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A Primer on Emergency Occupational Licensing Reforms for Combating COVID-19

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The pandemic of COVID-19 has created a significant strain on the healthcare system in the United States. As of March 26, the Centers for Disease Control and Prevention has confirmed 68,440 cases of the disease and 994 deaths in the United States.[1] As COVID-19 continues to spread, these numbers are only expected to increase, and with that so does the potential to overwhelm the US healthcare system.

American regulatory policy limits the country's healthcare capacity in a variety of ways. In response, states must consider a range of temporary measures to allow the supply of healthcare professionals to meet the sudden growing demand and provide adequate care to patients. The existing web of state occupational licensing laws creates rigidity in healthcare labor supply. In this brief we highlight actions states have taken to reform occupational licensing, and we produce a novel ranking of these interventions as guidance to policymakers.

Currently, Italy is reporting a surge of infections among healthcare personnel. These infections make up 8.3 percent of the country's total infections.[2] With Italian hospitals overwhelmed from the onslaught of infected patients, the healthcare system is struggling. As Europe's hardest-hit country, Italy is being forced to relax its own regulatory regime, calling in retired doctors and waiving occupational licensing requirements to treat the overwhelming influx of patients.

The situation in the United States may not play out to be as severe as in Italy; however, the problem in Italy shows how deadly a general healthcare staffing shortage can be. Without additional capacity, COVID-19 could strain American hospitals to their breaking point. Complicating this dilemma even more, much of America's healthcare workforce falls into the population considered to be

at a higher risk for severe illness. Registered nursing, an occupation that is already experiencing shortages across the nation, has over one million individuals age 50 or older.[3]

States such as New York, which currently has the most cases in the United States, at 32,966, are already preparing for staffing shortages.[4] Although expert projections on how COVID-19 will affect the United States vary in severity, they all seem to agree that the virus will test the limits of hospitals across the nation. With the number of infected Americans only expected to grow in the coming weeks, it is vital that American hospitals are well equipped to fight this pandemic.

We proceed in this brief by highlighting how occupational licensing creates a lack of flexibility in the market for healthcare professionals. We then analyze recent action taken by states to combat the crisis, and we offer a novel ranking of which interventions are likely to be most effective in adding healthcare staff capacity.

WHY OCCUPATIONAL LICENSING CREATES BARRIERS IN AN EMERGENCY

The United States healthcare system was in a weak position before the outbreak of COVID-19 owing to long-standing regulatory policies. Specifically, America has many regulations that restrict the available supply of healthcare, including but not limited to Medicare's Graduate Medical Education residency limit, certificate-of-need laws, and occupational licensing laws. While occupational licensing laws affect many professions, they are ubiquitous in healthcare—nearly 44 percent of healthcare and education workers are licensed.[5] Licensing is implemented with the intention of establishing a minimum level of quality and encouraging human capital formation for professionals throughout their career.

In healthcare professions, occupational licensing laws limit paths to begin working, mandating education, training, and exams that all professionals must undergo in order to begin practicing. These requirements are rigid, reducing healthcare supply flexibility and preventing supply from quickly adapting to meet sudden changes in needs, such as the current pandemic. While policy should not be designed for extremely rare events, it should be flexible enough to adapt to a novel crisis.

Research shows that occupational licensing reduces the supply of workers in a profession.[6] Looking at select occupations, Morris M. Kleiner estimates that states without licensing experienced 20 percent faster growth in the number of professionals than states that licensed those select occupations.[7] Across a larger sample of professions, Kleiner found an 11.4 percent reduction in the number of professionals as a result of the barriers created by occupational licensing.[8] These findings are evidence that licensing laws have reduced the supply of healthcare professionals as a result of elevated entry costs. The rigidity of licensing requirements makes it more difficult for new professionals to enter an occupation quickly in response to a sudden surge in demand.

Because licensing laws are passed at the state level, they also reduce the interstate mobility of workers. State boards typically require professionals licensed in other states to apply, pass exams, and pay fees in order to begin practicing in their new home. These additional costs and delays, which can be as long as several months, reduce the interstate mobility of licensed workers by 36 percent compared to similar unlicensed workers.[9] In a public health emergency, licensing substantially reduces the ability of workers to move to the areas that need additional care quickly.

