

Which State Best Suits Your Medical Practice— an Analysis and Reference Guide

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ABSTRACT

In choosing a state to set up a practice, physicians should consider tax and regulatory policy, especially those regulations most relevant to their specialty or practice model. Important issues include: certificate-of-need (CON) requirements, in-office dispensing regulations, office-based surgical restrictions, pilot maintenance-of-licensure efforts, medical board action climate, medical liability climate, continuing medical education (CME) requirements, and whether the state elected to expand Medicaid. Taxes include: individual income, corporate income, sales, gross receipts, physician gross income, and various provider taxes.

General Considerations

The majority of articles discussing the best state in which to practice medicine have offered superficial analyses, focusing on physician satisfaction surveys, a handful of broad taxes (such as income and property), medical liability insurance premiums, and the local weather. A more in-depth guide is needed to make physicians aware of potential pitfalls associated with certain practice models in each state.

The best states generally undertake policies designed to reduce the cost of medical care. Decreased cost leads to increased access, and greater access permits physicians to compete for patients based on quality. State methods to reduce costs to physicians and patients generally take the form of lower taxes and fewer regulatory hurdles that interrupt the patient-physician relationship. Less favorable states have generally taken the opposite approach, and have been more likely to “double down,” attempting to address perceived inefficiencies with more regulatory requirements that often fail to achieve desired improvements.

Physicians might first look at each state’s comprehensive ranking, which weights all categories equally, then evaluate a narrowed list of states on the basis of considerations most relevant to their practice.

Ranking Methodology

Classification criteria for the tiered ranking system are listed in Table 1. Ranked factors were assigned scores as follows: +1 if pro-physician compared to other states, 0 if neutral, or -1 if anti-physician.

States’ overall ranking by tier is given in Table 2. Details

concerning tax policy are listed in Table 3, and regulatory policy in Table 4.

Table 1. Scoring Factors

Item	Scoring
Individual Income Tax	at 0% = +1, above 0% up to 7.99% = 0, at or above 8% = -1
Corporate Income Tax	at 0% = +1, above 0% up to 7.99% = 0, at or above 8% = -1
Sales Tax	at 0% = +1, above 0% up to 6% = 0, above 6% = -1
General Gross Receipts Tax	if present = -1
Physician Gross Receipts Tax	if present = -1
Provider Taxes	if none present = +1
Medicaid Expansion	+1 if opted not to expand, -1 if expanded, 0 if undecided
Certificate of Need	+1 if no certificate requirements, -1 if any type of certificate required
In Office Dispensing	+1 if easily arranged, 0 if difficult to obtain permit, -1 if prohibited
Surgical Restrictions	+1 if no restrictions enacted, 0 if minimal amount in place, -1 if extensive
Pilot Maintenance of Licensure	no assignment given, rapidly changing and limited data
Medical Board Actions	+1 if per capita index <2, 0 if index between 2 to 5, -1 if index >5
Professional Liability Ranking	+1 if in top ten states per capita, -1 if in the bottom ten states
Continuing Medical Education	+1 if at 0, 0 if between 0 and 50, -1 if at 50 or above
Price Transparency Grade	No assignment given due to difficulty interpreting limited data
GME needed for licensure	No assignment given

