# HOUSE BILL 67:
# Healthcare Workforce Reforms.

*2025-2026 General Assembly*

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| **Committee:** | Senate Finance. If favorable, re-refer to Rules and Operations of the Senate | **Date:** | June 10, 2025 |
| **Introduced by:** | Reps. Reeder, Campbell, Potts, Lambeth | **Prepared by:** | Jason Moran-Bates<br>Jessica Garrett<br>Stewart Sturkie<br>Staff Attorneys |
| **Analysis of:** | Third Edition | | |

***FINANCE OVERVIEW: The finance provisions of H67 are as follows:***

***Part I. Interstate Medical Licensure Compact***

- ***Fees for licensure under the compact.***

***Part II. International Physician Licensure***

- ***Fees for licensure as an internationally-trained physician.***

***Part IV. Physician Assistant Interstate Licensure Compact***

- ***Fees for licensure under the compact.***
- ***Fees paid by states participating in the compact.***
- ***Annual renewal fees for licensure as a physician assistant that are being charged under the North Carolina Administrative Code would be codified in statute.***

## PART I. INTERSTATE MEDICAL LICENSURE COMPACT

***OVERVIEW: Part I 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.***

**BILL ANALYSIS:**

Part I of the bill would create Article 1O of Chapter 90 of the General Statutes, titled Interstate Medical Licensure Compact.

**G.S. 90-21.161 (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. 90-21.162 (Definitions)** would create definitions.

**G.S. 90-21.163 (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. 90-21.164 (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. 90-21.165 (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. 90-21.166 (Fee for expedited licensure)** allows a member state issuing an expedited license to impose a fee for the expedited license.

**G.S. 90-21.167 (Renewal and participation)** would allow a physician to renew an expedited license and outline a renewal process to do so.

**G.S. 90-21.168 (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. 90-21.169 (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. 90-21.170 (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. 90-21.171 (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. 90-21.172 (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. 90-21.173 (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. 90-21.174 (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. 90-21.175 (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. 90-21.176 (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. 90-21.177 (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. 90-21.178 (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. 90-21.179 (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. 90-21.180 (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. 90-21.181 (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. 90-21.182 (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. 90-21.183 (Severability and construction)** would provide a severability clause.

**G.S. 90-21.184 (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.

Part I of the bill would also make the technical and conforming changes necessary to allow the North Carolina Medical Board to implement the Compact.

**EFFECTIVE DATE:** This part would be effective January 1, 2026.

## PART II. INTERNATIONAL PHYSICIAN LICENSURE

***OVERVIEW: Part II would allow for internationally-trained physicians to practice medicine in North Carolina.***

**BILL ANALYSIS:**

Part II of the bill would allow licensure for internationally-trained physicians. Applicants for licensure would have to:

- Be offered employment in a North Carolina hospital or physician's office in a rural county.
- Have a valid license to practice medicine in a foreign country.
- Complete 130 weeks of medical education at a school eligible to be certified by the Educational Commission for Foreign Medical Graduates.
- Complete two years of postgraduate training or actively practice medicine for 10 years after graduation.
- Pass an exam, receive specialty certification, or demonstrate clinical competence to the North Carolina Medical Board.
- Not have a revoked, suspended, restricted, or denied license, conviction for a crime of moral turpitude, or a violation of a law involving the practice of medicine in any jurisdiction.
- Practice for medicine for at least five years.
- Speak English fluently.
- Be legally authorized to work in the United States.
- Pay an application fee.

The license would become inactive if the licensee left the qualifying employment. Practicing medicine outside of one of the qualifying employment areas would be a Class 3 misdemeanor.

The Medical Board would be required to collect information to evaluate the implementation and success of the international licensure provisions of this bill.

