



Regulatory Transparency Project

Unlocking Innovation & Opportunity

COVID-Era Healthcare Solutions for the Post-COVID World

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Introduction

The pandemic forced government at all levels to confront mounds of red tape that stood in the way of both public health and economic recovery. This was a long overdue reckoning. We've witnessed an unprecedented rollback of regulations, accompanied by the corresponding power of the private sector to solve problems: neighbors helping neighbors; companies donating and repurposing; and ingenuity flourishing in science, supply chains, and education. In healthcare, we've learned important lessons about how Americans can benefit when we unleash the power of human innovation and cut the red tape holding it back. But the lessons learned battling COVID-19 ought to outlive the pandemic, so that the regulatory obstacles of the past don't hamper our ability to be fully prepared for the future. States can play an important role in moving toward innovative, patient-centered healthcare by empowering medical entrepreneurship and expanding access to treatments.

Regulations are often justified in the name of public health and safety. But governments rolled back myriad rules for the express purpose of dealing with the pandemic. If these rules were not needed (indeed, if those rules were not helpful) during the greatest public health crisis in recent memory, they certainly can't be justified in times of peace and plenty. In this paper, we've highlighted four specific reforms that will promote employment in the healthcare field and boost the supply of medical services even after the pandemic passes: 1) eliminating Certificate of Need (CON) laws, 2) jettisoning restrictions on telemedicine, 3) expanding the scope of practice for qualified individuals, and 4) allowing the practice of medicine across state lines. For each, we describe the state of existing policies, analyze constitutional concerns, highlight COVID-era reforms, and recommend permanent changes.

I. Eliminate Certificate of Need Laws

A. The Problem

Just months before the COVID-19 outbreak, [a family-run ambulance business](#) in Florida sought to expand its operations into a neighboring county. In Florida, ambulances must secure permission from the government through a "Certificate of Need" ("CON") before opening or expanding. Employees of Brewster Ambulance Service dutifully filled out the paperwork, paid the application fee, and showed up at a hearing where they described their dedication to providing high-quality care. Despite the company's long track record, county officials denied the application – not because Brewster lacked the proper equipment or failed to meet safety standards, but because local officials deemed another ambulance business "unnecessary." Just months later, a pandemic would hit and Brewster would be forced to sit on its hands, unable to respond to the rapidly increasing demand for medical transportation.

CON laws are unlike typical occupational regulations, which purport to ensure a person's fitness for their trade. Instead, CON laws require would-be entrepreneurs to prove to state officials' satisfaction that a new business is "needed." In some states, existing businesses are given the opportunity to object that a new business is not needed. In practice, bureaucrats largely defer to existing providers who deem more competition undesirable, creating a "Competitor's Veto" over new competition. Depending on the state, CON laws may regulate utilities (like gas or electric companies), transportation companies (like taxis and household movers), or medical providers (including ambulances). When it comes to medicine, providers must sometimes secure a Certificate of Need before offering innovative services or purchasing medical equipment, including hospital beds.

Allowing existing businesses to regulate and eliminate their own competition is a bad idea in any industry, but it is outright dangerous when potentially life-saving services are on the line.

While perhaps well-intentioned, CONs don't make sense in principle. Proponents originally believed that, unless artificially constrained, medical providers might purchase more equipment than is needed in a given community. As a result, these healthcare personnel would administer unnecessary or overpriced services to recoup their costs. Based on this theory (and with the support of powerful interest groups who stood to benefit), Congress passed an act in 1974 that tethered federal funds to a state's adoption of a CON law. By 1980, every state except for Louisiana had passed a version of the law.

But less than a decade later, Congress repealed the federal strings it had attached based on new evidence that CON laws undermine, rather than further, their goals. The Federal Trade Commission (FTC) and the Department of Justice [have said](#) that “on balance, CON programs are not successful in containing health care costs,” and that they “pose serious anticompetitive risks that usually outweigh their purported economic benefits.” Nowadays, proponents use other justifications – some of which conflict with the original purpose. They say, for example, that CON programs are necessary to encourage investment in rural healthcare. Others suggest that they are needed to subsidize hospitals, which are required by law to provide emergency care to anyone who walks into the ER, and which would otherwise go out of business without the subsidy. Still others argue that concentrating care will aid scalability or improve quality.

