

FSMB Interstate Medical Licensure Compact: an Economist's View

Michael L. Marlow, Ph.D.

The Federation of State Medical Boards (FSMB) proposed creation of an Interstate Medical Licensure Compact (IMLC or Compact) in 2014. The Compact was enacted in May 2015 when it met the minimum requirement that seven state legislatures sign it into state law: Alabama, Idaho, Illinois, Minnesota, Montana, Nevada, Utah, South Dakota, Wyoming, and West Virginia have signed on so far.

Its stated intent is to expedite licensing of physicians who want to practice in multiple states without completing detailed license applications. FSMB states that the IMLC serves three needs: (1) to lessen existing physician shortages; (2) to meet the expected influx of millions of new patients as a result of the Affordable Care Act (ACA); and (3) to increase access to medical care in underserved areas via telemedicine. Once the licensing board in their primary state attests to their qualifications, other states in the Compact can quickly grant licenses to physicians who meet their requirements.

This commentary argues that the Compact represents attempts by the FSMB to consolidate its own power and control over physicians, and that it has little relationship to improving quality of care. It thus represents a major misstep for medical care.

Licensure in a Free Market

It is broadly understood by economists that occupational licensing creates market power for members of occupations, with little to no attendant gains in safety or product quality.¹ The economics literature has examined many professions that require all workers to have licenses. These include dentists, lawyers, barbers, manicurists, public accountants, plumbers, electricians, cosmetologists, and physicians. Licensing has been found to impose costly burdens on entrants, to eliminate competition by the unlicensed, and to limit numbers of licenses. Quality and access are also diminished for consumers who pay higher prices to workers protected from competition.

By 1900, all states required state licenses for the practice of medicine.² Licensed physicians then began exercising their market power to restrict entry. From 1910 to 1938, numbers of physicians per 100,000 members of the population fell from 157 to 130 (in part because number of medical schools fell by half).² As early as 1958, economists began suspecting that licensing mostly helped physicians raise prices to patients.^{3,4} In 1962, economist Milton Friedman argued that licensure reduces both the quantity and quality of medical practice, reduces opportunities available to people who would like to be physicians, forces the public to pay more for lower quality medical service, and retards technological development.⁵ He concluded that licensure should be eliminated as a requirement for the practice of medicine.

This view is consistent with the rent-seeking model of public-choice theory that predicts that sellers seek government programs and laws that benefit them financially. Medical licenses are compacts between state licensing boards and government officials. Government confers substantial "rents" to well-organized

physician groups while distributing the costs over the millions of patients. "Rents" provide strong incentives to lobby politicians for favorable treatment. Patients have little incentive to fight, given that their costs are spread thinly over many millions of citizens and that they may incorrectly believe that licensing protects their interests.

This view is also consistent with physicians being busy trying to protect their competitive advantage that their licensure confers. For example, they work hard within their medical societies to lobby for legislation that limits and restricts the scope of practice of nurse practitioners (NPs) and physician assistants (PAs). Recent success by dentist groups in limiting the ability of dental hygienists to practice on their own also indicates the profitability of stifling competitive threats from related occupations.⁶ Allowing hygienists to work independently of dentists is associated with roughly 10 percent higher wages and six percent increases in the employment growth of hygienists. These same regulations lower dentists' hourly earnings by 16 percent, and reduce their employment growth by 26 percent.

Proponents of licensing, however, claim that information asymmetry makes licensing necessary.^{7,8} The typical argument is that patients lack the knowledge and expertise to correctly judge the qualifications of physicians, or will fail to take the time necessary to acquire the knowledge. Licensing authorities are thus argued to overcome this information problem by setting minimum qualifications for the practice of medicine.

There are two problems with this view. One is that proposals for licensing typically stem from physicians rather than patients. This is understandable because physicians understand that licenses will reward them with economic rents—extra profits due to laws stifling competition.⁹ Studies indicate that licensing legislation was the result of organized physicians employing the political system for limiting entry to support their incomes, and such laws have not improved mortality rates.¹⁰⁻¹² A recent study estimates that restricted entry into medical schools in the Netherlands results in a rent of at least 20 percent of doctors' earnings.¹³

The other problem is that little evidence supports the belief that licensing protects patients from incompetent or unscrupulous physicians.¹¹ State licensing boards do not decide the range of services that physicians may offer. Medical licensing is not specialty-specific and is awarded to medical school graduates who pass comprehensive exams.

