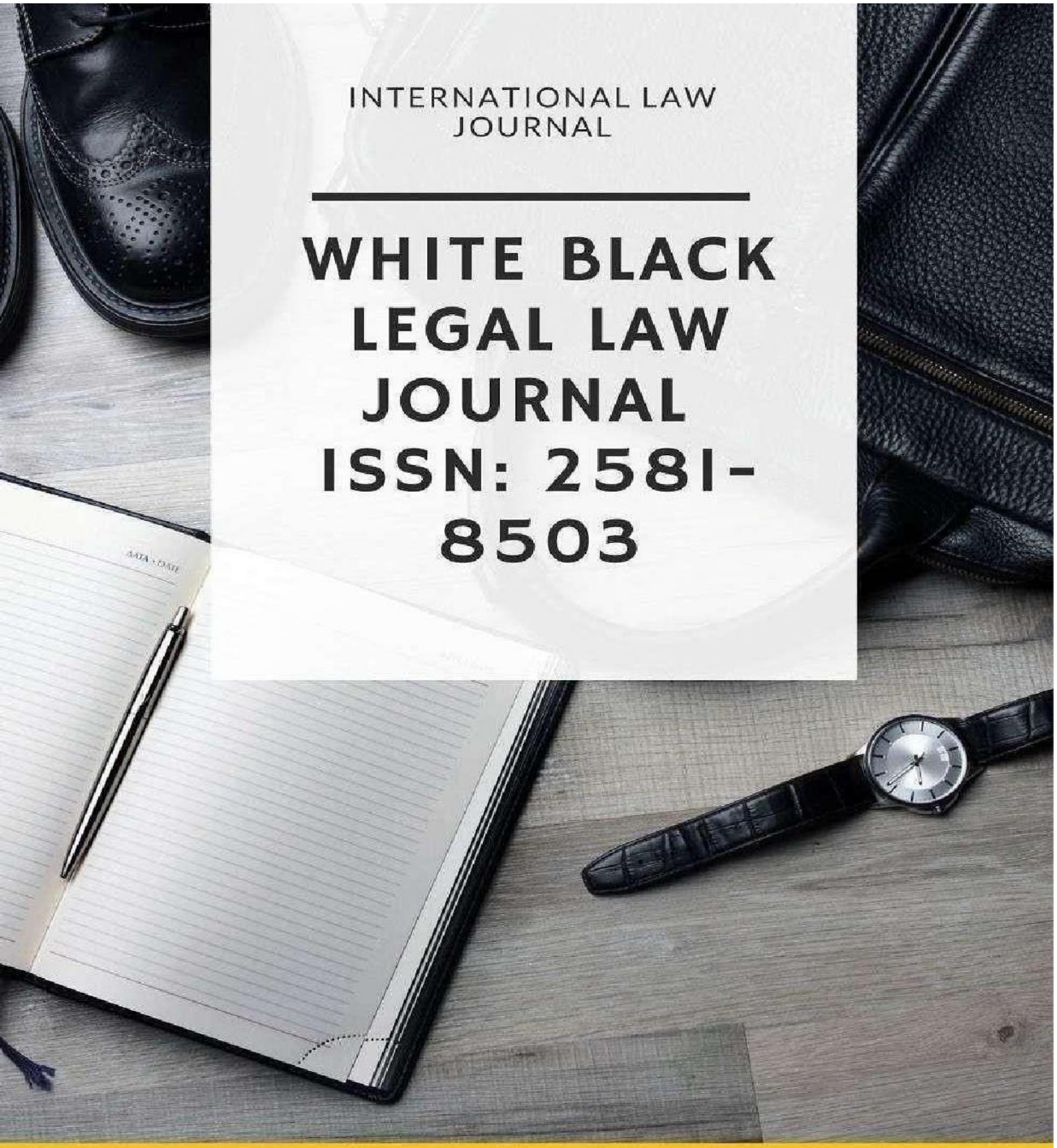

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LICENSURE COMPACT: WHAT IT MEANS FOR CROSS BORDER TELEHEALTH IN 2026