**EFFECTIVE DATE:** This part would be effective January 1, 2026.

**PART III. MASTER'S LEVEL PSYCHOLOGIST REFORMS**

***OVERVIEW: Part III would allow certain licensed psychological associates to practice without supervision by a licensed psychologist or licensed psychological associate and would address the practice of neuropsychology and forensic psychology by licensed psychological associates. It would also allow certain licensed psychological associates to provide health services without supervision, or to qualify for certification as a health services provider psychological associate. It would also make changes to the procedure for appointing psychologist members to the North Carolina Psychology Board (the Board).***

**CURRENT LAW:**

- Licensed psychological associates are currently prohibited from practicing psychology without the supervision of a qualified licensed psychologist.
- Licensed psychological associates are currently prohibited from providing health services without the supervision that is required by rules of the Board.
- When a Board member's term expires, or when a vacancy arises, the North Carolina Psychological Association, on advice of the chairs from psychology graduate departments in the State, proposes a list of three names to the Governor. The Governor then makes an appointment from that list.

**BILL ANALYSIS:**

Part III would do the following:

- Allow a licensed psychological associate to independently practice without supervision by a licensed psychologist or licensed psychological associate if:
    - They have 4,000 hours of post-licensure experience in providing psychological services under supervision by at least one qualified licensed psychologist or qualified licensed psychological associate. This experience must be obtained between 24 and 60 consecutive months.
    - They document that they received average or above average performance ratings for all 4,000 hours of post-licensure experience.
    - They apply for independent practice with proof of the experience listed immediately above.
- Require licensed psychological associates to demonstrate their specialized education and training to the Board before practicing neuropsychology or forensic psychology. It would would instruct the Board on considerations for whether or not an associate is qualified to practice in those areas and define "Neuropsychology" and "forensic psychology."
- Allow a licensed psychological associate, who is certified as a health services provider psychological associate, to provide health services without supervision if they meet the requirements outlined above.
- Allow a licensed psychological associate, who was licensed before June 30, 2013 and can demonstrate that they have provided health services psychology under supervision for 4,000 hours between 24 and 60 consecutive months, to qualify for certification as a health services provider psychological associate
- Change the process for appointing a psychologist member to the Board. It would require the Board, the North Carolina Psychological Association, and the North Carolina Association of Professional Psychologists to form a nominating committee and seek nominees from licensees. The committee would then send a list of three eligible persons to the Governor, who would appoint someone from the list.
- Make technical changes.

**EFFECTIVE DATE:** This part would be effective October 1, 2025

**PART IV. PHYSICIAN ASSISTANT INTERSTATE LICENSURE COMPACT**

***OVERVIEW: Part IV would make North Carolina a member of the PA Licensure Compact, which allows physician assistants to practice in any state that is a member of the Compact.***

**BILL ANALYSIS:** Part IV would add a new article to Chapter 90 with the details of the PA Licensure Compact (Compact).

**G.S. 90-270.200. Purpose** would set forth that the purpose of the PA Licensure Compact is to enhance the interstate portability of physician assistant licensure while still maintaining patient safety.

**G.S. 90-270.201. Definitions** would create definitions for "adverse action," "compact privilege," "conviction," "criminal background check," "data system," "executive committee," "impaired practitioner," "investigative information," "jurisprudence requirement," "license," "licensee," "licensing board," "medical services," "model compact," "participating state," "PA," "PA Licensure Compact Commission or Commission," "qualifying license," "remote state," "rule," "significant investigative information," and "state."

**G.S. 90-270.202. State participation in this Compact** would require states participating in the Compact to license physician assistants (PA) using a nationally recognized exam, conduct criminal background checks on PA applicants, have a mechanism to investigate complaints against PAs, and to follow all the Compact's rules.

**G.S. 90-270.203. Compact privilege** would allow PAs to practice in states different from their states of licensure if they met education, certification, and licensure requirements in their home state and have a license unencumbered by any adverse actions or discipline. The privilege to practice in the other state would last until the home state license expired, lapsed, or was revoked.

**G.S. 90-270.204 Designation of the state from which licensee is applying for a compact privilege** would state that the home state of a PA licensee is the state in which that licensee resides. The Compact Commission must be notified if the home state changes.

