Keeping you informed from Washington, D.C.

January 30, 2025

Early Executive Actions

In the first two weeks of his new administration, **President Trump** has issued a flurry of Executive Orders and directives related to health, including a regulatory freeze and a pause on many Federal health agency communications with the public. Our advocacy staff are carefully monitoring both the activities of Congress and the Administration to identify areas that may impact medical regulation.

Today, the nation is saddened by the tragic accident involving the collision of American Airlines Flight 5342 and a U.S. military helicopter. Our hearts and prayers go out to the friends and families of those who lost their lives last night.

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Executive Orders

On January 20, the **Trump Administration** issued executive orders, including a some affect health care issues, including:

- **Withdrawing the United States from the World Health Organization** and calling for a replacement of U.S. Global Health Security Strategy
- **Initial Rescissions of Harmful Executive Orders and Actions** Canceling 78 Biden Administration EOs including:
  - EO 14087: President Biden's order that prompted the **Center for Medicare and Medicaid Innovation (CMMI)** to create three drug pricing experiments to reduce drug costs
  - EO 13987: Organizing and Mobilizing the United States Government To Provide a Unified and Effective Response To Combat COVID-19
  - EO 13988: Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation
  - EO 13995: Ensuring an Equitable Pandemic Response and Recovery
  - EO 13996: Establishing the COVID-19 Pandemic Testing Board and Ensuring a Sustainable Public Health Workforce for COVID-19 and Other Biological Threats
  - EO 13997: Improving and Expanding Access to Care and Treatments for COVID-19
  - EO 14009: Strengthening Medicaid and the *Affordable Care Act*
  - EO 14021: Guaranteeing an Educational Environment Free From Discrimination on the Basis of Sex, Including Sexual Orientation or Gender Identity

    - EO 14070: Continuing To Strengthen Americans' Access to Affordable, Quality Health Coverage
    - EO 14075: Advancing Equality for LGBTQI Individuals
    - EO 14099: Moving Beyond COVID-19 Vaccination Requirements for Federal Workers
- **EO Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government**: Enforces use of "sex" rather than "gender" in the Federal government and rescinds several resources such as the White House Toolkit on Transgender Equality.
- **EO Protecting the Meaning and Value of American Citizenship** Would end birthright citizenship for people born in the U.S. to parents with lawful temporary residency status. **This order, however, is currently under a nationwide 14-day temporary restraining order due to Constitutional violations.**

Regulatory News

Trump Administration
On January 20, **President Trump** issued a **regulatory freeze,** requiring rules that have not yet been finalized or published in the Federal Register to be reviewed by the appointed head of department or delegated appointee before being sent to the Office of the Federal Register. Certain rules may be exempt for emergencies or other urgent situations.

Reproductive Care
The **Congressional Research Service** released a **report** on reproductive health provisions covered by FY 2025 NDAA. The report includes information on reproductive health screening and preventive services, contraception services, and infertility services offered by TRICARE.

Federal Contact
The FSMB's federal legislative staff will continue to track and monitor legislation and regulations of interest to state medical boards. If there is specific legislation you would like us to assist with, please contact **Lisa Robin**, Chief Advocacy Officer, at lrobin@fsmb.org, or by phone at (202) 463-4006.

Executive Orders

On January 16, **North Carolina Gov. Josh Stein** issued an **EO** that ordered state Cabinet agencies not to cooperate with prosecution and penalties against health care providers who provided legal reproductive health services, including abortion, and ordered a review of how patient reproductive care health information is stored to "maximize protections for individual privacy." It also tasked the Dept. of Health and Human Services to "ensure North Carolinians have reliable, consistent access to safe and legal reproductive health care medications and birth control," and offered protections for pregnant Cabinet agency employees, among other aspects.

On January 20, **Florida Gov. Ron DeSantis** issued an **EO** declaring a state of emergency (SOE) in preparation for winter storm impacts, including permitting Floridians to receive early prescription refills, including controlled substances, other than those listed under Schedule II.

Regulatory News

Board Structure and Function
The **Pennsylvania Board of Osteopathic Medicine** issued a **final rule** making several licensure changes including:

- An updated definition of "graduate medical training" to reflect ACGME accreditation changes since 2020
- Updated requirements relating to NBOME changes including removal of practical assessment requirements
- Amendment of the license type "temporary license" to "temporary graduate training license" and allows the license to be renewable
- Creation of sections for licensure by endorsement requirements

The **Texas Medical Board** issued a **proposed rule** adding requirements for evaluation of professional and/or work history for licensure applicants. The rule allows for remedial measures if the applicant has less than 5 years of active clinical practice preceding their application.

