HOUSE BILL 681:
Healthcare Flexibility Act.

2023-2024 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Finance. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	May 22, 2024
Introduced by:	Reps. K. Baker, Reeder, Lambeth, Potts	**Prepared by:**	Jason Moran-Bates Committee Staff
Analysis of:	PCS to First Edition H681-CSBCf-35		

OVERVIEW: The Proposed Committee Substitute to H681 would establish North Carolina as a member of the Interstate Medical Licensure Compact ("Compact"), which creates a voluntary, expedited pathway to state licensure for physicians who want to practice medicine in multiple states (Part I); it would also allow nurse practitioners to work without the supervision of a physician (Part II); require anesthesiologists to be present at certain parts of procedures in order to obtain insurance reimbursement (Part III); require all procedures performed at in-network healthcare facilities to notify patients if there will be any out-of-network charges (Part IV); and prohibit most non-hospital healthcare facilities from charging facility fees and prohibit hospitals from charging facility fees for identified procedures (Part V).

PART I: INTERSTATE MEDICAL LICENSURE COMPACT

CURRENT LAW: Under current law, physicians licensed in other states must apply to the North Carolina Medical Board before being licensed to practice in this state.

BILL ANALYSIS: Part I would create Article 1M of Chapter 90 of the General Statutes, titled Interstate Medical Licensure Compact and make conforming changes to several other statutes in Chapter 90.

G.S. 90-21.141 (Purpose) outlines the purpose of the article would be to strengthen access to health care and to provide a streamlined process that allows physicians to become licensed in multiple states.

G.S. 90-21.142 (Definitions) would create definitions.

G.S. 90-21.143 (Eligibility) would require a physician to meet all of the following eligibility requirements in order to receive an expedited license: graduation from an accredited medical school, passed each component of United States Medical Licensing Examination within three attempts, successfully completed graduate medical education, hold a specialty certification, possess an unrestricted license to practice medicine, have no convictions for any offense, have never held a license subject to discipline, have not had a controlled substance license or permit suspended, and not under active investigation.

G.S. 90-21-144 (Designation of state of principal license) would require a physician to designate a state of principle license in the application process. The state of principal license would be the state where the physician possesses a license to practice medicine and is either (i) the principal residence of the physician, (ii) the physician conducts 25% of their practice in the state, or (iii) the location of the physician's employer.

G.S. 90-21.145 (Application and issuance of expedited licensure) outlines the following process for licensure through the Compact:

- Physician would file an application with member board of the state of principal license.
- Member board would perform a criminal background check.
- Member board would evaluate application and issue a letter of qualification, either verifying or denying the physician's eligibility.
- If a physician is eligible, then the physician would pay any fees and complete the registration process outlined by the Interstate Commission.
- Physician would receive an expedited license.

G.S. 90-21.146 (Fee for expedited licensure) allows a member state issuing an expedited license to impose a fee for the expedited license.

G.S. 90-21.147 (Renewal and participation) would allow a physician to renew an expedited license and outline a renewal process to do so.

G.S. 90-21.148 (Coordinated information system) would require the Interstate Commission to establish a database of all physicians who are either licensed or have applied for licensure. Member boards would report to the Interstate Commission any public action, complaint, or disciplinary information against a physician with an expedited license. Member boards would be able to share information with other member boards upon request.

G.S. 90-21.149 (Joint investigations) would permit a member board to participate and share information with other member boards in joint investigations of a physician licensed by both member boards.

G.S. 90-21.150 (Disciplinary actions) addresses if a license issued by a member board in the state of principal license is revoked, then all licenses issued to the physician by member boards would automatically be revoked. If a license is revoked by a member board not in the state of principal licensure than any licenses granted to the physician would be revoked for 90 days, to allow the member boards time to investigate. Any disciplinary action taken against a physician would be deemed unprofessional conduct subject to discipline by other member boards.

G.S. 90-21.151 (Interstate Medical Licensure Compact Commission) is composed of two voting representatives from each member state. The Interstate Commission must meet at least once a year, provide public notice of all meetings, make its official records available, and establish an executive committee.