Table 2. Overall Ranking by State

Tier 1			
1. South Dakota	8 (+8, -0)	27. Michigan	-1 (+2, -3)
2. Wyoming	5 (+6, -1)	28. Hawaii	-1 (+2, -3)
Tier 2			
3. Idaho	4 (+4, -0)	29. New Mexico	-1 (+3, -4)
4. Wisconsin	4 (+5, -1)	30. Pennsylvania	-1 (+3, -4)
5. Indiana	3 (+4, -1)	31. Delaware	-1 (+3, -4)
6. North Dakota	3 (+4, -1)	32. North Carolina	-1 (+3, -4)
7. Texas	3 (+5, -2)	33. Maine	-1 (+3, -4)
8. Alaska	3 (+5, -2)	34. Kentucky	-2 (+1, -3)
Tier 3			
9. Nebraska	2 (+3, -1)	35. Arkansas	-2 (+1, -3)
10. Colorado	2 (+3, -1)	36. Iowa	-2 (+2, -4)
11. Alabama	2 (+3, -1)	37. Louisiana	-2 (+2, -4)
12. Missouri	2 (+3, -1)	38. Vermont*	-2 (+3, -5)
13. Mississippi	2 (+4, -2)	39. Washington	-2 (+3, -5)
14. Montana	2 (+4, -2)	40. New Hampshire	-2 (+4, -6)
15. Oklahoma	1 (+2, -1)	Tier 5	
16. Georgia	1 (+2, -1)	41. Connecticut	-3 (+2, -5)
17. Utah	1 (+2, -1)	42. Rhode Island	-3 (+2, -5)
18. Florida	1 (+3, -2)	43. DC	-3 (+2, -5)
19. South Carolina	1 (+3, -2)	44. Oregon	-4 (+1, -5)
20. Kansas	1 (+3, -2)	45. Maryland	-4 (+1, -5)
21. Nevada	1 (+4, -3)	46. New York	-4 (+1, -5)
Tier 4			
22. Arizona	0 (+2, -2)	47. California	-4 (+2, -6)
23. Tennessee	0 (+3, -3)	48. Ohio	-5 (+1, -6)
24. Virginia	0 (+1, -1)	49. Illinois	-5 (+1, -6)
25. Minnesota	0 (+4, -4)	Tier 6	
26. West Virginia	-1 (+2, -3)	50. Massachusetts	-7 (+0, -7)
		51. New Jersey	-9 (+0, -9)

* Will likely be last in 2017 when single payor is established— could ban private medicine

In Table 2, the first number is the state’s total score, the second number indicates the number of areas in which the state was above average, and the second (negative number) is the number of areas in which the state was below average.

Taxation

The highest tiers of individual,¹ corporate,² and sales taxes³ are listed in Table 3 and should require no additional explanation. Provider taxes can come from many categories and are typically justified by states as a means of financing Medicaid programs.⁴ Every state except Alaska levies some type of provider tax, and the three most popular categories for generating provider tax revenue are hospitals, intermediate care facilities, and nursing homes.⁴ A small minority of states have enacted a provider tax narrowly tailored to physicians' gross receipts.⁴

Regulations

Certificate of Need (CON)

Certificate-of-need (CON) laws were initially effected as part of the Health Planning and Resources Development Act of 1974. They were designed as state-sponsored cost-restricting mechanisms to ensure that there was a need for a specified health service prior to approving capital investment. The theory was that hospital A might want an MRI machine to compete with hospital B, while the town only has enough business to support one MRI machine. If both hospitals were to purchase machines, the risk of over-use of government funds (ordering too many MRIs) to pay off the machines increases. States' CON laws vary widely in severity.⁵ Independent physicians wishing to purchase radiology equipment and other items traditionally owned by hospitals should be more cautious about entering states with these regulations. Hospitals often use CON laws to prevent perceived competition from physicians. Only 14 states are entirely free of CON laws, and these deserve special consideration from radiologists and surgeons.⁵

In-Office Dispensing of Prescription Medications

These regulations are most important to direct primary care practices, which often attempt to increase their value to patients by dispensing prescription medications, often at cost lower than the pharmacy. Eleven states prohibit physicians from dispensing even non-narcotic medications on a monthly basis: Arkansas, Maryland, Massachusetts, Montana, New Jersey, New Mexico, New York, North Carolina, Oregon, Texas, and Utah.⁶ Physicians who have not opted out of Medicare can easily run afoul of Stark regulations in this area, and those dispensing medications priced higher than cost must ensure compliance with anti-kickback statutes.⁷ Details have unfortunately not been summarized in comprehensive fashion in any single location, and further discussion of this topic would warrant an entire article. The Jasos Group authored a helpful summary,⁸ and Progressive Medical has the best single-page review.⁹ The Office of the

Inspector General issued a summary report in 1989 that is now outdated.¹⁰

Surgical Restrictions

These regulations are complex. The Federation of State Medical Boards (FSMB) provides a comprehensive overview of surgical regulations.¹¹ States without specific restrictions on outpatient surgery obviously provide physicians with greater practice flexibility. Surgeons should take note of the 10 states with the most severe restrictions: California, Florida, Kentucky, Louisiana, New Jersey, North Carolina, Ohio, South Carolina, Tennessee, and Texas. A surgeon desiring to open an outpatient surgical center in one of these states should carefully review the regulations prior to making this investment. The Accreditation Association for Ambulatory Health Care also provides a helpful summary.¹²

Pilot Maintenance of Licensure (MOL)