Continuing Medical Education
The **Florida Board of Medicine** issued a **proposed rule** expanding CME options available to fulfill disciplinary order obligations. The rule removes provisions specifying webinar eligibility requirements, and instead allows for:

1. AMA Category 1 CME credits or any course accepted for the AMA physician recognition award.
2. Any postgraduate training program accredited by ACGME
3. ACEP, Category I; AAFP prescribed credit; ACOG cognates; and study courses required by those specialty certification boards approved by the Board for the purpose of sitting for specialty recertification examinations.

Pending Legislation of Interest

Additional Licensure Pathways
Connecticut SB 1054 - "Shell bill" that would mandate that statutes be amended "to facilitate qualified and experienced foreign medical doctors who lawfully migrate to the U.S. in becoming licensed to practice medicine in the state" by providing **provisional licenses** to IMGs who:

- Completed a residency *and* received education and training outside of the U.S. that is "substantially similar" to the education and training that physicians obtain in the U.S.

Provisional licensees must practice under supervision of a Connecticut-licensed physician, and, after **two years**, licensees will be eligible for an unrestricted license.

Minnesota SF 509 - Requires ("**must**") the Board to issue a **limited license** to an individual that has:

- Satisfied specified requirements in **MN Sec. 147.037**, including:
  - A degree medical or osteopathic school approved by the board as equivalent to accredited United States or Canadian schools based upon its faculty, curriculum, facilities, accreditation, or other relevant data;
  - Not being under license suspension or revocation;
  - Filed an application with the Board and paid a fee; and
  - ECFMG certification;
- Federal immigration status;
- Practiced medicine for at least 60 months (five years) within the last 10 years outside the U.S.;
- Evidence of an offer to practice medicine "within the context of a collaborative agreement [detailed specifically in the legislation] within a hospital or clinical setting" where the limited licensee and physicians work together to provide patient care in a designated rural area or underserved urban community;
- Submitted two letters of recommendation, one from a physician the applicant has worked with and another from an administrator of the hospital or clinical setting where applicant previously worked, that "attest to the applicant's good medical standing;" and
- Passed Steps 1 and 2 of the USMLE or COMLEX-USA, within three attempts.

Applicants are **not** required to "present evidence… of the completion of one year of [accredited] graduate clinical medical training." Employers must pay the limited licensees an amount equivalent to that of a medical resident, carry medical malpractice insurance, and are prohibited from retaliating or discipling an employee for raising a complaint relating to these terms. After one year of limited practice, a collaborating physician must submit a letter to the board attesting that the limited licensee "has a basic understanding of federal and state laws regarding the provision of health care," documentation standards, and standards of care, amount other topics itemized in the legislation.

After **two years** of limited practice in good standing with at least 1,692 hours per year of practice, the board **must** issue a full, unrestricted license, so long as the licensee submits a letter of recommendation from a physician that participated in their collaborative practice and passed USMLE Step 3 or COMLEX-USA Level 3 within three attempts.

Additionally, the limited license holder must submit to the board, every six months or upon request, a statement certifying that they are [still] employed as a physician and whether they have been subjected to professional discipline. The board may suspend or revoke a limited license if the licensee is no longer employed as a physician in the state, and the limited licensee can change employers, but must still follow the statute's requirements to achieve full licensure.

The bill, if enacted, would become effective **January 1, 2026**.

North Dakota SB 2270 – Requires ("**shall**") the Board to issue a **provisional license** to a qualifying international physician who has:

- Been granted a medical doctorate or substantially similar degree by a domestic or

international medical program - defined as any medical school, residency or internship program, or entity that provides medical education/training eligible for ECFMG certification or is “substantially similar” to the education/training required by the Board for licensure - in good standing;
- Maintained a license in good standing *within* the last five years without pending disciplinary action;
- Completed *either* a residency or “substantially similar” postgraduate medical training program; *or* has seven years of practice experience as a physician;
- An ECFMG certification;
- Passed all Steps of the USMLE;
- Proficiency in English;
- Federal immigration status (application can come first, but practice must be subsequent to obtaining work authorization);
- Paid applicable fees and completed an application; and
- An offer of employment from a health care provider, defined as a health system, hospital, hospital-based facility, emergency facility, or urgent care clinic, operating in the state.

The provisional license **automatically converts** to a full medical license after *three years* of active practice in the state, wherein the licensee can pursue employment outside of the original sponsoring facility.

The Board is authorized to revoke provisional licenses if the licensee ceases to work for a qualifying employer during the provisional period or if there is clear and convincing evidence shows the physician violated the medical, safety, competency, or conduct standards; an appeals process is provided. Further, the Board may verify training equivalency, review examination results, and conduct background investigations, among other enumerated regulatory powers.