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Abstract

Telehealth has made distance less important to the clinical encounter while state medical licensing continues to make geography legally decisive. Connecticut's full operational participation in the Interstate Medical Licensure Compact in 2026 provides a timely case study of this tension. Connecticut enacted the Compact in 2022, but on March 15, 2026 it became fully operational as a State of Principal Licensure, allowing eligible Connecticut physicians to obtain Letters of Qualification and use the Compact's expedited pathway to seek licenses in participating jurisdictions. This article examines that development at the intersection of public health, administrative law, professional regulation, federalism, and digital health policy. It argues that the Compact is best understood not as a national medical license or unrestricted interstate telemedicine, but as a mechanism for reducing the administrative friction of multiple state licenses while preserving the authority of the state where the patient is located. That distinction has practical consequences for physicians, patients, hospitals, insurers, telehealth platforms, and regulators. Greater licensing portability can support specialist access, continuity of care, workforce flexibility, and care for mobile or underserved populations. Yet licensure reform cannot by itself cure barriers involving reimbursement, broadband access, digital literacy, prescribing, malpractice, privacy, emergency planning, or unequal distribution of clinicians. Connecticut's 2026 implementation therefore illustrates both the promise and limits of cooperative state regulation. The article concludes that the Compact offers a credible model of regulatory interoperability, but its public health value should be measured by patient access and outcomes rather than the number of licenses processed. Sustainable cross border telehealth requires portability with accountability, coordinated oversight, and continued attention to the social conditions that determine whether legally available care is genuinely accessible.

Keywords: Telehealth; Interstate Medical Licensure Compact; Public Health Law; Physician Licensure; Health Care Access.

1. Introduction

A patient can cross a state boundary in seconds. A physician's legal authority to continue treating that patient may not travel so easily. That mismatch has become one of the central regulatory problems of American telehealth. A Connecticut physician may know a patient's history, medications, test results, and treatment plan in detail. If the patient travels or relocates to another state, however, the legality of a remote consultation ordinarily turns on the law of the jurisdiction in which the patient is physically located. Technology has weakened the clinical significance of geography while licensing law continues to give geography substantial legal force. Connecticut's 2026 implementation of the Interstate Medical Licensure Compact is therefore more than an administrative update. It is part of a broader effort to reconcile state based professional regulation with a health system increasingly capable of delivering care across borders. The development is particularly important because Connecticut did not first join the Compact in 2026. Public Act 22 81 enacted the Compact in 2022. The decisive 2026 step was operational: on March 15 Connecticut became fully functional as a State of Principal Licensure, enabling qualifying Connecticut physicians to obtain a Letter of Qualification and use the Compact process to seek expedited licenses elsewhere.

The distinction matters. The Compact does not create a single national license. Connecticut General Statutes section 20 10d describes a streamlined process that allows physicians to become licensed in multiple states and expressly provides that the practice of medicine occurs where the patient is located at the time of the physician patient encounter. Thus, portability is achieved through coordinated licensing rather than through the disappearance of state authority.

This article examines what that architecture means for cross border telehealth in 2026. It places Connecticut's development within public health law, administrative law, federalism, and health equity. Its central claim is that the Compact can reduce a real barrier to care without solving the larger structural problems of digital medicine. The relevant policy question is not whether licensing should disappear, but whether state regulation can become sufficiently interoperable that clinically appropriate care moves more easily while patient protection and regulatory accountability follow it.

2. State Medical Licensure and the Geography of Care

Medical licensing in the United States has historically been a state function. State medical boards determine who may practise, investigate complaints, impose discipline, and enforce professional standards. That territorial model was relatively intuitive when physician and patient ordinarily occupied the same place. Telehealth disrupted the factual premise without automatically changing the legal framework.

Federal telehealth guidance continues to emphasize that health professionals must be licensed or otherwise legally permitted to practise in the state where the patient is located. It also advises providers to verify patient location before an appointment. This is not a technical detail. A patient who joins the same video consultation from Connecticut on Monday and another state on Friday may place the physician in two different licensing environments even though the physician has not moved. The public health justification for licensing remains substantial. Medicine involves diagnosis, prescribing, invasive intervention, access to sensitive information, and decisions with serious consequences. A jurisdiction has a legitimate interest in ensuring competence and retaining authority to investigate practitioners who treat its residents. The harder question is whether duplicative licensing processes remain proportionate when the same physician seeks authority in many states and much of the underlying credential information is identical.

