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Gabriel Scheffler

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UNLOCKING ACCESS TO HEALTH CARE: A FEDERALIST APPROACH TO REFORMING OCCUPATIONAL LICENSING

*Gabriel Scheffler*¹

ABSTRACT

Several features of the existing occupational licensing system impede access to health care without providing appreciable protections for patients. Licensing restrictions prevent health care providers from offering services to the full extent of their competency, obstruct the adoption of telehealth, and deter foreign-trained providers from practicing in the United States. Scholars and policymakers have proposed a number of reforms to this system over the years, but these proposals have had a limited impact for political and institutional reasons.

Still, there are grounds for optimism. In recent years, the federal government has taken a range of initial steps to reform licensing requirements for health care providers, and these steps have the potential to improve access to health care. Together, they illustrate a federalist approach to licensing reform, in which the federal government encourages the states to reform their licensing regimes, while largely preserving states' control over the system. These steps include: (1) easing federal licensing restrictions for health care providers in certain areas where the federal government possesses regulatory authority; (2) creating incentives for states and professional bodies to experiment with reforms; (3) intensifying the Federal Trade Commission's focus on licensing boards' anti-competitive conduct; and (4) generating additional pressure for state-level reforms through expanding health insurance and promoting delivery system reforms under the Affordable Care Act.

This article argues that a federalist approach represents the most promising path toward reforming occupational licensing in health care. Federal intervention in licensing is necessary, due to states' lack of

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incentives to experiment with licensing reforms, the externalities of their licensing regimes, and their inability to resolve their own collective action problems. Nevertheless, large-scale federal preemption of state licensing laws is unlikely, due to a combination of interest group politics, Congress's tendency toward incrementalism, and its reliance on the states to administer federal policies. A federalist approach also has functional advantages over outright federal preemption: it allows for more experimentation in constructing new licensing regimes, and it enables the federal government to take advantage of states' institutional expertise in regulating occupations. Finally, this approach presents a model for how the federal government can play a constructive role in occupational licensing in other fields besides health care, and in other areas of state regulatory policy.

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INTRODUCTION

Occupational licensing has been enjoying something of a renaissance of late. After a number of years in which scholars and policymakers paid scant attention to licensing,² there has been a noticeable surge in government initiatives and scholarly work focused on licensing in recent years.³ To name a few recent developments: the Senate held a hearing on occupational licensing and antitrust doctrine in 2016;⁴ the Federal Trade Commission (FTC) formed an “Economic Liberty Taskforce” in 2017, which has focused in large part on licensing;⁵ the Supreme Court in 2015 held that state licensing boards are not automatically immune from federal antitrust scrutiny,⁶ leading several states to restructure their licensing systems;⁷ both the Trump Administration and the Obama Administration have publicly discussed the harms of licensing;⁸ and prominent media outlets, such as the *New York Times*, the *Wall Street Journal*, and *National Public Radio* have featured stories on licensing.⁹

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2. Morris M. Kleiner, *Occupational Licensing*, 14 J. ECON. PERSP. 189, 189-90 (2000) (“[E]ven though occupational licensing has historically been among the most examined institutions in labor economics, this institution has received relatively little recent attention, either from academics or the public policy press.”).
 3. See, e.g., Rebecca Haw Allensworth, *Foxes at the Henhouse: Occupational Licensing Boards Up Close*, 105 CAL. L. REV. 1567, 1569 (2017) (“[A] movement against wasteful occupational licensing rules and regulations is gaining steam.”); Ryan Nunn, *The Future of Occupational Licensing Reform*, BROOKINGS (Jan. 30, 2017), <https://www.brookings.edu/opinions/the-future-of-occupational-licensing-reform/> (describing how “an increasingly broad array of stakeholders and policymakers have indicated a desire to reform occupational licensing”).
 4. *License to Compete: Occupational Licensing and the State Action Doctrine Before the Subcomm. on Antitrust, Competition Policy & Consumer Rights of the S. Comm. on the Judiciary*, 114th Cong. (2016), available at <https://www.judiciary.senate.gov/meetings/license-to-compete-occupational-licensing-and-the-state-action-doctrine>.
 5. *FTC Launches New Website Dedicated to Economic Liberty*, FED. TRADE COMM’N (Mar. 16, 2017), <https://www.ftc.gov/news-events/press-releases/2017/03/ftc-launches-new-website-dedicated-economic-liberty>.
 6. *N.C. State Bd. of Dental Exam’rs v. FTC*, 135 S. Ct. 1101, 1110 (2015).
 7. See *infra* Part III C.
 8. DEP’T TREASURY OFF. ECON. POL’Y, THE COUNCIL OF ECON. ADVISERS, AND THE DEP’T OF LABOR, OCCUPATIONAL LICENSING: A FRAMEWORK FOR POLICYMAKERS (2015) [hereinafter WH REPORT]; THE COUNCIL OF ECON. ADVISERS, THE GROWTH POTENTIAL OF DEREGULATION (2017).
 9. See, e.g., Patricia Cohen, *Moving to Arizona Soon? You Might Need a License*, N.Y. TIMES (June 17, 2016), <https://www.nytimes.com/2016/06/18/business/economy/job-licenses.html>; Jacob Goldstein, *Why*

This resurgence of interest in licensing is warranted. Recent data suggest that roughly one-quarter of the workforce in the United States is licensed.¹⁰ Workers in licensed professions must obtain permission from the government—generally the state government, though some professions are licensed by the federal government or local governments¹¹—to be granted the legal authority to work in their chosen field.¹² To obtain a license, applicants typically must prove that they meet certain education and training standards, pass an examination, pay a fee to the licensing board, and fulfill other administrative requirements.¹³

A growing body of empirical research finds that the current licensure system imposes substantial economic burdens on workers and consumers.¹⁴ Most licensing restrictions are set not by disinterested

It's Illegal to Braid Hair Without a License, NPR (June 12, 2012), <http://www.npr.org/sections/money/2012/06/21/154826233/why-its-illegal-to-braid-hair-without-a-license>; see e.g., Josh Zumbrun, *Occupational Licenses May Be Bad for the Economy, But Good for Workers Who Have Them*, WALL ST. J. (Apr. 18, 2016, 1:13 PM), <https://blogs.wsj.com/economics/2016/04/18/occupational-licenses-may-be-bad-for-the-economy-but-good-for-workers-who-have-them/>.

10. See Jason Furman & Laura Giuliano, *New Data Show that One-Quarter of U.S. Workers Hold an Occupational License*, WHITE HOUSE COUNCIL OF ECON. ADVISERS BLOG (June 17, 2016), <https://obamawhitehouse.archives.gov/blog/2016/06/17/new-data-show-roughly-one-quarter-us-workers-hold-occupational-license>; *Data on Certifications and Licenses*, BUREAU OF LABOR STATISTICS, <https://www.bls.gov/cps/certifications-and-licenses.htm#highlights> (last modified Jan. 18, 2019).
11. Morris M. Kleiner & Alan B. Krueger, *Analyzing the Extent and Influence of Occupational Licensing on the Labor Market*, 31(2) J. LAB. ECON. S173, S184 (2013) [hereinafter Kleiner & Krueger, *Labor Market*] (reporting the results of a survey on the licensure status of around 2,500 individuals that “about two-thirds of the licensed individuals in our sample are licensed at the state level, followed by the federal and local levels”).
12. The term occupational licensing generally “encompasses all forms of regulation that give the licensed practitioner the legal authority to engage in his occupation or profession.” BENJAMIN SHIMBERG ET AL., OCCUPATIONAL LICENSING: PRAC. & POL’Y 8, 9. (1972). This contrasts with *certification*, which is “a nongovernmental mechanism for granting recognition to certain individuals within an occupation or profession.”
13. See BENJAMIN SHIMBERG, OCCUPATIONAL LICENSING: A PUBLIC PERSPECTIVE 25-31 (1980).
14. According to one rough “back-of-the-envelope” calculation, licensing in the U.S. results in up to 2.85 million fewer jobs nationwide, with an annual cost to consumers of \$203 billion. Morris Kleiner et al., *A Proposal to Encourage States to Rationalize Occupational Licensing Practices* (Nat’l Bureau of Econ. Research, 2011) (unpublished proposal to the Brookings Institution Hamilton Project) [hereinafter Kleiner, *A Proposal*]; MORRIS KLEINER, REFORMING OCCUPATIONAL LICENSING POLICIES 6 (2015),

regulators, but rather by members of licensed professions who have an economic incentive to erect regulatory barriers that limit competition and deliver “economic rents”—profits that exceed what would exist in a competitive market.¹⁵ Licensing results in higher wages for licensed workers, but reduces employment and wages for unlicensed workers, creates higher prices for consumers, and limits access to services.¹⁶ Empirical research also strongly suggests that licensing reduces geographic mobility.¹⁷ Workers in licensed professions typically must be licensed in each state in which they practice, and states often impose varying requirements to obtain and maintain a license, making it more difficult for workers to relocate from one state to another.¹⁸ These costs are disproportionately borne by certain groups, such as immigrants and individuals with criminal records.¹⁹

available at https://www.brookings.edu/wp-content/uploads/2016/06/THP_KleinerDiscPaper_final.pdf.

15. Jason Furman, Chairman, Council of Economic Advisers, Transcript of Speech at the Brookings Institution on Occupational Licensing and Economic Rents at 1 (Nov. 2, 2015), available at https://obamawhitehouse.archives.gov/sites/default/files/page/files/20151102_occupational_licensing_and_economic_rents.pdf. But see Sandeep Vaheesan & Frank Pasquale, *The Politics of Professionalism: Reappraising Occupational Licensure and Competition Policy*, ANN. REV. L. SOC. SCI. 309, 322 (2018) (arguing that “[b]y restricting entry, occupational and professional regulations establish market shelters that enhance the bargaining power of workers, raising wages and improving worker welfare.”).
16. See, e.g., WH REPORT, *supra* note 8, at 4 (reviewing the empirical literature on the impacts of licensing on the labor market, and finding that licensing restrictions lead to prices that are 3 to 16 percent higher, that licensed workers earn 10 to 15 percent more than unlicensed workers studies with similar levels of education and training, and that licensing reduces interstate mobility).
17. See, e.g., *id.* at 15 (finding that “there are substantial differences in the likelihood of moving across State lines between workers in highly licensed occupations versus other workers, while there are only modest differences between the two groups in the likelihood of moving within a State”); Morris S. Kleiner et al., *Barriers to Labor Migration: The Case of Occupational Licensing*, 21 INDUS. RELATIONS 383 (1982); Arlene Holen, *Effects of Professional Licensing Arrangements on Interstate Labor Mobility and Resource Allocation*, 73 J. POL. ECON. 492, 492 (1965); Janna E. Johnson & Morris M. Kleiner, *Is Occupational Licensing a Barrier to Interstate Migration?*, (Nat’l Bureau of Econ. Research, Working Paper No. 24107, 2017).
18. See WH REPORT, *supra* note 8, at 8, 25, 27.
19. See, e.g., Michelle Natividad Rodriguez & Beth Avery, *Unlicensed & Untapped: Removing Barriers to State Occupational Licenses for People with Records*, NAT’L EMP. L. PROJECT, 1 (2016), <http://nelp.org/content/uploads/Unlicensed-Untapped-Removing-Barriers-State-Occupational-Licenses.pdf> (finding over 12,000 licensing

One important problem with the current licensure system that has received less attention is that it impedes access to health care. Although licensing requirements for health care providers are widely viewed as necessary to protect public safety, several features of the licensure system obstruct access to health care while doing little to ensure quality. For instance, licensing restrictions prevent health care providers such as nurse practitioners from offering services to the full extent of their competency, obstruct the adoption of telehealth by often requiring that health care providers be separately licensed in each state in which their patients are located, and deter foreign-trained providers from practicing in the United States by requiring them to complete costly often duplicative training and testing.²⁰

Despite criticism of this system, the United States licensing regime has proven to be remarkably resistant to change. One reason for this is interest group politics: many of the benefits of licensure accrue to the licensed professionals who make up these organizations, while its costs are dispersed broadly across the population.²¹ Yet the story is more complicated than that: licensing is also often viewed as a signal of the prestige and value of a profession, so many licensed professionals regard efforts to reform licensing as attacks on their profession's worth.²² These dynamics have led some scholars to conclude that the political process is incapable of reforming licensing, and that litigation is the only viable option.²³

This article shows that while these barriers are formidable, they are not insuperable. In recent years, the federal government has taken a number of initial steps aimed at improving access to health care by reforming licensing restrictions for health care providers. For instance, the federal government has recently eased licensing restrictions for health care providers in certain areas where it already possesses regulatory authority, created incentives for states and professional

restrictions that automatically disqualify individuals with any type of felony, and over 6,000 restrictions that disqualify people with a misdemeanor); WH REPORT, *supra* note 8, at 38, 41.

20. *See infra* Part II.

21. *See* John Blevins, *License to Uber: Using Administrative Law to Fix Occupational Licensing*, 64 UCLA L. REV. 844, 848 (2017) (“[O]ccupational licensing is difficult to reform because it provides concentrated benefits to an organized few, while imposing costs diffusely on the public.”); David Schleicher, *Stuck! The Law and Economics of Residential Stability*, 127 YALE L.J. 78, 119 (2017) (“The politics of occupational licensing follow a classic Olsonian script.”). *See generally*, MANCUR OLSON, THE LOGIC OF COLLECTIVE ACTION: PUBLIC GOODS AND THE THEORY OF GROUPS 43 (1965); George Stigler, *The Theory of Economic Regulation*, 2 BELL J. ECON. & MGMT. SCI. 3 (1971).

22. SHIMBERG ET AL., *supra* note 12, at 210.

23. *See, e.g.* Blevins, *supra* note 21, at 870.

bodies to experiment with reforms, intensified its focus on licensing boards' anti-competitive conduct, and created additional pressure for state-level reforms through expanding health insurance and promoting delivery system reforms under the Affordable Care Act (ACA).²⁴

Together, these steps represent a *federalist approach* to licensing reform, in which the federal government incentivizes states to change their licensing laws, while largely preserving states' control over their licensing regimes. Although these measures are limited, they demonstrate that the federal government is capable of reforming licensing, and together they pave a path toward improving access to health care. They also illustrate the range of tools the federal government has at its disposal to reform the licensing system, short of simply preempting state law.

Describing an approach in which the federal government intrudes onto a traditional area of state sovereignty as “federalist” may appear to be a misnomer.²⁵ Yet the traditional notion of “dual federalism,” in which the federal government and states have completely separate spheres of authority and do not coordinate with one another,²⁶ is no longer as relevant today when “Congress’s lawmaking reach . . . is now essentially unlimited with respect to the areas into which federal statutory power can go.”²⁷ Rather, as argued by Professor Abbe Gluck, federalism today—“in the sense of state power, relevance, autonomy, and sovereignty—mostly comes and goes at Congress’s pleasure.”²⁸ This new brand of federalism, which Gluck has labeled “intrastatutory

24. *See infra* Part III.

25. Heather K. Gerken, *Federalism as the New Nationalism: An Overview*, 123 YALE L.J. 1889, 1890 (2014) (“You might think that a ‘nationalist school of federalism’ is a contradiction in terms. It isn’t.”).

26. Philip J. Weiser, *Towards a Constitutional Architecture for Cooperative Federalism*, 79 N.C. L. REV. 663, 665 (2001).

27. Abbe R. Gluck, *Nationalism as the New Federalism (and Federalism as the New Nationalism): A Complementary Account (and Some Challenges) to the Nationalist School*, 59 ST. LOUIS U. L.J. 1045, 1049 (2015) [hereinafter Gluck, *New Federalism*]. *See also* Theodore W. Ruger, ‘Our Federalism’ Moves Indoors 38 J. HEALTH POL., POL’Y & L. 283, 284-285 (2013) (“[T]his binary toggle is a far-from-realistic depiction of American federalism as it has operated for at least half a century.”).

28. Gluck, *New Federalism*, *supra* note 27, at 1049. Professor Gluck has developed this argument in a series of papers. *See generally* Abbe R. Gluck, *Intrastatutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond*, 121 YALE L. J. 534, 540 (2011) [hereinafter Gluck, *Intrastatutory Federalism*]; Abbe R. Gluck, *Our [National] Federalism*, 123 YALE L.J. 1996, 1998 (2014) [hereinafter Gluck, *[National] Federalism*]; Abbe R. Gluck, *Federalism from Federal Statutes: Health Reform, Medicaid, and the Old-Fashioned Federalists’ Gamble*, 81 FORDHAM L. REV. 1749, 1749 (2013) [hereinafter Gluck, *Federalism from Federal Statutes*].

federalism” or “national federalism,”²⁹ stems specifically from Congress’s decisions to delegate the administration of federal schemes to the states. This notion of federalism—which this article hereafter will refer to simply as “federalism”—is expansive, and encompasses a range of distinct federal-state arrangements.³⁰

In applying this federalist framework to the specific context of occupational licensing, this paper explores how it can be used to overcome the institutional and political economy factors that have served to entrench the problems in the existing regulatory apparatus. This emphasis differs from that of Gluck, who focuses on how state administration of federal law can both serve national ends and effectuate traditional federalist values, as well as on the implications of these arrangements for legal doctrine.³¹ It also is distinct from much of the existing literature on federalism and public choice, which tends to focus on questions of how—and to what extent—federalism doctrine should incorporate public choice theory and on how public choice dynamics support or undermine potential justifications for federal intervention.³²

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29. Gluck, *[National] Federalism*, *supra* note 28, at 1998. *See also* Gerken, *supra* note 25, at 1893-94 (“Too often federalism scholars have treated sovereignty and autonomy as if they were the only forms of state power . . . They’ve neglected the different but equally important forms of state power that are at the heart of the nationalist school’s work on federalism: The power states enjoy as national government’s agents.”). Edward Rubin refers to this relationship between the federal government and the states as “decentralization,” and distinguishes it federalism. *See* Edward Rubin, *The Myth of Accountability and the Anti-Administrative Impulse*, 103 MICH. L. REV. 2073, 2085-86 (2005) (contrasting decentralization, a “managerial strategy” in which “the central government . . . decides how decisionmaking authority will be divided between itself and the geographic subdivisions and when that allocation will be changed,” with federalism, which “grants subsidiary units a final say in certain areas.”); Edward L. Rubin & Malcolm Feeley, *Federalism: Some Notes on A National Neurosis*, 41 UCLA L. REV. 903, 910-915 (1994) (distinguishing between decentralization and federalism, and arguing that “many standard arguments advanced for federalism are clearly nothing more than policy arguments for decentralization.”).
30. Gluck, *Intrastatutory Federalism*, *supra* note 28, at 540 (“[T]he typically undifferentiated category of ‘cooperative federalism’ has far more internal nuances than we currently acknowledge.”).
31. *See, e.g.*, Gluck, *Federalism from Federal Statutes*, *supra* note 28, at 1756; *see also* Gerken, *supra* note 25, at 1893 (arguing that “federalism can be a tool for improving national politics, strengthening a national polity, bettering national policymaking, entrenching national norms, consolidating national policies, and increasing national power.”).
32. *See* Roderick M. Hills, Jr., *Federalism and Public Choice*, in RESEARCH HANDBOOK ON PUBLIC CHOICE & PUBLIC LAW 207, 207 (Daniel A. Farber & Anne Joseph O’Connell eds., 2010) (“The public choice literature on federalism and its near-relation, localism, is voluminous in size but narrow

The article shows that this federalist approach is more feasible than two alternatives: either appealing to state governments to reform their own licensing regimes, or alternatively, calling on the federal government to simply preempt state licensing laws. Proposals in the first category (dual federalist proposals) appeal to state governments to restructure their licensing regimes, but often do not acknowledge states' lack of incentives to enact sufficient reforms.³³ By contrast, proposals in the second category advocate that the federal government should step in and preempt large swaths of state law, but they do not take into account the institutional and political challenges involved in such an approach.³⁴

This article evaluates both of these approaches and concludes that they are implausible and that federalism represents the best path toward reforming licensing. Some amount of federal intervention is necessary because states lack the incentives to experiment with large-scale licensing reforms on their own; each state's licensing laws impose externalities on the citizens of other states and on the national labor market; and states face collective action problems.³⁵ Although this might seem to support federal preemption, a federalist approach is in fact more viable: it is more flexible and capable of overcoming interest group opposition and it obviates Congress's historical unwillingness to repeal large areas of state law. Moreover, a federalist approach has important functional advantages over full-scale federal preemption, including encouraging experimentation in the face of policy uncertainty and making use of states' administrative experience.³⁶

in focus . . . Most of this literature revolves around the idea of mobility between competing subnational jurisdictions.”). *See, e.g.*, Robert D. Cooter and Neil S. Siegel, *Collective Action Federalism: A General Theory of Article I, Section 8*, 63 STAN. L. REV. 115, 161-62 (2010); Richard L. Revesz, *Rehabilitating Interstate Competition: Rethinking the ‘Race to the Bottom’ Rationale for Federal Environmental Regulation*, 67 N.Y.U. L. REV. 1210, 1212 (1992).