Rhode Island HB 5108 – Authorizes the board to issue **limited licenses** to qualifying internationally-trained physicians (ITPs) that have:
- Received a degree of doctor of medicine or its equivalent from a legally chartered medical school outside the U.S. recognized by the WHO;
- Been licensed or authorized to practice medicine *and* has practiced medicine for at least **one year**;
- ECFMG certification (that can be waived at the Board’s discretion if the applicant hails from a non-cooperating country);
- Passed USMLE Steps 1 & 2;
- Entered into an agreement with the participating healthcare facility - defined as FQHC, CHC, hospital, or other facility approved by the Board - that “shall develop, assess and evaluate the applicant's familiarity with nonclinical skill standards appropriate for medical practice in the state, according to criteria developed or approved by the Board; and
- Satisfied any other criteria required by the Board.

The limited license is valid for *one year*, but may be renewed once, for a total of two years. After this period, licensees are eligible for a **restricted license**, so long as they:
- Complete the facility’s assessment and evaluation;
- Pass USMLE Step 3; and
- Practice in a physician shortage area designated by the Board.

Restricted licensees can practice independently in a primary care specialty, psychiatry, or other specialty approved by the Board. After a minimum of **two years** of restricted practice (**four years overall**), the licensee is eligible to apply for a full, unrestricted license.

Wyoming SF 155 – Requires (“**shall**”) the Board to grant a **provisional license** to qualifying international physicians that have:
- A medical doctorate or “substantially similar degree” by a domestic or international medical program of good standing;
- Been in good standing with the foreign licensing or regulatory institution at all times for the last *five years* and have no discipline pending;
- Completed a residency or substantially similar PGT *or* have at least *seven years’* practice experience;
- At least five years of practice experience (if completed a residency/PGT)
- Passed all Steps of the USMLE;
- English language proficiency;
- Eligibility to obtain Federal immigration status;
- An offer for employment at any health care provider - defined as health systems, hospitals, hospital-based facilities, freestanding emergency facilities and urgent care clinics - that operates in the state; and
- Completes an application, pays fees, and submits to a criminal background investigation.

Provisional licensees must provide annual proof of compliance with the health care provider employment and continuing education requirements.

The Board may revoke the provisional license if the licensee ceases working at the health care

provider during the provisional period, or apply license discipline in line with **W.S. §§ 33-26-401 — 33-26-410**. Provisional licenses **automatically** convert to full license after **three years** of practice in good standing.

Associate Physicians
Missouri HB 1010 - Adds FQHCs to medically underserved areas as qualifying places of practice for APs, and makes APs **eligible for full physician licensure** if they:

- Are good license standing;
- Pass USMLE Step 3;
- Complete at least 60 months (five years) of collaborative practice as an AP;
- Complete "postgraduate training under a preceptor" of 120 hours of core categories including family medicine, pediatrics, inpatient or outpatient psychiatry, internal medicine, and gynecology, as well as 120 hours of seven elective categories that are listed. The training is defined as "consist of on-the-job, hands-on training, including performing medical procedures."
- Complete 100 CME hours biennially; and
- Receive letters of recommendation from their collaborating physician and another physician licensed in good standing in the state.

Board Authority/COVID-19
Iowa SF 117 – Prohibits the Board from restricting a practitioner's prescriptive authority, so long as prescription is consistent with their scope of practice.

Mississippi HB 1288 – Authorizes pharmacists to provide ivermectin to adult patients pursuant to a collaborative pharmacy practice agreement containing a non-patient-specific prescriptive order. The bill also requires the Board of Pharmacy to establish standard procedures for this task, including providing the patient with a screening risk assessment tool and fact sheet.

Texas SB 883 – Prohibits the state from restricting a physician from prescribing for off-label use a prescription drug to treat COVID-19. The bill also forbids the Board from taking disciplinary action against a physician for doing so, provided the treatment of the patient meets the medical standard of care.

Mississippi HB 1430 – Prohibits the Board of Medical Licensure from adopting any rule that prohibits physicians or APRNs from prescribing drugs for off-label use.

Board Structure and Function
Arizona SB 1235 – Changes the composition of the Osteopathic Board to include four public members (current law requires two) and three osteopathic physicians (current law requires five) who have practiced medicine for five years, with licenses in good license standing, and who currently practice with direct patient contact.

The bill would also change the composition of the Medical Board to include seven public members (current law requires four), one of which must be a licensed practical or professional nurse; and five members who are actively practicing medicine (current law requires eight), which must hail from at least three different counties.

If enacted, these changes would activate once the current Board members' terms expire.

Illinois SB 210 – Extends the license of a health care professional that expires during a public health emergency for three months.

Iowa SSB 1032 – Authorizes the Director of the Dept. of Inspections to coordinate audits and investigations into the Board of Medicine; currently, the Board is excepted.