The Compact responds to that administrative burden while preserving state oversight. This is why it is better described as regulatory portability than deregulation. It seeks to make multiple licenses easier to obtain, not to render licensing irrelevant.

3. The Interstate Medical Licensure Compact

The IMLC establishes an expedited route for eligible physicians to obtain licenses in participating jurisdictions. Connecticut's statute states that the Compact is intended to strengthen access to health care, enhance portability, and ensure patient safety. It also makes clear that the Compact creates another pathway for licensure and does not otherwise replace a state's existing licensing requirements.

A physician begins through an eligible State of Principal Licensure. That state determines whether the physician satisfies Compact criteria and, if so, issues a Letter of Qualification. The physician may then select participating jurisdictions in which expedited licenses are sought. The receiving states still issue their own licenses and retain authority over practice within their borders. The Compact contains requirements relating to medical education,

graduate training, examinations, specialty certification or other qualifying pathways, unrestricted licensure, criminal history, controlled substance matters, and professional discipline. A physician who does not qualify for the Compact may still pursue ordinary state licensure. The Compact therefore accelerates licensing for a defined group rather than creating universal reciprocity.

4. Connecticut's Path to Full Participation

Connecticut enacted the Compact through Public Act 22 81 in 2022. Section 20 10d now incorporates the Compact into state law. Implementation, however, occurred in phases. According to the Interstate Medical Licensure Compact Commission, the first phase, completed in October 2022, allowed qualified physicians from other member jurisdictions to seek expedited Connecticut licensure.

The second phase required technical integration enabling Connecticut itself to operate as a State of Principal Licensure. On March 15, 2026, the Commission announced completion of that work. Qualifying Connecticut physicians could then access the integrated Compact process from Connecticut as their principal licensing state. This is the development that gives the 2026 story its practical importance.

The difference between legislative membership and operational capacity should be kept clear in scholarship and public discussion. Saying simply that Connecticut joined the Compact in 2026 risks misstating the chronology. A more accurate account is that Connecticut joined legislatively in 2022 and achieved full State of Principal Licensure functionality in 2026. The title of this article uses "joins" in the practical sense of full operational participation, while the analysis preserves the legal distinction.

5. What the 2026 Development Means for Cross Border Telehealth

For Connecticut physicians, the most immediate consequence is a more efficient route to multistate practice. A qualifying physician can use Connecticut as the State of Principal Licensure, receive a Letter of Qualification, and pursue expedited licenses in participating jurisdictions. This may be especially useful for specialists, academic physicians, health systems, and virtual care practices serving patients in several states.

The Compact does not, however, authorize a Connecticut physician to treat every patient in every member state merely because the physician holds a Connecticut license. HHS guidance explains that a telehealth appointment occurs in the state where the patient is located.

Connecticut's Compact statute adopts the same principle. A physician therefore needs the relevant legal authority in the patient's jurisdiction.

The practical compliance question becomes deceptively simple: where is the patient at the time of the encounter? Health systems need reliable workflows for obtaining and documenting that information. A home address alone may be inadequate for a student, traveler, seasonal resident, or patient temporarily caring for relatives elsewhere.

This feature of telehealth regulation also shows why portability can matter to continuity of care. A longstanding therapeutic relationship may be interrupted not because the clinical relationship has deteriorated, but because the patient has crossed a jurisdictional line. Expedited multistate licensing can reduce those disruptions when physicians choose to obtain authority in the states where their patients commonly travel or reside.

6. Public Health Significance

The Compact's strongest public health claim is that reduced licensing friction can expand the pool of clinicians legally available to patients. The effect may be especially important for specialties concentrated in major medical centers, for rural communities, and for patients with uncommon or complex conditions. Telehealth can make specialist expertise technically reachable; licensing portability helps make that reach legally usable.

The benefit should not be overstated. A licensing compact does not create physicians, add appointment slots, guarantee insurance coverage, or make care affordable. It changes the regulatory conditions under which existing clinicians may serve patients across state lines. That is meaningful, but it is one component of access rather than access itself.