33. Schleicher, *supra* note 21, at 149 (“A too-easy answer is that states and localities should simply fix the problem by changing their policies. These governments created the problem, the argument goes, so they should fix it. But it is not so easy.”) (citing Eric A. Posner & Adrian Vermeule, *Inside or Outside the System?*, 80 U. CHI. L. REV. 1743 (2013)).
34. Philip Weiser terms this latter type of proposal as “preemptive federalism.” Weiser, *supra* note 26, at 665-66 (“Preemptive federalism, like dual federalism, views the federal government and the states as two separate spheres, but instead of leaving room for state regulation, it preempts all state authority and supplants it with a unitary federal regime.”).
35. *See infra* Part IV.B.
36. *See infra* Part IV.C.

A federalist approach is not only theoretically viable, but also the federal government has already begun to adopt such an approach—albeit in an ad hoc limited fashion. Even these limited steps have the potential to improve access to health care, if recognized and scaled up. Yet some of these federal actions, and the ways in which they have begun to influence licensing requirements for health care providers, have hitherto largely gone unrecognized.³⁷

Although this article focuses specifically on licensing requirements for health care providers, the analyses and conclusions in this paper are relevant for other areas of licensing, as well as for other kinds of state regulation that also deliver economic rents and have nationwide economic externalities. There is a growing recognition among researchers and policymakers that state and local regulatory policies on subjects such as occupational licensing, land-use regulation, and non-compete agreements have important economic implications for the United States as a whole.³⁸ For instance, according to one study, stringent land use regulations in “high productivity” cities like New York and San Francisco lowered overall US growth by thirty-six percent from 1964 to 2009.³⁹ Other research suggests that land-use regulations have played an important role in the rise of economic inequality.⁴⁰ This article provides a general framework for how policymakers can address these issues, and explores some of the specific

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37. See, e.g., Ruger, *supra* note 27, at 285 (“Some crucial areas of health care that have for decades been unquestionably fair game for federal regulation under the post-New Deal commerce clause, like the practice of medicine by individual physicians, have nonetheless gone entirely unregulated by Congress.”).
38. See, e.g., OFFICE ECON. POL’Y, U.S. DEP’T TREASURY, NON-COMPETE CONTRACTS: ECONOMIC EFFECTS AND POLICY IMPLICATIONS (2016); Furman, *supra* note 15, at 1-2; Lawrence H. Summers, *The Inequality Puzzle*, 33 DEMOCRACY (2014), available at <https://democracyjournal.org/magazine/33/the-inequality-puzzle/>. (“Probably the two most important steps that public policy can take with respect to wealth inequality are the strengthening of financial regulation to more fully eliminate implicit and explicit subsidies to financial activity, and an easing of land-use restrictions that cause the real estate of the rich in major metropolitan areas to keep rising in value.”); Ilya Somin, *Time to Get Moving on Making It Easier for Americans to Move*, WASH. POST: VOLOKH CONSPIRACY BLOG (Sept. 23, 2016), <https://www.washingtonpost.com/news/volokh-conspiracy/wp/2016/09/23/time-to-get-moving-on-making-it-easier-for-americans-to-move> (describing an “increasing cross-ideological consensus among experts in the field” that land-use regulations and occupational licensing represent important problems).
39. Chang-Tai Hsieh & Enrico Moretti, *Housing Constraints and Spatial Misallocation* 11 AM. ECON. J.: MACROECONOMICS 1 (2019).
40. See Peter Ganong & Daniel Shoag, *Why Has Regional Income Convergence in the U.S. Declined?*, 102 J. URB. ECON. 76 (2017).

tools that the federal government has at its disposal to affect state regulation, short of outright preemption.

This article proceeds in four parts. Part I provides a brief overview of the occupational licensing system in the United States, including states' legal authority to license workers, and their history of doing so. Part II explores some of the problems with this system, in particular focusing on how licensing requirements for health care providers serve to impede access to health care. Part III examines several recent steps that the federal government has taken to reform licensing restrictions for health care providers which illustrate a federalist approach to licensing reform. Part IV compares the federalist approach to alternative proposals that either rely primarily on state-level reforms or call for federal preemption, and concludes that these alternative approaches are inadequate. It evaluates the justifications for federal intervention and outlines several practical and normative advantages of this federalist approach over full-scale federal preemption.

I. LICENSING AND ITS ORIGINS

A. *Structure and Function*

Occupational licensing statutes typically have several components: they offer a definition of the relevant profession (though often that statutory definition can be quite broad and vague);⁴¹ they provide that it is unlawful to practice, attempt to practice, or hold oneself out as practicing in that profession without a license;⁴² they enumerate certain educational, training, and testing requirements to obtain a license; they specify the range of services professionals are allowed to offer—their so-called “scope of practice”—along with any conditions that are attached to these services; they enumerate disciplinary penalties for those who violate these standards and procedures for enforcing such violations; and they usually establish a state licensing board to interpret and enforce the act.⁴³

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41. See, e.g., IND. CODE ANN. § 25-22.5-1-1.1 (West 2019) (quoted in Sandra Johnson, *Structure of Governmental Oversight of Quality in Healthcare*, in OXFORD HANDBOOK U.S. HEALTH L. 502-503 (I. Glenn Cohen, Allison K. Hoffman, & William M. Sage eds., 1st ed., Oxford University Press 2017)) (defining the “practice of medicine” as including “the diagnosis, treatment, correction, or prevention of any disease, ailment, defect, injury, infirmity, deformity, pain, or other condition of human beings; the suggestion, recommendation, or prescription or administration of any form of treatment, without limitation; [and] the performing of any kind of surgical operation upon a human being, including tattooing”).
42. See, e.g., CAL. BUS. & PROF. CODE § 2052 (West 2019); 63 PA. STAT. AND CONS STAT. ANN. § 422 (West 2018).
43. See Johnson, *supra* note 41, at 490; BARRY R. FURROW ET AL., HEALTH LAW 6 (3d ed. 2015); TIMOTHY S. JOST, *Introduction—Regulation of the*

States have delegated authority to set and enforce licensing restriction to licensing boards, which in turn are largely populated by members of licensed professions.⁴⁴ These boards are charged with “serv[ing] as gatekeepers to determine the qualifications and competence of applicants . . . see[ing] that standards are adhered to by practitioners, and when necessary, adjudicat[ing] disputes between the public and members of the regulated occupation.”⁴⁵ The fact that many of these boards are primarily composed of members of the licensed professions presents an obvious conflict of interest, as these professionals have an incentive to insulate themselves from competition by erecting excessive barriers to entry and to be lenient when enforcing violations against their peers.⁴⁶

B. History

Physicians were among the earliest professions to be licensed, with a number of states establishing medical licensing laws prior to the Revolutionary War.⁴⁷ The early licensing laws were “primarily honorific”—they typically did not regulate entry into the profession or establish minimum educational standards, and they were rarely enforced.⁴⁸ In the early 1800s, states began to pass measures designed

Healthcare Professions, in REGULATION OF THE HEALTHCARE PROFESSIONS 2-5 (1997).

44. Allensworth, *supra* note 3, at 1570 (finding that “of the 1,790 total [licensing] boards [in the United States], 1,515, or 85 percent, are required by statute to be comprised of a majority of currently licensed professionals, active in the very profession the board regulates.”); Aaron Edlin & Rebecca Haw, *Cartels by Another Name: Should Licensed Occupations Face Antitrust Scrutiny?*, 162 U. PA. L. REV. 1093, 1103 (2014) (surveying all occupational licensing boards—including, but not limited to—health care professions in Florida and Tennessee, and finding that “license-holders active in the profession have a majority on 90% of boards in Florida and 93% of boards in Tennessee.”). *C.f.* David Swankin, *The Role of the Public Member on Licensing Boards*, FEDERATION FORUM (Fall 2010), https://www.fsbpt.org/download/Forum_Fall2010_PublicMember.pdf (noting that in California, all non-health licensing boards have a majority of public members).
45. SHIMBERG ET AL., *supra* note 12, at 14-15.
46. CAROLYN COX & SUSAN FOSTER, FTC, THE COSTS AND BENEFITS OF OCCUPATIONAL REGULATION 1 (1990); FURROW ET AL., *supra* note 43, at 4; SHIMBERG ET AL., *supra* note 12, at 13; Edlin & Haw, *supra* note 44, at 1111; Alan Levine et al., *State Medical Boards Fail to Discipline Doctors with Hospital Actions Against Them*, PUB. CITIZEN at 14 (2011), <https://www.citizen.org/sites/default/files/1937.pdf>.
47. Lewis A. Grossman, *The Origins of American Health Libertarianism*, 13 YALE J. HEALTH POL’Y, L. & ETHICS 76, 88-89 (2013).
48. PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 44 (1982).

to render their medical licensing laws more effective, but shortly thereafter, many states weakened or repealed their laws in response to a backlash from advocates promoting “medical freedom.”⁴⁹

After the Civil War, there was a “second wave” of physician licensing, and states one after another began to pass exclusionary licensing laws that punished unlicensed practice by fine or imprisonment.⁵⁰ These laws expanded beyond traditionally-licensed professions such as physicians and dentists to professions such as accountants and nurses.⁵¹ What drove this expansion is a matter of some scholarly debate:⁵² some have argued that it primarily represented an attempt to limit competition and increase market power;⁵³ others have found evidence that it was driven by a desire to exclude low-quality practitioners in the face of advances in science and technology that made it more difficult for consumers to assess practitioners’ quality on their own.⁵⁴

At first, even these new exclusionary licensing laws still did not substantially restrict entry into most professions, either because the requirements they imposed were weak or the licensing boards they established were ineffective.⁵⁵ Charles Eliot, who was President of

49. Grossman, *supra* note 47, at 102-04.

50. *Id.* at 129.

51. Marc T. Law & Sukkoo Kim, *Specialization and Regulation: The Rise of Professionals and the Emergence of Occupational Licensing Regulation*. 65 J. ECON. HIST., 723, 730-731 (2005).

52. Timothy Stolfus Jost, *Oversight of the Quality of Medical Care: Regulation, Management, or the Market?* 37 ARIZ. L. REV. 825, 828 (1995) (“The nineteenth century origins of physician licensure have been thoroughly studied, and a variety of theories have emerged as to why licensure was in fact adopted.”).

53. *See, e.g.*, STARR, *supra* note 48, at 103; Samuel L. Baker, *Physician Licensure Laws in the United States, 1865-1915*, 39 J. HIST. MED. ALLIED SCI. 173, 192 (1984).

54. *See* RICHARD HARRISON SHRYOCK, *MEDICAL LICENSING IN AMERICA, 1650-1965*, 43-44 (1967); Law & Kim, *supra* note 51, at 729 (finding that licensing restrictions were adopted during the Progressive ERA in response to developments which made it harder for consumers to evaluate provider quality). These explanations are not necessarily mutually exclusive. *See* CHRISTY FORD CHAPIN, *ENSURING AMERICA’S HEALTH—THE PUBLIC CREATION OF THE CORPORATE HEALTH CARE SYSTEM* 14-15 (2015) (describing how the American Medical Association harnessed scientific discoveries at the end of the 19th century to make licensing standards more stringent, improving physicians’ quality and increasing their market power).

55. Law & Kim, *supra* note 51, at 726.

Harvard from the late nineteenth to early twentieth century,⁵⁶ reportedly “remarked that in those days anybody could ‘walk into a medical school from the street’ . . . [adding] that many who did walk in ‘could barely read and write.’”⁵⁷ In the decades that followed, however, state legislatures began to ratchet up the requirements to obtain a license, for example, by requiring medical schools to lengthen their curricula and requiring doctors to pass an exam.⁵⁸

As the twentieth century progressed, many other professions sought and were granted licensure by state governments.⁵⁹ By the middle of the 20th century, states had enacted more than 1,200 statutes for at least 75 different occupations.⁶⁰ Over 300 occupations were licensed by 1973.⁶¹ A 1994 study found that over 800 occupations were licensed by at least one of the 50 states.⁶² More recent evidence has confirmed that the expansion of licensing has continued to the present day. Morris Kleiner and Alan Krueger found that the proportion of the workforce licensed at the state level grew from less than 5 percent in the early 1950s to 29% by 2008.⁶³ More recent evidence based on a larger survey sample suggests that a slightly lower proportion of the workforce – closer to one-quarter – holds an occupational license.⁶⁴

C. *Legal Authority and Policy Justifications*

States’ constitutional authority to license professions stems from the police power, which under the Tenth Amendment reserves to the states the authority to pass regulations that further the public’s health,

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56. *Charles William Eliot*, HARV. U., <https://www.harvard.edu/about-harvard/harvard-glance/history-presidency/charles-william-eliot> (last visited Oct. 10, 2017).
57. Walter Gellhorn, *The Abuse of Occupational Licensing*, 44 U. CHI. L. REV. 6, 9 (1976); *see also* STARR, *supra* note 48, at 102.
58. *See* STARR, *supra* note 48, at 104-05; Baker, *supra* note 53, at 189-90.
59. SHIMBERG ET AL., *supra* note 12, at 16 (“Between 1910 and 1919 approximately 130 statutes regulating 14 [health-related] professions were passed.”)
60. Law & Kim, *supra* note 51, at 725-726.
61. COX & FOSTER, *supra* note 46, at 3 (citing D. L. Martin, *Will the Sun Set on Occupational Licensing?*, 53 ST. GOV. 63 (1980)).
62. Kleiner, *Occupational Licensing*, *supra* note 2, at 190 (citing COUNCIL OF STATE GOVERNMENTS, OCCUPATIONS AND PROFESSIONS LICENSED BY THE STATES, PUERTO RICO AND THE VIRGIN ISLANDS (1994)).
63. Kleiner & Krueger, *Labor Market*, *supra* note 11, at S176; Morris M. Kleiner & Alan B. Krueger, *The Prevalence and Effects of Occupational Licensing*, 48 BRIT. J. INDUS. REL. 676, 677-678 (2010) [hereinafter Kleiner & Krueger, *Prevalence and Effects*].
64. *See supra* note 10 and accompanying text.

safety, and general welfare.⁶⁵ The primary justification for licensure—and the one that has been expressly recognized by the courts—is to protect the public from inept or dangerous practitioners.⁶⁶ Courts have historically been very deferential in reviewing states’ authority to invoke the police power, typically upholding legislation under this power if its contribution to health and public safety is “at least fairly debatable.”⁶⁷ While there have been some recent successful constitutional claims brought against licensing regimes,⁶⁸ courts have generally been unwilling to strike down licensing schemes as unconstitutional.⁶⁹

65. FURROW ET AL., *supra* note 43, at 5.
66. *See Dent v. West Virginia*, 129 U.S. 114, 122 (1889). (“The power of the State to provide for the general welfare of its people authorizes it to prescribe all such regulations as in its judgment will secure or tend to secure them against the consequences of ignorance and incapacity, as well as of deception and fraud.”). *See also* *Thomas v. Collins*, 65 S.Ct. 315, 329 (1945), (Jackson, J., concurring) (“The modern state owes and attempts to perform a duty to protect the public from those who seek for one purpose or another to obtain its money. When one does so through the practice of a calling, the state may have an interest in shielding the public against the untrustworthy, the incompetent, or the irresponsible, or against unauthorized representation of agency. A usual method of performing this function is through a licensing system.”); Timothy S. Jost, *Oversight of the Competence of Healthcare Professionals*, in *REGULATION OF THE HEALTHCARE PROFESSIONS* 1, 20 (1992). *But see* Nick Robinson, *The Multiple Justifications of Occupational Licensing*, 93 WASH. L. REV. 1903 (2018) (proposing other justifications for occupational licensing besides consumer protection).
67. Johnson, *supra* note 41, at 494; FURROW ET AL., *supra* note 43, at 15; MARK A. HALL ET AL., *HEALTH CARE LAW AND ETHICS* 1207-08 (8th ed. 2013) (“Courts uniformly have upheld state licensing regulations so long as they are rationally related to serving some legitimate state interest.”) (citing *Williamson v. Lee Optical of Oklahoma Inc.*, 348 U.S. 483 (1955)). *See also* *Nat’l Ass’n for the Advancement of Psychoanalysis v. Cal. Bd. of Psychology*, 228 F.3d 1043 (9th Cir. 2000); *Sherman v. Crynsc*, 786 N.E.2d 139 (Ill. 2003).
68. *See, e.g., Patel v. Texas Dep’t of Licensing & Regulation*, 469 S.W.3d 69, 73 (Tex. 2015) (holding that a Texas law requiring eyebrow-threaders to obtain a cosmetology license violated the Due Process Clause); *St. Joseph Abbey v. Castille*, 712 F.3d 215, 226-227 (5th Cir. 2013) (invalidating a Louisiana law prohibiting unlicensed casket sales).
69. *See Blevins*, *supra* note 21, at 876 (“[C]onstitutional law provides a weak doctrinal toolkit to challenge occupational licensing laws. Courts can only invalidate them by ignoring decades of firmly established, and strongly deferential, precedent.”); Edlin & Haw, *supra* note 44, at 1134 (“Constitutional suits alone cannot curtail the anticompetitive effects of professional licensing . . . [because] they are almost impossible to win.”); Joseph Sanderson, Note, *Don’t Bury the Competition: Occupational Licensing and a Toolbox for Reform*, 31 YALE. J. REG. 455, 456 (2014) (“With a handful of exceptions . . . courts have upheld even the most

The justification for licensure has the most force in fields such as health care, where the public lacks the information or expertise to properly evaluate the competence of practitioners, and where incompetent practitioners can inflict severe harm.⁷⁰ If consumers cannot distinguish between high- and low-quality practitioners, then there is less incentive for practitioners to undertake the costly investments necessary to improve the quality of their services, which in turn reduces the average quality of the service being provided.⁷¹ In addition, in some contexts, low-quality practitioners can inflict harm not only on the persons who paid for their services, but also on third parties as well.⁷²

Nevertheless, many economists and legal scholars have expressed skepticism that licensing improves quality, arguing that its primary purpose is to limit competition and drive up the wages of licensed professionals.⁷³ They point to several factors, including: the dearth of

egregiously protectionist licensing schemes as constitutional.”). *But see* David E. Bernstein, *The Due Process Right to Pursue a Lawful Occupation: A Brighter Future Ahead?*, 126 YALE L.J. 287, 287 (2016) (“Recent precedent . . . suggests that courts are becoming more protective of what has traditionally been considered a subset of liberty of contract: the right to pursue an occupation.”); Clark Neily, *Beating Rubber-Stamps into Gavels: A Fresh Look at Occupational Freedom*, 126 YALE L.J. 304, 305 (2016) (arguing that “several trends in constitutional scholarship and doctrine suggest that a transformation of that jurisprudence may be closer at hand than many would suppose.”).