Occupational licensing laws also clearly dictate the tasks that each profession is allowed to perform.[10] Historically, the American Medical Association has exerted substantial influence over scope-of-practice laws. As a result, many states do not allow healthcare professionals to practice to the full extent of their education and training.[11] In a rapidly evolving public health crisis, flexibility is essential to provide quality care and meet the sudden change in patient needs.

A RANKING OF RECENT REFORMS

Several states have enacted emergency reforms in response to the crisis. Policymakers are to be commended for taking quick action. List 1 (page 7) sorts responses by state, and List 2 (page 8) categorizes the responses by intervention as of March 25, 2020. We proceed by ranking the reforms that have been implemented into different tiers based on our expectation of their effectiveness. Tier 1 reforms we believe to be most effective, tier 2 we believe to be moderately effective, and tier 3 we believe to be least effective.

TIER 1: MOST EFFECTIVE REFORMS

Blanket Expansion of Medical Scope of Practice

At the time of this writing, Maryland is the only state to have enacted a significant reform that grants all healthcare professionals the authority to work beyond their current scope of practice in healthcare facilities. New York has enacted this type of reform for select licensed health professionals.

Healthcare professionals learn a lot in their education, and while society may not want registered nurses (RNs) to practice like a physician under normal circumstances, at some point it may be necessary to give them an expanded role, especially given America's older physician population. Freeing medical professionals from the normal limits of regimented scope-of-practice restraints will allow all medical providers to be more creative in deploying nurses and potentially devising better ways to make use of their abilities.

Many healthcare professionals such as physician assistants (PAs) and nurse practitioners (NPs) are not allowed to practice to their full skill sets and apply their full training because of scope-of-practice laws. In many states, PAs and NPs are not allowed to practice without a supervising physician. If a physician becomes sick with COVID-19, that physician's PA or NP will be able to

do little in states with restrictive scope-of-practice laws. Blanket expansions of medical scope of practice, like the one Maryland has already enacted, would automatically grant PAs and NPs broader scope of practice to help alleviate demand surges for healthcare services.

Given the large number of trained medical professionals, expanding their scope of practice can rapidly increase the availability of care and do so across the country. These professionals already have experience with the staff, team members, and institutional knowledge of the facilities they work in. In many states, NPs and PAs are already permitted to practice to the full extent of their medical training. There is no evidence that granting this authority reduces the quality of care received by patients.[12]

Waiving Licensure Requirements

Eight states (Idaho, Maine, Michigan, Missouri, New Hampshire, New York, Pennsylvania, and Texas) have waived or modified licensing requirements for professionals. Idaho, Maine, and Missouri in particular, have granted broad authority for the waiving of all licensure requirements in the case of unmet need arising from COVID-19. The remaining states have modified licensing requirements on a more limited basis.

This measure is also likely to be very effective at increasing healthcare capacity and would complement a blanket expansion in medical scope of practice. As already-established medical professionals move into their full scope of practice, temporarily waiving licensing requirements will reduce the training of new professionals to the absolute minimum necessary for narrow tasks, such as operating the ventilators of severely ill patients. Even if healthcare providers significantly increase the number of ventilators available, they will still experience shortages without the requisite operating personnel. Experienced licensed practical nurses (LPNs) could be trained to be able to operate the ventilators temporarily to support the RNs and specialists running the ventilators during the crisis. Ensuring that they are well trained for their specific tasks and not having them waste time meeting requirements irrelevant for their roles during the public health emergency will help expand healthcare capacity more rapidly. Aspiring health professionals currently in the early stages of education can be trained to perform simple procedures and care relatively quickly under appropriate supervision and guidance.

Many nurses that could potentially begin practicing are currently locked out. Pearson VUE has suspended all offerings of the nursing board exams during the declared health crisis until April 17, preventing qualified nurses from entering the workforce.[13] Waivers or modifications of licensing requirements would allow these nurses to begin working much more quickly. Pennsylvania and Texas have enacted specific reforms for nurses.