**G.S. 90-270.205. Adverse actions** would allow any Compact state to take adverse action against any PA practicing in that state. This includes the ability to investigate PAs and revoke their Compact privileges. Home states must give the same priority to conduct reported by remote states that they would give to conduct reported in their own state.

**G.S. 90-270.206. Establishment of the PA Licensure Compact Commission** would establish the Commission charged with administering the Compact. Each member state would be allowed one member on the Commission. Commission meetings would be open to the public except if discipline, contract negotiation, or legal matters were being discussed. The Commission would be financed by assessments levied on member states and would be prohibited from incurring financial obligations without sufficient funds on hand to meet those obligations. An Executive Committee of nine individuals would be tasked with running the Commission. Both Commission and Executive Committee members would be held harmless and indemnified for their official actions. The Commission would have the following powers:

- Establish, a code of ethics, fees, bylaws, and a fiscal year.
- Maintain financial records.
- Adopt rules.
- Take actions necessary to administer the Compact.
- Maintain insurance.
- Take necessary legal actions.
- Accept gifts and donations.
- Lease, purchase, and dispose of real property.
- Borrow money.
- Appoint committees.
- Elect officers.
- Approve state membership in the Compact.

**G.S. 90-270.207. Data system** would require the Commission to develop and maintain a data and reporting system accessible to all Compact member states. All member states must report:

- Identifying information of licensees.
- Licensure data.

- Adverse action taken against licensees.
- Denials of licensure applications.
- Significant investigative information.
- Other information as determined by rule.

**G.S. 90-270.208. Rulemaking** would allow the Commission to adopt rules after notice and opportunity for public comment. Adopted rules would have the force of law in member states unless the member state's law about medical services PAs can perform conflict with the Commission rules. In that case, the state law would preempt the rule to the extent of the conflict. If a majority of legislatures of member states enact legislation rejecting a rule, that rule would no longer have any effect. Emergency rules could be adopted after 24-hour notice and without opportunity for public comment, provided the regular rule-making procedures are applied retroactively within 90 days.

**G.S. 90-270.209. Oversight, dispute resolution, and enforcement** would allow the executive and judicial branches of each member state to enforce and implement Compact provisions. States that fail to comply with Compact terms may be terminated from the Compact only after all other means of securing compliance have been exhausted. The Commission will attempt to resolve any disputes between member states and between member and non-member states.

**G.S. 90-270.210. Date of implementation of the PA Licensure Compact** would make the Compact effective after seven states enact legislation that is not materially different from the Model Compact. Additional states will become members of the Compact after they enact legislation that is not materially different from the Model Compact. Any state may leave the Compact by repealing the Compact-enacting legislation.

**G.S. 90-270.211. Construction and severability** would require the Compact's and the Commission's authority to be construed broadly. Any provisions of the Compact that are struck down will not affect the viability of the remainder of the Compact.

**G.S. 90-270.212. Binding effect of Compact** would allow states to enforce all laws that do not conflict with the Compact, but state laws in conflict with the Compact would be superseded.

Part IV would make conforming changes in Chapter 90 and codify an initial license or privilege fee as well as an annual registration fee applicable to all physician assistants and Compact privilege holders operating in North Carolina. Physician assistants in North Carolina are currently required to pay these fees via administrative rule; therefore, these provisions essentially codify the current requirements for physician assistants licensed in North Carolina while extending the applicable fees to Compact privilege holders. The fees would be as follows:

- Initial License or Privilege Fee – $230.00.
- Annual Registration Fee – $140.00 for those who register no later than 30 days after their birthday, otherwise the fee is $165.00.

**EFFECTIVE DATE:** This part would become effective nine months after it becomes law.

**PART V. PHARMACIST TEST AND TREAT**

***OVERVIEW: Part V would allow licensed pharmacists to test for and treat influenza. It would require insurers to cover healthcare services lawfully provided by pharmacists if those services would have been covered had they been provided by a different healthcare provider. It would also standardize the credentialing process of pharmacists by insurers and clarify that the coverage requirements for***

***prescription drugs apply to third-party administrators and pharmacy benefits managers, as well as insurers.***

**CURRENT LAW:** Under current law, only immunizing pharmacists under G.S. 90-85.15B and clinical pharmacist practitioners under G.S. 90-18.4 may administer drugs or determine appropriate healthcare for a patient.