Maryland SB 423 – Repeals obsolete and redundant language, clarifies existing provisions, and creates consistency across statutes. Specifically, the bill provides definitions (such as "rehabilitation program" which is analogous to a PHP), defines membership criteria, term limits, and quorum requirements for allied health advisory committees; explicitly allows the Board to set fees to "generate sufficient funds to... [support] license programs... and other services," and allows the Board to set additional "education, certification, training, or examination requirements" for license applicants, including displaying written English language competency. The bill also updates the grounds for disciplinary actions, providing clearer definitions of violations and misconduct and establishes new reporting obligations for medical professionals and institutions, among other aspects.

Regarding supervised medical graduates (SMGs), a licensure class analogous to associate physicians, the bill adds COMLEX-USA as an equivalent requirement to the USMLE (SMGs applicants must pass Steps/Levels 1 & 2 of either, if enacted).

Massachusetts SD 1925 – Requires the Board to collect data concerning the cultural, ethnic, linguistic, and educational composition of the physician workforce through the inclusion of *voluntary* demographic questions in the licensure application. Further, the bill requires the Board to share this data with the Center for Health Information and Analysis within 60 days of the end of each year.

Mississippi H 1437 – Clarifies that no applicant may be granted licensure unless they hold a diploma from a medical or osteopathic medicine college listed in the World Directory of Medical Schools, or an equivalent, Board-approved entity. The bill requires applicants to submit fingerprints or other biometrics when applying for licensure and allows applicants to electronically transmit a licensure renewal notice. In addition, the bill would allow physicians not currently practicing medicine to apply for retired status, which would exempt them from license renewal and CME requirements.

The bill authorizes the Board to issue a temporary license, not exceeding 14 days in length, to a physician temporarily in the state, and a one-year, temporary license if the applicant is in residency or an internship program through the Office of Mississippi Physician Workforce or ACGME; the temporary license may be renewed annually but may not extend beyond eight years, except when in combination with a Ph.D. program.

In addition, the bill authorizes the Board to issue reciprocal licenses to military-trained applicants, their spouses, or other individuals who establish residence in Mississippi, so long as the individual has an active license in good standing with a similar scope in another state or territory.

The bill amends the **limited institutional license program**, raising the maximum length of this license from five years to eight (unless the limitation is waived by the Board).

The bill allows individuals who had their licenses revoked or suspended to petition the Board to reinstate their license within three to five years of license discipline.

Finally, the bill defines the practice of medicine and authorizes the Board to take disciplinary action. Regarding Board composition, the bill allows the Governor to select nominees *outside* of the recommendations of the Mississippi State Medical Association and appoint three public members not related to the health care industry.

Mississippi SB 2075 - Authorizes the Board's Executive Director to issue temporary licenses, valid for up to one year, to applicants in an internship, residency or fellowship program created through the Office of Mississippi Physician Workforce or accredited through ACGME.

The bill amends the **limited institutional license program**, raising the maximum length of this license from five years to eight, and explicitly letting the Board discipline all licensees for violations enumerated in **MS Code § 73-25-29**.

Oregon HB 3279 – Authorizes the Oregon Dept. of Emergency Management to issue temporary professional licenses during states of emergency to formerly licensed individuals, so long as they held an active license within the last 10 years and their license was not revoked due to disciplinary measure. These temporary licenses last 180 days, are renewable, but expire at the end of the state of emergency during which they were issued.

Tennessee HB 233 – Extends the sunset of the Board of Osteopathic Medicine to June 30, 2029.

Virginia SB 1438 – Directs each board regulated by the Dept. of Health Professions to enact rules to provide a licensure by endorsement pathway for qualified applicants, and provide public comment opportunities, with the Board of Medicine being first to do so.

Corporate Practice of Medicine

Vermont H 71 – Prohibits corporations from practicing medicine and from interfering with health care providers' professional judgement. The bill also requires health care entities to publicly report on their ownership composition, with the exception of independent provider organizations consisting of two or fewer physicians and provider organizations that are owned or controlled by another health care entity.

Washington SB 5387 – Forbids an individual or entity without a license to practice medicine, own a medical practice, employ licensed health care providers, or otherwise engage in the practice of medicine. In a professional service corporation organized for the purpose of establishing a medical practice, licensed providers must hold the majority of voting shares, majority of the directors, and hold all officer positions except for secretary and treasurer. The bill also establishes restrictions on the shareholders and limits the actions of non-licensed employees.

Continuing Medical Education

Maryland SB 458 – Requires applicants for licensure renewal to complete an implicit bias and structural racism training program approved by the Cultural and Linguistic Health Care Professional Competency Program; current law only requires implicit bias training.

Mississippi HB 1342 – Requires physicians to complete Board-created CME in cultural competence and implicit bias in order to renew their license; although there is no set number of hours licensees must complete.

