



**United States of America  
Federal Trade Commission**

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

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

## I. Introduction

Good afternoon. Many thanks to ALEC and Mike Slabinski for inviting me to speak today about our common interest in occupational licensing reform. This topic has been an interest of mine at least since I served as Chief of Staff to then-Chairman Tim Muris and helped advance the agency's competition advocacy efforts. Later, I sought out the opportunity to do *pro bono* work for Institute for Justice while at Kirkland & Ellis LLP. Along the way, I co-authored an article on the topic that – unfortunately – gave me statistics I can still cite as relevant today.<sup>1</sup> So we have much work yet to do on this issue. But before I explain, let me give the standard disclaimer that I speak only for myself, and not for the Federal Trade Commission or any other Commissioner.

There are some occupations for which licensing seems unnecessary. But you don't have to look long and hard for legislatures that disagree. For example, Louisiana's Horticulture Law requires that any establishment that sells arranged cut flowers, floral designs and ornamental plants must employ someone who holds a florist license.<sup>2</sup> Every grocery store or big-box store in the state that wants to sell flower arrangements needs someone with this license to work there for at least 32 hours per week.<sup>3</sup> To obtain your retail florist license, you must pay not only \$100 each year for the license fee, but \$114 to take the exam. And to increase your chance of passing the exam, you probably want to study the exam reference material, which costs another \$70.<sup>4</sup> If you

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<sup>1</sup> Mark C. Schechter & Christine S. Wilson, *The Learned Professions in the United States: Where Do We Stand Thirty Years After Goldfarb?*, in EUROPEAN COMPETITION LAW ANNUAL 2004 555 (Claus-Dieter Ehlermann & Isabela Atanasiu eds., June 2006).

<sup>2</sup> LA REV. STAT. § 3:3804.

<sup>3</sup> Louisiana Department of Agriculture and Forestry, Louisiana Horticulture Commission, Retail Florist License, <http://www.ldaf.state.la.us/ldaf-programs/horticulture-programs/louisiana-horticulture-commission/> (last visited June 16, 2020).

<sup>4</sup> Texas A&M University Press, "Flowers: Creative Design," <https://www.tamupress.com/book/9781585441716/flowers/> (last visited June 16, 2020).

want to sell cut flowers without arranging them, you can do so under a dealer’s permit, but not within three hundred feet of a retail florist’s place of business.<sup>5</sup>

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

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

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

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<sup>5</sup> LA REV. STAT. § 3:3808 (I)(1).

<sup>6</sup> Robert Pindyck & Daniel Rubinfeld, *MICROECONOMICS* 625-26 (8th ed. 2017).

<sup>7</sup> Jason Narlock & Matthew Stevenson, *Healthcare workforce 2025* (2017) (“demand for downstream practitioners, such as nurse practitioners, registered nurses and physician assistants, is likely to increase across many states as hospital systems work to fill physician shortages and/or contain costs. ... We see a particularly strong correlation between downstream practitioner demand and state practice and licensure laws. Projected demand for nurse practitioners, for instance, is often higher in states allowing for full practice authority.”).

<sup>8</sup> Hannah Kuchler, *US coronavirus hotspots desperately seek trained medical staff*, FINANCIAL TIMES, April 4, 2020 (“Demand for doctors and nurses with experience in emergency departments and intensive care units has soared in recent weeks as the pandemic has spread. ... As an acute shortage of medical staff begins to take its toll in New York, the epicentre of the outbreak in the US, mayor Bill de Blasio on Friday proposed a draft of healthcare workers. ... The US has fewer physicians per capita than hard-hit countries such as Italy and Spain, with 2.6 per thousand people compared with 4 and 3.9, respectively, although it has more nurses, according to the Kaiser Family Foundation, a healthcare policy think-tank.”).

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

Several states have eased the rules specifically for military spouses, by mandating the issuance of a state occupational license if the spouse is licensed in another state with substantially equal or higher licensing standards.<sup>9</sup> Arizona in April 2019 went a step further, with a universal licensing recognition law that obligates state boards to issue licenses to applicants who have been licensed in another state for at least one year and meet other basic requirements.<sup>10</sup>

Let me be clear: states have a valid interest in ensuring that the medical professionals who serve their citizens are competent, in good standing, and up to date on their continuing medical education. Ideally, any restrictions would be narrowly tailored to permit competition to the fullest extent possible while honoring the state's legitimate goals of protecting residents from malpractice.