Under a free market in medical care, patients are better protected by the market than by state licensing. A tough liability system provides compensation for serious harm and encourages sound practices as determined by solid insurance underwriting of risk. Denial of malpractice liability insurance also provides a means of removing incompetent physicians.¹⁴ Assignment of liability for physician malpractice toward hospitals, insurers, and employers also creates incentives for these groups to closely monitor physician performance.¹⁵ Experience-rated premiums also create

financial incentives for inept physicians to improve or retire.¹⁶ Hospitals privilege physicians based on their evaluation of their education, skills, experience, and malpractice history.

Licensure in a Not-So-Free Market

The medical market bears little resemblance to the one that led Milton Friedman in 1962 to argue for the elimination of medical licensing. The medical market can no longer be classified as a free market. Resources are no longer allocated efficiently through a system of prices reflecting consumer preferences (demand) and resource scarcity (supply). The current medical market is highly distorted by the third-party payment system of private insurance markets; creation and growth of public insurance (Medicare and Medicaid created in 1965) that also used third-party payments; tax policies that subsidize employer-contributions for medical insurance; government price controls; and the many not-for-profit and public hospitals.

Third-Party Payments

Reducing the number of services for which patients pay directly is a fundamental change. The majority of direct, or out-of-pocket payments are insurance deductibles and co-payments. Out-of-pocket spending by consumers was \$339 billion, or 12 percent of national health expenditures (NHE), in 2013.¹⁷ Out-of-pocket spending declined from a 15 percent share of health spending in 1998.¹⁷ Expansion of public insurance programs as a third-party payer has also substantially lowered the direct costs of receiving medical treatment. Medicare spending of \$586 billion in 2013 accounted for 20 percent of NHE.¹⁷ Medicaid spending of \$449 billion in 2013 accounted for 15 percent of NHE.¹⁷

Third-party payments insulate patients from costs as they understand that doctors and hospitals bill insurance companies or the government. This separation of costs from benefits ultimately leads to over-consumption of medical care. Consider the costs facing a patient who is considering a medical procedure with a price tag of \$1,000, and who has met his insurance deductible. With a co-payment of 10 percent, the patient bears \$100 in out-of-pocket expenses because his insurance company pays \$900. As long as the procedure offers at least \$100 in benefits, the patient will undergo the procedure. If the patient were responsible for the full \$1,000, he would choose the procedure only as long as expected benefits were at least \$1,000. There is an incentive for both consumers and producers that results in more doctor visits, medical prescriptions, and more medical tests and procedures when the cost in the cost: benefit equation considered by the consumer is not the total cost. Considerable fraud also occurs, with recent estimates of as much as \$98 billion, or about 10 percent of annual Medicare and Medicaid spending.¹⁸

Tax Policy

Tax expenditures are subsidies delivered through the tax code in the form of deductions, exclusions, and other tax preferences. Two of the largest tax expenditures are the exclusion of employer-

contributions for medical insurance from income and payroll taxation. In 2014 this tax expenditure lowered income tax collections by \$250 billion from what otherwise would have occurred.¹⁹ Employers have an incentive to provide workers with insurance policies because the tax expenditure allows them to lower their total compensation costs. By shifting compensation from wage income to insurance, total compensation costs fall. Workers don't normally realize that their insurance benefit is offset by lower pay, and thus they underestimate their insurance cost, thus fostering greater consumption of insurance, which also promotes expansion of medical spending through the incentives for over-consumption stemming from third-party payment arrangements.

Non-profit Hospitals

There is a widespread misconception that private hospitals and private insurance are free-market entities, but they are not. They are strongly regulated and controlled by government or, as in the case of the McCarran-Ferguson Act of 1945, they are provided with special status that exempts them from anti-trust laws and allows them to operate as monopolies or oligopolies. Of the 4,974 U.S. community hospitals in 2013, 2,904 (58 percent) are non-profit, non-governmental; 1,060 (21 percent) are for-profit; and 1,010 (20 percent) are state and local government entities.²⁰ This is not a free market in hospitals.