Members of the academic medical community and the FSMB are concerned about the lack of broad physician endorsement of the current maintenance-of-certification (MOC) regime. Physicians have begun to vote with their feet by opting out of the ever more frequent and more expensive examinations, arguing that the process has not been shown to increase quality of care. As a result, efforts are underway in some states to tie MOC to maintenance of licensure (MOL), altering what was designed to be a "feather in your cap" to a new "minimum standard." These efforts have been well documented by Paul Kempen, M.D., Ph.D.,¹³ and Kenneth Christman, M.D.,¹⁴ in this journal. MOL proposals were defeated in Ohio, other state medical associations have been fighting efforts by the FSMB, and data is gradually being aggregated online.¹⁵ While they are not currently incorporated in the rankings because of lack of official action in most states, physicians should follow these developments closely before selecting a new location, and consider promoting the passage of model legislation on this issue in their state.¹⁶

Medical Licensure Board Actions

The ability to police negligent, corrupt, or otherwise harmful physicians is an important function of state medical boards, but most state medical boards operate outside traditional due process and our court systems' rules of evidence, making their investigations of physicians ripe for potential abuse. Public Citizen's Health Research Group historically ranked medical boards based on per capita (physician) actions.¹⁷ While this group favored increased board action against physicians, their rankings can be inverted for well-meaning physicians who would like to minimize their risk of an unwarranted investigation. Public Citizen gathered its data largely from reports released by the FSMB, which has now decided to stop releasing the

information.¹⁸ For smaller states, the limited number of physicians can lead to wide variations on an annual basis. The Texas State Medical Board provides one example of the misery these entities are capable of inflicting on physicians.¹⁹

Medical Liability Actions

A healthy medical liability climate occurs in states that have lower incidence of nuisance suits, and appears to be less related to the size of verdicts. Diederich Healthcare has the most useful comprehensive rankings, on a per-capita (physician) payout basis.²⁰ Academic studies differ in opinion about why some states have a more favorable climate than others. Readers should note that caps (on non-economic damages) are likely overrated for two reasons: 1) studies have shown that these made little difference in claims,²¹ and 2) eight states attempting to impose these non-economic damage caps have had them overturned on constitutional grounds at the state supreme court level.²²

Continuing Medical Education (CME)

Lifelong learning is a wonderful concept, and physicians should not attempt to rest on their laurels after residency or at any other point in their careers. Whether the highly formalized CME process achieves its purported aims, or educates physicians better than other less formalized methods of self-education, is debatable. For physicians who are confident that they do not need an auditor to ensure they are consistently furthering their own medical knowledge, there are five states that have no continuing medical education requirements: Colorado, Indiana, Montana, New York, and South Dakota.²³ Many states have multiple subcategories that can make fulfilling these requirements more onerous.²⁴ Twelve states require 50 CME hours per year, an especially burdensome number, while the average for those requiring CME is around 25 hours per year.²⁵ While physicians with a D.O. degree in Vermont are required to have an unremarkable 15 hours of CME per year, in the future physicians with an M.D. degree will have “CME required, with criteria to be determined by the board,” vague language that could lead to unpredictable new requirements during future licensure renewals.²⁶

Price Transparency

This remains an important issue for third-party-free practices. Many private entities are attempting to aggregate and disseminate this information, but regulations in this arena have not had much impact. A study by the Health Care Incentives Improvement Institute attempted to give each state a ranking, but the data is limited and rapidly changing.²⁷ The best single resource for a summary in this arena is the National Conference of State Legislatures’ summary; of note, California, Florida, Maryland, Oregon, and New Jersey all have online databases representing some attempt at price

transparency.²⁸ All five databases fall well short of the simple steps taken by Dr. G. Keith Smith at the Surgery Center of Oklahoma.²⁹

Medicaid Expansion

The states are fairly evenly split regarding Medicaid expansion.³⁰ Estimates from *The New York Times* show that a Medicaid expansion would cause an increase in spending in most states (but not all).³¹ Not all levels of expansion are equivalent, but the decision to expand should generally be concerning to physicians due to anticipated tax increases needed to fund the higher levels of state spending. Indiana and Utah have not yet made official decisions.³¹

Special Considerations in Various States

Physicians need to be aware of issues unique to individual states that could not be easily worked into the tiered rankings above. Remember that “direct primary care” practices charge a periodic fee for services and do not bill any third parties on a fee-for-service basis. Any per visit charge must be less than the monthly equivalent of the periodic fee. Many describe these practices as “concierge for the masses.”