**BILL ANALYSIS:** Part V would allow licensed pharmacists to administer CLIA-waived tests to diagnose individuals with influenza and treat those individuals. Pharmacists would not be allowed to treat any health condition with a controlled substance on Schedules I through IV.

The North Carolina Medical Board and North Carolina Board of Pharmacy, in conjunction with the State health Director would be required to adopt statewide protocols to implement the pharmacist test and treat provisions of this bill.

Insurers would be required to cover healthcare services provided by pharmacists acting within their scope of practice if the services would have been covered if provided by another type of healthcare provider. Services provided by pharmacists must be covered on the same terms as they are covered for other providers.

Insurers that delegated credentialling of pharmacists to a contracted healthcare facility would have to accept the credentialling for all pharmacists employed by, or contracted with, the facility.

All requirements relating to the coverage of prescription drugs that applied to insurers under Chapter 58 (Insurance) would also apply to third-party administrators and pharmacy benefits managers.

**EFFECTIVE DATE:** The provisions dealing with insurance coverage and requirements would be effective October 1, 2025, and apply to contracts issued, renewed, or amended on or after that date. The remainder of the part would be effective when it becomes law.

## PART VI. PHYSICIAN ASSISTANT, NURSE PRACTITIONER, AND CERTIFIED NURSE MIDWIFE REFORMS

***OVERVIEW: Part VI would allow certain physician assistants in team-based settings to practice without supervision by a physician. It would also allow them to prescribe drugs, initiate non-pharmacological therapies, certify medical documents, be qualified technicians under the Women's Right to Know Act, be attending providers for purposes of postpartum insurance coverage, and perform health assessments for childcare facilities. It would remove nurse practitioners and certified nurse midwives from the joint supervision of the Medical Board and Board of Nursing and have them regulated solely by the Board of Nursing.***

**CURRENT LAW:** Under current regulations in the North Carolina Administrative Code, all physician assistants must have a supervisory agreement with a licensed physician. The physician's supervision must be continuous, but it does not necessarily have to be in person. Physician assistants can prescribe mediations as long as the criteria for doing so are included in their supervisory agreements with a supervising physician. Nurse practitioners and certified nurse midwives are regulated by a joint subcommittee of the Medical Board and Board of Nursing.

**BILL ANALYSIS:**

Part VI would do the following:

- Create a definition in the Practice of Medicine Act for "team-based setting," which would include a physician-owned medical practice and health facilities where physicians have meaningful control over patient care. It would not include pain management clinics.
- Amend G.S. 90-9.3 to clarify that physician assistants working in a team-based setting do not have to provide the North Carolina Medical Board (Board) with the contact information for a supervising physician before engaging in medical acts.
- Create requirements for physician assistants practicing in a team-based setting. Those individuals must (i) have more than 4,000 hours of general experience and 1,000 hours of supervised experience in their chosen specialty, (ii) work in a team-based practice as defined in G.S. 90-1.1(4d), and (iii) submit proof to the Board that they are compliant with (i) and (ii). All physician assistants who practice in a perioperative setting must be supervised.
- Require individuals holding a physician assistant volunteer license and who are subject to supervision requirements to submit an intent to practice form with the Board or meet the team-based requirements described above.
- Make a technical change to G.S. 90-12.4B.
- Allow physician assistants in a team-based setting to prescribe, dispense, compound, and administer drugs, plan and initiate non-pharmacological therapeutic regimens, and authenticate any document a physician may authenticate. Physician assistants would not be permitted to provide the final interpretation of diagnostic imaging. Physician assistants would be permitted to provide the final interpretation of X-rays when supervised by a physician.
- Permit physician assistants certified in obstetrical ultrasonography to be qualified technicians under Article 1I.
- Allow physician assistants to be attending providers for purposes of postpartum insurance coverage.
- Allow physician assistants to perform health assessments for childcare facilities.
- Allow the Medical Board to adopt permanent rules necessary to enforce the provisions of the bill.
- Remove nurse practitioners and certified nurse midwives from the authority of a joint subcommittee of the Medical Board and Board of Nursing and give the Board of Nursing the sole authority to regulate those professions and make conforming changes.
- Remove the nurse practitioner member from the Medical Board and replace it with an additional physician assistant member and make conforming changes.
- Give the Board of Nursing authority to adopt rules to implement the provisions of the part.