G.S. 90-21.152 (Powers and duties of the Interstate Commission) would outline the powers and duties of the Interstate Commission, which include (i) promulgating rules, (ii) issuing advisory opinions, (iii) enforcing compliance with the Compact, (iv) establishing a budget, (v) reporting annually to the legislatures of member states, (vi) maintaining records, and (vii) performing such functions necessary to achieve the purposes of the Compact.

G.S. 90-21.153 (Finance powers) would allow the Interstate Commission to levy on and collect an annual assessment from each member state to cover the cost of the operations and activities of the Interstate Commission and its staff.

G.S. 90-21.154 (Organization and operation of the Interstate Commission) provides a chairperson, a vice-chairperson and a treasurer would be elected annually. The officers and employees of the Interstate Commission would be immune from suit and provided limited liability.

G.S. 90-21.155 (Rulemaking functions of the Interstate Commission) would require the Interstate Commission to promulgate reasonable rules to effectively achieve the purposes of the Compact.

G.S. 90-21.156 (Oversight of Interstate Compact) outlines the executive, legislative and judicial branches of state government would be responsible for enforcement of the Compact. The provisions of the Compact would not override existing State authority to regulate the practice of medicine.

G.S. 90-21.157 (Enforcement of Interstate Compact) charges the Interstate Commission with the enforcement of the provisions and rules of the Compact. The Interstate Commission would also be permitted to initiate legal action against a member state in default.

G.S. 90-21.158 (Default procedure) outlines the grounds for default and the procedure for the Interstate Commission to follow in the event of a member state default. This would include providing written notice, remedial training, and technical assistance to a member state. A member state may only be terminated from the Compact upon an affirmative vote of a majority of the Commissioners.

G.S. 90-21.159 (Dispute resolution) would direct the Interstate Commission to resolve disputes arising among member states, and to promulgate rules for mediation and binding dispute resolution.

G.S. 90-21.160 (Member states; effective date; amendment) would explain any state is eligible to join the Compact and the Compact is effective upon the enactment of the Compact by no less than 7 states.

G.S. 90-21.161 (Withdrawal) would allow a member state to withdraw from the Compact by repealing the enacting statutes of the Compact and providing proper notice.

G.S. 90-21.162 (Dissolution) would dissolve the Compact upon the withdrawal or default of the member state which reduces membership of the Compact to one member state.

G.S. 90-21.163 (Severability and construction) would provide a severability clause.

G.S. 90-21.164 (Binding effect of Compact and other laws) would clarify the Compact does not prevent the enforcement of any laws in a member state and any member state laws in conflict with the Compact would be superseded. All lawful actions of the Interstate Commission, and all agreements between the Interstate Commission and the member states, would be binding.

EFFECTIVE DATE: Part I of this act would be effective October 1, 2024.

PART II: FULL PRACTICE AUTHORITY FOR EXPERIENCED NURSE PRACTITIONERS

CURRENT LAW: All nurse practitioners must be supervised by a physician, regardless of how long they have been practicing. There is no definition for advanced practice nursing or licensure for advanced practice nurses. A joint subcommittee of the Medical Board and Board of Nursing have authority over nurse practitioners.

BILL ANALYSIS: Part II would eliminate the joint subcommittee that currently regulates nurse practitioners and turn its duties over to the Board of Nursing. A committee comprised of three nurse practitioners and two physicians would make recommendations to the Board of Nursing.

Any nurse practitioner with 4,000 hours of practice experience would be able to practice without supervision of a physician, provided the nurse practitioner had not been disciplined by the Board of Nursing in the last five years.

Definitions would be created for "advanced nursing practice," "Advanced Practice Registered Nurse," "collaborating provider," and "collaborative provider agreement." The Board of Nursing would be authorized to license advanced practice registered nurses and collect fee for their licensure.

Conforming changes would be made throughout the statute that deals with nurse practitioner practice (G.S. 90-18.2), and the Board of Nursing would have authority to adopt rules necessary to implement the provisions of this part.

EFFECTIVE DATE: The statutory changes in this part would be effective January 1, 2025. The provisions giving the Board of Nursing authority to adopt rules would be effective when the bill becomes law.