North Dakota HB 1511 – Requires the Board to develop an instructional course related to abortion

law; physicians engaging in the practice of obstetrics must complete the course as a part of licensure or renewal.

Criminal Background Checks
Missouri HB 992 – Authorizes the Board to require fingerprint submissions for licensure and renewal application, which must be then submitted to the state highway patrol and FBI to conduct a state and federal criminal history background check. All records related to criminal history discovered through this background check must be available to the Board.

Diversity, Equity, & Inclusion
Arizona SB 1256 – Forbids any governmental agency, including regulatory boards, from using DEI programs for hiring or training purposes and from requiring DEI programs for employees or prospective employees.

Connecticut HB 6331 – Prohibits public institutions of higher learning from maintaining a DEI office, requiring a diversity statement, or considering a person's immutable characteristics (such as race and sexual orientation) in any admissions, scholarship, or employment decision.

Iowa HSB 53 – Forbids public institutions of higher learning from mandating, requiring, or incentivizing participation in DEI or critical race theory (CRT) courses, with exceptions for racial, ethnic, or gender studies.

Iowa HSB 60 – Prohibits institutions of higher learning that participate in the Iowa Tuition Grant Program (including private schools) from establishing or maintaining DEI offices.

Mississippi SB 2223 and HB 1609 – Forbids public institutions of higher learning, including medical schools, from using funds to establish or sustain a DEI office or contract with a DEI officer. The bill also forbids public institutions from making diversity training mandatory, or requiring a diversity statement, and establishes civil penalties for violators.

Nebraska LB 552 – Prohibits public postsecondary educational institutions from having a DEI office or officer, requiring individuals to provide a DEI statement, requiring students to participate in a DEI program, and spending public money on a DEI program.

Gender Affirming Care
Connecticut HB 6615 – Prohibits physicians from performing surgery on minors as part of gender dysphoria treatment.

Connecticut HB 6609 – Prohibits providers from performing surgeries or prescribing hormonal medication to minors for uses not approved by the FDA, including gender dysphoria. Instead, the bill requires providers to *promote* psychotherapy for minors dealing with stress from gender dysphoria.

Kansas SB 63 and HB 2071– Prohibits health care providers from rendering gender affirming care and establishes penalties for violators, forbids state funds from providing or subsidizing gender transition medication or surgery for minors, and forbids medical assistance for gender affirming care.

Missouri HB 1038 and HB 1016 – Forbids health care providers from performing surgery or prescribing or administering hormonal medication to aid in gender transition to minors. The bill creates an exemption for patients who received GAC hormonal medication before August 28, 2023, which will last until March 1, 2026.

Missouri HJR 69 – Establishes the right of individuals to make their own medical decisions without government interference, as long as it is made freely, supported by a licensed physician, and consistent with widely accepted standards of care. In addition, the bill forbids the state from interfering with this right, or with a person or entity assisting an individual exercising this right. Lastly, the bill establishes the right for adults to make and carry out their own gender-affirming care decisions, including hormonal treatment and surgery.

Oregon SB 899 – Forbids physicians from performing gender reassignment surgery on minors, except in cases of a medically verifiable sex development disorder, treatment of infection or ailment caused by a gender transition procedure, or medical emergency.

Vermont H 55 – Expands health insurance coverage for gender-affirming health care services and requires health insurance plans and Vermont Medicaid to provide coverage for fertility-related services.

Healthcare Practitioners' Scope of Practice
Arkansas SB 99 – Authorizes PAs to delegate tasks, so long as the delegating PA remains responsible for the delegated acts, the employee is not represented as a licensed provider, and the tasks are performed under the supervision of the PA. Current law only authorizes physicians to act in this manner.

Connecticut SB 1064, **HB 6598**, and **SB 1069** – SB 1064 allows APRNs relocating to the state to

sign any forms for services and provide behavioral health services within the APRN scope of practice, provided that they have more than 2,000 independent practice hours. HB 6598 expands the scope of practice of homeopathic physicians, while SB 1069 permits naturopathic physicians to prescribe medication.

Massachusetts HD 3581 – Enables PAs to authorize psychiatric holds, so long as they complete three hours of specialized training; current law only allows physicians to do this.

Mississippi HB 974 – Adds the licensure and regulation of anesthesiologist assistants (AAs) to the Board's purview, including determining licensure qualifications, granting temporary licenses, and taking disciplinary actions. The bill forbids AAs from assisting in the practice of medicine unless under supervision.

Mississippi HB 1357 – Adds APRNs to the definitions of nursing and revises key provider definitions including certified registered nurse midwife, certified registered nurse anesthetist (CRNAs), "certified nurse practitioner, and clinical nurse specialist; as well as "collaboration" and details the terms of collaboration agreements. The bill allows APRNs (after 5,000 clinical practice hours) and CRNAs (after 8,000) to practice independently. Lastly, the bill authorizes APRNs to apply for controlled substance prescriptive authority after completing a Board-approved educational program.

