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INTERSTATE MEDICAL LICENSURE COMPACT

House Bill 5455 as reported from committee
Sponsor: Rep. Rylee Linting
1st Committee: Health Policy
2nd Committee: Rules
Revised 3-31-26

(Enacted as Public Act 6 of 2026)

SUMMARY:

House Bill 5455 would amend the Public Health Code to reinstate Michigan's participation in the Interstate Medical Licensure Compact, which is an agreement among states that enact it to streamline licensing requirements for physicians seeking to practice in one or more states other than the one where they live and are licensed.[1]

Michigan became a member of the compact on September 24, 2019. The provisions enabling Michigan's participation were added as section 16189 of the Public Health Code by 2018 PA 563. That legislation included language automatically repealing section 16189, and thus Michigan's participation in the compact, on March 28, 2022. That date was extended by 2022 PA 38 for an additional three years, to March 28, 2025. Section 16189 was repealed on that date. However, as the state's withdrawal from the compact is not effective for one year, Michigan will continue to be an active member of the compact through March 28, 2026.[2]

House Bill 5455 would reenact the compact's provisions (including numbering the new section as 16189), except that it would not include language providing for a future repeal. The bill would thus ensure Michigan's membership in the compact beyond March 28, 2026.

The compact's provisions (included in full in the bill) are briefly described below.

Section 1 – Purpose. The compact declares as its purpose the development of a comprehensive process that complements the existing regulatory authority of state medical boards and allows physicians to become licensed in multiple states. The compact states that it creates another pathway for licensure but does not otherwise change a state's existing medical practice act. The compact affirms that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter and therefore requires the physician to be under the jurisdiction of the state medical board where the patient is located.

Section 2 – Definitions. This section defines 15 relevant terms, including physician, interstate commission, medical practice act, member state, practice of medicine, offense, and rule.

Section 3 – Eligibility. This section defines the eligibility requirements a physician must meet to receive an expedited license under the compact.

[1] https://www.legislature.mi.gov/documents/2017-2018/billanalysis/House/pdf/2017-HLA-4066-99CF832E.pdf
Also see these 2019 FAQs: https://www.michigan.gov/lara/-/media/Project/Websites/lara/bpl/Shared-Files/MD-DO-POD/Interstate-Medical-Licensure-Compact-Commission-Information.pdf
[2] https://www.michigan.gov/lara/bureau-list/bpl/health/hp-lic-health-prof/medical

Section 4 – Designation of State of Principal License. A physician must designate a compact member state as their state of principal license for purposes of registration for expedited licensure under the compact. It must be a state where they are licensed, and also their state of residence, where at least 25% of their practice occurs, or where their employer is located.

Section 5 – Application and Issuance of Expedited Licensure. This section describes the process for seeking licensure under compact, including filing an application for an expedited license, verification of eligibility, registration, and payment of any fees.

Section 6 – Fees for Expedited Licensure. A member state issuing an expedited license may impose a fee for a license issued or renewed through the compact. The interstate commission created in section 11 may develop rules regarding fees for expedited licenses, but the rules cannot limit the authority of a member state to impose a fee.

Section 7 – Renewal and Continued Participation. This section describes the process for an eligible physician to renew an expedited license, including not having been subject to criminal penalties or license-related sanctions, compliance with continuing professional development or continuing medical education requirements, and payment of renewal fees.

Section 8 – Coordinated Information System. The interstate commission must establish a database of all physicians who are licensed or have applied for expedited licensure. Member boards must submit complaint, disciplinary, and investigatory information about physicians in the database. This information is confidential but can be shared among member states for investigation or discipline.

Section 9 – Joint Investigations. A member board may participate with other member boards in joint investigations of physicians. A subpoena issued by a member state is enforceable in other member states, and member states can share investigatory information, including licensure and disciplinary records of physicians.

Section 10 – Disciplinary Actions. Disciplinary action taken by a member board against a compact-licensed physician constitutes unprofessional conduct that can be subject to discipline by other member boards. If a member board revokes or suspends a physician's license, all licenses issued to that physician by other member boards are automatically suspended for 90 days to allow those boards to investigate. If the principal licensure member board revokes or suspends a physician's principal license, all licenses issued by other member boards are placed on the same status. If the principal licensure member board subsequently reinstates the license, however, reinstatement by the other member boards does not happen automatically but requires action by those boards consistent with their state laws.

Section 11 – Interstate Medical Licensure Compact Commission. This section creates the Interstate Medical Licensure Compact Commission to administer the compact. Each member state appoints two representatives to serve as commissioners. A member state with both allopathic and osteopathic licensing boards must appoint one representative from each. The commission must meet at least once a year, have bylaws, record minutes, and conduct business only with a majority of commissioners present. Commission meetings must provide public notice and be open to the public, with certain closed-session exceptions. Information and official records must be available to the public. The commission must establish an executive committee and officers, who, except for rulemaking, can act on behalf of the commission.

Section 12 – Powers and Duties of the Interstate Commission. This section describes the commission's powers and duties, which include, upon request of a member state or member board, issuing advisory opinions as to the meaning of the compact or its bylaws, rules, or actions. The commission must develop a budget and report annually to member states about its activities during the previous year. These reports must include reports of financial audits.

Section 13 – Finance Powers. The interstate commission may collect an annual assessment from each member state to cover the costs of its operations and activities. The total assessment, subject to appropriation, must cover the approved annual budget. The aggregate assessment must be allocated using a formula determined by the commission and imposed by rule.

