diagnose and treat the sick who live in underserved regions), the member states of the Interstate Medical Licensure Compact have allied in common purpose to develop a comprehensive process that complements the existing licensing and regulatory authority of state medical boards, and provides a streamlined process that allows physicians to become licensed in multiple states, thereby enhancing the portability of a medical license and ensuring the safety of patients. The compact creates another pathway for licensure, but does not otherwise change a state's existing medical practice act. The bill specifies that the compact also adopts the prevailing standard for licensure, and affirms that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter, and therefore, requires the physician to be under the jurisdiction of the state medical board where the patient is located.

House Bill 4066—a new act comprising 24 sections—describes in detail an alternative licensing process for allopathic and osteopathic physicians that promises to speed their licensure allowing them to practice medicine in many states.

Section 2 – Definition. This section of the bill defines 15 terms, including '*physician*, '*interstate commission*,' '*medical practice act*,' '*member state,' 'practice of medicine,' 'offense'* and *'rule.'* Specifically, 'rule' is defined to mean a written statement by the Interstate Commission promulgated pursuant to section 12 of the compact that is of general applicability, implements, interprets, or prescribes a policy or provision of the compact, or an organization, procedural, or practice requirements of the Interstate Commission, and has

---

[1] According to the Interstate Medical Licensure Compact (IMLC) website, http://www.imlcc.org/:
IMLC member states issuing letters of qualification and licenses: *Alabama, Arizona, Idaho, Illinois, Iowa, Kansas, Montana, Nebraska, West Virginia, Wisconsin, Wyoming* (11 states)
IMLC member states issuing licenses: *Colorado, Minnesota, Mississippi, Nevada, New Hampshire, Utah* (6 states)
IMLC passed; implementation delayed: *Maine, Pennsylvania, South Dakota, Tennessee, Washington* (5 states)
Compact legislation introduced: ***Michigan***, *Rhode Island, Texas, Washington D.C.* (3 states and D.C.)

the force and effect of statutory law in a member state *if the rule is not inconsistent with the laws of the member state.* The term includes the amendment, repeal, or suspension of an existing rule.

Section 3 – Eligibility. This section defines the eligibility requirements a physician must meet to receive an expedited license under the terms and provisions of the compact.

Section 4 – Designation of State of Principal License. This section requires a physician to designate a 'member' state as the state of principal license for purposes of registration– the state of primary residence where at least 25 percent of the physician's practice of medicine occurs.

Section 5 – Application and issuance of expedited licensure. This section describes the protocol a physician seeking licensure through the compact must follow, including the filing of an application for an expedited license, registration, verification of eligibility, and payment of fees.

Section 6 – Fees for expedited licensure. This section allows a 'member state' issuing an expedited license authorizing the practice of medicine, or the regulating authority of the member state, to impose a fee for the license issued (or renewed) through the compact. Further, the interstate commission is authorized to develop rules regarding fees for expedited license. However, the bill prohibits those rules from limiting the authority of a 'member state', or the state's regulating authority (in Michigan, the Department of Licensing and Regulatory Affairs) as it imposes and determines the amount of a fee.

Section 7 – Renewal and Continued Participation. This section describes the manner in which an eligible physician would renew an expedited license with the interstate commission—including a clean controlled substance license, compliance with all continuing professional development or continuing medical education requirements, and payment of renewal fees.

Section 8 – Coordinated Information System. This section requires the interstate commission to establish a database of all physicians licensed, and all who have applied for expedited licensure. The database would entail confidential disciplinary and investigatory information that would be shared among member states.

Section 9 – Joint Investigations. This section authorizes a member board to participate with other member boards in joint investigations of physicians. A subpoena issued by a member state would be enforceable in the other member state, and member states could share investigatory information.

Section 10 – Disciplinary actions. Any disciplinary action taken by any member board against a compact-licensed physician would be deemed unprofessional conduct, and could be subject to discipline by other member boards. Disciplinary action includes revocation of a physician's license in every state where he or she is eligible to practice.