**EFFECTIVE DATE:** The provisions authorizing the Medical Board and Board of Nursing to adopt rules would be effective when they become law. This remainder of this part would be effective June 30, 2026, or whenever the rules were adopted, whichever comes first.

## PART VII. PHARMACIST COLLABORATIVE PRACTICE

***OVERVIEW: Part VII would allow clinical pharmacist practitioners to perform medical tasks, acts, and functions when working under a practice agreement with a licensed physician. It would establish requirements for those agreements. It would also require insurers to cover services provided by clinical***

***pharmacist practitioners and clarify that prescription drug coverage provisions of Chapter 58 (Insurance) also apply to third-party administrators and pharmacy benefits managers.***

**CURRENT LAW:** Under current law, clinical pharmacist practitioners can only provide drug management therapy to patients.

**BILL ANALYSIS:**

Part VII would do the following:

- Allow clinical pharmacist practitioners working under a practice agreement with a licensed physician to perform medical acts, tasks, and functions, provided the following conditions are met:
    - There must be a site-specific supervising physician who conducts periodic reviews of the health care services provided by the clinical pharmacist practitioners.
    - Delegation of specific healthcare services must be included in a written practice agreement between the supervising physician and the clinical pharmacist practitioner.
    - The practice agreement between the physician and the clinical pharmacist practitioner may allow the clinical pharmacist practitioner to substitute biosimilars for currently prescribed drugs.
- Allow physicians to supervise as many clinical pharmacist practitioners as they deem can be safely supervised and allow other healthcare practitioners to collaborate with the clinical pharmacist practitioners. Group practices may implement one site-specific, multi-provider practice agreement.
- Require insurers who delegate credentialling agreements for pharmacists to a third party to accept all credentialling of pharmacists the third party employs or contracts with. Insurers would be required to cover all healthcare services provided by pharmacists acting within their scope of practice if those services would have been covered if they had been provided by other healthcare providers. It would also make the prescription drug coverage requirements in Chapter 58 (Insurance) applicable to third-party administrators and pharmacy benefits managers to the same extent they apply to insurers.
- Give the North Carolina Medical Board and North Carolina Board of Pharmacy the authority to adopt rules to implement the act.

**EFFECTIVE DATE:** The rules provisions would be effective when the bill becomes law. The remainder of the part would be effective October 1, 2025, and apply to insurance contracts entered into, renewed, or amended on or after that date.

## PART VIII. ALLEVIATE THE DANGERS OF SURGICAL SMOKE

***OVERVIEW: Part VIII would establish standards in hospitals and ambulatory surgical facilities for the evacuation/filtering of surgical smoke produced by energy-generating devices.***

**BILL ANALYSIS:**

Part VIII would require hospitals and ambulatory surgical centers to adopt and implement policies that require the use of an evacuation/filtering system for surgical smoke that is likely to be generated during a surgical procedure.

The following definitions apply:

- Smoke evacuation/filtering system. –Stand alone, portable equipment that effectively captures, filters, and eliminates surgical smoke at the site of origin before the smoke makes contact with the eyes or respiratory tracts of occupants in the room. This equipment is not required to be interconnected to the hospital or ambulatory surgical ventilation or medical gas system.
- Surgical smoke. – The gaseous by-product produced by energy-generating devices, including surgical plume, smoke plume, bio-aerosols, laser-generated airborne contaminants, or lung damaging dust.

The Department of Health and Human Services would be authorized to take adverse action against a hospital or ambulatory surgical facility for violation.