College students, retirees, temporary workers, caregivers, and families moving between states may wish to maintain established relationships with clinicians. HHS expressly recognizes that transient populations can face continuity problems under state licensing rules. A physician with licenses in the jurisdictions where patients spend substantial time can provide more stable care, subject to applicable clinical and legal requirements.

The Compact may also support surge capacity and health system planning. Multistate health organizations can develop physician networks with a broader lawful reach. Yet emergency practice rules, reimbursement policies, credentialing, hospital privileges, and payer requirements remain distinct questions. Licensing portability can support workforce flexibility without eliminating those additional layers.

7. Health Equity and the Digital Divide

Telehealth is often described as an equalizer because it can reduce travel, time away from work, childcare burdens, and geographic isolation. Those benefits are real, but digital care can also reproduce inequality. Reliable broadband, an appropriate device, digital literacy, language access, disability accessibility, and a private place for consultation are unevenly distributed.

A public health evaluation of Connecticut's participation should therefore look beyond the number of Letters of Qualification or expedited licenses. The better measures are patient centered: whether waiting times fall, whether specialist access improves, whether rural and underserved populations actually use the expanded services, and whether continuity improves for mobile patients.

The distinction between legal availability and practical accessibility is crucial. A specialist may be legally permitted to see a patient across a state line while the patient remains unable to afford the visit or connect reliably. Regulatory reform can open the door, but social and economic conditions determine who can walk through it.

Connecticut should therefore connect IMLC implementation with broader digital health policy. Licensing data, telehealth utilization, geographic access, language needs, disability access, and health outcome indicators can help determine whether the reform produces public value rather than merely administrative efficiency.

8. Patient Safety, Discipline, and Administrative Accountability

The IMLC is designed to preserve the disciplinary authority of member states. Connecticut's statute states that participating medical boards retain jurisdiction to impose adverse action against a license issued through the Compact. This feature matters because the legitimacy of interstate practice depends upon patients having a regulator capable of responding when standards are breached.

Coordinated licensing may also improve information exchange among boards. The Compact contains mechanisms concerning investigations, disciplinary action, and a coordinated information system. In an interstate environment, the ability of regulators to learn promptly about serious proAdministrative efficiency should not become a reason to weaken procedural fairness. Physicians remain entitled to the protections provided by applicable law when boards investigate or discipline them, while patients need accessible complaint mechanisms. The challenge is to make interstate oversight faster and more coherent without converting

shared information into automatic or unreviewed punishment.

This is an administrative law problem as much as a health law problem. The Compact creates a joint interstate structure, but the exercise of regulatory power still affects licenses, livelihoods, and patient safety. Transparency, notice, reasoned decision making, and appropriate review remain central to legitimate administration.

9. Malpractice, Standard of Care, and Emergency Planning

An expedited license does not eliminate professional liability. HHS advises clinicians offering telehealth in more than one state to confirm that their malpractice insurance covers all relevant locations. Physicians and health systems should therefore treat Compact expansion as a trigger for insurance review rather than assume that existing coverage automatically follows every new license. Remote practice also requires attention to the standard of care. A video encounter may be clinically appropriate for one condition and inadequate for another. The physician must be prepared to determine when remote assessment should end and local in person care should begin. Technology changes the medium of care, not the professional obligation to exercise appropriate clinical judgment.

Emergency planning is particularly important when physician and patient are far apart. A clinician should know the patient's current location and have a workable process for directing the patient to local emergency services or other immediate care when necessary. The legal ability to conduct the consultation is only one part of safe interstate practice.

For organizations, these issues favor standardized workflows. Patient location verification, consent, insurance coverage, emergency contact information, referral pathways, and documentation should be built into telehealth operations rather than left to improvisation during a difficult encounter.

10. Prescribing, Privacy, and the Limits of Licensure Reform

Prescribing illustrates why a medical license cannot be treated as a complete telehealth compliance solution. HHS notes that providers prescribing through telehealth must comply with federal law and applicable state law. Rules can differ according to the medication, the existence of a patient relationship, controlled substance requirements, and other conditions.