Nebraska LB 554 – Creates the Nebraska Health Professions Commission, details its structure, and tasks the Commission with reviewing or initiating scope of practice proposals and proposals seeking to credential new health professions and submit its findings to the Legislature.

New Mexico HB 117 – Authorizes PAs to certify the death of a patient via a death certificate.

South Dakota HB 1071 – Redefines "collaboration" as the consultation with, or referral to an appropriate physician or other healthcare provider by a PA, based on factors such as the patient's condition, the PA's education and experience, and the standard of care. The bill introduces the "collaborative agreement" (replacing "practice agreement"), a written contract between a PA and a collaborating physician or qualified PA, outlining the terms and conditions of their professional relationship. Notably, the bill allows PAs to practice without a collaborative agreement if they are certified by the National Commission on Certification of Physician Assistants and have completed at least 2,080 practice hours.

Vermont H 75 – Authorizes naturopathic physicians, NPs, and PAs to engage in end-of-life care (including the discussion of self-administered life-terminating medication); current law only allows physicians to do so. The bill also allows naturopathic physicians to sign and issue DNR orders and clinician orders for life-sustaining treatment; current law allows physicians, osteopathic physicians, APRNs, NPs, and PAs to do so.

License Portability
Connecticut SB 1049 – Authorizes statutes be amended "to provide telehealth access to Connecticut residents while out of state" traveling, working, or attending school.

New Mexico SB 12 – Allows health care providers who have not obtained a New Mexico telehealth license to provide second opinions and consultations for prospective treatment to patients in the state.

Wyoming HB 241 – Authorizes health care providers to provide telehealth services to people in state without a Wyoming license, provided that the practitioner is not physically present in the state and has a valid, unencumbered license in good standing in another state or territory.

Licensure Compacts
Arkansas SB 101 – Enters Arkansas into the PA Licensure Compact.

Connecticut SB 1050 – Mandates that statutes be amended to require "(1) the streamlining of the criminal history records check process required for participation in the IMLC, and (2) the Commissioner of Public Health to develop a grant proposal to secure funding to modernize systems and reduce processing times to ensure compliance" with the Compact.

Illinois SB 209 – Enters Illinois into the PA Licensure Compact.

New Mexico SB 46 – Enters New Mexico into the IMLC.

Medical Aid-in-Dying
Connecticut HB 5625 and **HB 5454** – HB 5625 allows physicians to prescribe medication to terminally ill patients, enabling them to self-administer it to end their life, and HB 5454 allows terminally ill patients to make decisions about their end-of-life care that avoid "lengthy, painful deaths."

Medical Ethics
Iowa SF 103 – Requires the Board to adopt rules to implement the most recent version of the**AMA's Code of Medical Ethics** by July 1, 2026.

Nebraska LB 655 – Allows healthcare providers to decline participation in or payment for services they object to on conscience grounds.

Oregon HB 3330 – Allows practitioners and health care facilities to refuse to perform procedures related to abortion, physician-assisted suicide, or gender-affirming care so long as the refusal is based on ethical, moral, or religious beliefs.

Medical Marijuana
Indiana HB 113 – Legalizes marijuana for recreational and medical purposes, establishes a regulatory framework and excise tax for cannabis, creates the Indiana Cannabis Commission (ICC) and Advisory Committee to oversee the program, and facilitates research into marijuana. For medicinal uses, a bona fide patient-physician relationship must be established by an in-person visit, a "serious medical condition" is necessary for recommendation, and is defined as any medical condition a physician deems the benefits outweigh the risks, and the recommending physician must coordinate care with the patient's existing primary care physician; violation of these requirements could subject the physician to professional discipline.

Nebraska LB 483 - Limits medicinal marijuana forms to pills and liquid tinctures.

Nebraska LB 651 and LB 705 – Legalizes marijuana for medical purposes; authorizes patients to use, and patients and caregivers to possess marijuana pursuant to a physician's recommendation.

New Hampshire SB 264 – Requires PAs to recommend medical cannabis consistent with a collaboration agreement if such an agreement is required.

New York S 3105 – Allows for the reciprocity of out-of-state medical marijuana licenses.

Military Licensure
Illinois SB 186 – Authorizes active-duty military members, their spouses, and veterans to temporarily practice under an out-of-state license under a three year, non-renewable temporary permit, so long as the individual in question has a valid license in good standing and practices within their scope of practice. Temporary licensees must meet all state licensure requirements before the expiration of their three-year permit in order to obtain a permanent license. The bill does not apply to a license governed by an interstate licensure compact unless the compact provides otherwise.