A growing body of research now shows that CON laws simply harm consumers. Rather than ensuring an “adequate” number of providers in rural or urban areas, they create shortages. The average patient in a CON state has access to 30% fewer hospitals; 14% fewer ambulatory surgery center (ASCs); 30% fewer rural hospitals; 13% [fewer](#) rural ASCs; 25% [fewer](#) open-heart surgery programs; and fewer [psychiatric care](#) facilities, [dialysis](#) clinics, [neonatal intensive care units](#) (NICU), and [alcohol and drug abuse](#) facilities. The predictable result of suppressing competition is that CON laws [inflate prices](#) and [result in worse patient outcomes](#). Yet in [39 states](#), CON laws remain on the books – largely at the behest of certificate-holding hospitals and others that have an interest in the laws' anticompetitive effects.

Thus, despite an ongoing opioid epidemic, CON laws are [thwarting the creation](#) of drug rehabilitation centers. Though people lack access to mental health treatment, CON laws [prevent the construction](#) of mental health facilities. And while some cancers are survivable if detected early, CON laws [block innovative](#) and potentially lifesaving screening services.

As in any other industry, consumers of medicine – patients – are best able to determine whether a new service is necessary. We don't allow the government to dictate how many coffee shops are “necessary” or whether a new version of the iPhone is “needed.” Instead, we give people the opportunity to offer goods and services and empower consumers to decide which to buy. The same should go for healthcare: healthcare providers must be free to respond to consumer demand.

CON laws are not only demonstrably harmful to consumers, they deprive individuals of economic opportunity in the healthcare industry. For example, Ursula Newell-Davis of New Orleans, Louisiana, was recently [robbed of her dream](#) of helping special-needs families due to the state's equivalent of a Certificate of Need program. As an experienced social worker, she frequently encountered families who lacked care for their special-needs children. But when Ursula set out to start a “respite” business aimed at giving family caregivers time to themselves and teaching children

basic life skills, the state informed her that there were already “enough” respite businesses around. But adequacy of care is not a simple numbers game. Regardless of how many providers exist, Ursula wanted the chance to offer something special based on her years in social work and her experience raising a special-needs son. And many of Ursula’s clients told her that they didn’t want to use the respite business down the road; rather, they wanted to use her business. Human needs are constantly changing, and they cannot be predicted by any one bureaucrat. CON laws prevent consumers from determining which businesses suit or do not suit them, and they thwart entrepreneurs like Ursula trying to fill in the gaps.

B. The Solution

Although CON laws purport to do things like reduce wasteful spending, encourage investment in rural care, and ensure an adequate number of services, the evidence shows that they fail. Indeed, they tend to result in higher costs, fewer providers (including rural providers), longer waits, and longer drives to access care. Because these laws deprive people of their ability to earn a living solely for the benefit of certificate-holders, they raise due process and equal protection concerns.

CON laws also implicate the Interstate Commerce Clause, which reserves the power to regulate commerce between the states to Congress. The Supreme Court has interpreted this provision as not only restricting states from unduly burdening interstate commerce, but also as prohibiting them from regulating in ways that discriminate against out-of-state businesses. CON laws not only create cartels, they sometimes create cartels of in-state actors who exercise their “veto” power to exclude competition from out-of-state providers. They can also burden interstate commerce (for example, by restricting the number of ambulance trips between states), making them subject to a Commerce Clause challenge.

Because CON laws create small cartels, they also run contrary to many states’ [anti-monopoly provisions](#), which prohibit the state from creating or maintaining monopolies or restricting economic competition. CON laws do not make a medical entrepreneur’s ability to start or expand their business conditional upon his or her skill; they make it conditional upon whether the government determines there are enough businesses around – an inherently monopolistic determination.