Section 11 – Interstate Medical Licensure Compact Commission. This section authorizes the creation of the Interstate Medical Licensure Compact Commission by the member states, to administer the interstate medical licensure compact (a discretionary state function). The Interstate Commission comprises two voting members from each member state. In states where both allopathic and osteopathic licensing boards operate, the member state would be required to appoint one representative from each licensing board.

This section also describes the organizational structure and internal operations of the Interstate Commission. For example, the commission must meet at least once each year, have bylaws, record minutes, provide minutes to members, allot one vote to each commissioner, and only conduct business with a quorum (specified as a "majority of commissioners") present. Further, commission meetings would have to provide public notice, and be open to the public. (However, the bill describes seven instances in which the commission could work in a closed session.) Information and official records (to the extent not otherwise designated in the compact or its rules) would have to be available to the public for inspection. Finally, the commission would be required to have an executive committee and officers, who would have the power to act on behalf of the Interstate Commission, with the exception of rulemaking.

Section 12 – Powers & Duties of the Interstate Commission. This section describes in detail the powers and duties of the commission, including, upon the request of a member state or a member board, the issuance of advisory opinions concerning the meaning or interpretation of the compact, its bylaws, rules, and actions. Further, the commission would develop a budget, and report annually to the legislatures and governors of the member states about the activities of the Interstate Commission during the preceding year. These reports would have to include reports of financial audits.

Section 13 – Finance Powers. This section specifies that the Interstate Commission may collect an annual assessment from each member state to cover the costs of the operations and activities on the commission and its staff. The total assessment, subject to appropriation, must be sufficient to cover the annual budget approved each year. The aggregate annual assessment amount must be allocated using a formula to be determined by the Interstate Commission, which would promulgate a rule binding upon all member states.

Section 14 – Organization & Operation of the Interstate Commission—Immunity from Liability. This section further describes the commission's internal operations, including its elected officers who serve without compensation.

Further, the section specifies that the "officers and employees of the interstate commission shall be immune from suit and liability, either personally or in their official capacity, for a claim for damage to or loss of property or personal injury or other civil liability caused or arising out of, or relating to, an actual or alleged act, error, or omission that occurred, or that such person had a reasonable basis for believing occurred, within the scope of interstate commission employment, duties, or responsibilities; provided that such person shall not be

protected from suit or liability for damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of such person."

Under the model legislation, the Interstate Commission would be required to defend its employees when they were sued, provided that the actual or alleged act, error, or omission did not result from intentional or willful and wanton misconduct on the part of such person. The bill also specifies that to the extent not covered by the state involved or the interstate commission, the representatives or employees of the Interstate Commission would be held harmless in the amount of a settlement or judgment, provided that the actual or alleged act, error, or omission did not result from intentional or willful and wanton misconduct on the part of such persons.

Section 15 – Rulemaking Functions of the Interstate Commission. This section authorizes the Interstate Commission to promulgate reasonable rules in order to effectively and efficiently achieve the purposes of the compact. The rules deemed appropriate must be made under a rule-making process that conforms to the "Model State Administrative Procedure Act" of 2010 (and subsequent amendments). Within 30 days of a rule's promulgation, a person may file a petition for judicial review of the rule.

Section 16 – Oversight of Interstate Compact. The executive, legislative, and judicial branches of state government in each member state would enforce the compact and would be required to take all actions necessary and appropriate to effectuate the compact's purposes and intent. The provision of the compact and rules would have standing as statutory law, but would not override existing state authority to regulate the practice of medicine.

Section 17 – Enforcement of Interstate Compact. The Interstate Commission may, by a majority vote of the commissioners, initiate legal action in the U.S. District Court for the District of Columbia, or in the federal district where the interstate commission has its principal office, to enforce compliance with the provisions of the compact, and its promulgated rules and bylaws, against a member state in default.

Section 18 – Default Procedure. This section describes in detail the manner in which a member state could default on its compact responsibilities, and the process the Interstate Commission would be required to follow with the defaulting state, including to provide remedial training and specific technical assistance regarding the default. If a state failed to cure the default, it would be terminated from the compact, upon a vote by a majority of the commissioners.