Section 14 – Organization and Operation of the Interstate Commission. The interstate commission must adopt bylaws and annually elect or appoint a chairperson, vice-chairperson, and treasurer, who serve without compensation. The officers and employees of the commission are immune from liability for a claim arising from an act or omission occurring in the scope of their duties. The commission must defend its employees when they are sued. To the extent not covered by the state involved or the commission, commission employees are held harmless in the amount of a settlement or judgment. However, these protections do not apply if the act or omission is the result of the employee's intentional or willful and wanton misconduct.

Section 15 – Rulemaking Functions of the Interstate Commission. The interstate commission must promulgate reasonable rules to achieve the compact's purposes. The rules have the force of statutory law in a member state as long as they are not inconsistent with that state's laws. The rules must be made under a rulemaking process that conforms to the "Model State Administrative Procedure Act" of 2010. A person may file a petition for a rule's judicial review within 30 days of its promulgation.

Section 16 – Oversight of Interstate Compact. All branches of state government in each member state must enforce the compact and take all actions necessary to effectuate its purposes. The compact and its rules have standing as statutory law but do not override existing state authority to regulate the practice of medicine. The interstate commission is entitled to service of process and has standing to intervene in any state judicial or administrative proceeding that may affect its powers, responsibilities, or actions.

Section 17 – Enforcement of Interstate Compact. The commission may initiate an action in the U.S. District Court for the District of Columbia, or in the federal district where the commission has its principal office, to enforce compliance with the compact and its rules and bylaws against a member state that is not in compliance.

Section 18 – Default Procedures. This section describes procedures concerning a member state found to have defaulted on its compact responsibilities. The commission must notify the state of the default and how to remedy it and provide training and assistance regarding the default. If the state fails to cure the default, it can be terminated from the compact by a majority vote of the commission. That decision of the commission is appealable in court.

Section 19 – Dispute Resolution. When requested by a member state, the interstate commission must attempt to resolve disputes subject to the compact that may arise among member states or member boards. The commission also must promulgate rules that provide for both mediation and binding dispute resolution.

Section 20 – Effectiveness and Amendments. The compact becomes effective and binding after legislative enactment into law by at least seven states. Nonmember states are invited to participate in the activities of the interstate commission on a nonvoting basis before they adopt the compact. The interstate commission may propose amendments to the compact, but no such amendment can take effect until enacted by all the member states.

Section 21 – Withdrawal. To withdraw from the compact, a state legislature must repeal the statute that enacted the compact. The withdrawal cannot take effect until one year after the date of the repeal. A state considering withdrawal must notify the interstate commission, which in turn will notify the other member states.

Section 22 – Dissolution. The compact will dissolve when there is only one member state.

Section 23 – Severability and Construction. The compact is declared to be severable, which means that if a provision is held to be unenforceable, the remaining provisions are still enforceable. The compact should be liberally construed to effectuate its purposes, and nothing in the compact is intended to prohibit the applicability of other compacts in member states.

Section 24 – Binding Effect of Compact and Other Laws. All laws in a member state that conflict with the compact are superseded to the extent of the conflict. All lawful actions of the interstate commission, including its rules and bylaws, are binding on member states.

Proposed MCL 333.16189

BACKGROUND:

As of February 2026, 42 states[3] belonged to the Interstate Medical Licensure Compact or were implementing membership. The Department of Licensing and Regulatory Affairs (LARA) indicated that about 4,800 doctors (both M.D.s and D.O.s) were licensed to practice in Michigan under the compact at the end of March 2026.

BRIEF DISCUSSION:

During testimony before the House Health Policy Committee in January 2026, the bill sponsor and several committee members highlighted the practical impact of Michigan's pending withdrawal from the compact. The sponsor noted that Michigan has participated in the IMLC since 2019 and described the prior sunset as the reason reenactment is now required. She also stated that compact participation has supported timely access to physician services and that the compact has been used by a substantial number of Michigan physicians.

Committee discussion focused on the implications for patient access to care if Michigan's participation were to lapse. One member referenced input from hospital leaders in the Upper Peninsula, explaining that many physicians who practice in the region rely on compact privileges and that the loss of those privileges could negatively affect staffing and service availability. Testimony also referenced statewide reliance on compact licensure, with thousands of physicians potentially affected. The sponsor observed that the compact previously passed with broad bipartisan support.

[3] https://imlcc.com/participating-states/ Michigan was still counted as one of the 41 member states, as described above. Guam and the District of Columbia are also compact members.

FISCAL IMPACT:

House Bill 5455 would have a neutral fiscal impact on the Department of Licensing and Regulatory Affairs, as the bill would allow LARA to continue existing practices. The bill would reinstate the Interstate Medical Licensure Compact, which was automatically repealed in March 2025. Currently, Michigan will remain a member of the compact until March 2026, given that membership withdrawal goes into effect a year after the effective date of the repealing statute. This bill would extend compact membership beyond March 2026.

LARA has indicated, however, that if membership is not reinstated, the department may incur costs of up to $192,000.

POSITIONS:

The following entities indicated support for the bill:

- Trinity Health – Michigan (1-21-26)
- AARP Michigan (1-22-26)
- Henry Ford Health (1-21-26)
- Michigan Academy of Family Physicians (1-22-26)
- Michigan Association of Health Plans (1-21-26)
- Michigan College of Emergency Physicians (1-21-26)
- Blue Cross Blue Shield of Michigan (1-21-26)
- Michigan Health and Hospital Association (1-22-26)
- Michigan Society of Anesthesiologists (1-22-26)
- Michigan Osteopathic Association (1-22-26)
- Corewell Health (1-22-26)

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■ This analysis was prepared by nonpartisan House Fiscal Agency staff for use by House members in their deliberations and does not constitute an official statement of legislative intent.