Because CON laws conflict with state and federal constitutional guarantees of liberty, they have been the subject of several lawsuits on behalf of would-be business owners arguing that the laws are unconstitutional. But lawsuits are a last resort, and given the relatively short shrift that courts now give to economic liberty, including the right to earn a living, they are difficult to win. They are inferior to an obvious legislative solution: taking these laws off of the books. In practice, repeal can be difficult because vested interests have strong incentives to resist. But progress is possible. In 2019, Florida repealed several of its CON requirements, including those governing general hospitals, complex medical rehabilitation beds, and tertiary hospital services. In 2020, both Tennessee and Montana made sweeping reforms. And during COVID-19, at least [24 states temporarily suspended](#) or made emergency changes to their CON laws. Repealing Certificate of Need programs is not a silver bullet solution for creating an abundance of affordable healthcare services, but it is an important step towards increasing access to care.

II. Eliminate Restrictions on Telehealth

A. The Problem

During the height of the pandemic, many people avoided leaving their homes – including limiting their trips to the doctor’s office. According to the [Centers for Disease Control and Prevention](#), four in ten adults reported delaying or avoiding care. Twelve percent even avoided urgent and emergency care, which was more common among people with underlying health conditions or disabilities. Telehealth should’ve been an easy alternative. Thanks to secure platforms, high-quality video, and other advancements in technology, it’s theoretically easy for people to obtain mental health consultations, monitor chronic conditions, or get quick advice about whether to go to the emergency room from the comfort of the home. Telehealth is particularly useful to vulnerable populations like the elderly, who lack ease of transportation, or people who live in rural areas, who may lack choice or live farther away from specialists. But regulation often stands in the way of these benefits.

Take [Dr. Celeste Mohr](#), a Texas-licensed dentist who recently moved to South Carolina. Dr. Mohr no longer maintains a brick and mortar office in Texas, nor does she keep a brick and mortar office in South Carolina. As a caregiver to two special-needs sons, she works from her home and fits in teledentistry visits when she has time. But in 2020, the Texas Board of Dental Examiners banned teledentistry, preventing Dr. Mohr from providing remote care at a time when people most desired to get services from home. Teledentistry is safe and effective. It offers patients a means of swiftly securing a second opinion or getting quick advice of whether to seek immediate treatment at the ER or to instead see a dentist. Texas’s ban didn’t protect consumers; it protected traditional practitioners from legitimate competition.

In addition to bans like Texas’s, states have employed four primary barriers to telehealth: licensure requirements, in-person exams, discriminatory reimbursement policies, and prescription limitations.

a. Licensure

While falling short of a full-blown ban, in practice, licensure laws often deny qualified out-of-state licensees the opportunity to provide telehealth. Licensure rules that pre-date telehealth require professionals to be licensed in the state where the patient resides, meaning that even people with the requisite education, training, and experience must pay fees and secure an entirely new license to provide their services virtually in another state. And they must secure dozens of licenses if they wish to practice across the entire country. It’s perfectly legal for a patient to fly or drive to another state and visit a provider in person. Laws should accommodate the fact that technology has eliminated the need to travel.

b. In-person exams

Laws that require an initial in-person exam act as a functional equivalent to a ban for out-of-state telehealth providers, since it’s often impractical to travel long distances just to meet in person. These laws also frustrate technological advancements that render in-person consultations unnecessary. Eye health is a good example: thanks to [technological innovations](#), consumers can now accurately test their vision using their phones, but some states require in-person exams before such technology may be used or a prescription may be provided. In opposing a proposed Washington law that would have required an in-person comprehensive eye exam prior to any prescription, the [FTC argued](#) that the decision of whether to require a comprehensive exam should be based on a person’s symptoms, status, or history, rather than being mandated across the board. State laws that require “unnecessary

tests of dubious benefit,” the Commission said, “drive[] up the cost of health care and den[y] telehealth” to people who could benefit.