Allowing healthcare students in the end stages of training and in clinical rotations to begin practicing their profession would be another simple option to expand the healthcare supply with little

risk. By allowing those in their final year of training to immediately practice, policymakers can augment the workforce by approximately 30,000 physicians and 158,000 nurses in the United States.[14] Italy has already implemented this measure, allowing the cohort of physicians in training to begin working in hospitals nine months before its scheduled graduation.[15]

Additionally, many laws require foreign physicians who have studied, trained, or practiced overseas to go through a training process to prove competency. States could consider temporarily waiving the required training if these physicians have adequate proof of their education. At the very least, states could allow foreign-trained physicians a scope of practice similar to an NP.

States should look to reforms made in Idaho, Maine, and Missouri as best practices to help immediately ease burdens placed upon the healthcare system from COVID-19. Steps taken by the other five states are good first steps, but broader waivers would be much more effective.

TIER 2: MODERATELY EFFECTIVE REFORMS

Out-of-State Temporary License

Fourteen states (and Colorado, whose reforms are currently pending) have enacted reforms allowing out-of-state licensed medical professionals to obtain a temporary emergency license to practice. These reforms will make it easier to move the supply of healthcare workers to meet sudden spikes in demand and, at the very least, even out regional shortages and surpluses. Some states, or regions within states such as California,[16] face shortages of healthcare professionals in even non-crisis times. Allowing temporary licenses for out-of-state residents can smooth the shortages and surpluses. Such reform may also be beneficial if different areas face different levels of outbreaks.

However, allowing recognition for out-of-state licenses is less beneficial when crises are widespread rather than contained within certain regions. If the entire country faces a shortage of healthcare professionals, the effectiveness of this reform may be reduced.

In short, this reform allows capacity to shift from geographic pockets with the least need to pockets with the greatest need. This reform does not work to enhance overall capacity like the tier 1 reforms highlighted in the preceding section.

TIER 3: LEAST EFFECTIVE REFORMS

Allowing Retired Personnel to Practice

Seven states (Illinois, Iowa, Maryland, Massachusetts, New York, North Carolina, and Texas) have allowed retired medical personnel the authority to practice. Although this reform does add some immediate capacity, its effectiveness is limited owing to the high risk of morality from the virus

for older citizens. When providers shift their limited healthcare resources to treating coronavirus patients, that will leave fewer medical professionals to provide treatments for other ailments. Retired and older healthcare professionals can safely help fill that gap and provide care to patients with ailments that will not give these retired professionals a disproportionate chance of severe complications and death.

The number of retired healthcare professionals, however, is limited. Because of their age, they likely have a lower stamina, requiring them to work shorter hours. While retired healthcare professionals are highly skilled and experienced, their return will add a limited amount of staff for hospitals.

Extended Expiration and Waiving Continuing Education

Four states have either extended expiration of licenses or eliminated continuing education requirements (Iowa, Maryland, Oklahoma, and Pennsylvania). During a public health emergency, it makes sense for states to waive these requirements. Waiving continuing education requirements will allow healthcare professionals to focus on treating patients, and their hours are expected to surge in response to increased demand. Because of the increased demand, licenses should be extended indefinitely until after the emergency ends. The overall ability of this reform to increase capacity, however, is limited. The most cumbersome barriers associated with occupational licensing remain in place with this type of reform.

Waived Fees

Georgia, Pennsylvania, and South Carolina have waived fees associated with obtaining occupational licensing. Waiving initial licensing and continuing education fees temporarily will reduce the costs of healthcare workers entering and remaining in the workforce. While this waiver may not have a substantial effect on the size of the workforce, it will make it easier for professionals, especially as the federal government considers stimulus programs. While this reform will do little to expand the supply of healthcare, it will prevent a reduction in supply while not penalizing noncompliance with rules that do not affect patient care.

ANOTHER POSSIBLE REFORM: MILITARY TRAINING

Another option that states have not implemented at the time of this writing is allowing additional military personnel to be trained and allowing those already trained to administer care. There is a large number of military personnel trained for medical care who are unable to practice medicine because of licensing laws but who could immediately be allowed to practice.

Additionally, the military could quickly mobilize and train service members to operate ventilators and the few relevant healthcare tasks that accompany such operation. The military has much

shorter, intense training regimens. Health providers can use the local National Guard barracks as makeshift "triage" centers for patients on ventilators. Italy has been forced to use hospital hallways and waiting rooms, but in a worst-case scenario, military installations would be a much better solution to prevent hospital overflow.