70. *See* Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AMER. ECON. REV. 941, 967 (1963) (“The choice among these alternatives [licensure, certification, and laissez-faire approaches to regulating occupations] in any given case depends on the degree of difficulty consumers have in making the choice unaided, and on the consequences of errors of judgment. It is the general social consensus, clearly, that the laissez-faire solution for medicine is intolerable. The certification proposal never seems to have been discussed seriously.”).
71. *See generally* George A. Akerlof, *The Market for “Lemons”: Quality Uncertainty and the Market Mechanism*, 84 Q. J. ECON. 488 (1970).
72. Kleiner, *Occupational Licensing*, *supra* note 2, at 192 (“[I]t is argued that in some cases, a poor quality service is not just a matter between employer and employee. A doctor who makes a bad diagnosis may cause a widespread epidemic. A boilermaker who installs a furnace incorrectly may cause a building to catch fire, injuring or killing many persons. In this sense, requiring a practitioner to be trained at a minimum level recognizes a form of regulation which may produce positive social payoffs.”).
73. Gellhorn, *supra* note 57, at 11 (“That restricting access is the real purpose, and not merely a side effect, of many if not most successful campaigns to institute licensing schemes can scarcely be doubted.”); Law & Kim, *supra* note 51, at 724 (“The dominant view today is that the regulatory licensing process has been captured by industry to erect entry restrictions for its own benefit.”); Keith B. Leffler, *Physician Licensure: Competition and Monopoly in American Medicine*, 21 J.L. & ECON. 165, 165 (1978) (“It is

empirical evidence showing that occupational licensing improves quality;⁷⁴ the fact that licensing requirements often do not bear any relation to competency or to the specific demands of a profession;⁷⁵ the fact that licensing requirements often vary dramatically from state to state;⁷⁶ the practice of “grandfathering” current practitioners when a profession becomes licensed (allowing them to practice even when they do not meet all the standards imposed by the new licensing law);⁷⁷ and the evidence that a profession’s political power is an important determinant of whether or not it is licensed, as well as the restrictiveness of licensing laws.⁷⁸

Although many licensing requirements likely do little to improve quality, some of the critiques of licensing may be overstating the evidence. While it is true that most empirical scholarship does not find that licensing requirements improve quality, much of this scholarship has focused on relatively small discrepancies among states’ licensing policies for professions that have long been subject to licensure.⁷⁹ By

widely believed among economists that barriers to entry into medical practice have been erected for the economic advantage of those practicing medicine.”).

74. See, e.g., WH REPORT, *supra* note 8, at 3 (reviewing several empirical studies on the impact of licensing on quality); Edlin & Haw, *supra* note 44, at 1116 (“The economic research on quality of service as a function of licensing paints a murky picture.”).
75. See, e.g., DICK M. CARPENTER II ET AL., INST. FOR JUSTICE, LICENSE TO WORK: A NATIONAL STUDY OF BURDENS FROM OCCUPATIONAL LICENSING 7, 8 (2nd ed. 2017) (finding that licensing laws on average require cosmetologists to have over 10 times as many days of training as emergency medical technicians.); Gellhorn, *supra* note 57, at 13-19 (citing numerous examples, such as citizenship and residency requirements); Paul J. Larkin, Jr., *Public Choice Theory and Occupational Licensing*, 39 HARV. J.L. & PUB. POL’Y 209, 219-220 (2016) (“There also appears to be no rational relationship between the stringency of the licensing requirements and the demands placed on practitioners.”).
76. See CARPENTER II ET AL., *supra* note 75, at 7 (finding that four states require four years of experience to obtain a residential landscape contractor license, while forty other states require no experience).
77. SHIMBERG ET AL., *supra* note 12, at 13; Kleiner et al., *A Proposal*, *supra* note 14, at 8.
78. See, e.g., Benjamin J. McMichael, *The Demand for Healthcare Regulation: The Effect of Political Spending on Occupational Licensing Laws*, 84 S. ECON. J. 297, (2017); Chris Paul, *Physician Licensure Legislation and the Quality of Medical Care*, 12(4) ATLANTIC ECON. J. 18, 20-21 (1984); William D. White, *Mandatory Licensing of Registered Nurses: Introduction and Impact*, in OCCUPATIONAL LICENSURE AND REGULATION 47, 57-61 (Simon Rottenberg ed., 1980).
79. WH REPORT, *supra* note 8, at 60 (“[M]ost of the empirical evidence on licensing comes from looking at very specific examples. While the aforementioned studies indicate that occupational licensing does not

contrast, the few empirical studies that focus on the initial adoption of licensing laws for health care professions find that they have in fact had important impacts on consumers' health and safety.⁸⁰

Moreover, even some of the fiercest critics of licensing concede that the justification for licensing is stronger in health care.⁸¹ Thus, in the context of health care, most reform proposals have tended to focus on reforming specific aspects of the existing licensing system, rather than getting rid of it altogether.⁸²

II. THE IMPACT OF LICENSING ON ACCESS TO HEALTH CARE

Many of the costs of the current licensing system have been well-documented. By limiting entry into the licensed profession, licensing reduces employment in those professions, thereby increasing the wages of licensed professionals and raising the prices that consumers pay for services.⁸³ Restrictive rules of practice (known as "scope of practice" restrictions) further depress wages for licensed professions subject to these restrictions (such as nurses or dental hygienists) and elevate them

guarantee quality improvements, they likewise do not indicate that all licensing frameworks fail to increase service quality").

80. See, e.g., Mark Anderson et al., *The Effect of Occupational Licensing on Consumer Welfare: Early Midwifery Laws and Maternal Mortality* 27 (NBER Working Paper No. 22456, 2016); Law & Kim, *supra* note 51.
81. See, e.g., MILTON FRIEDMAN, *CAPITALISM AND FREEDOM* 138 (1962) ("I agree that the case for licensure is stronger for medicine than for most other fields."); James C. Cooper & William E. Kovacic, *U.S. Convergence with International Competition Norms: Antitrust Law and Public Restraints on Competition*, 90 B.U. L. REV. 1555, 1566 (2010) ("No one seriously disputes the need for some form of professional regulation in the presence of large information asymmetries and serious spillover effects. In most cases it is difficult, if not impossible, for a consumer to judge the quality of her physician or attorney, and these practitioners are unlikely to internalize the full costs of their mistakes. Some level of state credentialing and regulation makes sense."); Shirley V. Sornoy, *Beyond Medical Licensure*, 38 REG. 26, 26 (2015) ("But when it comes to medical professionals, many of the staunchest critics of licensing back off.").
82. See *infra* Part IV. But see FRIEDMAN, *supra* note 81, at 135-160; Charles H. Baron, *Licensure of Health Care Professionals: The Consumer's Case for Abolition*, 9 AM. J.L. & MED. 335, 336-341 (1983); Shirley Sornoy, *Medical Licensing: An Obstacle to Affordable, Quality Care*, 621 POL'Y ANALYSIS 1, 1 (2008).
83. See, e.g., Maya N. Federman, David E. Harrington, & Kathy J. Krynski, *The Impact of State Licensing Regulations on Low-Skilled Immigrants: The Case of Vietnamese Manicurists*, 96(2) AM. ECON. REV. 237 (2006); Kleiner & Krueger, *Labor Market*, *supra* note 11; Kleiner & Krueger, *Prevalence and Effects*, *supra* note 63.

for professions not subject to them (such as doctors or dentists).⁸⁴ Differences among states' licensing regimes, combined with a lack of reciprocity, make it more difficult for practitioners to relocate or practice in multiple states.⁸⁵

This article focuses on one problem that has not received as much attention: how certain features of current licensure system for health care providers impede access to health care without improving quality. Namely, excessive scope of practice restrictions prevent health care providers such as nurses or dental hygienists from offering services they are qualified to provide;⁸⁶ differences in state licensing requirements, which—combined with the requirement that providers be licensed in each state in which they practice—make it more difficult for health care providers to relocate or use telehealth to deliver services in multiple states;⁸⁷ and the refusal to recognize the training completed overseas by foreign health care workers who relocate to the United States.⁸⁸

These features of the licensing system limit access to health care by making it less affordable, contributing to lengthy wait times, and skewing the distribution of health care resources.⁸⁹ Although the most

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84. Edlin & Haw, *supra* note 44, at 1112; Morris M. Kleiner et al., *Relaxing Occupational Licensing Requirements: Analyzing Wages and Prices for a Medical Service*, 59(2) J.L. & ECON. 261, 261-64 (2016) [hereinafter Kleiner et al., *Relaxing Requirements*].
85. *See e.g.*, Johnson & Kleiner, *supra* note 17, at 1-2, 19.
86. *See, e.g.*, LEONARD J. FINOCCHIO ET AL., REFORMING HEALTH CARE WORKFORCE REGULATION: POLICY CONSIDERATIONS FOR THE 21ST CENTURY 9-13 (1995); Yong-Fang Kuo et al., *States with the Least Restrictive Regulations Experienced the Largest Increase in Patients Seen by Nurse Practitioners*, 32(7) HEALTH AFF. 1236, 1241-42 (2013).
87. *See, e.g.*, NAT'L CONFERENCE OF STATE LEGISLATURES, TELEHEALTH: POLICY TRENDS AND CONSIDERATIONS 4 (2015); Amy E. Zilis, *The Doctor Will Skype You Now: How Changing Physician Licensure Requirements Would Clear the Way for Telemedicine to Achieve the Goals of the Affordable Care Act*, 2012 J.L. TECH. & POL'Y 193, 201-203 (2012).
88. *See, e.g.*, Dean Baker, *Globalization Hurt Factory Workers. Why Not Doctors?*, L.A. TIMES (Nov. 27, 2016), <http://www.latimes.com/opinion/op-ed/la-oe-baker-doctor-protectionism-20161127-story.html>; Catherine Rampell, *Path to United States Practice is Long Slog for Foreign Doctors*, N.Y. TIMES (Aug. 11, 2013), <https://www.nytimes.com/2013/08/12/business/economy/long-slog-for-foreign-doctors-to-practice-in-us.html>.
89. *See, e.g.*, FURROW ET AL., *supra* note 43, at 2-3 (“Despite its laudable goals, however, restrictive licensing also produces some negative outcomes. Health care professionals and their patients are constrained in their choices concerning treatment, for example, and licensure raises the costs of health care.”); Baron, *supra* note 82, at 339 (“Because of its

prominent barrier to accessing health care in the United States has long been the lack of affordable health insurance,⁹⁰ surveys find that affordability and wait times are substantial impediments to accessing care in the United States, even for those who have health insurance.⁹¹ A 2016 study of eleven developed countries by the Commonwealth Fund found that U.S. respondents were the most likely to report cost-related problems in accessing care, and that at least one in five Americans waited six days or more to see a doctor or nurse the last time they needed care (with low-income Americans especially likely to have to wait).⁹² According to one estimate, Americans spend 2.4 billion hours each year making doctors' visits—only 17% of which is actually spent seeing a doctor.⁹³ These challenges are especially acute in some geographic areas that have shortages of health care providers, or where patients must travel long distances to see a provider.⁹⁴

The sections below describe how certain licensure laws hinder access to health care through excessive scope of practice restrictions, restrictions on telehealth, and limitations on immigrant health care providers.

anticompetitive tendencies, licensure has produced higher health care costs than those which would prevail in a competitive market.”).

90. Having health insurance is of course an important component of being able to access care. *See generally* Benjamin D. Sommers et al., *Health Insurance Coverage and Health—What the Recent Evidence Tells Us*, 377 *NEW ENG. J. MED.* 586, 588 (2017) (reviewing several recent empirical studies on the effects of health insurance on access to health care and health outcomes).
91. *See* Timothy Jost, *Affordability: The Most Urgent Health Reform Issue for Ordinary Americans*, *HEALTH AFF. BLOG* (Feb. 29, 2016), <http://healthaffairs.org/blog/2016/02/29/affordability-the-most-urgent-health-reform-issue-for-ordinary-americans/>; Sara Heath, *Solutions for Reducing Healthcare Appointment Wait Times for Patients*, *XTELLIGENT HEALTHCARE MEDIA* (Mar. 12, 2018), <https://patientengagementhit.com/news/solutions-for-reducing-healthcare-appointment-wait-times-for-patients>.
92. Robin Osborn et al., *In New Survey of Eleven Countries, US Adults Still Struggle with Access to and Affordability of Health Care*, 35 *HEALTH AFF.* 2327, 2330 (2016).
93. Kristin N. Ray et al., *Opportunity Costs of Ambulatory Medical Care in the United States*, 21 *AM. J. MANAGED CARE* 567 (2015).
94. Julia Foutz et al., *The Role of Medicaid in Rural America*, *KAISER FAMILY FOUND.* (Apr. 25, 2017), <https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/>; Elizabeth J. Brown et al., *Racial Disparities in Geographic Access to Primary Care in Philadelphia*, 35 *HEALTH AFF.* 1374, 1379 (2016).

A. *Scope of Practice*

Licensure laws limit access to health care by restricting what types of services non-physician providers are allowed to provide and subjecting them to excessively stringent physician supervision requirements.⁹⁵ Health care providers' scopes of practice vary widely, depending on the profession they pursue. On one end of the spectrum, physicians are the only profession whose legal scope-of-practice is "all-encompassing."⁹⁶ State physician practice acts authorize physicians to perform any function encompassed by "the practice of medicine," ranging from drawing blood to performing open-heart surgery.⁹⁷ Although there are other non-regulatory mechanisms that, in practice, serve to prevent physicians from providing services that they are unqualified to provide,⁹⁸ physician organizations have historically resisted imposing any legal limitations on their legal scope-of-practice.⁹⁹

By contrast, other health care providers, such as nurses and physician assistants, have much narrower scopes of practice and are often subject to restrictions on their ability to practice or have supervision requirements. These restrictions vary dramatically from state to state, and occasionally may even vary within a given state.¹⁰⁰ For example, although 22 states and the District of Columbia allow Nurse Practitioners (NPs) to provide certain types of health care services independently (including diagnosing patients, initiating and managing certain conditions, prescribing medications, and referring), 16 states require that NPs be supervised by a physician to prescribe

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95. E. KATHLEEN ADAMS & SARA MARKOWITZ, IMPROVING EFFICIENCY IN THE HEALTH-CARE SYSTEM: REMOVING ANTICOMPETITIVE BARRIERS FOR ADVANCED PRACTICE REGISTERED NURSES AND PHYSICIAN ASSISTANTS, THE HAMILTON PROJECT at 6 (2018).
96. Barbara Safriet, *Impediments to Progress in Health Care Workforce Policy: License and Practice Laws*, 31 INQUIRY 310, 311 (1994) [hereinafter Safriet, *Impediments*].
97. *Id.*
98. Barbara J. Safriet, *Federal Options for Maximizing the Value of Advanced Practice Nurses in Providing Quality, Cost-Effective Health Care*, in THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH 443, 453 (The Nat'l Acads. Press, 2011) (these include "norms deriving from common sense and decency, professional ethics and judgment, institutional credentialing and voluntary accreditation standards, and insurance concerns.") [hereinafter Safriet, *Federal Options*].
99. See William M. Sage & Linda H. Aiken, *Regulating Interdisciplinary Practice*, in REGULATING HEALTHCARE PROFESSIONS 74, 74 (Timothy Jost ed., 1992).
100. Barbara J. Safriet, *Closing the Gap Between Can and May in Health-Care Providers' Scope of Practice: A Primer for Policymakers*, 19 YALE J. REG. 301, 313-315 (2002) [hereinafter Safriet, *Closing the Gap*].

medications, and 12 states require NPs to have physician oversight to prescribe, diagnose, and treat patients (as of March 2019).¹⁰¹ Similarly, while all states require Physician Assistants to be supervised by a physician, some states specifically require them to work in the same facility as their supervising physicians, while others require only that the physician be reachable by phone.¹⁰²

A burgeoning body of empirical research suggests that excessive scope of practice restrictions limit access to care without improving quality. For instance, one study found that more stringent scope-of-practice restrictions for NPs increase the price of well-child visits without any evidence of improved health outcomes.¹⁰³ Another study found that more stringent scope-of-practice restrictions for dental hygienists reduces access to dental care.¹⁰⁴ Other research found that the stringency of scope-of-practice restrictions for Certified Nurse Midwives does not affect maternal or infant health outcomes.¹⁰⁵ One recent study found that broadening prescriptive authority for NPs is associated with improvements in patients' mental health and decreases in mortality related to mental health.¹⁰⁶

A wide range of organizations and institutions, including the Institute of Medicine, the Pew Health Professions Commission, the Rand Corporation, and the FTC, have focused in particular on the potential of expanding scope of practice restrictions for Advanced Practice Nurses (APNs) (a category of registered nurses who have graduate degrees which includes Nurse Practitioners, Registered Nurse Anesthetists, Nurse-Midwives, and Clinical Nurse Specialists)¹⁰⁷ to improve access to both primary care and acute care without sacrificing

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101. *State Practice Environment*, AM. ASS'N NURSE PRAC. (Sept. 18, 2017), <https://www.aanp.org/legislation-regulation/state-legislation/state-practice-environment>.
102. FURROW ET AL., *supra* note 43, at 33.
103. Kleiner et al., *Relaxing Requirements*, *supra* note 84, at 263.
104. Tanya Wanchek, *Dental Hygiene Regulation and Access to Oral Healthcare: Assessing the Variation Across the US States*, 48 BRITISH J. OF INDUS. REL. 706, 723 (2010).
105. Sara Markowitz et al., *Competitive Effects of Scope of Practice Restrictions: Public Health or Public Harm?*, 55 J. HEALTH ECON. 201, 216 (2017).
106. Diane Alexander & Molly Schnell, *Just What the Nurse Practitioner Ordered: Independent Prescriptive Authority and Population Mental Health* (Fed. Res. Bank of Chicago, Working Paper No. WP-2017-8, 2016).
107. *Advanced Practice Nurses*, NURSING LICENSE MAP, <https://nursinglicensemap.com/advanced-practice-nursing/> (last visited Mar. 18, 2019).

quality.¹⁰⁸ Drawing on empirical research finding that the quality of care provided by APNs is similar to that provided by physicians for certain services,¹⁰⁹ these organizations have recommended that states allow APNs “to practice to the full extent of their education and training.”¹¹⁰

B. Telehealth

Another way in which state licensing impedes access to health care without improving quality is by making it more difficult for health care providers to practice in multiple states, either remotely via telehealth or in-person.¹¹¹ Through the use of video and data transmission, telehealth can allow patients to remotely access consultations, diagnoses, and treatments when no providers are readily available nearby, or to help providers communicate with each other and manage care more efficiently.¹¹² Proponents of telehealth have hailed its

108. See, e.g., FED. TRADE COMM’N, POLICY PERSPECTIVES: COMPETITION AND THE REGULATION OF ADVANCED PRACTICE NURSES (2014); see FINOCCHIO ET AL., *supra* note 86, at 11.

109. See, e.g., R.P. Newhouse et al., *Advanced Practice Nurse Outcomes 1990-2008: A Systematic Review*, 29 NURSING ECON. 230, 235 (2011); Julie Stanik-Hutt et al., *The Quality and Effectiveness of Care Provided by Nurse Practitioners*, 9 J. NURSE PRACTITIONERS 492, 496 (2013); Mary O. Mundinger et al., *Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A Randomized Trial*, 283 J. AM. MED. ASS’N 59 (2000).

110. INST. MED., THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH 1 (2011) [hereinafter INST. MED.]. See also FINOCCHIO ET AL., *supra* note 86, at 9; FED. TRADE COMM’N, *supra* note 108, at 38.

111. This article follows the American Telemedicine Association in using the terms telehealth and telemedicine interchangeably. *Telemedicine FAQs*, AM. TELEMEDICINE ASS’N (Sept. 20, 2017), <http://www.americantelemed.org/main/about/about-telemedicine/telemedicine-faqs>. Others use both terms to describe “the use of technology to exchange information to improve a patient’s health status,” but understand telemedicine to refer to only direct clinical services and the term telehealth to refer to a broader scope of health-related services (e.g., patient education, remote monitoring, etc.). Tracy A. Lustig, *The Role of Telehealth in an Evolving Health Care Environment: Workshop Summary*, INST. MED. NAT’L ACAD. SCI., 3 (2012) (citing Dr. Thomas S. Nesbitt).