Price Controls

Both Medicare and private insurance companies used to pay physicians retroactively for "usual, customary and reasonable charges," meaning doctors typically received what they invoiced. Now, price controls on medical procedures are seen by government as a remedy for controlling cost escalation. Medicare pays doctors through a fee-for-service arrangement whereby the doctor provides a service to a patient, and Medicare pays the doctor a set fee. Medicare price controls were imposed on hospitals in 1983 and on physician fees in 1992. Insurance companies quickly followed, with physician fees being mostly covered by government or contractual controls.

Price controls create several significant problems in medical markets. One problem concerns rationing, since the price mechanism may no longer ration medical care. The free market rations medical care by removing any shortage through price increases. Shortages that accompany a price control, however, require someone to determine who receives and who does not receive medical care. Serious doubts inevitably arise over fairness of outcomes no matter who makes such choices. Service quality may also suffer when medical facilities or physicians are forced to charge prices below what they would otherwise charge.

Price controls are circumvented, as by increasing the frequency of office visits and medical procedures. For example, a price control on office visits may cause physicians to require that their patients come in twice for medical procedures that previously were conducted within one visit. Quality of care is likely to fall along with job satisfaction in this environment.

Government price controls, followed by private insurers' constraints on physician fees, have contributed greatly to the

extraordinary expansion in use of NPs and PAs in physician offices in recent years. Inevitably, government looks to expanded use of NPs and PAs as a long-term strategy for cutting costs by creating further distance between patients and highly-trained physicians, and by expanding scope of practice to non-physician practitioners. It should be remembered, however, that the third-party payment mechanism is itself a leading reason for rapidly rising medical costs.

Physicians are also increasingly using the retainer approach (a.k.a. concierge medicine) in response to falling per-patient revenues.²¹ Rather than increase the daily number of patients—a move that lowers quality to patients and lowers occupational satisfaction of physicians, concierge medicine provides guaranteed revenues and permits either reducing the number of patients, or at least providing differentiated-service arrangements. The move toward concierge medicine thus is partly a reaction by physicians to government interventions.

Current Implications of Licensure

Much has changed in the economic value of licensure, as the practice of medicine no longer takes place in a market free of government intervention. Although restricting who can provide certain services would generally act to increase fees, this is not the case in a market that has been disrupted by government intervention. Medical licensure no longer so clearly translates into higher prices for patients. The laws of supply and demand in determining fees do not operate when government has instituted strict price controls for services provided by physicians, and private insurers have adopted fees based on these governmentally price-fixed fees. Thus, a decreased supply of physicians resulting from licensure does not translate to higher physician fees. Moreover, shortages and decreased access to care are symptoms of the current market that is heavily distorted by government intervention.

Notice also that the information asymmetry continues to exist in the current medical market. The various mechanisms often believed to resolve this asymmetry (being sued for malpractice, medical liability premiums being linked to claims experience, private credentialing by hospitals, certification by specialty boards, brand name) may be no more effective than medical licensure in preventing harm to patients.

The cruel reality is that these various mechanisms, rather than protecting patients, may harm them. Studies indicate that it is difficult to quantify any proposed benefits from maintenance of certification (MOC) programs.^{22,23} The comprehensive 2010 Institute of Medicine (IOM) report contained particularly candid comments, concluding that “the CE [continuing education] system, as it is structured today, is so deeply flawed that it cannot properly support the development of health professionals.”²⁴ Certification by specialty boards likewise does not protect patients. Specialty board websites often contain disclaimers that indicate that certification does not guarantee competence. In fact, certification boards may reflect nothing more than revenue-raising schemes for the boards that have no proven benefit for patients.

While MOC is extremely costly and not particularly effective in protecting patients, physicians who choose to ignore it risk losing their hospital privileges, thus depriving patients of the services

of good physicians. Moreover, while being sued can certainly be a strong deterrent to providing poor care, many doctors who are sued and whose cases settle never committed any malpractice. Cases are settled all the time based on business decisions made by the insurance company, paying out a smaller sum so as to avoid the very high costs of going to trial—even if the doctor did nothing wrong.

Hospitals frequently aggressively retaliate against physicians who compete with hospitals’ services (e.g. establishing a private MRI center that competes with the hospital’s MRI in their radiology department). As codified in medical staff bylaws, this type of anti-competitive conduct by hospitals is often referred to as “economic credentialing.” Hospitals also frequently retaliate against physician whistleblowers, acting to end the careers of physicians who spoke up to try and correct sub-standard or unsafe care. Neither of these actions helps protect patients.

