



Economic Affairs Interim Co
62nd Montana Legislature

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Draft for HB 525 Semifinal Report

Proposed Title: *Whose Interests Are At Stake?*

Public Boards for Private Means?

Or

Public Boards for Public Health, Safety, and Welfare?

Sections:

- 1) Overview of HB 525 requirements -- The Narrow Sunset Review vs. Board Problems.
- 2) Private Payment (Board Fees) for Public Health, Safety, Welfare - does it make sense or is it a trade-off to allow self-regulation?
- 3) Concerns about boards as indicated through the EAIC Survey or Committee meetings:
 - professions under the thumb of other professions on the same board - incorporating SB 165 concerns as well as overlapping interests and whether the legislature really defines scope of practice or whether boards are doing that;
 - conflicts of interest in screening panels;
 - unlicensed practice and whether this is a BIG DEAL or a private interest (depending on public health, welfare, and safety);
 - a concern that all boards are treated the same by the division when not all problems are the same (uniformity vs. particularity).
- 4) Concerns about boards' indirect costs and board fees
- 5) Concerns voiced to the Efficiency in Government Committee regarding reciprocity in licensing.
- 6) Options for using boards to gather information (e.g. primary care providers in health care) or implement state programs (e.g. drug registry, marijuana physician components, or possibly the state prison training programs that result in background check problems).
- 7) Other areas for improvement.

Summary to Date: A) Actions by EAIC
B) Recommended options

Appendices: Responses to questions posed for HB 525 reviews by all reviewed boards

#5 Concerns voiced to the Efficiency in Government Committee on health care licensing

Suggestion 8: Allow a broad policy of reciprocity to recognize health care professionals who are licensed in neighboring states. Stakeholders suggest that Montana health care licensing boards should recognize licenses issued in other states and allow those licensed professionals to practice in Montana without obtaining a license from a Montana licensing board. This change would require the drafting of legislation.

Reasons for Change: Stakeholders say reciprocity would allow Montana to better compete with other states in hiring health care professionals, reduce delays in hiring, and reduce administrative hurdles for health care facilities.¹

- 37-1-304. Licensure of out-of-state applicants -- reciprocity.** (1) A board may issue a license to practice without examination to a person licensed in another state if the board determines that:
- (a) the other state's license standards at the time of application to this state are substantially equivalent to or greater than the standards in this state; and
 - (b) there is no reason to deny the license under the laws of this state governing the profession or occupation.
- (2) The license may be issued if the applicant affirms or states in the application that the applicant has requested verification from the state or states in which the person is licensed that the person is currently licensed and is not subject to pending charges or final disciplinary action for unprofessional conduct or impairment. If the board or its screening panel finds reasonable cause to believe that the applicant falsely affirmed or stated that the applicant has requested verification from the other state or states, the board may summarily suspend the license pending further action to discipline or revoke the license.
- (3) This section does not prevent a board from entering into a reciprocity agreement with the licensing authority of another state or jurisdiction. The agreement may not permit out-of-state licensees to obtain a license by reciprocity within this state if the license applicant has not met standards that are substantially equivalent to or greater than the standards required in this state as determined by the board on a case-by-case basis.

¹<http://leg.mt.gov/content/Committees/Interim/2011-2012/Efficiency-in-Government/Topic-Areas/Medicaid/jan2012-nonmedicaid-ideas.pdf>

Outline For HJR 33 Report

- Overview 2011 session actions, interim reviews, U.S. court case
- Sections 1) Committee activities
 2) Background information
- a) information gathered for a health insurance exchange and the Affordable Care Act -
 - i) health insurance coverage in Montana - indications from study by Bureau of Business and Economics Research for State Auditor
 - ii) status of health insurers in Montana - by premium in small group and individual market, by medical loss ratio, and regarding rate review (by federal officials and Leif Associates)
 - iii) status of Montana Comprehensive Health Association and the federal counterpart
 - iv) subsidies paid to employers to help buy health insurance, under Insure Montana and under the Affordable Care Act
 - v) status of the health co-operative that has received federal funding under the Affordable Care Act to provide an insurance alternative
 - vi) other??
 - b) information related to ways to address health care efficiencies and access
 - i) health care provider status in Montana and shortages plus options for expanding access
 - ii) use of the Board of Medical Examiners and the Board of Nursing licensing and renewal process to improve data gathering needed by DPHHS and as a way of decreasing the amount of time spent by physicians and others in responding to the same questions by various credentialing organizations.
 - iii) network adequacy for managed care insurers - having a hospital, primary care provider, and pharmacy within a 30-mile radius of enrollee
 - iv) other??
- Appendix Common terms and how they are used/referenced in the Affordable Care Act

Establishing a Health Insurance Exchange in Montana

Draft Report for HJR 33

Overview

Decisions by the 2011 Legislature not to pass legislation that would have implemented parts of the Affordable Care Act and a veto by the governor of a bill prohibiting creation of a health insurance exchange under the Patient Protection and Affordable Care Act set the stage for a philosophical void regarding how to proceed in the interim. However, passage of House Joint Resolution No. 33 to study creation of a health insurance exchange provided a starting point after that study bill was assigned to the Economic Affairs Committee (the Committee).

The Committee slipped back to the philosophical void after hearing from federal officials in late August 2011 that even if the 2013 Legislature chose to implement a state-based health insurance exchange the action would not be timely enough to have a state-run health insurance exchange running as of January 1, 2014. The federal officials noted that shared regulatory options might be available and that a state might be able to take over a federally run exchange after at least one year, although details were being worked out. The Economic Affairs Committee decided to simply stay informed of activities being pursued in Montana related to a health insurance exchange but took no action as members awaited the U.S. Supreme Court's decision on constitutional challenges to the Patient Protection and Affordable Care Act. The U.S. Supreme Court heard arguments on several constitutional questions regarding the Affordable Care Act in March and expects to provide a decision by late June 2012.

The following report contains information presented to the Economic Affairs Committee over the 2011-2012 interim as well as basic information that may be of help to Montana legislators if the U.S. Supreme Court upholds the Affordable Care Act and legislation is proposed to implement some components of the Patient Protection and Affordable Care Act. Another section will address options regarding health care provisions that legislators might want to consider if the Patient Protection and Affordable Care Act is overturned--sort of a "what next" review. In Appendix A, there is a list of topics related to the Affordable Care Act along with information from proposed -- or -- adopted rules.

Table 1 - Funding to Montana Government, Private Sector under the Affordable Care Act

Category	To Government	To Private Sector	Total Funding
<i>Total Amount</i>	\$18,559,360	\$82,418,690	\$100,978,050
Employers/Business	\$3,634,238	\$3,131,625	\$6,765,869
Health Care Facilities/Clinics	\$500,000		\$500,000
Health Centers	\$185,498	\$811,820	\$997,318
Maternal - Pregnancy	\$7,676,955	\$212,000	\$7,888,955
Medicare & Medicaid Special Projects	\$201,824	\$2,840,094	\$5,471,920
Prevention & Public Health	\$2,631,826	\$2,840,094	\$5,471,920
Private Insurance/Health Exchange of which the Co-op Health Plan	\$2,769,016	\$66,304,276	\$69,073,292
Workforce and Training	\$960,003	\$6,244,625	\$7,204,628
Source: The Henry J. Kaiser Foundation, ACA Federal Funds Tracker, accessed April 12, 2012: http://healthreform.kff.org/federal-funds-tracker.aspx			