Occupational Licensure Reform
Maryland HB 482 – Authorizes applicants to file a request with a department for review of their criminal history to determine their eligibility for licensure. The decision of the department is binding unless there is an adverse change to the applicant's criminal history, and if the department determines that the applicant would be denied, it may advise the applicant of any action they can take to remedy the disqualification. The bill also allows the applicant to submit a revised request for predetermination of eligibility after they take remedial action, or one year since the initial request.

Pain Management/Prescribing Practices
Colorado HB 1063 - Allows doctors to recommend psilocybin in crystalline polymorph form (which can better control dosage, stability, and therapeutic outcomes), *if* the FDA first approves it for such use.

Massachusetts HD 4196 – Establishes a pilot program under the Dept. of Health to allow for the research and development of psilocybin services for adults with PTSD and terminal conditions, among other ailments.

Missouri HB 951 – Allows health care providers to administer psilocybin to patients 21 years or older who require end-of-life care, or suffer from PTSD, substance use disorder, or any other condition for which treatment with psilocybin has shown efficacy in FDA-registered clinical trials.

New York S 2625 – Allows a licensed pharmacist to prescribe and order FDA-approved medication assisted therapy under a non-patient-specific regimen for the treatment of opioid use disease.

Physician Misconduct
Mississippi HB 1299 – Prohibits health care professionals and students from performing any “intimate” examination on a patient who is sedated, anesthetized, or unconscious unless given specific informed consent, in the case of a medical emergency, a court order, or if the exam is within the scope and standard of care for the procedure and the patient's representative has given informed consent.

New York A 2629 – Requires the DA or other prosecuting authority to notify the Office of Professional Medical Conduct within 24 hours of the conviction of a licensed physician or PA.

Reproductive Care
Arizona HB 2681 – Requires physicians providing abortion-inducing drugs to:

- Verify the pregnancy exists;

- Determine the patient's blood type and, if the patient is Rh negative, offer RhoGAM at the time of the abortion. In cases in which the unborn child is less than 12 weeks' gestational age, the physician is required to inform the patient of the risks of not having Rh testing; and
- Inform the patient of possible physical and psychological aftereffects associated with abortion-inducing drugs.

The bill also requires physicians to be credentialed to handle complication management, or have signed an agreement with a physician who is credentialed to do so. In addition, the bill requires the providing physician to schedule a follow-up visit within 1-2 weeks after administering the drug.

Arkansas SB 100 – Requires the Arkansas Medicaid Program to recognize PAs as PCPs, but does not change the PA scope of practice.

Connecticut HB 5714 – Requires pharmacists dispensing mifepristone to provide written information that its effects may be reversed if the patient decides to continue with the pregnancy.

Illinois SB 156 – Requires physicians, after performing an abortion, to provide the patient with an informed consent form offering specified options for disposal of the fetal tissue. In cases which the patient elects to release the fetal tissue to the physician, the latter must provide for the disposition of the tissue through interment or cremation within seven days. In addition, the bill requires physicians who perform abortions and individuals that transfer fetal tissue must submit annual reports to the Dept. of Public Health. The bill also provides immunity for patients receiving an abortion. Finally, the bill requires the Dept. of Public Health to submit an annual report on the number of abortions, procedure type, and method of disposal of fetal tissue to the Legislature.

Minnesota SF 461 and HF 24 – Requires "medical personnel" to take all reasonable measures to preserve the life and health of the "born alive" infant after an abortion.

Mississippi HB 902 – Repeals two current bans on abortion - after 15 weeks' gestational age and after detectable fetal heartbeat, except in cases of medical emergency or severe fetal abnormality.

Mississippi HB 1418 – Establishes the right to obtain and engage in contraception and authorizes civil action if violated. The bill also authorizes physicians, and pharmacists under a collaborative practice agreement, to provide contraceptives.

Mississippi SB 2224 – Classifies mifepristone and misoprostol as Schedule IV substances.

Mississippi SB 2056 – Provides the right to obtain and engage in contraception and forbids the state and its agents to infringe upon this right; and also authorizes a health care provider to provide contraception.

Nebraska LB 512 – Requires physicians, prior to providing an abortion-inducing drug, to examine the patient in person, verify pregnancy, determine whether the pregnancy is ectopic, document the gestational age and location of the pregnancy, determine the patient's blood type (so as to offer Rh immunoglobin treatment if Rh negative). The bill also requires the physician to schedule a follow-up visit with the patient within two weeks of administering the drug, during which the physician must confirm that the pregnancy is terminated and assess the patient for adverse events. Lastly, the bill requires the physician to file an abortion report within 30 days.