A similar fight is now taking place in the realm of teledentistry. After enacting a first round of [regulation](#) targeting teledentistry, California recently proposed requiring x-rays prior to any teledentistry encounter, regardless of whether the dentist believes it to be medically necessary. The proposal elicited [vigorous opposition](#) from Golden State Warriors star Draymond Green, who witnessed firsthand how the high cost of care affects less affluent communities. Any in-person requirement that is not medically necessary for the patient is anathema to the purpose of telehealth.

c. Reimbursement

Reimbursement policies are yet [another barrier](#) that can make telemedicine impossible. Medicare, Medicaid, and private insurance policies sometimes limit reimbursement for virtual services depending on the specialty. Pennsylvania’s Medicaid program, for example, [only reimburses](#) for telehealth services provided by physicians, certified registered nurse practitioners, or certified nurse midwives, but no other professionals. Other states limit reimbursement based on the patient setting. [Six states](#) only permit reimbursement so long as there is no traditional provider within a certain distance. [Twenty-three states](#) require patients to receive their treatment in clinical settings rather than at home. Some reimbursement policies require a patient-provider relationship, which in turn can only be established by an in-person exam, making it significantly more difficult to get telehealth on demand. Even where states do reimburse, they may require lower-than-market reimbursement rates or only reimburse for in-state providers. The results are protectionist on their face.

d. Prescription limitations

Prescribing medication is an essential part of treatment, particularly when it comes to mental health or addiction. Yet [in many cases](#), prescribers must have an in-person visit with a patient before prescribing a medication over the phone or by video; in some cases, they are [prohibited from prescribing certain medications](#) altogether.

B. The Solution

State barriers to telehealth have resulted in several lawsuits on behalf of frustrated providers who have had their livelihood taken away. In 2021, Dr. Mohr and an online teledentistry platform filed suit challenging Texas’s ban: the lawsuit’s theory was that the ban was irrational, that it deprived providers of due process, and that it exceeded the Board’s regulatory authority. Their case followed on the heels of another [Texas lawsuit](#) arguing that the state Medical Board had committed an antitrust violation by colluding with providers to block competition by telehealth practitioners. And in Washington D.C., a Virginia-based counselor recently [filed suit](#) alleging that the District’s licensure requirements violated her First Amendment rights.

Fortunately, during the pandemic, both the federal government and the vast majority of states took some positive steps to foster telehealth. Perhaps the most sweeping example is [Arizona](#), which created the first-of-its-kind state registration approach for providers. The law allows licensed providers from other states to offer and bill any medical service that can be billed and can reasonably take place by digital communication, in contrast to states that have required reciprocity or taken a piecemeal approach and permitted telehealth on a profession-by-profession basis. Moreover, unlike some states that limit coverage to “live” interactions, Arizona includes interactions that take place only by phone or that utilize email and online chat. It further prohibits healthcare boards from

enforcing any rule that requires patients to visit providers in person before receiving most prescriptions. Under this reform, patients will enjoy convenient access to services and specialists they could not reach or obtain coverage for before; furthermore, hospitals, long term care facilities, and others will be able to create new innovations that improve the provision of care.

At the federal level, Congress responded to the pandemic by creating [flexibilities](#) under Medicare, including lifting location and geographic restrictions, relaxing qualifying technology requirements, expanding the list of covered services, easing licensure requirements, allowing direct supervision via telemedicine, reimbursing based on the in-person rate, and [expanding ways](#) of complying with the Health Insurance Portability and Accountability Act (HIPAA). Congress later made some of these changes [permanent](#) and vowed to study whether to do the same with others.

Several other states similarly passed temporary reforms like [allowing out-of-state physicians](#) to provide telemedicine services, eliminating the requirement for preexisting provider-patient relationships, and [mandating Medicaid reimbursement](#) for telehealth where in-person reimbursement is allowed. The results have been beneficial to providers and consumers. One example is [Dr. Beverly Jordan](#) from Enterprise, Alabama, who (because of the Centers for Medicare and Medicaid Services' relaxation of telehealth rules) was able to see 30 telemedicine patients in just one week. Prior to the changes, the costs of using an online platform and the lack of insurance coverage made it infeasible for her to work. But after the government made it easier to offer the service, platforms began offering free trials and insurers offered coverage, liberating both Dr. Jordan and her patients to enjoy telehealth.