## **II. The FTC's role in healthcare occupational licensing**

This is an issue of concern for the Federal Trade Commission because it affects competition. Market incumbents – people who are already licensed in a state – claim health and safety justifications for state-specific licensing and constraints on the scope of practice. But some of them may be more interested in putting up barriers to entry and blocking competitors.<sup>11</sup>

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<sup>9</sup> United States Department of Labor, Military Spouse License Recognition Options, *available at* [https://www.veterans.gov/milspouses/military\\_spouse\\_txt.htm](https://www.veterans.gov/milspouses/military_spouse_txt.htm).

<sup>10</sup> ARIZ. REV. STAT. § 32-4302 (2019). However, even this statute requires the applicant, if not the spouse of an active-duty member of the armed forces, to have “establishe[d] residence in this state,” which can be a hurdle to working in Arizona. *See, e.g.,* Ryan Randazzo and Mitchell Atencio, *Here's what you need to know about Arizona's new law for out-of-state work licenses*, THE ARIZONA REPUBLIC, April 22, 2019 (“But some agencies have major questions about how to apply the law. For example, architects, engineers, geologists, home inspectors, landscape architects and surveyors licensed by the Board of Technical Registration may actually face additional difficulty obtaining a license in Arizona because of the bill's residency requirement, said Executive Director Melissa Cornelius.”)

<sup>11</sup> Maureen K. Ohlhausen and Greg Luib, *Brother, May I?: The Challenge of Competitor Control Over Market Entry*, JOURNAL OF ANTITRUST ENFORCEMENT (2015).

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

States also can have under-utilized health care resources already within their borders, in the form of non-physicians who are not practicing to the full extent of their abilities.<sup>13</sup> The FTC has urged state legislators and policymakers to consider whether restrictions on nurses’ scope of practice are supported by valid safety concerns.<sup>14</sup> For example, agency staff has supported the Veterans’ Administration proposal to grant “full practice authority” to Advanced Practice Registered Nurses.<sup>15</sup>

### **III. Recognizing licenses across state lines**

ALEC has developed model policies on things like universal recognition, so that a license granted in one state will be recognized in another state.<sup>16</sup> We have seen the fruits of these efforts in the healthcare sector, where states allow doctors and nurses to cross state lines and still be able

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<sup>12</sup> Fed. Trade Comm’n, POLICY PERSPECTIVES: OPTIONS TO ENHANCE OCCUPATIONAL LICENSE PORTABILITY (Sept. 2018), *available at* [https://www.ftc.gov/system/files/documents/reports/options-enhance-occupational-license-portability/license\\_portability\\_policy\\_paper\\_0.pdf](https://www.ftc.gov/system/files/documents/reports/options-enhance-occupational-license-portability/license_portability_policy_paper_0.pdf).

<sup>13</sup> *See supra* note 7; *see also* Yong-Fang Kuo, et al., *States with the least restrictive regulations experienced the largest increase in patients seen by nurse practitioners*, HEALTH AFFAIRS, 32(7), 1236-1243 (2013).

<sup>14</sup> Fed. Trade Comm’n, COMPETITION AND THE REGULATION OF ADVANCED PRACTICE NURSES (Mar. 2014), *available at* <https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf>.

<sup>15</sup> Fed. Trade Comm’n, Press Release, FTC Staff Supports Department of Veterans Affairs Proposed Rule to Grant Full Practice Authority to Advanced Practice Registered Nurses (2016), *available at* <https://www.ftc.gov/news-events/press-releases/2016/07/ftc-staff-supports-department-veterans-affairs-proposed-rule>.

<sup>16</sup> American Legislative Exchange Council, Model Interstate-Mobility and Universal-Recognition Occupational Licensing Act (The Freedom to Travel and Work Act), September 3, 2019.

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

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

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

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

#### **IV. During the pandemic**

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

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<sup>17</sup> See *supra* note 14.