**EFFECTIVE DATE:** The part would become effective January 1, 2026.

**PART IX. COMMUNITY COLLEGE BEHAVIORAL HEALTH WORKFORCE ENHANCEMENT**

***OVERVIEW: Part IX would direct the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services (Commission) to engage in rulemaking to allow graduates from Community Colleges with associate degrees in human services fields and specified experience to qualify as an Associate Professional, a Qualified Professional, or a Qualified Substance Abuse Prevention Professional.***

**BILL ANALYSIS:**

Part IX would do the following:

- Provide definitions for *Associate Professional*, *Commission*, *Qualified Professional*, *Qualified Substance Abuse Prevention Professional*, and *Staff Definitions Rule*.
- Require the Commission to implement the *Staff Definitions Rule* until revised permanent rules are adopted.
- Provide the following new qualifications, in addition to current ones, for the following:
    - Associate Professional may be a graduate of a community college with an associate degree in a human services field with less than two years of experience with the population served.
    - Qualified Professional may be a graduate of a community college with an associate degree in a human services field and has two years of supervised mental health, developmental disabilities, and substance abuse services experience with the population served.
    - Qualified Substance Abuse Prevention Professional may be a graduate of a community college with an associate degree in a human services field and has two years of supervised experience in addictions and recovery prevention.
- Allow accumulated supervised experience in substance abuse prevention prior to the completion of a bachelor's degree to qualify for specified pathways.
- Give the Commission additional rulemaking authority.
- Direct the Commission to amend any additional rules necessary to implement this act.
- Sunset this part when permanent rules are adopted.

**EFFECTIVE DATE:** This part would be effective when it becomes law.

**PART X. MARRIAGE AND FAMILY THERAPY LICENSURE REFORMS**

***OVERVIEW: Part X would amend the licensure by reciprocity provisions for marriage and family therapists by: (i) reducing the practical experience requirement from five years to two years, and (ii) allowing applicants to pass the exam required by the marriage and family therapy board in California, in lieu of the national exam.***

**CURRENT LAW:** Under current law, applicants for marriage and family therapist licensure by reciprocity must by licensed in another jurisdiction for five years, have an unrestricted license in good standing, have no complaints in the other jurisdiction, and pass a national exam.

**BILL ANALYSIS:** Part X would amend the licensure by reciprocity provisions for marriage and family therapists in the following ways:

- It would reduce the practice experience requirement from five years to two years.
- It would allow applicants to pass the exam required by the marriage and family therapist licensure board in the state of California instead of the National Marriage and Family Therapy Examination.

The North Carolina Marriage and Family Licensure Board would have authority to adopt rules to implement to provisions of this part.

**EFFECTIVE DATE:** The part would be effective October 1, 2025, and apply to applications for licensure on or after that date.

**PART XI. LIMITATIONS ON AGREEMENTS WITH HEALTH CARE PROFESSIONALS**

***OVERVIEW: Part XI would prohibit employment contracts with healthcare workers from containing nondisclosure provisions that would restrict (i) the reporting of safety violations, ethical violations, or illegal activities, or (ii) providing new practice information to a patient on request. It would also prohibit hospitals from including non-compete provisions in their employment contracts with healthcare workers.***

**BILL ANALYSIS:** Part XI would prohibit employment contracts with physicians, physician assistants, and nurses from containing any of the following:

- Provisions restricting the ability of the healthcare worker to report illegal activities, safety violations, or ethical violations to the appropriate authorities.
- Provisions restricting the ability of healthcare workers to provide new practice information to a patient upon the patient's request.
- If the contract is with a hospital, provisions containing a non-compete clause.

Any contractual provisions in violation of this part would be void, and healthcare professionals who prevail in a suit challenging the enforceability of non-disclosure or non-compete provisions would be entitled to recover their reasonable attorneys' fees.

**EFFECTIVE DATE:** The part would be effective October 1, 2025, and apply to contracts entered into on or after that date.

**PART XII. EFFECTIVE DATE**

Except as otherwise provided, this bill would be effective when it becomes law.