It's time for states to make those changes permanent. Massachusetts recently passed [legislation](#) applying the same standard of care to in-person and telehealth visits and clarifying that a face-to-face encounter is not a prerequisite for telemedicine. Colorado removed restrictions on the types of technology that can be used to provide telehealth services, allowing it across any communications platform that complies with HIPAA. Idaho extended waivers that allow more medications to be prescribed via telehealth, expand the types of technology that can be used, and permit out-of-state providers to offer their services in state. And several other states have [proposed](#) codifying temporary COVID-era changes into law.

Removing these obstacles has been good policy during the pandemic and will remain so once it is over. State should consider 1) permitting telehealth so long as providers abide by the same standard of care applicable to brick and mortar providers, 2) permitting licensees to establish a provider-patient relationship via online care and eliminating other in-person requirements where unnecessary, 3) eliminating redundant licensure requirements or defining the place of practice based

on where the provider is located,¹ 4) and eliminating reimbursement limitations that are specific to telehealth.

III. Allow Medical Professionals to Help Patients as They Were Trained to Do

A. The Problem

State “[scope of practice](#)” laws dictate what treatments, procedures, and processes doctors, nurses, pharmacists, and other healthcare practitioners may perform for patients. These rules are established by elected lawmakers and appointed bureaucrats, who are susceptible to the lobbying of vested interests who often seek to prevent other professionals from competing against them. As a result, these laws vary from state to state in arbitrary ways that aren’t grounded in patient safety. For example, a nurse practitioner who has been trained to examine, diagnose, and treat patients in one state could be fined or even imprisoned for doing the same in another. In short, scope of practice laws often needlessly [increase the cost of care](#) and prevent trained, competent healthcare professionals from helping patients.

Imagine if states only permitted car dealerships to provide oil changes. Customers who could have had their oil changed for \$40 at Jiffy Lube might be forced to spend \$80 at a dealership instead. This would make oil changes more expensive and job opportunities for auto mechanics more scarce. It might even deter car owners from getting oil changes they need, resulting in long-term damage to their cars. In the same way, scope of practice laws in healthcare often result in patients paying more than necessary, which both reduces employment opportunities for nurses and other paramedical providers and harms patients by making it harder for them to get care when they need it.

Dianna Malkowski, a physician assistant (PA) in Wisconsin, [recounted](#) how scope of practice rules prevented her from helping patients during the height of the pandemic. With fewer patients willing or able to risk in-person visits, Dianna decided to get involved in telemedicine. To her dismay, Wisconsin law made it nearly impossible for her to do her job remotely: state rules require a physician to supervise each PA and do not allow a physician to oversee more than four PAs at a time. This expensive and burdensome requirement meant that telemedicine companies weren’t interested in hiring PAs.

Thirty-eight states have similar restrictions. Wisconsin and 11 other states [limit](#) PAs’ scope of practice to the specialty of their supervising physician, even if the PA herself is trained in other areas of medicine. This means that PAs are often prevented from doing work they are qualified to do. If a PA observes that her hospital has immediate needs in the ICU, for example, she must go through

¹ Some states have created special licenses for out-of-state physicians who seek to practice across state lines; others have crafted special standards of care for the practice of telemedicine. Nine state medical boards, for example, [issue special licenses](#) or certificates related to telehealth. While more permissive than requiring full-blown licensure, these measures may still unnecessarily burden vital and safe practices. As the FTC [wrote in opposition](#) to a proposed Alaska measure that would have imposed special standards on the practice of telemedicine, “The development of additional ‘safeguards’ solely for telehealth providers might lead to the adoption of unnecessary restrictions that would only serve to restrict competition, and thereby undermine [the] goal of enhancing access[.]” The Interstate Medical Licensing Compact is likewise [inadequate](#), as it streamlines the process of applying for multiple licenses but still requires licenses and fees in every state. Arizona’s approach, which unilaterally extends recognition to out-of-state licensees that register with the state, comes the closest to liberating providers from other states – though licensure at the individual state level can still be overly burdensome.

the cumbersome process of finding a new supervisor and formally changing her work rather than immediately filling that need. Unsurprisingly, these laws have [prevented physician assistants](#) from quickly providing help during the outbreak of COVID-19.