112. According to the Department of Health and Human Services (HHS), the term *telehealth* encompasses four basic functions: (1) *synchronous communication*—live video interactions, such as those between a patient and a provider; (2) *store-and-forward technology*—the transmission of medical data, videos, and digital images to a provider; (3) *remote patient monitoring*—the transmission of “personal health and medical data collection from an individual in one location, which is transmitted to a provider in a different location”; and (4) *mobile health*—“[s]martphone apps designed to foster health and well-being.” U.S. DEP’T HEALTH &

potential to change the delivery of health care as “transcendent.”¹¹³ It holds particular promise for improving access to care, especially for people who live far away from major health care centers and for people afflicted with chronic conditions who require frequent consultation with health care providers.¹¹⁴

Early evaluations of telehealth programs have been encouraging, though they also suggest that telehealth should not be viewed as a panacea. One study of an electronic exchange system linking primary care providers and specialists at San Francisco General Hospital found that around 20% of specialist consultations were resolved without requiring an in-person visit, and that wait times were dramatically reduced for those patients who did require an in-person visit.¹¹⁵ A study of Teladoc, a direct-to-consumer telehealth company, found that its service made accessing care more convenient, though it also had the potential to further stress overtaxed health care systems by leading to greater utilization of health care services.¹¹⁶

Perhaps the most important barrier to more widespread adoption of telehealth is state-specific occupational licensing regimes.¹¹⁷ As many

HUM. SERVICES, E-HEALTH AND TELEMEDICINE 5 (2016) [hereinafter U.S. DEP’T HEALTH & HUM. SERVICES].

113. Carl F. Ameringer, *State-Based Licensure of Telemedicine: The Need for Uniformity but Not a National Scheme*, 14 J. HEALTH CARE L. & POL’Y 55, 56 (2012).
114. See U.S. DEP’T HEALTH & HUM. SERVICES, *supra* note 112, at 4; Bill Frist, *Telemedicine: A Solution to Address the Problems of Cost, Access, and Quality*, HEALTH AFFAIRS BLOG (Jul. 23, 2015), <http://healthaffairs.org/blog/2015/07/23/telemedicine-a-solution-to-address-the-problems-of-cost-access-and-quality/>. *But see* Lori Uscher-Pines & Ateev Mehrotra, *Telehealth Alone Will Not Increase Health Care Access for the Underserved*, RAND BLOG (Dec. 16, 2016), <https://www.rand.org/blog/2016/12/telehealth-alone-will-not-increase-health-care-access.html> (concluding that expanding telehealth will generate new demand for health care services that will require in-person visits, and proposing several potential solutions.).
115. Alice Hm Chen et al., *eReferral—A New Model for Integrated Care*, 368 NEW ENG. J. MED. 2450, 2451 (2013).
116. Uscher-Pines & Mehrotra, *supra* note 114; J. Scott Ashwood et al., *Direct-To-Consumer Telehealth May Increase Access to Care but Does Not Decrease Spending*, 36 HEALTH AFFAIRS 485 (2017).
117. See, e.g., Julia Adler-Milstein et al., *Telehealth Among US Hospitals: Several Factors, Including State Reimbursement and Licensure Policies, Influence Adoption*, 33 HEALTH AFFAIRS 207 (2014) (finding that states which require out-of-state providers to have a special license to provide telehealth have lower rates of telehealth services); Ameringer, *supra* note 113, at 57 (“But serious obstacles to the implementation of telemedicine exist. Among the most significant of these are state-based licensure schemes.”); Heather L. Daly, *Telemedicine: The Invisible Legal Barriers to the Health Care of the Future* 9 ANNALS HEALTH L. 73, 90 (2000)

as four out of five states require health care providers to be licensed in the state where the patient is located, so that health care providers who provide telehealth to patients in multiple states must have separate licenses for each state.¹¹⁸ Some states also require providers to have an in-person consultation with the patient before providing services remotely through telehealth.¹¹⁹ A health care provider who is licensed in one state but practices in a state in which she does not have a license may face loss or suspension of her license, civil damages, or criminal penalties.¹²⁰ In some states, in-state physicians may also be liable if they seek a consultation from an out-of-state physician.¹²¹

(“[A]pplication requirements, inconsistencies in the laws applicable to health care providers, and the lack of coordination make licensing an effective barrier to the expansion of telemedicine.”); Diane E. Hoffman & Virginia Rowthorn, *Legal Impediments to the Diffusion of Telemedicine*, 14 J. HEALTH CARE L. & POL’Y 1, 8 (2011) (“State laws regarding physician licensure present the greatest challenge to the interstate practice of telemedicine.”); Peter D. Jacobson & Elizabeth Selvin, *Licensing Telemedicine: The Need for a National System*, 6 TELEMEDICINE J. & E-HEALTH 429, 431 (2000) (“The current state-based medical licensure system may constitute one of the most significant barriers to the wide dissemination of telemedicine.”); Safriet, *Closing the Gap*, *supra* note 100, at 315-316 (“[T]he crazy quilt of licensure laws has repeatedly been identified as the greatest legal impediment to ‘telepractice’ or ‘telehealth’ systems that would allow HCPs [health care providers] to monitor, diagnose, and treat patients at distant sites through telecommunications technology”); Kathleen M. Vybomy, *Legal and Political Issues Facing Telemedicine*, 5 ANNALS HEALTH L. 61, 66 (1996) (“Perhaps the most significant barrier to a nationwide telemedical practice is the traditional system of state-by-state physician licensing”). Other barriers to the adoption of telehealth besides licensing include resistance from insurers to reimburse providers for telehealth services, and resistance from providers to offer them. Austin Frakt, *You Mean I Don’t Have to Show Up? The Promise of Telemedicine*, N.Y. TIMES (May 16, 2016), <https://www.nytimes.com/2016/05/17/upshot/you-mean-i-dont-have-to-show-up-the-promise-of-telemedicine.html>.

118. U.S. DEP’T HEALTH & HUM. SERVICES, *supra* note 112, at 7-8.
119. Lustig, *supra* note 111, at 18. *See, e.g.*, *Teladoc Inc. v. Tex. Med. Bd.*, 112 F. Supp. 3d 529, 534 (W.D. Tex. 2015) (challenging a 2015 Texas Medical Board rule requiring an in-person evaluation before a physician could issue a prescription).
120. *See* Joy E. Matak, Note, *Telemedicine: Medical Treatment Via Telecommunications Will Save Lives, But Can Congress Answer the Call?: Federal Preemption of State Licensure Requirements Under Congressional Commerce Clause Authority & Spending Power*, 22 VT. L. REV. 231, 233 (1997); Thomas R. McLean, *The Future of Telemedicine and Its Faustian Reliance on Regulatory Trade Barriers for Protection*, 16 HEALTH MATRIX 443, 463 (2006) (“[I]n the current market, when a state finds a provider who uses cyberspace to avoid compliance with its licensure act, that state will aggressively prosecute the provider.”).
121. Matak, *supra* note 120, at 242 (citations omitted).

Although the basic education and training requirements for physician licensure are similar across states, physicians face an array of administrative and financial barriers to getting and maintaining licenses in multiple states.¹²² For example, state licensing boards may require that applicants complete additional testing or coursework; provide references, transcripts, and a picture; pay fees; or participate in an in-person interview.¹²³ Many states also require physicians to have medical malpractice coverage in order to hold a license, so providers practicing in multiple states may have to comply with multiple insurance codes.¹²⁴ Fulfilling these procedures can be time-consuming and costly. These factors may help to explain why, according to a 2010 HRSA report, only 22% of licensed physicians hold multiple state licenses.¹²⁵ Such state-level requirements are also difficult to justify from a quality perspective, since medical practice standards are evidence-based and medical training standards are set nationally.¹²⁶

State licensure presents even more formidable barriers for professions such as nurses and physician assistants seeking to offer services through telehealth, since they are subject as well to scope-of-practice and supervision restrictions that vary widely by state.¹²⁷ For example, a nurse who can prescribe medications or diagnose patients independently in one state may be subject to physician supervision requirements in another. Providers must be careful to abide by the specific scope-of-practice and supervision requirements in each state in which they operate, or risk disciplinary sanctions. Applicants may also have to wait a substantial amount of time for the licensing board to process their application. For example, one report found that nursing school graduates in California had to wait as long as 24 weeks for their licenses to be processed, while experienced nurses from out-of-state also waited for months to get a California license.¹²⁸

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122. Alison M. Sulentic, *Crossing Borders: The Licensure of Interstate Telemedicine Practitioners*, 25 J. LEGIS. 1, 18 (1999).
123. Janet M. Torpy, *Medical Licensure*, 304 J. AM. MED. ASS'N 1268, 1268 (2010).
124. See McLean, *supra* note 120, at 464.
125. MARY K. WAKEFIELD, HEALTH RES. & SERVICES ADMIN., TELEHEALTH LICENSURE REPORT 1, 26 (2010).
126. See Robert Kocher et. al., *Doctors Without State Borders: Practicing Across State Lines*, HEALTH AFFAIRS BLOG (Feb. 18, 2014), <http://healthaffairs.org/blog/2014/02/18/doctors-without-state-borders-practicing-across-state-lines/>.
127. Sulentic, *supra* note 122, at 19 (“The barriers facing a nonphysician who wishes to offer his services in a different state through telemedicine may in fact be impossible to surmount.”).
128. Eryn Brown, *Licensing Logjam for California Nurses*, KAISER HEALTH NEWS (Aug. 17, 2016), <http://khn.org/news/licensing-logjam-for->

States have taken some limited steps to address these obstacles. Most states have a “consultation exception” that allows out-of-state health care providers to “practice medicine in that state at the behest and in consultation with a referring physician’ practicing within the state.”¹²⁹ Other states allow out-of-state physicians to procure a “limited license” or “special purpose” license for telemedicine, which essentially allows out-of-state providers to provide a limited set of services, such as teleradiology, without a full license.¹³⁰ A few states have taken more dramatic steps: for example, Alabama and Pennsylvania have reciprocity agreements with other states, granting in-state licenses to other states that accept their licenses.¹³¹ Yet on the whole, these steps have been either too limited in scope or not sufficiently widespread to remove the barriers that licensing presents for telehealth.¹³²

C. Foreign-Trained Providers

Licensure also impedes access to care without improving quality by subjecting nearly all foreign-trained health care providers to the same burdensome licensing requirements, even if they are highly-trained and experienced. State medical practice acts require that all medical graduates seeking licensure no matter how well-trained and educated they are, must overcome a daunting set of obstacles in order to practice legally in the United States. These include passing the three steps of the United States Medical Licensing Examination (a process which usually takes years to complete and requires paying thousands of dollars in fees) and completing a residency in the United States (which also takes years and has a limited number of vacancies).¹³³ States vary in the length of the residency they require international medical graduates

california-nurses/ (“We can’t license our graduates,’ McFarland lamented. ‘Nurses want to retire, they want to train the next generation. We have hospitals investing in residency programs and they can’t start the new nurses they want to hire. At the end of the day, who’s suffering? Our nurse graduates and our patients.’”).

129. Zilis, *supra* note 87, at 208 (quoting Jon Linkous, *Telemedicine and State Licensure*, AM. TELEMEDICINE ASS’N (Apr. 19, 2010), <http://americantelemed.blogspot.com/2010/04/telemedicine-and-state-licensure.html>).

130. FURROW ET AL., *supra* note 43, at 10; Zilis, *supra* note 87, at 209-210.

131. NAT’L CONFERENCE OF STATE LEGISLATURES, *supra* note 87, at 16.

132. FURROW ET AL., *supra* note 43, at 9-10.

133. See Brenton D. Peterson et al., *Doctors with Borders: Occupational Licensing as an Implicit Barrier to High Skill Migration*, 160 PUB. CHOICE 45, 51 (2014); *Fees and Payment*, EDUC. COMM’N FOR FOREIGN MED. GRADUATES, <https://www.ecfmg.org/fees/index.html> (Dec. 31, 2018).

to complete in order to get a license.¹³⁴ Only physicians who were trained in Canada are exempt from having to complete a residency again in the United States.¹³⁵

This contrasts with the process in some other countries, which allows foreign providers to obtain a license more easily if they meet certain indicators of competency or training. For example, some Canadian provinces allow immigrant physicians to practice family medicine in the Canada without doing a residency there, if they completed similar postgraduate work in certain other countries.¹³⁶ New Zealand automatically allows physicians from the United Kingdom, Australia, and Canada to practice in New Zealand.¹³⁷

The licensing process in the United States likely deters many high-quality foreign-trained providers from practicing here.¹³⁸ According to a 2014 report by former Massachusetts Governor Deval Patrick's Advisory Council for Refugees and Immigrants, foreign-trained health care providers "are 5 times more likely to be underemployed and twice as likely to work in a different field than U.S.-trained providers."¹³⁹ One of the report's authors estimated that there could be more than 60,000 foreign-trained doctors living in the United States who are not licensed to practice.¹⁴⁰ Research finds that patients in the United States who are cared for by international medical graduates have similar or better outcomes than patients who are cared for by U.S. medical graduates.¹⁴¹ Foreign medical graduates disproportionately practice primary care and

134. Peterson et al., *supra* note 133.

135. Rampell, *supra* note 88.

136. *Id.*

137. McLean, *supra* note 120, at 504 (citing Med. Counsel of N.Z., *Policy on Registration in New Zealand* (May 2004), <http://www.mcnz.org.nz/Default.aspx?tabid=983>).

138. See Peterson et al., *supra* note 133, at 50; Simón Rios, *For Doctors Trained Abroad, Challenges to Practicing Medicine Often Insurmountable*, WBUR (Sept. 30, 2016), <http://www.wbur.org/commonhealth/2016/09/30/foreign-trained-doctors-challenges>.

139. GOVERNOR'S ADVISORY COUNCIL FOR REFUGEES & IMMIGRANTS TASK FORCE ON IMMIGRANT HEALTHCARE PROFESSIONALS IN MASSACHUSETTS, *RX FOR STRENGTHENING MASSACHUSETTS' ECONOMY AND HEALTHCARE SYSTEM 1*, 12 (2014).

140. Rios, *supra* note 138.

141. See, e.g., John J. Norcini et al., *Evaluating the Quality of Care Provided by Graduates of International Medical Schools*, 29 *HEALTH AFFAIRS* 1461, 1466-67 (2010); Yusake Tsugawa et al., *Quality of Care Delivered by General Internists in US Hospitals Who Graduated from Foreign Versus US Medical Schools: Observational Study*, 356 *BRIT. MED. J.* 1 (2017).

practice in underserved communities in the United States that lack adequate access to health care.¹⁴²

III. A FEDERALIST APPROACH

Over the past few years, the federal government has taken several steps to improve access to health care by encouraging states to reform their licensing requirements for health care providers. It has eased licensing restrictions for health care providers working at military hospitals and the Department of Veterans Affairs (VA), over which the federal government has jurisdiction. It has provided funding for states and professional bodies to improve access to telemedicine. The FTC has stepped up its antitrust enforcement and advocacy efforts against licensing boards that engage in anticompetitive conduct. Finally, the ACA has indirectly placed pressure on states to implement further reforms through expanding health insurance and promoting delivery system reforms.

These measures represent a range of different federal-state dynamics. For instance, the funding schemes fit into the classic paradigm of “cooperative federalism,” in which the federal government offers states fiscal support to enact certain desired reforms.¹⁴³ By contrast, the VA’s and FTC’s actions arguably represent more substantial incursions onto states’ sovereignty. Yet none of these measures attempts to coopt or preempt state’ authority over licensing altogether. The section below describes each of these measures in more detail, how they might improve access to health care, and the scope for future efforts to build on this progress. Although the steps taken to date have been somewhat ad hoc and limited, they can form the basis for a coherent and effective general approach to a less costly and more effective licensing system.

142. Amelia Goodfellow et al., *Predictors of Primary Care Physician Practice Location in Underserved Urban or Rural Areas in the United States: A Systematic Literature Review*, 91 ACAD. MED. 1313 (2016). This seems at least in part attributable to the J1 visa-waiver program, which allows foreign physicians to become eligible for green cards if they work for three years in an area designated by HRSA as “Health Professional Shortage Areas.” See Talia R. Kahn, et al., *Retention of J-1 Visa Waiver Program Physicians in Washington State’s Health Professional Shortage Areas*, 85 ACAD. MED. 614, 614-615 (2010).

143. Gluck, *Intrastatutory Federalism*, *supra* note 28, at 584 (referring to Medicaid and SCHIP as “classic cooperative federalism programs”); Elizabeth Weeks Leonard, *Rhetorical Federalism: The Value of State-Based Dissent to Federal Health Reform*, 39 HOFSTRA L. REV. 111, 122-123 (2010) (“Conditional spending programs, such as Medicaid, are prime examples of cooperative federalism.”).

A. *Federal Licensing Changes*

Although health care providers are licensed by the states, the federal government exerts some limited authority over licenses for providers who work as employees for federal government agencies such as the VA. It has a history of using this authority to relax licensing restrictions to improve access to health care for military and veteran populations. For example, military health care providers (including doctors, nurses, dentists, psychologists) who have a license can work in a military hospital without obtaining a license in the state in which the specific facility they are working at is located.¹⁴⁴ Other federal programs, such as the Veterans Administration, the Indian Health Service, and the Public Health Service have similar programs.¹⁴⁵

In recent years, the federal government has increasingly used this power to ease licensing restrictions with the aim of improving provider mobility and increasing telehealth utilization. In 2011, Congress passed the Servicemembers' Telemedicine & E-Health Portability (STEP) Act, which expanded the existing state licensure exemption for health care professionals treating Department of Defense (DOD) patients to "include qualified DOD civilians and personal service contractors" and to remove the requirement that care for service members be delivered in a military facility.¹⁴⁶ A 2016 memorandum from the Assistant Secretary of Defense for Health Affairs for the Department of Defense further enlarged this exemption by applying it to health care providers in TRICARE (the civilian health care program for service members and their dependents)¹⁴⁷ and clarifying that telemedicine services could be delivered at the patient's home.¹⁴⁸ In 2018, the VA promulgated a rule

144. See Sulentic, *supra* note 122, at 36 (citing 10 U.S.C. § 1094(d)-(e)(1)).

145. *Id.*; see, e.g., VETERANS HEALTH ADMIN., VHA HANDBOOK 1100.19 (2012), at 14 ("Applicants being credentialed in preparation for applying for clinical privileges must possess at least one full, active, current, and unrestricted license that authorizes the licensee to practice in the state of licensure and outside VA without any change being needed in the status of the license.").

146. *One Page Summary on the H.R. 1832, the STEP Act*, U.S. CONGRESSMAN GLENN 'GT' THOMPSON, <https://thompson.house.gov/sites/thompson.house.gov/files/One%20Page%20Summary%20on%20the%20STEP%20Act.pdf> (last visited Jan. 8, 2019).

147. *About Us*, TRICARE, <https://www.tricare.mil/About> (last visited Nov. 25, 2018).

148. Ellen L. Janos & Carrie Roll, *U.S. Department of Defense Expands Telemedicine Access for Military Members*, MINTZ (Mar. 8, 2016), <https://www.mintz.com/insights-center/viewpoints/2016-03-us-department-defense-expands-telemedicine-access-military>.

allowing VA health care providers to deliver care through telehealth regardless of where the provider or patient is located.¹⁴⁹

The VA has also used its regulatory authority to relax scope-of-practice restrictions for APNs in VA facilities. In 2016, the VA finalized regulations granting “full practice authority” for three categories of APNs—Nurse Practitioners, Clinical Nurse Specialists, and Certified Nurse-Midwives.¹⁵⁰ This rule expanded the scope of the services that these professionals can offer, for example, clarifying that Certified NPs have the authority to take patient histories, provide physical exams, order laboratory images, and prescribe medications.¹⁵¹ The rule also expressly preempts conflicting state laws that circumscribe APNs’ scope of practice when they are working at the VA.¹⁵² The goal of the regulation is to “[increase] veterans’ access to VA health care by expanding the pool of qualified health care professionals who are authorized to provide primary health care and other related health care services to the full extent of their education, training, and certification, without the clinical supervision of physicians.”¹⁵³

Although no empirical research has yet assessed the impacts of these measures, they have the potential to improve access to care for service members, veterans, and their dependents.¹⁵⁴ These regulatory changes affect a sizable number of people: the VA alone serves over six million patients each year and is the nation’s largest employer of nurses.¹⁵⁵

These recent measures loosely fit what Abbe Gluck calls “field-claiming federalism,” which “denotes a set of small moves that

149. Authority of Health Care Providers to Practice Telehealth, 83 Fed. Reg. 21897 (May 11, 2018) (to be codified at 38 C.F.R. pt. 17).