FSMB as a Special Interest Group

It is tempting to characterize the FSMB as a “cartel” acting to aid or protect physicians from competition. But this view requires a free market in medicine that clearly does not exist. FSMB is not attempting to maintain or raise prices received by physicians, or enacting further restrictions on competition that would benefit physicians. FSMB is attempting to consolidate its own power and control over physicians. The Compact, in effect, allows FSMB to gain strength in at least two ways. One is that it will gain additional fees when more physicians take advantage of the streamlined interstate licensing process. Of 878,194 physicians with an active license to practice medicine in the U.S. in 2012, 78 percent held only one active license, 16 percent had active licenses in two jurisdictions, and six percent had active licenses in three or more jurisdictions.²⁵ Many dollars can be made by raising the number of active licenses. More fees also translate into greater lobbying resources.

One can predict that FSMB will attempt to raise fee income through requiring MOC programs for renewal of state medical licenses. FSMB’s own definition of “physician” requires MOC for most physicians participating in the Compact.²⁶ This step reinforces the growing trend of state licensing boards requiring physicians to enroll in official MOC programs.

Roughly 75 percent of U.S. doctors are “certified” by 24 privately run boards that “certify” mastering of their area of specialty.²⁷ However, studies indicate that it is difficult to quantify any proposed benefits from MOC programs.^{22,23} MOC programs are very good at generating fee revenue and salaries for the boards. For example, in 2012, the American Board of Internal Medicine (ABIM) received more than \$55 million in fees from physicians seeking certification, and various board members and its CEO were highly compensated.²⁸ Generous fee revenue appears to be mostly the norm for most boards.²⁹

The telemedicine issue is merely a pretext for FSMB’s power grab. FSMB claims that the Compact is needed because of the advent of telemedicine. But, designating the state medical board in which a patient is located as the overseeing authority for medical practice raises suspicions that FSMB is attempting to raise licensing revenue for itself and state licensing boards. Changing the location of medical care to where the physician is located, rather than the patient, is a simpler option. But this

approach is unlikely to create such an enlarged revenue pool.

In addition, the logic behind the claim that the Compact is necessary to expand access is highly suspect. It remains questionable that interstate medical licensing would increase the supply or number of physicians. If a doctor in Montana can now practice in Wyoming, some patients there may have access to another doctor. But, if the Montana doctor is spending time with Wyoming patients, then the doctor is spending less time with Montana patients. The net effect is likely to be close to zero. But, also notice that, if the Montana doctor had spare time there, then there is evidence of a surplus of doctors in Montana and not a shortage. In other words, FSMB does not appear to have thought this issue through. Again, this is evidence of a power grab by FSMB that has little to do with expanding access to medical care.

Conclusions

The FSMB plays its hand for all to see when it boldly states that the IMLC meets three needs related to access to care. It fails to understand that existing physician shortages and rising costs are a byproduct of the various government interventions outlined above.

Pushing telemedicine is just another high-risk strategy aimed at slowing down inevitable expansion of costs brought by years of government intervention into the market. The states that have signed the Compact mostly represent rural states that may be attempting to use telemedicine as a way around building in-state Centers of Excellence. Patients would be better off with more in-state physicians who can practice medicine in person.

The IMLC does nothing to address causes of job dissatisfaction found in a 2012 nationwide survey of more than 13,500 doctors.³⁰ More than 26 percent of physicians have closed their practices to Medicaid patients. More than 52 percent of physicians have limited the access Medicare patients have to their practices, or are planning to do so. Another seven percent plan to switch to cash-only “concierge” practices in which patients pay doctors an annual retainer fee. These responses represent counter-reactions to the growing presence of government intervention in medicine.

The Compact does not improve the lives of physicians, nor does it represent a long-term solution to projected shortfalls of 46,100 to 90,400 physicians by 2025.³¹

Growing the bureaucracy is never a mechanism for lowering costs, improving access to quality care, or facilitating physicians’ ability to care for their patients. If state licensing boards are really serious about improving the quality of medical care, they will begin figuring out how to promote a free market in medical care that attracts more physicians rather than further its declining quality by picking their pockets.

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Michael L. Marlow, Ph.D., is professor of economics and distinguished scholar at California Polytechnic State University, San Luis Obispo, Calif. He is also an affiliated scholar of the Center for the Study of Economic Liberty at Arizona State University. Contact: mmarlow@calpoly.edu.

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