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

Several states have relaxed their limitations on what nurses can do during the pandemic. For example, Louisiana has expanded the scope of practice for APRNs and Certified Registered Nurse Anesthetists (CRNAs) by temporarily suspending requirements for practicing only under the direction and supervision of a doctor licensed to practice in that state.<sup>19</sup> Alabama has authorized nurse practitioners to prescribe medication and perform all skills that are within the scope of their education and training.<sup>20</sup>

Many states have similarly waived requirements for being licensed in the state if a practitioner who is licensed elsewhere is working in the state to help fight the pandemic. For example, Florida’s surgeon general issued an executive order that allows health care providers with valid out-of-state licenses to help address COVID-19 for 30 days.<sup>21</sup> The governor of Colorado said he has asked the state’s occupational regulator “to cut through the red tape on licensing our medical

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<sup>18</sup> Centers for Medicare & Medicaid Services (CMS), Trump Administration Makes Sweeping Regulatory Changes to Help U.S. Healthcare System Address COVID-19 Patient Surge (Mar. 30, 2020), *available at* <https://www.cms.gov/newsroom/press-releases/trump-administration-makes-sweeping-regulatory-changes-help-us-healthcare-system-address-covid-19>.

<sup>19</sup> La. Proclamation No. 38 JBE 2020 (Mar. 31, 2020), *available at* <http://www.lsbns.state.la.us/Portals/1/Documents/news/govproclamation.pdf>.

<sup>20</sup> Ala. Proclamation (Apr. 2, 2020), *available at* [https://www.abn.alabama.gov/wpcontent/uploads/2020/04/2020-04-02-Fifth-Supplemental-SOE\\_COVID-19.pdf](https://www.abn.alabama.gov/wpcontent/uploads/2020/04/2020-04-02-Fifth-Supplemental-SOE_COVID-19.pdf).

<sup>21</sup> Scott A. Rivkees, Suspension of Statutes, Rules and Orders, Made Necessary by COVID-19, DOH No. 20-002 Emergency Order, Pursuant to the authority granted by Exec. Order No. 20-52 (Mar. 16, 2020), *available at* <http://www.flhealthsource.gov/pdf/emergencyorder-20-002.pdf> (“I find that strict compliance with the provisions of certain regulatory statutes and rules prescribing the procedures for conduct of state business by the Florida Department of Health will prevent, hinder, or delay necessary action in coping with the emergency caused by COVID-19”).

professionals” so those who are licensed in other states but residing in Colorado can be immediately licensed in the state “as quickly as possible to address this shortage” of workers.<sup>22</sup>

## **V. After the Pandemic**

The FTC has long championed removing these limitations on competition; it is unfortunate that a global pandemic was necessary to prompt it. All levels of government should consider whether the temporary waivers should be made permanent.

Even after Covid-19 becomes less of a burden on the healthcare system, the barriers created by excessive occupational licensing regulations will still harm Americans. For example, imposing unnecessary supervisory requirements on licensed nurses increases the risk for people in rural and other medically underserved areas that lack physicians or particular specialists such as anesthesiologists.<sup>23</sup>

The temporary waivers to address Covid-19 give the states the opportunity to observe whether the absence of these restraints results in any harm to patients. States as laboratories of democracy also have varied in the extent to which they are suspending regulations; they can learn from each other’s experiences as well.

Most of the temporary waivers during the pandemic have been granted through executive orders. Permanent changes in most states will require legislative action, and this should be within the scope of the possible. Just as many states have eased occupational licensing rules for the

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<sup>22</sup> Press Release, Colorado Dep’t of Regulatory Agencies, DORA Working to Increase Available Healthcare Workforce for Coronavirus Response (Mar. 13, 2020), *available at* <https://www.colorado.gov/pacific/dora/news/dora-guidelines-forhealthcare-workforce-coronavirus>.

<sup>23</sup> Federal Trade Comm’n Comment to Texas Medical Board on Its Proposed Rule 193.13 (Dec. 6, 2019), *available at* [http://www.ftc.gov/system/files/documents/advocacy\\_documents/ftc-comment-texas-medical-board-its-proposed-rule-19313-add-supervision-requirements-texas-certified/v200004\\_texas\\_nurse\\_anesthetists\\_advocacy\\_letter.pdf](http://www.ftc.gov/system/files/documents/advocacy_documents/ftc-comment-texas-medical-board-its-proposed-rule-19313-add-supervision-requirements-texas-certified/v200004_texas_nurse_anesthetists_advocacy_letter.pdf) (noting that imposing additional supervisory requirements on licensed Certified Registered Nurse Anesthetists in administering anesthesia increases the risk for people in rural and other medically underserved areas; of the 85 critical access hospitals in Texas, 33 are in counties where CRNAs are the only licensed, specialized providers of anesthesia and anesthesia-related services).



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