Florida

Florida had a 1.5% physician gross receipts tax until around 2001 when the judiciary eliminated it.³²

Hawaii

Hawaii has a hybrid between a gross receipts tax and a sales tax known as a general excise tax of around 4%.³³ This was listed as a sales tax in Table 1 for simplification purposes.

Illinois

The Medicaid climate in Illinois is yet another reason that it is one of the worst states to practice medicine. “Attorney General Lisa Madigan filed an antitrust lawsuit in June against the Carle Clinic Association and Christie Clinic for declining to enroll new Medicaid patients. The lawsuit alleges that the medical groups collectively boycotted new Medicaid patients by adopting identical policies in 2003.”³⁴

Kentucky

Kentucky has experimented with a provider tax in the past.

Massachusetts

In Massachusetts, a rule to tie licensure to electronic health record proficiency has been proposed.³⁵

Minnesota

The MinnesotaCare program enacted in the 1990s placed

a 2% gross receipts tax on physicians. It was briefly reduced to 1.5%, and then returned to 2%.³² Efforts to increase the amount of the tax for specific procedures have thus far been unsuccessful.³²

Missouri

Recently Missouri passed legislation enacting a new class of healthcare provider—the assistant physician.³⁶ Physicians who graduate medical school and pass step 1 and 2 of their national licensure exam (but strangely not step 3), who failed or elected not to obtain a residency spot, will be eligible for this new type of medical licensure if they find a physician willing to sign a collaborative agreement.³⁷ Space precludes a full discussion here.

New Hampshire

New Hampshire imposes a gross receipts tax, known as a business profits tax, of 8.5% on organizations with \$50,000 or more gross business income.³⁸ The state also levies a 0.75% business enterprise tax on all business with gross revenue of \$150,000 or more.³⁸

New Mexico

New Mexico's general gross receipts tax applies to physician's services that are not being delivered by a physician working for a 501(c)(3) nonprofit or employed by HMOs.³² It is levied at rates from 5.125% to 8.6875% depending upon the location of the business.³⁹

New York

A New York law requires all health workers to receive the influenza vaccination or wear a mask.

New Jersey

New Jersey enacted a 6% gross receipts tax on elective cosmetic procedures and a 3.5% flat tax on ambulatory surgical center income greater than \$300,000 in 2004. Studies demonstrated that "for every \$1.00 New Jersey collects from provider taxes the state actually loses \$3.39 in total revenue."³² Attempts by the legislative authors to later repeal the taxes were vetoed by the governor.³²

Ohio

The first attempt to implement a pilot Maintenance of Licensure (MOL) program was made in Ohio. Thanks largely to the efforts of Paul Kempen, M.D., and other physicians, this effort was blocked. In addition, the former executive director of the State Medical Board of Ohio, Richard Whitehouse, has now been ousted.⁴⁰ Ohio has a gross receipts tax, known as the commercial activity tax, which applies to physicians and most business sectors; it

is imposed on businesses with gross receipts of more than \$150,000 and is levied at a rate of 0.26% on gross receipts of more than \$1 million.⁴¹

West Virginia

From 1993 to 2010, West Virginia had a 2% physician gross receipts tax.³² A 10-year sunset of the 2% tax began around 2001.³² In 2009 the legislature betrayed the trust of the West Virginia State Medical Association and decided to enact separate legislation authorizing a specific physician provider tax of "two percent of the gross receipts derived by the taxpayer from furnishing physicians' services in this state."⁴² West Virginia places control of pricing and operational decisions by direct primary care practices in the hands of the state insurance commissioner and the body that governs CON issues, the West Virginia Health Care Authority.⁴³ Direct primary care physicians would be better off without this legislation.

Texas

Surprisingly, Texas prohibits physicians from dispensing medications unless they are in a rural area with no pharmacy within a 15-mile radius.⁴⁴ To obtain a Texas medical license, physicians must pass a separate medico-legal examination, an unnecessary barrier to initial licensure. The Texas Medical Board has been known for attempting to end physician careers based on anonymous allegations backed by little evidence.¹⁹

Vermont

The Vermont law enacting single-payer medicine as of 2017 gives the Green Mountain Care Board the authority to set all prices, and thus the ability to effectively ban private medicine in Vermont.⁴⁵

Oregon

Oregon has laws designed to regulate direct primary care physicians. The motivation for these types of laws in the five other states with this type of legislation (Washington, West Virginia, Utah, Arizona, and Louisiana) was to provide explicit assurance to physicians that this type of practice model does not amount to the unlawful sale of insurance. Oregon's language fails to explicitly state that direct primary care is "not insurance," and allows the insurance commissioner to retain full regulatory control over direct primary care practices.⁴⁶ Direct primary care physicians in Oregon are severely restricted and would be better off without any legislation at all.