150. Nursing Services, 38 C.F.R. § 17.415 (2016).

151. *Id.* The proposed rule would have also encompassed a fourth category of APNs, certified registered nurse anesthetists, but the VA revised its proposal to leave them out after the proposed rule was met with intense opposition from anesthesiologists. Virgil Dickson, *VA Finalizes Rule that Expands Scope of Nurse Practice*, MOD. HEALTHCARE (Dec. 13, 2016), <http://www.modernhealthcare.com/article/20161213/NEWS/161219974>.

152. 38 C.F.R. pt. 17 (2016).

153. *Id.*

154. Charlie Reed, *Telehealth Offers Hopes for Better Access to Specialists, Lower Costs*, STARS & STRIPES, (Mar. 21, 2013), https://www.stripes.com/news/telehealth-offers-hopes-for-better-access-to-specialists-lower-costs-1.212850#.WV_Ay02Wy71.

155. *VA Grants Full Practice Authority to Advance Practice Registered Nurses*, U.S. DEP’T VETERANS AFFAIRS (Dec. 14, 2016, 2:05 PM), <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2847>; *Veterans Health Administration: About VHA*, U.S. DEP’T VETERANS AFFAIRS, <https://www.va.gov/health/aboutVHA.asp> (last updated Dec. 27, 2018).

announce the federal government's entry into an area of traditional state authority."¹⁵⁶ The fit is not perfect: instead of announcing the federal government's entry into health licensing, these policies have incrementally expanded existing federal authority over health licensing requirements.¹⁵⁷ Yet these policies may still have "boundary-shifting" significance. Both the VA rules and the STEP Act are limited measures and mostly preserve states' control over licensing, but may "pave[] the way for further and more extensive [federal] regulation."¹⁵⁸ Indeed, some supporters of these measures have even hailed them as a potential first step for Congress on the path toward enacting national telemedicine legislation that applies to all health care providers.¹⁵⁹

B. Fiscal Support

Congress has taken a series of small steps to provide fiscal support to incentivize states to reform their licensing regimes to improve access to care. In 2002, Congress passed a law which authorized the Health Resources and Services Administration (HRSA) to award grants to state licensing boards to encourage cooperation and reduce barriers to telemedicine.¹⁶⁰ The 2009 American Recovery and Reinvestment Act (ARRA) created additional funding for the purpose of making licenses more portable across state lines.¹⁶¹ The 2010 ACA established the National Health Care Workforce Commission and authorized a series of grants to states to address health care workforce issues, with a particular focus on licensure portability,¹⁶² though Congress never appropriated the money requested by the Obama Administration to fund the commission.¹⁶³

HRSA's Licensure Portability Grant Program has contributed to an important and under-appreciated development: the formation of a

156. Gluck, *Intrastatutory Federalism*, *supra* note 28, at 587.

157. In addition, unlike the measures on which Gluck focuses, these ones do not give states the option of opting out of these provisions. *See id.* at 573.

158. *Id.* at 587.

159. *See* Meredith Lawrence, *DoD STEP Act - A Model for Public Healthcare?*, WORK SPACE TODAY (Aug. 1, 2013, 1:04 PM), <http://theworkspacetoday.com/2013/08/01/dod-step-act-a-model-for-public-healthcare/>.

160. Health Care Safety Net Amendments of 2002, Pub L. No. 107-251, § 102 (2002); WAKEFIELD, *supra* note 125, at 2.

161. WAKEFIELD, *supra* note 125, at 17.

162. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 5101, 124 Stat. 119 (2010); WAKEFIELD, *supra* note 125, at 2.

163. Peter I. Buerhaus & Sheldon M. Retchin, *The Dormant National Health Care Workforce Commission Needs Congressional Funding to Fulfill its Promise*, 32 HEALTH AFFAIRS 2021, 2022 (2013).

number of “interstate compacts” for health care professionals. These interstate compacts are regulatory agreements among states and professional organizations aimed at making it easier for providers to relocate from one state to another and to ease the barriers to telehealth.¹⁶⁴

The first such compact was the Nurse Licensure Compact (NLC), developed by the National Council of State Boards of Nursing (NCSBN) in the 1990s and implemented in 2000.¹⁶⁵ The NLC permits certain types of nurses in participating states to practice across state lines, either electronically or in person, without obtaining a new license.¹⁶⁶ It uses a system of “mutual recognition,” in which a nurse located in a state that has adopted the NLC may acquire a single multi-state license that allows him or her to practice in any other state that has adopted the NLC.¹⁶⁷ Of note, the NLC does not obviate all licensing barriers to interstate practice. For instance, nurses must still comply with the scope-of-practice regime in the state in which they are practicing.¹⁶⁸ Although the compact was developed before the establishment of HRSA’s Licensure Portability Grant Program, the NCSBN later received funding from the program to “[pursue] a range of activities to overcome the barriers to adopting the NLC.”¹⁶⁹ Currently 25 states participate in the NLC,¹⁷⁰ and in 2015, the NCSBN developed a similar compact for APNs, who were not included in the original agreement.¹⁷¹

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164. WAKEFIELD, *supra* note 125, at 9, 48. *See generally* Jill Elaine Hasday, *Interstate Compacts in a Democratic Society: The Problem of Permanency*, 49 FLA L. REV. 1, 2 (1997) (evaluating the democratic implications of interstate compacts); Matthew Pincus, *When Should Interstate Compacts Require Congressional Consent?*, 42 COLUM. J.L. & SOC. PROBS. 511, 513-14 (2009) (examining current doctrine concerning when interstate compacts require Congressional consent and proposing a new jurisprudential standard).
165. Sandra Evans, *The Nurse Licensure Compact: A Historical Perspective*, J. NURS. REG., Oct. 2015, at 11.
166. *NLC FAQs*, NAT’L COUNCIL ST. BOARDS NURSING, <https://www.ncsbn.org/94.htm> (last visited Dec. 28, 2018).
167. *Nurse Licensure Compact: What Nurse Employers Need to Knows*, NAT’L COUNCIL ST. BOARDS NURSING, https://www.ncsbn.org/NLCA_Employers_Fact_Sheet.pdf (last visited Jan. 2, 2019).
168. *Nurse Licensure Compact FAQ*, N.H. BOARD NURSING, <https://www.oplc.nh.gov/nursing/faq-nurse-compact.htm#scope> (last visited Sept. 22, 2017).
169. WAKEFIELD, *supra* note 125, at 16.
170. *Updated Map: Enhanced Nursing Licensure Compact (eNLC) May. 2018*, NURSE (May 23, 2018), <https://nurse.org/articles/enhanced-compact-multi-state-license-eNLC/>.
171. *APRN Compact*, NAT’L COUNCIL STATE BOARDS NURSING, <https://www.ncsbn.org/aprn-compact.htm> (last visited Sept. 22, 2017).

HRSA's Licensure Portability Grant Program also supported the development of a similar interstate compact for physicians, the Interstate Medical Licensure Compact (IMLC).¹⁷² The IMLC was developed by the Federation of State Medical Boards—an umbrella organization representing the various state medical and osteopathic licensing boards—and has been adopted in 25 states as of January 2019.¹⁷³ Unlike the NLC, the IMLC still requires physicians in participating states to acquire a separate license for each state in which they practice, but it aims to make it easier for them to do so.¹⁷⁴

In addition to nurses and physicians, a number of other health care professions have begun to form similar arrangements. Separate compacts are being developed for social workers, physical and occupational therapists, emergency medical services, psychologists, mental health counselors, pharmacists, and dentists.¹⁷⁵ While it remains to be seen how effectively these compacts will ease the adoption of telehealth services and improve interstate mobility, they represent one potential means of improving access to health care.¹⁷⁶

So far, the amount of federal funding provided to the states for licensing reform has been fairly minimal and narrowly targeted, and some scholars have urged the federal government to adopt a more

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172. *Federal Grant Awarded to Support State Medical Boards in Developing Infrastructure for Interstate Medical Licensure Compact*, FED'N STATE MED. BOARDS (July 17, 2015), <http://www.fsmb.org/siteassets/advocacy/news-releases/2015/compact-commission-grant.pdf>.
173. *Michigan Joins Interstate Medical Licensure Compact*, FED'N STATE MED. BOARDS (Jan. 8, 2019), <http://www.fsmb.org/advocacy/news-releases/michigan-joins-interstate-medical-licensure-compact/>.
174. Humayun J. Chaudhry et al., *Improving Access and Mobility – The Interstate Medical Licensure Compact*, 372 NEW ENG. J. MED. 1581 (2015).
175. *National Center for Interstate Compacts*, COUNCIL STATE GOV'TS, <http://apps.csg.org/ncic/> (last visited Sept. 22, 2017); Michael Ollove, *Make Doctor's Licenses Like Driver's Licenses? Medical Groups Say No*, PEW CHARITABLE TRUSTS (Dec. 11, 2015), <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/12/11/make-doctors-licenses-like-drivers-licenses-medical-groups-say-no>.
176. Christina DePasquale & Kevin Stange, *Labor Supply Effects of Occupational Regulation: Evidence from the Nurse Licensure Compact* (Nat'l Bureau of Econ. Research, Working Paper No. 22344, 2016) (finding that the adoption of the Nurse Licensure Compact did not have any significant impacts on mobility); Anna Louie Sussman, *Occupational Licensing Doesn't Seem to Restrict Nurses' Mobility*, WALL ST. J. (July 22, 2016), <https://blogs.wsj.com/economics/2016/07/22/occupational-licensing-doesnt-seem-to-restrict-nurses-mobility/> (“Morris Kleiner, a University of Minnesota economist who has studied licensing extensively, offered a complementary explanation: Nurses’ interstate migration is less affected by licensing than other licensed professionals”).

ambitious program. Economist Morris Kleiner has proposed a competition modeled on the Department of Education's "Race to the Top" program.¹⁷⁷ Others have proposed that the federal government utilize Medicaid and Medicare reimbursement as levers to influence states' licensing schemes.¹⁷⁸

These fiscal incentives largely fit into the classic mode of "cooperative federalism," in which the federal government provides the states with fiscal support on the condition that they enact certain federal policy goals.¹⁷⁹ Yet such measures can be more or less prescriptive, depending on how they are designed.¹⁸⁰ To the extent that the government adopts a more prescriptive approach, it would have to be careful not to run afoul of the Supreme Court's holding in *NFIB v. Sebelius* that sufficiently coercive federal financial incentives can violate the Constitution.¹⁸¹

C. Antitrust Remedies

Another way that the federal government has influence over state licensing laws is through antitrust enforcement. Although the FTC has long criticized states' occupational licensing laws as harmful and anticompetitive,¹⁸² until recently its power to challenge these laws has been hamstrung as state licensing boards have generally been assumed to be immune from federal antitrust scrutiny.¹⁸³ This changed in 2015

177. Kleiner et al., *A Proposal*, *supra* note 14, at 18-19.

178. See, e.g., Safriet *Impediments*, *supra* note 96, at 316; Barbara J. Safriet, *Health Care Dollars and Regulatory Sense: The Role of Advanced Practice Nursing*, 9 YALE J. REG. 417, 481-482 (1992) [hereinafter Safriet, *Health Care Dollars*].

179. Leonard, *supra* note 143, at 122-123 ("Conditional spending programs, such as Medicaid, are prime examples of cooperative federalism.").

180. See Abigail R. Moncrieff, *Federalization Snowballs: The Need for National Action in Medical Malpractice Reform*, 109 COLUM. L. REV. 844, 885 (2009); SHIMBERG ET AL., *supra* note 12, at 244.

181. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S.Ct. 2566, 2602 (2012).

182. See, e.g., COX & FOSTER, *supra* note 46; FED. TRADE COMM'N & DEP'T JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004).

183. Edlin & Haw, *supra* note 44, at 1099 ("Despite wide recognition of the potential for economic harm associated with allowing professions to control their licensing rules and define the scope of their art, real reform is elusive. Part of the reason is that, in the professional licensing context, the most powerful legal tool against anticompetitive activity appears unavailable. Most jurisdictions interpret antitrust federalism to shield licensing boards from the Sherman Act despite the fact that the boards often look and act like § 1's principal target."); Sanderson, *supra* note 69, at 469 (Although "the FTC has repeatedly taken on occupational licensing schemes . . . its successes have been minor and marginal; on the core issue of whether the Sherman Act or Federal Trade Commission Act can be

when the Supreme Court held in *North Carolina Board of Dental Examiners v. FTC* (hereafter *North Carolina Dental Examiners*) that state licensing boards are not automatically immune from federal antitrust scrutiny.¹⁸⁴

The dispute underlying *North Carolina Dental Examiners* began simmering in the early 2000s, when non-dentist providers began offering teeth-whitening services in North Carolina and charging lower prices than dentists had been charging.¹⁸⁵ The North Carolina State Board of Dental Examiners, a state licensing board composed primarily of dentists, became aware of this trend, and issued a number of cease-and-desist letters to the non-dentist providers, charging that teeth-whitening constituted the “practice of dentistry.”¹⁸⁶ The Board’s actions were successful, and the non-dentists ceased offering teeth-whitening in the state.¹⁸⁷ Thereafter, the FTC filed an administrative complaint against the Board, charging that its actions constituted anti-competitive conduct in violation the Federal Trade Commission Act.¹⁸⁸ In response, the Board claimed that because it was a state agency, it was immune from antitrust law under the “state action” doctrine.¹⁸⁹

The legal issue in *North Carolina Dental Examiners* concerned whether state licensing boards enjoy antitrust immunity under the state action doctrine. First established by the Supreme Court in 1943 in *Parker v. Brown*, the idea undergirding the state action doctrine is “that Congress, in passing the Sherman Act, could not have intended to prohibit all state economic regulation that displaces competition.”¹⁹⁰ In the decades that followed *Parker v. Brown*, lower courts had difficulty determining the parameters of this holding.¹⁹¹ Because states frequently govern by delegating regulatory authority to private citizens,¹⁹² the Court later provided in *California Retail Liquor Dealers Ass’n v. Midcal Aluminum, Inc.*, that private entities enjoy state-action immunity if they meet two conditions: (1) if their conduct is “clearly

used against state protectionism, the FTC’s defeat has been almost total.”).

184. N.C. State Bd. of Dental Exam’rs v. FTC, 135 S. Ct. 1101, 1114 (2015).

185. *Id.* at 1108.

186. *Id.* at 1107-08.

187. *Id.* at 1108.

188. *Id.* at 1108-09.

189. *Id.* at 1109.

190. *Parker v. Brown*, 317 U.S. 341, 350-51 (1943); *Sherman Act--State-Action Immunity--North Carolina State Board of Dental Examiners v. FTC*, 129 Harv. L. Rev. 371 (2015).

191. Edlin & Haw, *supra* note 44, at 1119-1120.

192. *Id.*

articulated and affirmatively expressed as state policy;” and (2) is “actively supervised’ by the State itself.”¹⁹³ The Supreme Court subsequently held that some government entities—including municipalities—only needed to meet the first standard to enjoy antitrust immunity, because there is a presumption that they operate in the public interest.¹⁹⁴

Until recently, most courts and commentators assumed that state agencies, including licensing boards, were included in this category of government entities and thus that they were essentially immune from antitrust scrutiny.¹⁹⁵ However, the Supreme Court had not directly addressed whether state agencies, including professional licensing boards, were subject to the second, “active supervision” requirement.¹⁹⁶

In its 2015 ruling, the Supreme Court held that “a state board on which a controlling number of decisionmakers are active market participants in the occupation the board regulates must satisfy *Midcal*’s active supervision requirement in order to invoke state-action antitrust immunity.”¹⁹⁷ The Court reasoned that because the dental board was controlled by dentists and there was no evidence of “active supervision” from the state, it was effectively a private actor and not immune from antitrust scrutiny under the state action doctrine.¹⁹⁸

In the wake of *North Carolina Dental Examiners*, a number of states have enacted new oversight standards in an attempt to satisfy the “active supervision” requirement and immunize their boards against antitrust scrutiny. States have taken different approaches: for example, Governor Bentley of Alabama issued an executive order requiring an executive branch agency or official to oversee state licensing boards;¹⁹⁹ Oklahoma Governor Mary Fallin issued an order requiring its attorney

193. *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.*, et al., 445 U.S. 97, 106 (1980) (quoting *City of Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389, 410 (1978) (opinion of Brennan, J.)).

194. *Hallie v. Eau Claire*, 471 U.S. 34, 45 (1985) (“We may presume, absent a showing to the contrary, that the municipality acts in the public interest.”).

195. Edlin & Haw, *supra* note 44, at 1121-1125; see Neil Katsuyama, *The Economics of Occupational Licensing: Applying Antitrust Economics to Distinguish Between Beneficial and Anticompetitive Professional Licenses*, 19 S. CAL. INTERDISC. L.J. 565, 569 (2010); Einer Richard Elhauge, *The Scope of Antitrust Process*, 104 HARV. L. REV. 667, 693 (1991); *Earles v. State Board of Certified Public Accountants of Louisiana*, 139 F.3d 1033, 1041 (5th Cir. 1988).

196. Edlin & Haw, *supra* note 44, at 1124.

197. *N.C. State Bd. of Dental Exam’rs v. FTC*, 135 S. Ct. 1101, 1114 (2015).

198. *Id.* at 1116.

199. Ala. Exec. Order No. 7 (2015), <https://nasba.org/app/uploads/2018/05/872.pdf>.

general's office to oversee state licensing boards;²⁰⁰ the Arkansas Legislature passed a bill entrusting oversight of its licensing rules to a legislative subcommittee;²⁰¹ and the Georgia Legislature gave its governor the direct authority to veto or modify its licensing boards' decision.²⁰²

In theory, states could also try to insulate their licensing boards from antitrust scrutiny, either "by creating regulatory boards that serve only in an advisory capacity, or by staffing a regulatory board exclusively with persons who have no financial interest in the occupation that is being regulated."²⁰³ Yet, at least so far, states appear to be more focused on satisfying the active supervision requirement.²⁰⁴ Professor Rebecca Haw Allensworth has characterized this new state of affairs as "the new antitrust federalism," in which antitrust immunity is conditioned "not on the fact of state regulation but on the process of regulation."²⁰⁵

The reverberations of *North Carolina Dental Examiners* are still being felt, and the extent to which such institutional changes will affect substantive licensing standards is still unclear. Many observers have expressed skepticism that the bar established by the Court will in practice constrain licensing boards from engaging in anticompetitive conduct or substantively alter states' licensing regimes.²⁰⁶ That being

200. Okla. Exec. Order No. 2015-33 (2015). Retrieved from www.sos.ok.gov/documents/executive/993.pdf.

201. ARK. CODE ANN. § 10-3-309 (2016).

202. GA. CODE ANN. § 43-1C-3(a) (2016).

203. FED. TRADE COMM'N, FTC STAFF GUIDANCE ON ACTIVE SUPERVISION OF STATE REGULATORY BOARDS CONTROLLED BY MARKET PARTICIPANTS (2015). See also Allensworth, *supra* note 3, at 1601 (arguing that "altering professional dominance on boards may be an attractive alternative to supervision . . .").

204. Suzanne Weiss, *States are Re-Examining the Way They Regulate a Variety of Occupations*, ST. LEGIS. MAG. (Jan. 1, 2017), <http://www.ncsl.org/bookstore/state-legislatures-magazine/licensed-to-labor636179334.aspx>. See also Nicole Livanos, *State Board Shake-Up: Legislative Action in the Wake of North Carolina Board of Dental Examiners v. Federal Trade Commission*, 7 J. NUR. REG. 60 (2016).