Scope of practice laws also make it difficult for people to obtain medicine. Ailments once considered debilitating or even deadly can now be effectively addressed with routine treatments. But laws often make those treatments needlessly complex, inconvenient, and unaffordable. For even the most standard medications, patients often must schedule and pay for an appointment with a physician and then travel to a pharmacy at a different location to fill the doctor's prescription, significantly [increasing the overall cost and decreasing the convenience](#) of obtaining care. This hits low-income patients particularly hard and may even result in some delaying or forgoing treatment altogether, which can be deadly.

For example, Texas [prohibits doctors from dispensing medicines](#) to patients unless they practice in certain "rural" areas more than fifteen miles from a pharmacy. In other words, while these doctors can prescribe medicines to patients, in most cases they can't fill those prescriptions – which denies many Texas doctors from providing a valuable service and ultimately makes it harder for patients to get the treatments they need. This law doesn't protect patient health and safety, but it does protect pharmacies from competition. Dr. Michael Garrett, an Austin-based family doctor who prescribes – and would like to dispense – routine medications to his own patients, has sued the state, arguing that the Texas Constitution forbids the government from irrationally restricting his right to pursue a chosen business.

B. The Solution

States should remove legal barriers that artificially limit the availability of qualified healthcare providers. This would allow medical professionals to practice at the top of their education and training. In addition to scope of practice requirements, requirements for in-person, real-time supervision and collaborative agreements should also be modified or rescinded.

Some states have already reduced their scope of practice restrictions and allowed for more provider autonomy. For example, [twenty-three states](#) allow nurse practitioners (NPs) to act as primary care providers, empowering them to diagnose patients, order and interpret diagnostic tests, manage treatment plans, and prescribe medications without physician supervision.

During the pandemic, many of the states that still restrict medical professionals from independent practice [temporarily suspended](#) these regulations, granting "emergency" licenses so professionals could legally provide skills that were in short supply – skills they have been trained to provide all along. Arizona Governor Doug Ducey, for example, issued an [order](#) allowing Certified Registered Nurse Anesthetists (CRNAs) to practice independently of physicians or surgeons. CRNAs receive highly specialized training to administer anesthesia and to intubate and ventilate patients – skills that were necessary for treating severe COVID-19 patients. And allowing CRNAs to use their advanced training to care directly for patients frees doctors to treat other medical conditions. Over a dozen states followed his lead, temporarily relieving CRNAs of direct supervisory restrictions during the pandemic: this allowed hospitals across the country to incorporate CRNAs into their intensive care teams. This has been particularly important in [rural areas](#), where there is already a severe shortage of highly specialized providers who can provide anesthesia and perform other necessary procedures related to COVID-19.

Letting pharmacists conduct routine tests and prescribe medications would also increase affordability and expand access to care. Some states already [allow](#) pharmacists to prescribe birth control, provide [vaccinations](#), and dispense [opioid overdose reversing medications](#). For example, [Idaho](#) permits pharmacists to prescribe treatments for a variety of common ailments, including influenza, strep throat, urinary tract infections, and cold sores. In fact, the U.S. Department of Veterans Affairs (VA) allows pharmacists to act as primary care providers, prescribing drugs and lab tests, making referrals to specialists, and even doing physical exams. In 2015, VA [pharmacists wrote 1.9 million prescriptions](#) for chronic diseases. Dr. Shannon Mentzel, Acting Chief of Pharmacy at the Phoenix VA, [testified to the House Health and Human Services Committee](#) in 2019 that the Phoenix VA Health Care System has 22 pharmacists practicing in primary care, which has led to better access to better quality care. At the El Paso VA, average [patient wait time fell from two months to two weeks](#) thanks to this reform.

During the pandemic, states and federal agencies temporarily eased restrictions on pharmacists' scope of practice. [Arizona](#) allowed pharmacists to refill some prescriptions for up to an additional 180 days without the patient having to see a doctor. The U.S. Department of Health and Human Services issued guidance permitting pharmacists to order and administer COVID-19 [tests](#) and [vaccines](#), noting that "Pharmacists are trusted healthcare professionals with established relationships with their patients." That made tests and vaccines far more accessible, because pharmacists often work inside grocery stores, big box retail retailers, hospitals, universities, nursing homes, and prisons.