Washington

Washington's gross receipts tax, known as the business and occupations tax, has a 1.5% service sector rate.⁴⁷

Table 3. Tax Climate Comparison

State	Individual Income Tax	Corporate Income Tax	Sales Tax	Gross Receipt Tax	Dr Tax	Provider Taxes	Medicaid Expansion
Alabama	5.00%	6.50%	4.00%			Hosp NH	No
Alaska	0.00%	9.40%	0.00%			None	No
Arizona	4.54%	6.50%	6.60%			others	Yes
Arkansas	7.00%	6.50%	6.00%			Hosp ICF NH	Yes
California	10.30%	8.84%	7.50%			Hosp ICF NH	Yes
Colorado	4.63%	4.63%	2.90%			Hosp NH	Yes
Connecticut	6.70%	9.00%	6.35%			Hosp ICF NH	Yes
Delaware	6.75%	8.70%	0.00%			others	Yes
D.C.	8.95%	9.98%	6.00%			Hosp ICF NH	Yes
Florida	0.00%	5.50%	6.00%			Hosp ICF NH	No
Georgia	6.00%	6.00%	4.00%			Hosp NH	No
Hawaii	11.00%	6.40%	4.00%			others	Yes
Idaho	7.40%	7.40%	6.00%			Hosp ICF NH	No
Illinois	5.00%	9.50%	6.25%			Hosp ICF NH	Yes
Indiana	3.40%	7.50%	7.00%			Hosp ICF NH	Undecided
Iowa	8.98%	12.00%	6.00%			Hosp ICF NH	Yes
Kansas	6.45%	7.00%	6.30%			Hosp NH	No
Kentucky	6.00%	6.00%	6.00%			Hosp ICF NH	Yes
Louisiana	6.00%	8.00%	4.00%			ICF NH	No
Maine	8.50%	8.93%	5.00%			Hosp ICF NH	No
Massachusetts	5.25%	8.00%	6.25%			Hosp NH	Yes
Michigan	4.35%	6.00%	6.00%			Hosp NH	Yes
Minnesota	7.85%	9.80%	6.88%		2% gross	Hosp ICF NH	Yes
Mississippi	5.00%	5.00%	7.00%			Hosp ICF NH	No
Missouri	6.00%	6.25%	4.23%			Hosp ICF NH	No
Montana	6.90%	6.75%	0.00%			Hosp ICF NH	No
Nebraska	6.84%	7.81%	5.50%			ICF NH	No
Nevada	0.00%	0.00%	6.85%			NH	Yes
New Hampshire	0.00%	8.50%	0.00%	8.50%		Hosp NH	Yes
New Jersey	8.97%	9.00%	7.00%			Hosp ICF NH	Yes
New Mexico	4.90%	7.60%	5.13%	5.1-8.7%		others	Yes
New York	8.82%	7.10%	4.00%			Hosp ICF NH	Yes
North Carolina	7.75%	6.90%	4.75%			Hosp ICF NH	No
North Dakota	3.99%	5.15%	5.00%			ICF	Yes
Ohio	5.93%	0.00%	5.50%	0.26%		Hosp ICF NH	Yes
Oklahoma	5.25%	6.00%	4.50%			Hosp NH	No
Oregon	9.90%	7.60%	0.00%			Hosp NH	Yes
Pennsylvania	3.07%	9.99%	6.00%			Hosp ICF NH	Yes
Rhode Island	5.99%	9.00%	7.00%			Hosp NH	Yes
South Carolina	7.00%	5.00%	6.00%			Hosp ICF	No
South Dakota	0.00%	0.00%	4.00%			ICF	No
Tennessee	0.00%	6.50%	7.00%			Hosp ICF NH	No
Texas	0.00%	0.00%	6.25%			ICF	No
Utah	5.00%	5.00%	4.70%			Hosp ICF NH	Undecided
Vermont	8.95%	8.50%	6.00%			Hosp ICF NH	Yes
Virginia	5.75%	6.00%	5.00%			ICF	No
Washington	0.00%	0.00%	6.50%	1.50%		Hosp ICF NH	Yes
West Virginia	6.50%	7.00%	6.00%		2% gross	Hosp ICF NH	Yes
Wisconsin	7.75%	7.90%	5.00%			Hosp ICF NH	No
Wyoming	0.00%	0.00%	4.00%			Hosp NH	No

[Providers include hospitals (hosp), intermediate care facilities (ICF), and nursing homes (NH).]