CONCLUSION

Because of the danger posed by the quick spread of and high hospitalization rate for COVID-19, states must be able to rapidly increase their capacity to provide care for patients in order to avoid a high death rate. America's current regulatory policies do not allow the supply of healthcare workers to respond to sudden, sharp changes in demand. To their credit, a number of states have enacted emergency reforms to occupational licensing to help meet growing demand. Other states should look to current national leaders such as Maryland, Idaho, Maine, and Missouri. Maryland has granted all medical professionals blanket authority to practice beyond their scope of practice. Idaho and Maine have granted broad authority to exempt professionals from licensing requirements. Reforms like these are likely to be most effective at providing the healthcare system the capacity it needs to meet ever-growing demand for healthcare services as a result of COVID-19.

List 1. Emergency Reforms Sorted by State

GEORGIA

- out-of-state emergency temporary permit (advance practice registered nurses [APRNs], MDs, PAs, respiratory care practitioners [RCPs])
- waived fees

COLORADO

- out-of-state licensing (proposed)

IDAHO

- "Waive Licensing and Related Requirements"

ILLINOIS

- out-of-state emergency temporary license (nurses, pharmacists, MDs, PAs, RCPs)
- retired or inactive licensees can practice (nurses, MDs, PAs, RCPs)

IOWA

- extended expiration
- inactive licensees can practice (nurses, MDs, PAs, RCPs)

KANSAS

- emergency temporary license

LOUISIANA

- emergency temporary permit (allied health practitioners)

MAINE

- waived or modified licensing requirements

MARYLAND

- extended expiration (all licensing boards)
- emergency temporary healthcare permit
- inactive licensees can practice
- blanket expansion of medical scope of practice

MASSACHUSETTS

- emergency temporary permit
- license reactivation for retired MDs

MICHIGAN

- nurse aide exam requirements waived
- continuing education requirements waived
- emergency temporary permit

MISSOURI

- waived or modified licensing requirements

NEW HAMPSHIRE

- emergency temporary permit for medical personnel
- nursing clinical experience requirements modified

List 1 (continued)

NEW JERSEY

- emergency temporary permit for medical personnel
- waived licensing requirements for out-of-state license
- waived fees

NEW YORK

- emergency temporary permit for medical personnel
- waived or modified licensing requirements
- blanket expansion of medical scope of practice (select personnel)
- license reactivation for retired MDs

NORTH CAROLINA

- inactive and retired medical licensees can practice

OKLAHOMA

- extended expiration

OREGON

- out-of-state medical personnel emergency temporary license

PENNSYLVANIA

- waived nursing fees
- extended expiration
- waived exam for graduate students temporarily

SOUTH CAROLINA

- waived fees
- waived requirements for out-of-state nurses

TENNESSEE

- out-of-state medical personnel emergency temporary license

TEXAS

- out-of-state medical personnel emergency temporary license
- waived exam requirements for graduate nursing students
- license reactivation for retired nurses

List 2. Emergency Reforms Sorted by Type of Reform

OUT-OF-STATE MEDICAL PERSONNEL TEMPORARY LICENSE

- Colorado (proposed)
- Georgia
- Illinois
- Kansas
- Louisiana
- Maryland
- Massachusetts
- Michigan
- New Hampshire
- New Jersey
- New York
- Oregon
- South Carolina
- Tennessee
- Texas

WAIVED OR MODIFIED LICENSING REQUIREMENTS

- Idaho
- Maine
- Michigan (nurse aide examination, continuing education)
- Missouri
- New Hampshire (modifies clinical experience requirements)
- New York (several occupations)
- Pennsylvania (nursing exam)
- Texas (nurses)

EXTENDED EXPIRATION

- Iowa
- Maryland
- Oklahoma
- Pennsylvania

BLANKET EXPANSION OF MEDICAL SCOPE OF PRACTICE

- Maryland
- New York (select personnel)

INACTIVE OR RETIRED LICENSEES CAN PRACTICE

- Illinois
- Iowa
- Maryland
- Massachusetts
- New York
- North Carolina
- Texas

WAIVED FEES

- Georgia
- Pennsylvania
- South Carolina

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NOTES

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