PART III: ANESTHESIA FLEXIBILITY

CURRENT LAW: No state law regulates billing practices for anesthesiologists, but the federal Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) requires anesthesiologists to meet seven criteria to legally be providing medical direction and receive Medicaid reimbursement for their services.

BILL ANALYSIS: Part III would require anesthesiologists to meet the TEFRA requirements before receiving insurance reimbursement, including from the State Health Plan or Prepaid Health Plans under Medicaid, for their services. The TEFRA requirements are:

- Performing and documenting a pre-anesthesia examination.
- Prescribing an anesthesia plan.
- Personally participating in the most demanding (e.g., induction and emergence) parts of the anesthesia procedure.
- Ensuring parts of the procedure not performed by the anesthesiologist are performed by certified nurse anesthetists or anesthesia assistants.
- Montior the procedure at frequent intervals.
- Remain physical present to assist in case of emergency.
- Provide indicated post-anesthesia care if necessary.

In addition, nurse anesthetist services must be reimbursed at 50% of the rate that an anesthesiologist would have received.

EFFECTIVE DATE: Section 3.(a) of this part act would be effective October 1, 2024, and apply to services rendered on or after that date. Sections 3.(b) and 3.(c) of this part would be effective October 1, 2024, and apply to insurance contracts issued, renewed, or amended on or after that date. The remainder of this part would be effective when it becomes law.

PART IV: SURPRISE BILLING

BILL ANALYSIS: Part IV would require insurers' contracts with in-network healthcare facilities to include a term requiring those facilities to notify patients if some services might be provided by out-of-network providers. The notification would have to be given at least 72 hours prior to the appointment for appointments made at least that far in advance, on the day of the appointment for appointments made less than 72 hours in advance, and as soon as reasonably possible for emergency care. The notification would have to include all the out-of-network providers who will be involved in the patient's care and the approximate cost to the insured for that care. The healthcare provider would have to obtained signed proof of receipt from the insured.

"Health care provider" would be defined to include anyone licensed under Chapter 90 to provide anesthesia, emergency, pathology, or radiology healthcare services. "Health services facility" would be defined to include a hospital; long-term care hospital; psychiatric facility; rehabilitation facility; nursing home facility; adult care home; kidney disease treatment center, including freestanding hemodialysis

units; intermediate care facility for individuals with intellectual disabilities; home health agency office; chemical dependency treatment facility; diagnostic center; hospice office, hospice inpatient facility, hospice residential care facility; and ambulatory surgical facility.

If any provisions of Part IV conflict with the federal No Surprises Act (Pub. L. No. 116-260, 134 Stat. 1182, Division BB, § 109), then the provisions of the federal act would be applied.

EFFECTIVE DATE: Part IV would be effective October 1, 2024, and apply to contracts entered into, amended, or renewed on or after that date.

PART V: FACILITY FEES

CURRENT LAW: Currently there are no laws or rules addressing when healthcare facilities may charge facility fees.

BILL ANALYSIS: **Part V** would prohibit healthcare providers from charging facility fees for any procedures that are not performed at a hospital's main campus, a remote location of a hospital, or a facility that includes an emergency department. "Remote location of a hospital" would be defined to mean "a hospital-based facility that is created by a hospital for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the hospital." It would not include any facilities bought or acquired by a hospital. Facility fees would also be prohibited, regardless of where the procedure is performed, for services identified by DHHS that can be safely and reliably performed in non-hospital settings. Hospitals and health systems would have to report annually to DHHS on the facility fees they charged. The charging of a facility fee that should have been prohibited would be considered an unfair and deceptive trade practice under Chapter 75. DHHS would be able to audit facilities for compliance and assess a $1,000 administrative penalty for each violation. DHHS must adopt rules to implement this part no later than January 1, 2025.

EFFECTIVE DATE: The provisions of Part V dealing with facility fees would be effective January 1, 2025. The provisions of Part V requiring DHHS to adopt rules would be effective when the act becomes law.

**Jessica Garrett of the Legislative Analysis Division substantially contributed to this summary.*