A physician may therefore be licensed in the patient's state yet still need a separate legal analysis before prescribing. Cross border telehealth programs should distinguish the authority to practise medicine from the authority to prescribe a particular drug through a

particular mode of care.

Privacy presents a similar limit. Telehealth depends on video systems, electronic records, messaging, remote monitoring, cloud infrastructure, and other data flows. HHS advises providers to consider state laws governing the collection and storage of protected health information in addition to federal requirements. Compact licensure does not harmonize those rules.

The lesson is broader than prescribing or privacy. The IMLC solves a licensing process problem. It does not establish a uniform national law of telemedicine. Reimbursement, informed consent, corporate practice rules, record retention, privacy, prescribing, malpractice, and professional standards may continue to vary. Multistate practice therefore requires a compliance architecture capable of tracking more than license status.

11. Federalism and Regulatory Interoperability

The IMLC is a notable example of horizontal cooperation among states. Rather than federalizing physician licensure, participating jurisdictions agree upon a common mechanism while retaining their own licensing authority. The arrangement respects the historic role of state medical boards and responds to the national reach of digital health without requiring a single federal license.

Its strength is also its limitation. Because states retain separate licenses and substantive rules, physicians can still face multiple fees, renewals, reporting duties, and legal standards. The Compact reduces duplication at the front end but does not erase regulatory fragmentation.

For that reason, the next phase of reform should focus on interoperability rather than simple deregulation. States can preserve meaningful differences while standardizing processes that do not materially advance patient safety when repeated. Credential verification, reporting formats, renewal data, and disciplinary communication are obvious areas for continued coordination.

The public law value of this model lies in its institutional modesty. It accepts that states have legitimate regulatory interests but asks whether those interests can be protected through shared infrastructure. Connecticut's 2026 implementation is therefore a test of whether cooperative federalism can adapt quickly enough to a clinical environment whose technology no longer respects territorial boundaries.

12. Policy Recommendations for Connecticut

First, Connecticut should measure the success of IMLC implementation through patient outcomes and access indicators. Administrative metrics such as processing time and the number of Letters of Qualification are useful, but they should be accompanied by evidence concerning specialist availability, waiting periods, continuity, geographic reach, and underserved populations.

Second, the Department of Public Health should maintain clear guidance explaining what Compact licensure does and does not accomplish. Physicians need to understand that an expedited license does not automatically resolve prescribing, reimbursement, privacy, informed consent, malpractice, or emergency planning obligations.

Third, health systems should develop location sensitive compliance workflows. The patient's physical location should be verified and documented for interstate telehealth encounters. License status, malpractice coverage, prescribing rules, and emergency pathways should be checked through systems that reduce the risk of individual oversight.

Fourth, Connecticut should treat digital equity as part of telehealth policy. The state can examine whether expanded interstate physician availability reaches communities facing specialist shortages and whether broadband, disability access, language services, and affordability remain obstacles.

Finally, regulators should continue to pursue interoperability with other member jurisdictions. The goal should be a system in which repeated administrative steps are reduced while the substantive protections that matter to patient safety remain enforceable.

13. Conclusion

Connecticut's full operational participation in the Interstate Medical Licensure Compact in March 2026 is a meaningful development, but its significance depends on describing it accurately. Connecticut enacted the Compact in 2022. The 2026 milestone was the completion of the technical and administrative integration needed for Connecticut to function as a State of Principal Licensure and issue Letters of Qualification to eligible physicians.

That development makes multistate practice easier. It does not create borderless medicine. The physician still requires appropriate authority where the patient is located, and the receiving jurisdiction retains regulatory power. The Compact therefore makes borders easier to navigate rather than making them disappear.

From a public health perspective, that may be enough to matter. Reduced licensing friction

can support specialist access, continuity of care, and more flexible physician networks. But the benefits will remain uneven unless policymakers also confront affordability, reimbursement, digital access, privacy, prescribing, malpractice, and the unequal distribution of clinicians.

The deeper lesson is that telehealth does not require a choice between rigid territorialism and regulatory abandonment. Connecticut's experience points toward a middle path: portability with accountability. As medicine becomes increasingly mobile, the law must learn to coordinate across borders without losing sight of the patient whose safety, access, and dignity justify regulation in the first place.

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