205. Rebecca Haw Allensworth, *The New Antitrust Federalism*, 102 VA. L. REV. 1387, 1387 (2016).

206. Herbert Hovenkamp, *Rediscovering Capture: Antitrust Federalism and the North Carolina Dental Case*, 4 CPI ANTITRUST CHRONICLE 1, 16 (2015) ("The standard that the Supreme Court has developed is actually not all that high. The final decision must come from a government decision-maker with power to review and disapprove, but largely under any standard that the state wishes to articulate. What the state cannot do, however, is simply paste the label 'sovereign' or 'agency' on a purely private actor."); David Hyman & Shirley Svorny, *If Professions Are Just "Cartels by Another Name," What Should We Do About It?*, 163 U. PA.

said, the Court's decision has clearly increased licensing boards' liability and subjected them to greater scrutiny: so far, it has triggered dozens of lawsuits from current or prospective licensees, most of which have been settled or dismissed.²⁰⁷

The FTC is also intensifying its efforts to challenge boards' anti-competitive conduct.²⁰⁸ For example, in 2016 the FTC and the Department of Justice submitted an amicus brief in favor of a telemedicine company's challenge to a series of regulations adopted by the Texas Medical Board restricting telehealth services in that state.²⁰⁹ In addition to litigation, the FTC has also stepped up its advocacy efforts directed at state legislatures, particularly with regard to scope of practice for APNs.²¹⁰ Between January 2010 and November 2015, the

L. REV. ONLINE 101, 112 (2015) ("Although active supervision may restrain some state licensing boards from engaging in some anticompetitive conduct, we are skeptical that it will actually do all that much to address the problems cataloged by Professors Edlin and Haw."); Joseph Sanderson, *North Carolina Board: Much Ado About Nothing*, YALE J. REG.: NOTICE & COMMENT (Mar. 4, 2015), <http://yalejreg.com/nc/north-carolina-board-much-ado-about-nothing-by-joseph-m-sanderson-2/> ("[W]hile North Carolina Board may have some effects on the margins, the broad landscape is largely unchanged."); Schleicher, *supra* note 21, at 122 (characterizing the Supreme Court's decision as "a minor move against occupational licenses."). For a more optimistic view, see William M. Sage & David A. Hyman, *Antitrust as Disruptive Innovation in Health Care: Can Limiting State Action Immunity Help Save a Trillion Dollars?*, 48 LOY. U. CHI. L.J. 723 (2017) (arguing that the decision has the potential to be a "disruptive innovation" that will make health care markets more efficient).

207. Allensworth, *supra* note 3, at 1582 (describing these lawsuits and arguing that "[t]hese suits not only expose states to significant financial liability, but they threaten to unravel the way that the occupations have been regulated for decades."); Weiss, *supra* note 204.
208. Fazal Khan, *The "Uberization" of Healthcare: The Forthcoming Legal Storm over Mobile Health Technology's Impact on the Medical Profession*, 26 HEALTH MATRIX 123, 162 (2016) ("[W]ith the Court validating that state licensing boards cannot automatically rely on state action immunity, the future portends a more aggressive FTC going after more state boards for anti-competitive regulations in the medical licensing and scope of practice arena.").
209. Brief for the United States and the Federal Trade Commission as Amici Curiae Supporting Plaintiffs-Appellee, *Teladoc Inc. et. al. v. Texas Medical Board*, et. al., No. 16-50017 (5th Cir. Sept. 9, 2016).
210. Maureen Ohlhausen, *Beyond Law Enforcement: The FTC's Role in Promoting Health Care Competition and Innovation*, HEALTH AFFAIRS BLOG (Jan. 26, 2015), <http://healthaffairs.org/blog/2015/01/26/beyond-law-enforcement-the-ftcs-role-in-promoting-health-care-competition-and-innovation/>; Khan, *supra* note 208, at 152 ("The Federal Trade Commission (FTC) has become increasingly involved in advocating for less restrictive scope of practice laws. In the wake of the Institute of Medicine's report on nursing and given expanded insurance coverage

FTC filed fifteen advocacy comments with state legislatures on scope of practice issues, and published a report on scope of practice issues for APNs.²¹¹ In 2017, it also formed a new “Economic Liberty Task Force,” which has focused in large part on occupational licensing.²¹²

D. The Affordable Care Act

Although the ACA explicitly preserves state authority in certain areas, including occupational licensing,²¹³ it indirectly created substantial pressure for states, licensing boards, and professional associations to reshape occupational regulations. It did so in two main ways. First, by dramatically expanding the number of Americans who have health insurance, the ACA accentuated concerns that there would be a shortage in the supply of physicians—and in particular, primary care physicians—in the United States to provide care for the newly insured, who tend to use health care services at a higher rate than the uninsured.²¹⁴ In response, many scholars and policymakers proposed

under the ACA’s individual mandate, many states that still require collaboration agreements are revisiting the practice”).

211. Andrew I. Gavil & Tara Isa Koslov, *A Flexible Health Care Workforce Requires a Flexible Regulatory Environment: Promoting Health Care Competition Through Regulatory Reform*, 91 WASH. L. REV. 147, 183 (2016).
212. Press Release, Federal Trade Commission, FTC Launches New Website Dedicated to Economic Liberty (Mar. 16, 2017), <https://www.ftc.gov/news-events/press-releases/2017/03/ftc-launches-new-website-dedicated-economic-liberty>. *But see* Vaheesan & Pasquale, *supra* note 15 (arguing that the Department of Justice and Federal Trade Commission should not prioritize policing occupational regulations, and that current antitrust framework’s emphasis on efficiency is ill-suited to evaluating occupational licensing regimes).
213. 42 U.S.C. § 18041(d) (2018); Gluck, *Intrastatutory Federalism*, *supra* note 28, at 582 (“We see that philosophy in . . . areas in which Congress chose not to regulate at all, leaving matters such as doctor licensing to the exclusive and historical province of state regulation.”).
214. *See, e.g.*, Nicholas Bagley, *Medicine as a Public Calling*, 114 MICH. L. REV. 57, 63 (2015) (“Policymakers’ greatest immediate concern is a coming ‘doc shortage,’ especially a shortage of primary-care physicians, who were in short supply even before the ACA’s enactment.”); Annie Lowrey & Robert Pear, *Doctor Shortage Likely to Worsen with Health Law*, N.Y. TIMES, July 29, 2012, at A1; Michael Ollove, *Are There Enough Doctors For The Newly Insured?*, KAISER HEALTH NEWS (Jan. 3, 2014), <https://khn.org/news/doctor-shortage-primary-care-specialist/>; Elisabeth Rosenthal, *The Health Care Waiting Game: Long Waits for Doctors’ Appointments Have Become the Norm*, N.Y. TIMES (July 6, 2014), <https://www.nytimes.com/2014/07/06/sunday-review/long-waits-for-doctors-appointments-have-become-the-norm.html>.

expanding scope-of-practice restrictions for APNs in order to meet this rising demand.²¹⁵

Second, the ACA contained a number of “delivery system” reforms aimed at making the delivery of health care more efficient. These included increased support for certain care delivery models, such as Federally Qualified Health Centers (FQHCs) and nurse-managed health clinics (NMHCs), which allow NPs to play larger roles in care delivery.²¹⁶ This emphasis on expanding roles for non-physician practitioners has in turn placed additional scrutiny on licensing boards’ efforts to restrict practitioners’ scopes of practice.²¹⁷

These reforms have coincided with—and likely contributed to—tangible changes in states’ licensing regimes.²¹⁸ Since the beginning of

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215. Thomas S. Bodenheimer & Mark D. Smith, *Primary Care: Proposed Solutions to The Physician Shortage Without Training More Physicians*, 32 HEALTH AFFAIRS 1881, 1884 (2013); Linda V. Green et al., *Primary Care Physician Shortages Could Be Eliminated Through Use of Teams, Nonphysicians, and Electronic Communication*, 32 HEALTH AFF. 11, 16 (2013); Peter D. Jacobson & Shelley A. Jazowski, *Physicians, the Affordable Care Act, and Primary Care: Disruptive Change or Business as Usual?*, 26(8) J. GEN. INTERNAL MED. 934, 934-35 (2011) (“Historically, the United States has fluctuated between projected physician shortfalls and surpluses. With the passage of the ACA, the nation will face a physician shortage in the coming decades . . . expanding the role of NPPs as primary care practitioners is probably the most immediate strategy for alleviating the primary care shortage”); Uwe E. Reinhardt, James Madison Professor of Econ. and Pub. Affairs, Transcript of statement before the U.S. Senate Comm. on Health, Lab., Educ. & Pensions entitled ‘30 Million New Patients and 11 Months to Go: Who Will Provide Their Primary Care?’, 113th Cong. 3 (2013), available at <https://www.help.senate.gov/imo/media/doc/Reinhardt.pdf>.
216. See J. Margo Brooks Carthon et al., *Federal Policies Influence Access to Primary Care and Nurse Practitioner Workforce*, 11(5) J. NURSE PRAC. 527, 528 (2015). See also Richard S. Saver, *Health Law’s Uneasy Relationship with Delivery System Innovation*, in OXFORD HANDBOOK U.S. HEALTH L. 659, 665-666 (I. Glenn Cohen, Allison K. Hoffman, and William M. Sage eds., 1st ed., Oxford University Press 2017) (“The Affordable Care Act’s initiatives to increase the number of nurses in clinical practice generally and demonstration grants for nurse practitioner training programs favor delivery models like retail clinics that depend heavily on nurse practitioner staffing.”).
217. FURROW ET AL., *supra* note 43, at 4 (“The Affordable Care Act fosters expanded roles for continuity of care, accessible preventive care, and management of chronic illness at a lower cost. The activities of the licensure boards in restricting the work of these professionals are coming under increased scrutiny.”).
218. See Gabriel Scheffler, *The Dynamism of Health Law: Expanded Insurance Coverage as the Engine of Regulatory Reform* 10 U.C. IRVINE L. REV. (forthcoming 2020); Johnson, *supra* note 41, at 504 (“The great concern over the shortage of primary care physicians to meet these goals is . . . fostering a push to expand practice opportunities for [APNs and PAs].”);

2010, the year the ACA was signed into law, ten states have expanded their scope-of-practice regimes for NPs to “Full Practice,” bringing the total number to 22 states and DC (as of June 2017).²¹⁹ Although there were likely many different factors that contributed to these changes, advocates and policymakers who pushed for the reforms in these states have cited concerns about not having enough health care providers to meet the rising demand for health care brought about by the ACA.²²⁰ For example, the National Governors Association issued a policy paper proposing that states reexamine their scope of practice laws for NPs, in part to meet the rising demand for health care due to the ACA.²²¹ Advocates of interstate compacts also cited concerns about the ACA’s insurance expansion leading to a shortage of health care providers.²²²

Although the connection between the ACA and occupational licensing may seem attenuated, this is not the first time that expanding

STUART H. ALTMAN ET AL., ASSESSING PROGRESS ON THE INSTITUTE OF MEDICINE REPORT THE FUTURE OF NURSING 5 (2016).

219. AM. ASS’N NURSE PRAC., *supra* note 101.
220. *See, e.g.*, Catherine Dower et al., *It is Time to Restructure Health Professions Scope-of-Practice Regulations to Remove Barriers to Care*, 32 HEALTH AFFAIRS 1971, 1971 (2013) (“With the ACA’s expansion of access to health care services, there is increasing interest in scope of practice—that is, what services may be provided by which health professions under what conditions. Scope-of-practice laws limit the bounds of professional practice for many providers. According to the Scope of Practice Legislation Tracking Database, established by the National Conference of State Legislatures, nearly 1,800 practice act–related bills were proposed in the United States between January 2011 and December 2012; of these, almost 350, or 20 percent, were adopted.”); Lydia DePillis, *In a Fight Between Nurses and Doctors, the Nurses are Slowly Winning*, WASH. POST. (Mar. 18, 2016), <https://www.washingtonpost.com/news/wonk/wp/2016/03/18/in-a-fight-between-nurses-and-doctors-the-nurses-are-slowly-winning/> (“For Beth Baldwin, president of the West Virginia Nurses Association, the measure was aimed at meeting the needs of people who live in rural areas where the nearest physicians might be miles away — especially as the Affordable Care Act has expanded the pool of those with access to insurance.”); Christine Vestal, *Nurse Practitioners Slowly Gain Autonomy*, KAISER HEALTH NEWS (July 19, 2013), <http://khn.org/news/stateline-nurse-practitioners-scope-of-practice/> (“The need for the law, advocates say, was urgent, particularly because Sandoval welcomed the Affordable Care Act’s Medicaid expansion in his state, one of only six Republican governors to do so”).
221. *The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care*, NAT’L GOVERNORS ASS’N (Dec. 20, 2012), <https://www.nga.org/files/live/sites/NGA/files/pdf/1212NursePractitionersPaper.pdf>.
222. *See, e.g.*, Chaudhry et al., *supra* note 174, at 1581-1582; *Nurse Licensure Compact*, NAT’L COUNCIL STATE BOARDS OF NURSING (Apr. 8, 2016), https://www.ncsbn.org/2016NLC_JPuate.pdf.

access to health care services has coincided with policymakers liberalizing regulatory barriers for health care providers. For example, the enactment of Medicaid and Medicare in 1965 led to similar concerns about a shortage of primary care physicians, which in turn contributed to the development of the first nurse practitioner programs.²²³

Further increasing the demand for health care and changing how care is delivered could add to the pressure to liberalize licensing requirements. Professor Barbara Safriet has argued that one way to place pressure on state licensing boards is to amend Medicaid and Medicare to ensure that APNs are eligible for reimbursement for services that they are equipped to provide, even if those services fall outside states' scope-of-practice laws.²²⁴ Professor Fazal Khan predicts that developments in mobile health care will “dramatically tilt the balance of power” in legislative battles over licensing, in the same way that Uber resulted in relaxed municipal licensing barriers for taxi services, and notes that so far “the federal government seems to have gone out of its way to promote this industry.”²²⁵

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Although this paper focuses on the federal government's licensing reform efforts with respect to health care providers, the federal government has recently taken a few steps that apply to non-health care fields as well. For instance, it has used its limited power over federal licenses to limit barriers for people with criminal records: in 2016, the Obama Administration issued an executive order to federal agencies to limit federal licensing restrictions that apply to people with criminal records, as part of a broader suite of actions designed to help

223. See, e.g., John Michael O'Brien, *How Nurse Practitioners Obtained Provider Status: Lessons for Pharmacists*, 60 AM. J. HEALTH-SYS. PHARMACY 2301 (2003); Safriet, *Health Care Dollars*, *supra* note 178, at 431-432.

224. Safriet, *Health Care Dollars*, *supra* note 178, at 481.

225. Khan, *supra* note 208, at 125, 162. See also FURROW ET AL., *supra* note 43, at 4 (“Three major factors are having a growing impact on the structure and practice of professional licensure. These are the expansion and accessibility of information concerning quality and outcomes of health care; a significant shift in approach to defining the standard of care; and public policy and payment supports for expanded roles for non-physician health care professionals.”); Nathan Cortez, *The Mobile Health Revolution?*, 47 U.C. DAVIS L. REV. 1173, 1200 (2014) (arguing that “contrary to prevailing sentiment, Congress and federal regulators are facilitating rather than stifling mobile health technologies”). See generally Matthew Wansley, *Virtuous Capture*, 67 ADMIN L. REV. 419, 422 (2015) (contending that “[i]n some cases, political actors can and should use interest groups—by altering their power and incentives—to pursue public interested regulatory goals”).

incorporate ex-offenders into society.²²⁶ It has directed additional federal funding to states: in 2017, the U.S. Labor Department awarded 7.5 million dollars to the National Conference of State Legislatures lead a coalition of 10 states to reduce barriers to labor market entry and “[i]mprove portability for selected occupational licenses across state lines.”²²⁷ Finally, although the FTC has been especially involved in health licensing issues,²²⁸ it has taken actions in other fields as well, including submitting public comments on state legislation and litigation that would affect licensing for attorneys, interior designers, and casket salesmen.²²⁹ In addition, it is at least possible to imagine comparable federal reforms in non-health care fields (such as expanding legal insurance) that would increase demand for a service or change how it is delivered, which in turn would increase pressure on licensing regimes in these fields.

IV. THE INADEQUACY OF ALTERNATIVE APPROACHES

Over the years, scholars and policymakers have advanced a variety of alternative proposals to reform state licensing for health care providers. These proposals vary both in the substance of their recommendations and the level of government at which they are aimed. Some reform proposals are addressed primarily to state policymakers, while others are addressed to the federal government, and call for it to

226. *Presidential Memorandum -- Promoting Rehabilitation and Reintegration of Formerly Incarcerated Individuals*, Press Release, OFF. PRESS SECRETARY (Apr. 29, 2016), <https://obamawhitehouse.archives.gov/the-press-office/2016/04/29/presidential-memorandum-promoting-rehabilitation-and-reintegration>; *Fact Sheet: President Obama Announces New Actions to Reduce Recidivism and Promote Reintegration of Formerly Incarcerated Individuals*, OFF. PRESS SECRETARY (June 24, 2016), <https://obamawhitehouse.archives.gov/the-press-office/2016/06/24/fact-sheet-president-obama-announces-new-actions-reduce-recidivism-and>.

227. *US Labor Department Awards \$7.5M to Fund Research for Improving Geographic Mobility For Workers In Licensed Occupations*, U.S. DEP’T LAB., (Jan. 12, 2017), <https://www.dol.gov/newsroom/releases/eta/eta20170112-0>; *Notice of Intent to Fund Project on Occupational Licensing Review and Portability: NOI-ETA-16-14*, U.S. DEP’T LAB., <https://www.doleta.gov/grants/pdf/NOI-ETA-16-14.pdf> (last visited Jan. 3, 2019).

228. *See, e.g.*, Ohlhausen, *supra* note 210, (“Not surprisingly, a significant portion of the FTC’s competition advocacy work is focused on the health care sector.”).

229. *Selected Advocacy Relating to Occupational Licensing*, FED. TRADE COMM’N, <https://www.ftc.gov/policy/advocacy/economic-liberty/selected-advocacy-relating-occupational-licensing> (last visited Sept. 26, 2017).

preempt state licensing laws. For the most part, however, such proposals largely ignore—or devote only cursory attention to—how the solutions they propose will overcome the same political dynamics which at least some of them acknowledge as being responsible for the deficiencies in our current system.²³⁰

This section outlines some of these proposals and explores why a federalist approach is more likely to succeed. It concludes that states are unlikely to implement major reforms to their own licensing regimes without any federal intervention, due to lack of incentives to experiment, the presence of externalities, and collective action problems. It also concludes that a federalist approach is more feasible than outright federal preemption, given interest group opposition and Congressional norms, and that a federalist approach has important functional advantages as well.

A. *Alternative Reform Proposals*

1. State Reform Proposals

Over the years, there have been numerous calls for states to reform their health licensing regimes. For instance, in 1995, the Pew Health Professions Commission released 10 recommendations for states to reform their licensing requirements for health care providers, such as standardizing entry-to-practice requirements, allowing “all professionals to provide services to the full extent of their current knowledge, training, experience and skills,” and “redesign[ing] health professional boards and their functions to reflect the interdisciplinary and public accountability demands of the changing health care delivery system.”²³¹ In 2011, the Institute of Medicine published a report on the future of nursing, which included a recommendation that states reform their scope-of-practice regulations for APNs to enable them “to practice to the full extent of their education and training.”²³²

The federal government has issued its own recommendations. In 2004, the FTC published a report on improving competition in health care, which included a recommendation that states “broaden the membership of state licensure boards” and “consider implementing uniform licensing standards or reciprocity compacts to reduce barriers to telemedicine and competition from out-of-state providers who wish

230. *See generally* Posner & Vermeule, *supra* note 33, at 1745 (describing such shifting between perspectives as the “inside/outside fallacy,” when “the theorist equivocates between the external standpoint of an analyst . . . and the internal standpoint of an actor within the system”).

231. FINOCCHIO ET AL., *supra* note 86, at ix.

232. INST. MED., *supra* note 110, at 9.

to move in-state.”²³³ The FTC released a report specifically focused on the regulation of APNs in 2014, which included a number of recommendations for state legislators.²³⁴ In 2015, the Obama White House issued a report on occupational licensing (including—but not limited to—licensing requirements for health care providers), which included a number of licensing “best practices” for states, including “[a]llowing practitioners to offer services to the full extent of their current competency, to ensure that all qualified workers are able to offer services.”²³⁵

These recommendations likely contributed to reforms at the state level. For instance, the Institute of Medicine report created momentum for states to expand their scopes of practices for APNs.²³⁶ The Obama Administration cited several states that proposed reforms in line with its recommendations after the release of its report.²³⁷

Yet despite the release of numerous different recommendations aimed at state policymakers over the years, many of the problems with our licensing system that were identified long ago still exist today. Some of the same critiques in the 2015 Obama White House Report (for instance, that the system of state licensing hinders provider mobility and that scope of practice restrictions are overly stringent) were articulated twenty years earlier in the 1995 Pew Health Professions Commission report,²³⁸ and those critiques in turn echo points made by Benjamin Shimberg in the 1970s and 80s.²³⁹

2. Federal Reform Proposals

Rather than calling on the states to reform their own licensing regimes, others have taken a different approach, proposing instead that the federal government preempt state health licensing regimes to make

233. *See, e.g.*, FED. TRADE COMM’N & DEP’T JUSTICE, *supra* note 182, at 22-25.