New York S 929 and A 2141 - Provides key definitions, including "regulated health information" and "regulated entity," requires the regulated entities to provide clear and accessible information to individuals regarding their health information, requires an individual's written consent to process or sell health information data, establishes the right for individuals to access their health information, request corrections, and obtain a copy of their data in a portable format; and requires regulated entities to implement reasonable administrative, technical, and physical safeguards to protect health information.

New York S 2692 – Requires limited service pregnancy centers to disclose orally and in writing if they do not have a licensed medical provider on staff who provides or supervises reproductive health services.

New York A 2581 – Creates a Dept. of Health Education and Outreach program on reproductive health services for consumers, patients, educators, and health care providers related to reproductive health services available in the state.

New York A 2452 and S 3146 – Authorizes physicians, PAs, NPs, and midwives licensed outside of the state that are in good-standing to provide reproductive care without first getting licensed in New York. These practitioners must first apply for licensure in New York, provide a letter declaring their intention to provide such services, and provide a letter from an employer indicating employment to provide services. Practitioners may provide services until their New York license or certification is approved or denied.

New York S 2533 – Authorizes licensed physicians to prescribe and order a non-patient specific order

of abortion medication to a licensed RN or pharmacist, who must provide the patient with a risk assessment and fact sheet and notify the patient's PCP.

North Dakota HB 1478 – Establishes that individuals have the right to receive, purchase, and engage in contraception. The bill also states that health care providers have the right to provide or assist with the provision of contraception, and decline to provide a contraceptive if they find the action morally or religiously objectionable.

North Dakota HB 1488 – Requires physicians to report each abortion performed and prohibits abortions on pregnant minors without parental consent, court authorization, or in emergencies. The bill establishes a hospital "abortion approval committee" to decide on cases within five days, except for emergencies. Abortions are permitted up to 15 weeks under a licensed physician, from 16 to 26 weeks with OBGYN oversight and committee approval for medical purposes, and after 27 weeks only if medically necessary and approved by the committee.

Oregon HB 3248 – Prohibits abortions unless a healthcare provider determines the unborn child's gestational age, except in emergencies. Abortions are banned after 15 weeks unless due to a medical emergency, rape, or incest, and must be conducted in designated facilities with safeguards. Providers must report all abortions to the Oregon Health Authority, which will publish annual statistics.

Vermont H 56 – Requires the Dept. of Health to establish an emergency supply of essential medications for reproductive and gender-affirming care.

Virginia SB 1493 – Authorizes individuals to access contraception, but provides that no one is compelled to provide contraceptives, if denial is based on religious or conscientious objections.

Wyoming HB 239 – Prohibits the state from denying or interfering with a person's right to have an abortion prior to viability, or in medical emergencies. The bill also penalizes practitioners who perform abortions outside of these parameters with up to one year in prison and a fine of up to $5,000. In addition, the bill allows practitioners or private medical facilities to object to, and restrain from performing an abortion that goes against their personal beliefs.

Wyoming HB 273 – Prohibits governmental entities from adopting any law, rule, or policy that targets pregnancy centers for oversight or regulation based on a stance against abortion.

Telemedicine
Maryland SB 372 – Repeals the limitation on "audio-only" telehealth visits under the definition of telehealth.

Vermont H 84 – Allows patients and providers to record telehealth appointments so long as both parties consent to the recording.

Legislation Affecting Board Authority

The FSMB continues to closely monitor legislative areas that could have significant implications on the practice and regulation of medicine: off-label treatment, reproductive health, and gender-affirming care. In addition to legislation highlighted in FSMB Advocacy Network News, all tracked COVID-19 adjacent legislation can be found **here**, all tracked reproductive health legislation can be found**here**, and all tracked gender-affirming care legislation can be found **here**.

State Contact
The FSMB's state legislative staff will continue to track and monitor legislation and regulations of interest to state medical boards. If there is specific legislation you would like us to assist with, please contact **John Bremer**, Director, State Legislation and Policy, atjbremer@fsmb.org, or by phone at (202) 463-4021.

This email is not intended as an exhaustive or comprehensive statement of the law on this topic. It does not constitute legal advice. Non–cited laws, regulation, and/or policy could impact analysis on a case–by–case or state–by–state basis. All information should be verified independently, as these areas of law change rapidly and there is no guarantee that the information presented reflects the current state of law and policy. If you have any questions about the contents of this document, please contact FSMB staff.

Resources for Regulators

- Resources for FSMB Members
- Pathway to Medical Licensure in the U.S.

Meetings & Events

April 24-26, 2025: **FSMB 113th Annual Meeting**, Seattle, Washington
September 3-6, 2025: 16th International Conference on Medical Regulation, Dublin, Ireland

more meetings & events

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To help medical boards keep up with current legislation around the country, FSMB tracks relevant legislation and regulations in state houses across the United States, as well as the U.S. Congress.

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