Section 19 – Dispute Resolution. This section requires the Interstate Commission to promulgate rules that provide both mediation and binding dispute resolution.

Section 20 – Member states, effective date and amendment. The bill specifies that the compact becomes effective and binding after legislative enactment into law by no less than seven states. [The Federation of State Medical Boards has surpassed this threshold.] The governors of non-member states (or their designees) are invited to participate in the

activities of the Interstate Commission on a non-voting basis before a state adopts the compact.

Section 21 – Withdrawal. To withdraw from the compact, a state legislature would repeal the statute that enabled the compact's creation. A state considering repeal would be required to notify the Interstate Commission, which in turn would notify the other member states.

Section 22 – Dissolution. The compact would dissolve when its members was reduced to one member state.

Section 23 – Severability & Construction. The bill specifies that the provisions of the compact are severable. Consequently, if any phrase, clause, sentence, or provision is deemed unenforceable, the remaining provisions are enforceable. The provisions of the compact are intended to be liberally construed, and nothing in the compact is intended to prohibit other state compacts in member states.

Section 24 – Binding effect of compact and other laws. This section specifies, among other things, that all laws in a member state that are in conflict with the compact are superseded to the extent of the conflict. Further, all lawful actions of the Interstate Commission, including all rules and bylaws promulgated by the commission, are binding upon the member states.

Enactment and 'Sunset'. House Bill 4066 specifies that the bill would take effect 180 days after it is enacted into law. In addition, the bill would be repealed effective three years after the effective date (sometimes called a "sunset" provision).
Proposed MCL 333.16189

House Bill 4067

House Bill 4067 would amend the Michigan Public Health Code to specify that any allopathic physician who holds an expedited license under the Interstate Medical Licensure Compact is authorized to engage in the practice of medicine, while any osteopathic physician who holds an expedited license is authorized to practice osteopathic medicine and surgery. Further, an individual who has an expedited license is considered a physician who is licensed under the code.

MCL 333.17001 & 333.17501

BACKGROUND INFORMATION:

For more information about the interstate medical licensure compact, including its impetus, its authors, and the state legislatures that have adopted it, please visit these websites:
http://www.imlcc.org/
http://www.fsmb.org/policy/advocacy-policy/interstate-model-proposed-medical-lic

Definition of "physician" under the bills. The bill includes a definition of "physician" that thousands of Michigan doctors could not meet, largely due to its requirement that practitioners be board certified in their specialty areas of medical expertise.

Specifically, under House Bill 4066, the term "physician" is defined at proposed MCL 16189(2)(k) to mean any person who:

1. Is a graduate of a medical school accredited by the liaison committee on medical education, the commission on osteopathic college accreditation, or a medical school listed in the international medical education directory or its equivalent;
2. Passed each component of the United States medical licensing examination (USMLE) or the comprehensive osteopathic medical licensing examination (COMLEX-USA) within three attempts, or any of its predecessor examinations accepted by a state medical board as an equivalent examination for licensure purposes;
3. Successfully completed graduate medical education approved by the accreditation council for graduate medical education or the American Osteopathic Association;
4. **Holds specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties or the American Osteopathic Association's Bureau of Osteopathic Specialists;**
5. Possesses a full and unrestricted license to engage in the practice of medicine issued by a member board;
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 held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal or foreign jurisdiction, excluding any action related to non-payment of fees related to a license;
8. Has never had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration; and
9. Is not under active investigation by a licensing agency or law enforcement authority in any state federal, or foreign jurisdiction.

FISCAL INFORMATION:

The Interstate Medical Licensure Compact would provide a supplementary process for the licensure of physicians practicing across state lines (expedited licensure). The magnitude of the fiscal impact would depend upon several factors, including: the number of physicians in Michigan applying through the expedited process to practice medicine in other states, the level of costs associated with the administration of membership within the compact, and the level of fees that the department collects.