234. FED. TRADE COMM’N, *supra* note 108, at 1.

235. WH REPORT, *supra* note 8, at 5.

236. *See* DePillis, *supra* note 220 (noting that nurses’ arguments to expand their scope-of-practice were “bolstered by a seminal report from the National Academies of Science in 2010, which recommended that states remove barriers to nurses practicing ‘to the full extent of their education and training.’”).

237. *Press Release - Fact Sheet: New Steps to Reduce Unnecessary Occupation Licenses that are Limiting Worker Mobility and Reducing Wage*, THE WHITE HOUSE - OFFICE OF THE PRESS SECRETARY, (June 17, 2016), <https://obamawhitehouse.archives.gov/the-press-office/2016/06/17/fact-sheet-new-steps-reduce-unnecessary-occupation-licenses-are-limiting>.

238. FINOCCHIO ET AL., *supra* note 86, at vi-vii.

239. *See* SHIMBERG ET AL., *supra* note 12, at 15.

our system more rational and uniform.²⁴⁰ Perhaps the most intuitive proposal along these lines is to replace our current patchwork of conflicting state licensing laws with a single system of federal licensure for health care providers.²⁴¹ There are compelling reasons to support a system of federal licensure. Since education and training standards for health care providers are largely standardized in the United States, it is difficult to justify the discrepancies among state licensing regimes on grounds of quality.²⁴² At the same time, differences among state requirements impede the adoption of telemedicine and make it more difficult for health care providers to relocate or practice in multiple states.²⁴³ Preempting state licensing laws and creating a single federal licensing regime could improve access to health care through both of these channels.²⁴⁴ Nevertheless, as far as I am aware, Congress has never seriously considered replacing state licenses for health care providers with a single federal licensing regime.

A more targeted proposal is for the federal government to specifically preempt state licensing restrictions that prevent health care providers from delivering services across state lines remotely through telehealth. There are several ways that Congress could do this: it could create a special federal license for telehealth; it could preempt state restrictions on out-of-state providers delivering health care via telehealth; or it could pass legislation specifying that the location where a health care provider practices be considered to be where the provider is located, rather than where the patient is located.²⁴⁵ Any of these proposals would require preempting state law and would mean that health care providers providing health care services remotely through telemedicine would have to be licensed only in the state in which they reside, and not necessarily the states in which their patients are located.

240. See, e.g., McLean, *supra* note 120, at 443.

241. See, e.g., Gavil & Koslov, *supra* note 211, at 195-196; McLean, *supra* note 120, at 446; Safriet, *Health Care Dollars*, *supra* note 178, at 447.

242. See Kocher et al., *supra* note 126.

243. See *supra* Part II(b).

244. See Zilis, *supra* note 87, at 213-14.

245. For some proposals along these lines, see, for example, Jacobson & Selvin, *supra* note 117, at 436; Rashid Bashshur, *Telemedicine and State-Based Licensure in the United States, Revisited*, 14 TELEMEDICINE & E-HEALTH 310 (2008); Matak, *supra* note 120, at 233; Shirley Svorny, *Svorny: Interstate Medical Licensure Compact Won't Help*, CLARION LEDGER, <https://www.clarionledger.com/story/opinion/columnists/2016/02/26/svorny-interstate-medical-licensure-compact-wont-help/80998064/> (last updated Feb. 27, 2016) [hereinafter Svorny, *Interstate Compact*]; Shirley Svorny, *Telemedicine Runs Into Crony Doctoring*, WALL ST. J. (July 22, 2016, 6:36 PM), <https://www.wsj.com/articles/telemedicine-runs-into-crony-doctoring-1469226979>.

This would remove one of the most important barriers to more widespread adoption of telehealth.

There has been at least one attempt to preempt state licensing restrictions on telehealth. In 1995, then-representative Ron Wyden introduced—and later withdrew—an amendment to the bill that became the Telecommunications Act of 1996, which would have prohibited states from “directly or indirectly restrict[ing] interstate commerce by prohibiting any licensed physician from conducting a consultation with a licensed provider in another state using any advanced telecommunications service.”²⁴⁶

Another option is for the federal government to preempt state scope-of-practice laws that prevent health care providers from practicing to the full extent of their competence and training. The 1993 Clinton health care plan included a provision stating that “[n]o State may, through licensure or otherwise, restrict the practice of any class of health professionals beyond what is justified by the skills and training of such professionals.”²⁴⁷ This proposal presumably would have preempted at least those state scope-of-practice restrictions that were clearly unrelated to providers’ qualifications, such as site restrictions that allow nurses and other providers to provide services in one location but not in another. It also would have enabled plaintiffs to sue state licensing boards or administrative agencies in federal court if their scope of practice restrictions were not justified by substantive training criteria.²⁴⁸

B. The Need for Federal Intervention

One might reasonably argue that the states should be left to reform their own licensure regimes, and question whether the federal government needs to be involved in licensing at all. Licensing has traditionally been controlled by the states, and “the core of our federal system is the principle that the states should take the lead unless there is a need for federal action.”²⁴⁹ Moreover, two of the standard

246. H.R. 1555, 104th Cong., (1st Sess. 1995). The proposal originally referred to “licensed health care provider,” instead of “licensed physician.” U.S. DEPT. OF COM., 105TH CONG., *TELEMEDICINE REPORT TO CONGRESS* (1997), available at <https://www.ntia.doc.gov/legacy/reports/telemed/cover.htm>.

247. Health Security Act, H.R. 3600, 103d Cong. § 1161 (1994). See also Ameringer, *supra* note 113, at 62.

248. See H.R. 3600, 103d Cong. § 1161 (1994).

249. Nicholas Bagley, *Federalism and the End of Obamacare*, 127 Yale L.J. - F. 1, 2 (2017), available at www.yalelawjournal.com/forum/federalism-and-the-end-of-obamacare; Collin Roth & Will Flanders, *How Occupational Licensing Laws are Fencing People Out of Opportunity*, FORBES (Apr. 27, 2017, 3:34 PM), <https://www.forbes.com/sites/>

justifications for federal preemption, correcting for discrimination against minority groups and compensating for states' lack of fiscal capacity, do not appear to justify federal intervention in occupational licensing.²⁵⁰

First, licensing does not reflect any obvious political pathologies, such as discrimination against minority groups. Although there are reasons to think that our licensing system disproportionately harms low-income individuals,²⁵¹ the fact that a state policy is regressive has not traditionally been treated as a sufficient basis for federal intervention.²⁵² Although scholars have historically argued that the occupational licensing disproportionately disadvantages minority groups,²⁵³ recent empirical scholarship finds that licensing might in fact have important benefits for historically disadvantaged groups, such as providing more accessible career pathways and helping to reduce statistical discrimination.²⁵⁴

Nor can federal intervention be justified on the basis that states lack the fiscal capacity to enact licensing reform.²⁵⁵ Although some

realspin/2017/04/27/how-occupational-licensing-laws-are-fencing-people-out-of-opportunity/#4974d6ee113b.

250. *Id.*

251. See FURMAN, *supra* note 15, at 3 (“[L]icensing requirements can exacerbate inequality by shifting resources to those who obtained licensed jobs and away from those who cannot and reallocating rents from often lower-income consumers to producers. This is especially problematic when obtaining a license requires paying large upfront costs, including tuition and lost wages from educational requirements, which many low-income workers cannot afford”).

252. See Bagley, *supra* note 249, at 9.

253. See, e.g., Stuart Dorsey, *Occupational Licensing and Minorities*, 7 L. & HUM. BEHAV. 171, 174 (1983); ALAN L. SORKIN, *HEALTH MANPOWER: AN ECONOMIC PERSPECTIVE* 78 (1977).

254. See Peter Q. Blair & Bobby W. Chung, *Occupational Licensing Reduces Racial and Gender Wage Gaps: Evidence from the Survey of Income and Program Participation 2* (HCEO Working Papers Ser. No. 2017-050, 2017); Marc T. Law & Mindy S. Marks, *Effects of Occupational Licensing Laws on Minorities: Evidence from the Progressive Era*, 52 J.L. & ECON. 351, 352 (2009); Beth Redbird, *The New Closed Shop? The Economic and Structural Effects of Occupational Licensure*, 82 AM. SOC. REV. 600 (2017). *But see* Benjamin Powell & Evgeny S. Vorotnikov, *Was Occupational Licensing Good for Minorities? A Critique of Marc Law and Mindy Marks by Daniel B. Klein*, 9 ECON. J. WATCH 210 (2012).

255. See Bagley, *supra* note 249, at 10 (arguing that a national solution to health care reform was necessary in part because states lack the fiscal or taxing capacity to expand health insurance coverage on their own); see also Eric Lee & Abigail R. Moncrieff, *The Positive Case for Centralization in Healthcare Regulation: The Federalism Failures of the ACA*, 20 KAN. J.L. & PUB. POL'Y 266 (2011).

licensing reforms (such as reciprocity agreements) that would allow workers to forgo obtaining a license would require states to forgo some revenue, they would not impose a substantial fiscal burden on states.²⁵⁶ In 2016, fees from occupational and business licenses together only accounted for a little more than one percent of states' total revenues on average.²⁵⁷ Other licensing reforms (such as expanding nurses' scopes of practice) would not necessarily even require states to forgo licensing fees.

Nevertheless, I argue that federal intervention is still necessary for three reasons: First, states lack the incentives to engage in large-scale experiments to reduce the burdens of their licensing systems. Second, individual state's licensing policies have externalities that affect the United States labor market as a whole. Third, licensing presents collective action problems that states cannot easily resolve on their own. These reasons apply to occupational licensing generally, not just to licensing requirements for health care providers. The following sections examine each of these claims in more detail.

1. Experimentation

One reason why federal intervention is necessary is that states lack sufficient incentives to engage in large-scale experimentation with their licensing regimes on their own. This might seem counterintuitive: one of the classic justifications for state governance is that it encourages experimentation and enables states to test policies on a smaller-scale before adopting them nationwide.²⁵⁸ However, as scholars have shown, states do not independently engage in as much regulatory experimentation as policymakers would like.²⁵⁹ Scholars cite several possible reasons for this relative lack of experimentation, including the costs of developing regulatory innovations and the ability of other states to “free ride” on successful innovations, and the fear of scaring off businesses.²⁶⁰

256. Kleiner, *Reforming Occupational Licensing Policies*, *supra* note 14, at 18.

257. *Annual Survey of State Government Tax Collections (STC)*, U.S. CENSUS BUREAU, tbl. “2016 Annual Survey of State Government Tax Collections Detailed Table (2016), available at <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk#>.

258. Lee & Moncrieff, *supra* note 255, at 269-270 (“Experimentation—the ability of states to act as laboratories of democracy—is probably the most frequently invoked functional advantage of state governance.”) (citing *New Ice State Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting)).

259. Gluck, *Federalism from Federal Statutes*, *supra* note 28, at 1764-65.

260. Gluck, *Intrastatutory Federalism*, *supra* note 28, at 567-568 (citing Susan Rose-Ackerman, *Risk Taking and Reelection: Does Federalism Promote Innovation?*, 9 J. LEGAL STUD. 593, 594, 615 (1980); Rubin & Feeley,

As discussed, there are several forces preserving the status quo with regard to licensing, including licensing's public choice dynamics.²⁶¹ Although states have been all too willing to "experiment" with imposing idiosyncratic requirements to obtain a license, they have not been nearly so willing to experiment with reforms that would ease the labor market burdens of licensing or fundamentally alter the structure of their licensing systems.²⁶² Many of the problems that plague our licensing system today stem from our licensing system's original architecture: for instance, Barbara Safriet describes the history of scope-of-practice laws as "exerting a gravitational force that continues to skew all attempts to modify non-physician scopes of practice."²⁶³

One advantage of a federalist approach is that it can encourage states to act more boldly than they would if left to their own devices.²⁶⁴ Some of the most important state policy innovations have come not when states act on their own, but when they implement federal law.²⁶⁵ For example, the ACA itself was famously modeled on Governor Romney's health care reform plan in Massachusetts, but that plan in turn was enabled by a Medicaid waiver from the Bush Administration.²⁶⁶ Similarly, as shown in Part III, many of the limited state experiments with licensing—such as the formation of interstate compacts and the adoption of new supervision regimes for licensing boards—are the result of federal prodding.²⁶⁷

A more ambitious federalist approach to licensing could incentivize states to adopt bolder experiments, such as those that have been adopted in Canada. In 1991, the Canadian province of Ontario enacted legislation that transformed its licensing system for health care providers from one much like that in the United States—a profession-specific licensing system with exclusive scopes of practice controlled by

supra note 29, at 925-926; David A. Super, Rethinking Fiscal Federalism, 118 HARV. L. REV. 2544, 2551-60 (2005).

261. *See supra* notes 21-23 and accompanying text.

262. Larkin, *supra* note 75, at 222 ("One of the benefits of a federal system is that states can explore different regulatory regimes. Yet some differences are inexplicable. It is difficult to imagine a legitimate justification for caring more about whether someone's hair looks 'marvelous' than whether his heart can be restarted.").

263. Safriet, *Closing the Gap*, *supra* note 100, at 308;

264. Gluck, *[National] Federalism*, *supra* note 28, at 2004-2005 ("[S]tate experimentation . . . has arguably been better effectuated from states implementing federal statutory schemes than from them acting alone").

265. Gluck, *Federalism from Federal Statutes*, *supra* note 28, at 1764-65; Rubin & Feeley, *supra* note 29, at 925.

266. *Id.* at 1765.

267. *See supra* Part III.

members of the licensed professions—to one common regulatory regime for all health professions controlled in large part by public appointees.²⁶⁸ The law also established an advisory council, charged with continually revisiting the regulatory regime and offering recommendations to update it, including whether regulated professions should no longer be regulated.²⁶⁹ A 2001 review of the Act—while noting various suggestions for improvements—concluded that it brought about “a clear paradigm shift in the manner and mode of health profession regulation in Ontario,” and that “[t]he paradigm of profession-centered regulation gave way to public interest regulation.”²⁷⁰

Canada has also implemented reforms to make licenses more portable across provinces and improve workers’ mobility. In 2009, the Canadian federal government and provincial and territorial governments signed a free trade agreement which made it easier for workers in regulated fields to move across provinces by requiring provincial regulators to demonstrate why workers from other provinces are not qualified to be licensed in their jurisdictions.²⁷¹ Thereafter, the provinces of British Columbia, Manitoba, Alberta, and Saskatchewan went even further by establishing mutual recognition for a number of different regulated professions.²⁷² These reforms appear much more wide-ranging and radical than the professional compacts that are being adopted in the United States.

2. Externalities

State policymakers also do not have incentives to take into account the impacts of their own state’s occupational licensing regimes on residents of other states. Each state’s licensure laws contributes to a national system that impedes the adoption of new modes of service delivery in fields such as health care and law that—if implemented—could improve access to services across the United States.²⁷³ Yet state

268. Safriet, *Closing the Gap*, *supra* note 100, at 327-28.

269. *About*, HEALTH PROFESSIONS REGULATORY ADVISORY COUNCIL, <https://www.hprac.org/en/about/mandate.asp> (last visited Sept. 26, 2017).

270. HEALTH PROFESSIONS REGULATORY ADVISORY COUNCIL, ADJUSTING THE BALANCE: REVIEW OF THE REGULATED HEALTH PROFESSIONS ACT 17 (2001).

271. HADRIAN MERTINS-KIRKWOOD, LABOUR MOBILITY IN CANADA ISSUES AND POLICY RECOMMENDATIONS, CANADIAN LABOUR CONGRESS 7 (October 2014).

272. *Professional or Skilled Tradesperson*, NEW WEST P'SHIP, http://www.newwestpartnershiptrade.ca/professional_or_skilled_tradesperson.asp (last visited Sept. 26, 2017).

273. See Gillian K. Hadfield, *Innovating to Improve Access: Changing the Way Courts Regulate Legal Markets*, 143 DAEDALUS 83 (2015).

policymakers only have incentives to take these developments into account to the extent that they affect their own states' residents. Nor do state policymakers have incentives to take fully into account the extent to which their licensing regimes affect health care spending, since the federal government shoulders almost one-third of the nation's health care expenditures.²⁷⁴

In addition, states do not have incentives to consider the impacts of their licensing systems on the U.S. labor market as a whole. Economists have recently documented worrisome declines in various indicators of "labor market fluidity" in recent decades, including the proportion of workers changing jobs, getting a new job, or relocating from one state to another.²⁷⁵ Reduced labor market fluidity in turn has been linked to lower employment, especially for young and less educated workers.²⁷⁶ Although it is unlikely that the growth of occupational licensing is the primary driver of this reduced fluidity, economists have hypothesized that it may be playing a contributing role by making it harder for workers to move to another state or get a new job.²⁷⁷ State legislatures and licensing boards do not have sufficient incentives to consider these macroeconomic effects when deciding which professions should be licensed and how their licensing rules should be structured, nor should they be expected to do so.²⁷⁸

274. *NHE Fact Sheet*, CENTERS FOR MEDICARE & MEDICAID SERVICES <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html> (last visited Nov. 10, 2017); see also Moncrieff, *supra* note 180, at 847-848 (making an analogous argument in the context of medical malpractice).

275. See Raven Molloy et al., *Understanding Declining Fluidity in the U.S. Labor Market*, BROOKINGS INST. (2016), <https://www.brookings.edu/bpea-articles/understanding-declining-fluidity-in-the-u-s-labor-market/>; Raven Molloy et al., *Declining Migration within the U.S.: The Role of the Labor Market*, NAT'L BUREAU OF ECON. RES., Working Paper No. 20065 (2014), <https://www.nber.org/papers/w20065.pdf>.

276. See Steven J. Davis & John Haltiwanger, *Labor Market Fluidity and Economic Performance*, (Nat'l Bureau of Econ. Research, Working Paper No. 20479, 2014); see also, ENRICO MORETTI, *THE NEW GEOGRAPHY OF JOBS* 154-177 (2012) (describing the disparity in mobility between more and less educated Americans, and the economic consequences of less educated Americans' lack of mobility).

277. See WH REPORT, *supra* note 8, at 39, 40; Davis & Haltiwanger, *supra* note 276, at 28; but see Raven Molloy et al., *Job Changing and the Decline in Long-Distance Migration in the United States*, 54 DEMOGRAPHY 631, 649 (2017).

278. Schleicher, *supra* note 21, at 150 ("[T]he central problem is that state and local policymakers do not have incentives to protect the broader national labor market. Only federal policymakers can be expected to act on behalf of such an interest").

3. Collective Action

The current system of state licensing also presents collective action problems because it insulates in-state professionals from out-of-state competition.²⁷⁹ Although state governments could in theory improve access to health care for their citizens by unilaterally reducing their own licensing barriers (for instance, by accepting out-of-state licenses or allowing out-of-state providers to deliver services remotely without an in-state license), doing so would increase competition for in-state professionals while at the same time benefiting out-of-state providers. This is similar to the dynamic in international trade that makes countries unwilling to unilaterally reduce tariffs, even though doing so would provide consumer benefits in the form of lower prices.²⁸⁰

A more plausible approach is for states to form bilateral or multilateral arrangements that would benefit both in-state and out-of-state professionals. Yet the transaction costs associated with forming and maintaining such agreements render it unlikely that all 50 states will be able voluntarily reach agreements that effectively address licensing barriers to accessing care for the full range of health care professions.²⁸¹ As discussed, professional regulatory organizations and states have already begun to form interstate compacts for a number of health care professions.²⁸² However, some of these agreements have only

279. Neil Siegel defines a “collective action problem” as “a situation in which individually rational action by states leads to collectively irrational results.” Neil S. Siegel, *Collective Action Federalism and Its Discontents*, 91 TEX. L. REV. 1937, 1941 (2013).