Table 4. Regulatory Climate Comparison

State	CON	Office Dispensing	Surgery Restrictions	Pilot MOL	Licensure Board	Liability ²⁰	CME	GME
Alabama	Yes	License (\$100)	Accreditation		2.69	5.18	25	1
Alaska	Yes	Free	Laser only		4.69		25	2
Arizona	No	License (\$200)	Yes		4.12		20	1
Arkansas	Yes	Special Permit	None		2.95		20	1
California	No	Free	Severe		2.86		25 / 50	1
Colorado	No	Free	Policy Stmt.	Attempt	4.08		0	1
Connecticut	Yes	CS Lic (\$10)	Accreditation		1.82	20.98	25	2
Delaware	Yes	Free	None		5.32		20	1
D.C.	Yes	license	None		1.47	19.31	25	1
Florida	Yes	License (\$100)	Severe		2.28		20	1
Georgia	Yes	Free	Accreditation		2.65		20	1
Hawaii	Yes	Free	None		3.53		20	1
Idaho	No	License (\$60)	None		2.43		20	1
Illinois	Yes	Free	Minor		3.45	15.64	50	2
Indiana	No	license(20)	Accreditation		3.25	4.18	0	1
Iowa	Yes	license(50)	None	Blocked	3.6		20	1
Kansas	No	Free	Minor		2.93		50	1
Kentucky	Yes	Free	Severe		3.94		20	2
Louisiana	Yes	license(75)	Severe		5.58		20	1
Maine	Yes	Free	None		3.05		50	3
Maryland	Yes	Special Permit	None		2.91	19.27	25	1
Massachusetts	Yes	Prohibited	Policy Stmt.	Attempt	1.66	22.37	50	2
Michigan	Yes	License (\$85)	None	Fighting	2.56		50	2
Minnesota	No	Free	None		1.49		25	1
Mississippi	Yes	Free	None	Attempt	3.56	4.15	20	1
Missouri	Yes	license(90)	None		2.76		25	1
Montana	Yes	Prohibited	None		2.63		0	2
Nebraska	Yes	Free	None		4.7		25	1
Nevada	Yes	license(\$350+WC)	Accreditation		2.07	4.85	20 / 35	3
New Hampshire	Yes	Free	None		2.65	16.99	50	2
New Jersey	Yes	Restrictions	Severe		2.26	23.24	50	3
New Mexico	No	Restrictions	None		5.28		25	2
New York	Yes	Prohibited	Accreditation	Fighting	2.98	38.83	0	1
North Carolina	Yes	Restrictions	Severe	Fighting	3.56	4.51	50	1
North Dakota	No	Free	None		3.75	2.96	20	1
Ohio	Yes	Free	Severe	Blocked	5.52		50	1
Oklahoma			Policy Stmt.	Blocked	4.65		20 / 16	1
Oregon	Yes	OMB approval	Accreditation	Attempt	3.36		30	1
Pennsylvania	No	Free	None		2.82	24.76	50	2
Rhode Island	Yes	Free	None		2.02	17.4	20	2
South Carolina	Yes	License (\$100)	Severe		1.33		20	1
South Dakota	No	license	None		2.71	4.88	0	3
Tennessee	Yes	Free	Severe		2.72		20	1
Texas	No	Prohibited	Severe	Fighting	2.79	3.02	24	1
Utah	No	Prohibited	None		2.44		20	2
Vermont	Yes	Free	None		2.78	4.36	Bd Cr / 15	1
Virginia	Yes	Bd Pharm license	Yes	Attempt	3.11		15	1
Washington	Yes	Free	Accreditation		4.45		50	2
West Virginia	Yes	License (\$35)	None		4.32		25 / 16	1
Wisconsin	Yes	Free	None	Attempt	1.9	3.07	15	1
Wyoming	No	Free	None		6.79		20	2

[Policy Stmt: policy statement. An agency issues recommended measures, but there is no dispositive statutory language. WC: additional workers' compensation requirements / restrictions apply to those seeking a license to dispense medications in the office.]

Conclusions

The climate in many states makes it difficult to practice independently or to maintain a financially viable practice at an affordable cost to patients. Physicians should research the taxes and regulations in a state before investing in a practice there.

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