The bill would require the Bureau of Professional Licensing to issue a letter of qualification for each Michigan physician applying for licensure through the compact. This process would entail background investigations on applicants, but the bill makes no mention to whether fees could be collected for this function. The department would receive fee revenue for out-of-state physicians applying through the compact for licensure to practice in Michigan. Since LARA is empowered to determine the amount of the fees to issue

expedited licenses, it may be assumed that the amount of the fees would likely be sufficient to adequately offset LARA's costs. Administrative costs would likely be incurred for LARA's participation in joint investigations and disciplinary actions related to physicians located within other states, and for IT costs related to information sharing between the department and the Interstate Commission. The Interstate Commission would be allowed to levy an annual assessment on member states to offset the Commission's administrative and information technology costs; this cost would likely be borne by existing department resources.

ARGUMENTS:

For:

Proponents of the bills—chiefly hospital systems—argue that facilitating expedited medical licensure through the Interstate Medical Licensure Compact serves to protect state sovereignty. They point out that unlike pre-emption under federal law, the compact allows the states and the state medical boards to continue to exercise their authority to protect patient welfare and regulate physicians.

Proponents argue, too, that the Interstate Medical Licensure Compact enhances patient accessibility to physicians—especially specialists—when patients live in remote and underserved areas of the country. If licensed in several states, physicians are able to consult with patients in underserved areas electronically through hospital-based telemedicine programs.

Against:

Opponents of the bills—mainly physicians—say the bills will incontrovertibly alter the definition of "physician," and that they do so in a manner that will prevent thousands of Michigan physicians from becoming licensed through the multi-state compact. Why? Although the bill defines the "practice of medicine" in precisely the way it is defined in the Michigan Public Health Code, the bill does not define "physician" in the same way. In the Michigan Public Health Code, a "physician" is simply defined as anyone who is licensed by the appropriate medical licensing board—allopathic or osteopathic. In contrast, House Bill 4066 defines "physician" in a way that would narrow the number of licensed physicians in Michigan by thousands of practitioners because it requires board certification in a medical specialty and contains stringent and unyielding disciplinary requirements. See ***Background Information****,* above.

According to committee testimony, approximately 25% of Michigan physicians do not maintain certification. Two bills under consideration by the House Health Policy committee this session, House Bills 4134 and 4135, seek to prohibit the Department of Licensing and Regulatory Affairs (LARA), the Michigan Board of Medicine, or the Michigan Board of Osteopathic Medicine and Surgery, from requiring maintenance of national or regional certification not specifically required in Article 15 of the Public Health Code before granting a license or license renewal.

Response:

For its part, the IMLC Commission indicates that roughly 80% of physicians meet the required standard for licensure through the IMLC.

Against:

Other opponents of the bills say it is far too early to join the interstate compact, because neither the compact's rules nor its costs can be known at this time. The Interstate Medical Licensure Compact is not yet fully implemented. Indeed, the chairperson of the Compact, Jon Thomas, acknowledged in his committee testimony that the Compact is "building the plane as we're flying it," because supporters did not want to invest millions of dollars in building the infrastructure from the ground up before the Compact was functional. Five states whose legislatures have adopted the IMLC have paused implementation, largely because of a dispute with the Federal Bureau of Investigation over access to its criminal background check system. Some of the bills' supporters advise waiting until more information is available to state officials before voting to join the interstate compact.

POSITIONS:

A representative of Ascension Michigan testified in <u>support</u> of the bills. (9-20-17)

A representative of the Interstate Medical Licensure Compact testified in support of the bills. (9-20-17)

The following organizations <u>support</u> the bills:

- Federation of State Medical Boards (9-20-17)
- Munson Healthcare (9-20-17)
- McLaren Healthcare (9-20-17)
- American Association of Retired Persons (9-20-17)
- Michigan Health and Hospital Association (9-20-17)
- Trinity Health (9-20-17)
- Michigan Primary Care Association (9-27-17)

A representative of the Michigan State Medical Society testified in <u>opposition</u> to the bills. (9-20-17)

Legislative Analyst: Jenny McInerney
Fiscal Analyst: Marcus Coffin

■ This analysis was prepared by nonpartisan House Fiscal Agency staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.