280. THOMAS OATLEY, INTERNATIONAL POLITICAL ECONOMY 80 (5th ed. 2012) (“[T]he logic of collective action helps us understand why governments rarely liberalize trade unilaterally, but have been willing to do so through negotiated agreements. Reciprocal trade agreements make it easier for export-oriented industries to overcome the collective action problem . . . Reciprocal trade agreements provide large benefits in the form of access to foreign markets to small groups of export-oriented firms . . . These . . . firms will solve the collective action problem they face and lobby for trade liberalization at home in exchange for the removal of foreign barriers to their exports”); see also Richard E. Levy, *Federalism and Collective Action*, 45 U. KAN. L. REV. 1241, 1251 (1997) (“Although[] a group of states is generally better off collectively if the members of the group pursue free trade policies, from the perspective of individual states there are strong incentives to behave in protectionist ways regardless of what other members of the group do”).

281. See Cooter & Siegel, *supra* note 32, at 139-44 (describing the transaction costs entailed in forming voluntary interstate agreements). But see Aziz Z. Huq, *Does the Logic of Collective Action Explain Federalism Doctrine?*, 66 STAN. L. REV. 217, 220 (2014) (arguing that simply identifying a collective action problem does not necessarily provide a sufficient justification for federal intervention).

282. See *supra* Part III(b).

come about after the federal government provided funding for them, many of them are relatively limited in scope, and there is limited empirical evidence as yet that any of them has achieved their goals, such as improving mobility or increasing access to telehealth.²⁸³

C. *Federalism Versus Federal Preemption*

Despite the intuitive appeal of federal preemption, a federalist approach to occupational licensing reform is more feasible than outright preemption. Interest group politics, as well as Congress's reluctance to preempt state law and its reliance on state administration, make it unlikely that Congress will preempt large swaths of state occupational licensing law. A federalist approach also has functional advantages: preserving state variation allows for more experimentation than setting one-size-fits-all standards at the federal level; and it enables the federal government to take advantage of states' institutional expertise in regulating occupations.

1. Interest Group Politics

Historically, professional associations and licensing boards—which, as discussed above, exert outsized influence in maintaining the status quo—have opposed federal preemption of state licensing laws.²⁸⁴ For instance, medical associations and licensing boards opposed the Clinton Administration's proposal to limit state scope of practice restrictions (one of the few occasions on which the federal government has seriously considered preempting state licensing laws), “arguing that more permissive practice laws would jeopardize the quality of care being delivered and that the federal government would be encroaching into a field of regulation more properly left to the states.”²⁸⁵ The American Medical Association and medical licensing boards (and likely also state legislatures) also oppose the idea of the federal government replacing our current system with a system of federal licensure, creating a federal license for telemedicine, or passing federal legislation that would preempt state restrictions on telehealth.²⁸⁶ Opponents of federal

283. See *supra* note 176 and accompanying text.

284. See *supra* note 21 and accompanying text.

285. Mark R. Yessian & Joyce M. Greenleaf, *The Ebb and Flow of Federal Initiatives to Regulate Healthcare Professionals*, in REGULATION OF THE HEALTHCARE PROFESSIONS 185 (Timothy Jost, ed., 1992).

286. Zilis, *supra* note 87, at 214; Sulentic, *supra* note 122, at 37; AM. MED. ASS'N, ISSUE BRIEF: INTERSTATE MEDICAL LICENSURE COMPACT (2017), available at <https://www.ama-assn.org/sites/default/files/media-browser/specialty%20group/arc/fsmb-interstate-medical-licensure-compact-issue-brief.pdf> (“Importantly, the [Interstate Medical Licensure] Compact is the first line of defense against troubling federal proposals to create a federal telemedicine license, or to change the site of practice from where the patient is located to where the physician is located for purposes

licensure argue that states are better able to ensure public safety, though they may also be concerned about the loss of revenue that would be associated with such a proposal.²⁸⁷ Even proponents of federal preemption concede that such efforts would face strong headwinds from interest groups.²⁸⁸

History suggests that a federalist approach may be more successful at overcoming interest group opposition than simply trying to preempt state licensing laws. In contrast to the federal preemption proposals discussed above, the federal government has already demonstrated that it is capable of implementing measures to encourage states to reform their licensing systems while largely preserving states' control over the system.²⁸⁹

There are a few reasons why a federalist approach might be better able to overcome interest group opposition. First, whereas preempting state licensing laws would require Congress to upend our existing system, a federalist approach would enable Congress to proceed in a more incremental fashion and to rely more on administrative agencies. As discussed above, federal agencies such as the Health Resources and Services Administration, the FTC, and the VA already possess some limited statutory authority over licensing. Congress could proceed by

of telemedicine, proposals which actually would usurp state authority to regulate the practice of medicine. The Compact is intended to prevent just that.”). By comparison, the American Nurses Association has taken a somewhat more open-minded attitude, though it still seems skeptical of federal licensing. Congress on Nursing Practice and Economic Licensure Portability Workgroup, Nursing Licensure Portability: Options and Information for Registered Nurses, NURSING WORLD (Apr. 2013), <https://www.nursingworld.org/~4af045/globalassets/docs/ana/ethics/licensure-issue-brief-07-08-13.pdf> (“In theory, the national and federal models would eliminate the barriers to practice across state lines, facilitating RN mobility and the provision of telehealth services. These models, however, warrant further examination given the dramatic change and untested ground they pose”).

287. Zilis, *supra* note 87, at 214-15.

288. *See, e.g.*, Gavil & Koslov, *supra* note 211, at 195-196 (“Our most provocative suggestion is to consider national licensure for health care professionals, to insulate the licensure process from state-level politics and mitigate the effects of silo-based turf battles that must be fought jurisdiction-by-jurisdiction We recognize, however, that states rely on licensure fees as a source of revenue, which likely would skew states’ financial incentives to cede their licensing authority, and Congress might be reluctant to preempt long-standing state authority.”); Edward H. Forgotson & John L. Cook, *Innovations and Experiments in Uses of Health Manpower: The Effect of Licensure Laws*, 32 L. & CONTEMP. PROBS. 731, 746 (1967) (“A federal program [of licensure], if it were feasible, would be the most expeditious means of reform. However, political realism makes this course seem unpromising at this time”).

289. *See supra* Part III.

building on this authority, for example by appropriating additional funds for states interested in implementing larger-scale reforms. Relying on agencies to implement this approach would have the additional advantage of helping to insulate it from interest group opposition. As Steven Croley has persuasively argued, administrative procedures such as notice-and-comment rulemaking and judicial review serve to bolster agencies' autonomy and level the playing field for less well-resourced interest groups to compete with better-resourced ones, thus rendering agencies less susceptible to interest group influence than Congress.²⁹⁰

Second, measures that indirectly affect licensing such as expanding health insurance, enacting delivery system reforms, or providing support for new health care delivery technologies would likely be supported by a much wider and more powerful coalition of interest groups since they intersect with many other issues besides licensing.²⁹¹

Finally, depending on how it is designed, a more incremental federalist approach may attract less intense opposition from interest groups. For example, regulatory associations for nurses and physicians have proven willing to accept federal funding to form interstate compacts, and have even been supportive of some of these initiatives.²⁹² That is not to say, however, that licensing boards and professional associations would necessarily support a federalist approach to licensing reform. For instance, in 1994, then-Representative Ron Wyden proposed an amendment to the Clinton Health Security Act that would

290. STEVEN P. CROLEY, REGULATION AND PUBLIC INTERESTS: THE POSSIBILITY OF GOOD REGULATORY GOVERNMENT 135-142 (2008); Steven P. Croley, *Public Interested Regulation*, 28 FLA. ST. U. L. REV. 7, 38 (2000). That is not to go so far as to say that agencies are not susceptible to interest group influence at all, nor that agency procedures have succeeded in completely leveling the playing field. To the contrary, there is a large body of empirical literature in law and political science that finds that business interests participate more and exert more influence in the rulemaking process relative to other types of interest groups. *See generally* Gabriel Scheffler, *Failure to Capture: Why Business Does Not Control the Rulemaking Process*, 79 MD. L. REV. (forthcoming 2020).

291. *See* Khan, *supra* note 208, at 127 (“[G]oing forward, the [California Medical Association] and other physician interest groups will likely find that nurse practitioners and other providers will have strong political and financial support to redraft licensing and scope of practice laws from information technology (IT) giants such as Apple, Google, Samsung, Facebook, and IBM. Further, from the perspective of physician organizations, this looming legislative battle might not be a fair fight.”). *See generally* Wansley, *supra* note 225.

292. *But see* Jerry L. Mashaw & Theodore R. Marmor, *The Case for Federalism and Health Care*, 28 CONN L. REV. 115, 126 (1995) (“Interest group opposition can be overcome in American politics, but this sort of success normally involves a moral crusade that leads in the direction of uniform rights for all citizens. The need for national uniformity, however, is exactly what federalist solutions deny.”).

have established federal grants for state medical licensing boards contingent on their meeting new federal performance standards.²⁹³ Even though this proposal was relatively deferential to state licensing boards, it was still met with suspicion from the state licensing boards and health care professions.²⁹⁴ Still, the initiatives described in Section III suggest that a federalist approach will be more likely to overcome these challenges.

2. Incrementalism and State Administration

Another obstacle in the path of preempting state licensing laws is that Congress has historically proven unwilling to repeal important areas of state regulation wholesale, especially in health care.²⁹⁵ Although most scholars who have examined the issue have concluded that Congress possesses the Constitutional authority to preempt state licensing laws,²⁹⁶ Congress has historically taken a narrower interpretation of its own constitutional authority to legislate on health care issues, dating back to the earliest days of the Republic.²⁹⁷ After

293. Yessian & Greenleaf, *supra* note 285, at 185.

294. *Id.* at 170.

295. Gluck, *Federalism from Federal Statutes*, *supra* note 28, at 1762 (“[O]ne is hard-pressed to identify any examples of major social policy legislation in which Congress wiped the slate clean of all preexisting state structures and enacted comprehensive, federal-only reform in a single legislative effort.”).

296. See, e.g., Daniel J. Gilman, *Physician Licensure and Telemedicine: Some Competitive Issues Raised by the Prospect of Practicing Globally While Regulating Locally*, 14 J. HEALTH CARE L. & POL’Y 87, 115 (2011) (“[L]icensing is an area traditionally ceded to the states. That is likely a political problem more than a constitutional one.”); Hoffman & Rowthorn, *supra* note 117, at 15 (“A national licensure system may raise Tenth Amendment concerns . . . [H]owever, arguments that the current state based system constrains interstate commerce could counter such concerns, especially if the license is limited to telemedicine.”); Nicole Huberfeld, *Be Not Afraid of Change: Time to Eliminate the Corporate Practice of Medicine Doctrine*, 14 HEALTH MATRIX 243, 288 (2004) (“Despite the jurisprudential inconsistencies, a reasonable conclusion can be reached that Congress would have the power under the Commerce Clause, despite federalism concerns, to legislate in the field of the corporate practice of medicine doctrine.”); Safriet, *Impediments*, *supra* note 96, at 311 (“Let me emphasize that, while people are often confused on this point, state-based licensure is not a constitutional imperative. It is simply a tradition”).

297. See Theodore W. Ruger, *Plural Constitutionalism and the Pathologies of American Health Care*, 120 YALE L.J. 347, 354 (2011) (“[M]embers of Congress in the nineteenth and early twentieth centuries continued to hold a limited conception of their own authority over health matters, both expressly in floor debates and implicitly in their failure to act.”); Theodore W. Ruger, *Of Icebergs and Glaciers: The Submerged Constitution of American Healthcare*, 75 L. & CONTEMP. PROBS. 215,

reviewing various federal initiatives to reform health workforce regulation, Yessian and Greenleaf conclude that “the great majority of federal initiatives proposed to regulate healthcare professionals” have been felled by “the federal government’s deep-seated bias toward inaction.”²⁹⁸

Instead, when Congress does legislate on social policy, it tends to do so incrementally and to actively rely on states to administer new federal programs.²⁹⁹ For example, the structure of the ACA relies heavily on states to interpret and administer the law.³⁰⁰ Abbe Gluck cites a few factors that contribute to Congress’s tendency toward incrementalism and state administration: a respect for states’ authority in areas where they have historically held regulatory authority; the difficulty of achieving consensus in Congress; a lack of knowledge about the best policy solution and a desire to test policies on a smaller-scale before adopting them nationwide; and a reliance on states’ expertise in administering new federal programs.³⁰¹

A federalist approach has political advantages over outright federal preemption that might render it more successful at overcoming these reservations. Gluck ventures that an approach that largely preserves states’ authority over licensing might “assuage concerns of legislators who are suspicious of, or politically opposed to, the current executive branch’s policy agenda” since members of Congress are more likely to trust their own state government officials.³⁰² By keeping the federal role vague, this approach might also “be more politically palatable to those

229 (2012) [hereinafter Ruger, *Icebergs*] (“From the late eighteenth century onward, Congress evidenced a consistent trend of legislating on healthcare topics with less than what others within and outside of government thought its full Commerce Clause authority would permit. In so doing, Congress appears to have been acting on a perception of its own power in this area that was more cramped than that shared by other branches”).

298. Yessian & Greenleaf, *supra* note 285, at 186.

299. Gluck, *Federalism from Federal Statutes*, *supra* note 28, at 1761-63; Ruger, *Icebergs*, *supra* note 297, at 233-34.

300. See Allison K. Hoffman, *What Health Reform Reveals about Health Law*, in THE OXFORD HANDBOOK OF U.S. HEALTH LAW 49, 60 (I. Glenn Cohen, Allison K. Hoffman, and William M. Sage eds., 2017) (“Both the establishment of the exchanges and the Medicaid expansion rely on state administrators to give content to the ACA’s broad strokes by interpreting and implementing the law The fact that two of the most important policies of the ACA rely on state-level implementation reflects both a history of shared governance in health regulation and also Congress’s opinion (at least in the Senate) that this federalist norm was important to preserve.”).

301. Gluck, *Federalism from Federal Statutes*, *supra* note 28, at 1761-64.

302. Gluck, *Intrastatutory Federalism*, *supra* note 28, at 573.

who generally resist federal aggrandizement or prefer ‘smaller’ government or local variation,” and it might prove to be less of an affront to those who think the states should continue to control licensing.³⁰³

Preserving state variation in licensing policy would also address the concern that Congress doesn’t have enough information to enact the optimal licensing reform.³⁰⁴ Although proponents of federal preemption may object that such an approach is slower and less efficient than having Congress step in and set federal standards,³⁰⁵ the potential downside of having the federal government pick certain standards and apply them nationwide is also bigger, since there is no guarantee that the federal government will set the optimal standards.³⁰⁶ For instance, if the federal government were to adopt federal scope-of practice standards, it could actually reduce access to care to the extent that the federal scope-of-practice standards were set to match the strictest state requirements.³⁰⁷

Finally, a federalist approach would enable the federal government to take advantage of states’ institutional experience in regulating occupations, and to avoid having to create an equivalent institutional apparatus at the federal level. Daniel Gilman, an Attorney Advisor at the FTC’s Office of Policy Planning, notes that there is currently no federal agency “with the authority, expertise, and experience to perform the various licensing functions undertaken by the states, and it would be difficult to create one.”³⁰⁸ He acknowledges that this challenge is not insurmountable: there is plenty of expertise about occupational regulation in the federal government, at agencies like the Department of Labor, HRSA, and the FTC. But some federal preemption proposals, such as creating a federal system of licensure, would necessitate creating

303. *Id.* at 572-573.

304. Vaheesan & Pasquale, *supra* note 15, at 4 (“We believe that critics should demonstrate a Burkean humility before upsetting arrangements that have long governed these fields”).

305. Svorny, *Interstate Compact*, *supra* note 245

306. Safriet, *Federal Options*, *supra* note 98, at 467 (describing the advantages and disadvantages of federal licensure, including “the likelihood that the very same forces that have prevailed in many states would succeed in bringing about a similar result at the national level—that is, in making sure that national standards would embody the most restrictive, rather than the most progressive and empowering, scope-of-practice provisions, thus actually making the situation worse in those states that currently pursue a more enlightened approach”).

307. *Id.*

308. Gilman, *supra* note 296, at 91.

an accompanying set of institutions capable of issuing, updating, and enforcing federal occupational licensing laws.³⁰⁹

* * *

All this is not to say that there is no role for federal preemption, nor that federal preemption is necessarily incompatible with a federalist approach. In fact, traditional cooperative federalist regimes have often made use of the threat of federal preemption: offering states the option of administering a certain program or having the federal government administer it.³¹⁰ Simply maintaining the generalized threat of federal preemption may provide additional impetus for states to reform their licensing regimes.³¹¹ In addition, as outlined above, a “field-claiming” approach, in which the federal government makes a small series of encroachments onto state territory, may represent a realistic path. Yet reformers would be better served by viewing preemption as one of several tools that can be used to prod the states into reforming their licensing regimes, rather than as an immediate or exclusive solution.

V. CONCLUSION

This article presents a model for how the federal government can encourage states to reform the current system of occupational licensing for health care providers, and argues that such an approach would be more viable than either leaving licensing to the states or advocating for outright federal preemption. Although this paper focuses primarily on occupational licensing in health care, it also suggests that a federalist model could be used to change the licensing systems governing other fields as well.³¹²

309. *Id.* at 115-16. *See also* WAKEFIELD, *supra* note 125, at 11 (“[G]iven the difficulties associated with central administration and enforcement, the states might play a role in implementation [of Federal Licensure]”).

310. *See* Evan Caminker, *The Unitary Executive and State Administration of Federal Law*, 45 KAN. L. REV. 1075, 1075 (1997) (“Congress frequently encourages states to become regulatory partners in federal programs, sometimes by threatening to preempt the existing regulations of non-participating states, and other times by rewarding participating states with substantial monetary subsidies”).

311. *See, e.g.*, Chaudhry et al., *supra* note 174, at 1582 (“[T]here has been concern among state boards that failure to generate a state-based approach to license portability could embolden supporters of a federal solution, such as national licensure, that might compromise states’ rights under the 10th Amendment and undo the patient-safety provisions (such as a state’s ability to investigate patient complaints locally) that are built into each state’s medical regulatory structures”).

312. *See supra* notes 224-227 and accompanying text.

Of course, that is not to say that affecting widespread change in our licensing system will be easy or quick. The licensing system in the United States has proven remarkably intractable since its inception, and any change will likely have to be incremental. Nearly half a century ago, in their study of occupational licensing, Benjamin Shimberg, Barbara F. Esser, and Daniel H. Kruger sketched out some of the challenges entailed in reforming the licensing system:

[T]he whole institution of occupational licensing is embedded in a morass of federal, state, and local legislation suffused with tradition, custom, and jealously guarded rights. There are clearly no simple solutions. To bring about change would involve not only modifications of hundreds of state laws and local ordinances but also negotiations among dozens of occupational interest groups that have, over the years, managed to achieve some sort of delicate balance within the existing structure. The possibility of change, even relatively minor change, is likely to be perceived as a threat by those who gain not only prestige but also tangible economic benefits from the existing structure. Anyone contemplating change must consider not only its operational aspects, such as amending existing legislation or modifying procedures, but also its psychological aspects—the way people perceive or respond to the proposed changes. It is probably best to think of modifications in licensing as an ongoing process—a spiral moving upward from one level to the next—that will not necessarily be accomplished in one, two, or even five years.³¹³

Despite the promise of recent developments and the resurgence of interest in licensing, this cautionary advice seems just as applicable today. Any large-scale change will require a strong and sustained commitment on behalf of the federal government, and will likely take place over a long period of time.

Nevertheless, this article provides some reasons for optimism. It shows that the federal government has a range of tools at its disposal to encourage states to reform their licensing regimes, that it has already taken some initial steps to encourage states to restructure their licensing requirements for health care providers specifically, and that even these limited measures have had tangible impacts on states' licensing regimes and in turn have the potential to improve access to health care.

This lesson is especially important today, as there is a growing appreciation of the important consequences that state and local regulations have for national issues such as health care, the labor market, and geographic mobility. Many scholars and policymakers grappling with these interactions have continued to view state and local regulatory policy through a dual federalist framework: either advocating

313. SHIMBERG ET AL., *supra* note 12, at 210.

for states to reform their own regulations, or alternatively, calling for large-scale federal preemption. By contrast, this article shows that at least in some contexts, a federalist solution may be the most realistic and normatively desirable solution, and that there is promising precedent for such an approach.