[Studies show that](#) scope of practice [restrictions](#) on [advanced practitioners](#) have [no discernible health benefit](#) for patients; indeed, one [report](#) found that "patients were more satisfied with consultations with nurse practitioners than those with doctors." Another [estimated](#) that if NPs could practice in every state without physician oversight, cost savings could reach \$810 million. This isn't surprising. Pharmacists are [already extensively trained](#) in medication therapy management and immunizations. They are often the first medical professionals patients consult with, and they're trained to catch duplicate treatments or dangerous drug interactions that physicians themselves might overlook. They are required to be experts in medication.

Giving NPs, CRNAs, pharmacists, and other trained medical professionals greater freedom to help patients wouldn't just help improve access to healthcare – it would also strengthen protections against the spread of disease. Medical professionals should be allowed to practice at the top of their training all the time – not just during emergencies. COVID-19 has driven many states to empower more medical professionals to help more patients – but if it's good in a pandemic, it should be good in other times.

IV. Allow Medical Professionals to Help Patients in Other States

A. The Problem

Each state has its own rules requiring people in certain professions – including healthcare – to get government permission before they can work. This means that doctors, nurses, pharmacists, and other professionals must undergo the long, cumbersome, and bureaucratic process of getting re-licensed every time they move to a new state. These anti-competitive barriers to work make it difficult for medical professionals to go where they are most needed. During a crisis, these barriers can deny people critical care. This is especially true during pandemics, where hotspots can flare up unpredictably.

[Debbi Chapman](#), an open-heart intensive care unit nurse and military spouse, eventually had to stop practicing medicine because she couldn't maintain her license, given that her husband's job required them to move from state to state every couple of years. By the time she could get through the paperwork, complete the testing, get her license, and find a new job in the new state, new orders would arrive requiring her family to move again – and start the tedious and expensive process all over. Unfortunately, Debbi's story is as common as it is nonsensical. Of course, medical professionals do not lose their knowledge and skills when they cross a state border. And nurses, like people working in most other healthcare professions, take the same standardized national tests no matter the state.

Unfortunately, medical professionals like Debbi have little recourse in the legal system. Courts have relegated the right to earn a living to a category of disfavored rights, meaning that the government can impose burdensome licensing requirements on professionalism virtually without legal limit. Although some courts have declared licensing restrictions unconstitutional in certain extreme circumstances, most such laws – even where detrimental to public safety – are effectively immune to legal challenge under existing precedent.

B. The Solution

State laws should be modernized to recognize out-of-state occupational licenses based on the training or testing requirements that a person has already completed. This would allow professionals who already hold a license in one state to be approved to work quickly in another. Because professionals don't lose their skills when they cross state lines, it makes no sense to prohibit an experienced and knowledgeable nurse or pharmacist from practicing in one state just because she moved there from a neighboring state.

Recent actions that temporarily rolled back restrictions on medical practitioners illustrate the need for reform. At the onset of the coronavirus pandemic, many states swiftly waived their licensing requirements for out-of-state healthcare workers and other occupations, recognizing that regulatory obstacles could literally mean the difference between life and death. In fact, some states already had [laws on the books](#) expressly allowing such waivers in times of emergency. Removing these requirements ensured that out-of-state nurses and physicians could cross state lines quickly and provide quality care at a critical time. But if these regulatory restrictions hurt more than they help, then the waivers that worked during the pandemic should be made permanent across the country.

In 2019, [Arizona became the first state](#) to allow new residents who are licensed in other states to obtain licenses when they make Arizona their new home. The Arizona approach has proven wildly successful: more than 1,100 people were approved for licenses in the first six months that the law was in effect, and thousands more were approved the year after. Its interstate recognition policy applies to a wide variety of occupations, including healthcare professionals like nurses, nurse anesthetists, and pharmacists. To date, a dozen states have enacted this policy, and dozens more have introduced legislation.

Conclusion

The more that states welcome medical entrepreneurship, the better for individual practitioners and consumers alike. In the post-pandemic world, let's take a page from COVID-era reforms and unleash innovative and potentially life-saving services from unnecessary restrictions.