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IN MEMORIAM

Michael E. Busch (January 4, 1947 – April 7, 2019)

On Sunday, April 7th, Speaker of the House Mike Busch passed away. He represented Anne Arundel County and the City of Annapolis in the General Assembly since 1986. He became Chairman of the Economic Matters Committee in 1994, where he oversaw health insurance and other aspects of the health care industry, putting him in touch with MedChi on a regular basis and individual doctors with whom he developed a personal relationship over the years. He always had an open door to hear physician concerns, even once he became Speaker in 2003. After fighting his way through a liver transplant (not alcohol related) and bypass surgery all within the last 2 years, he had been ill for several weeks fighting pneumonia, and unfortunately could not battle through it. He was a friend to all members of our law firm, and many of you as well. He will be missed as a legislator, but even more so as a good and decent man who was always ready with a smile and handshake, who helped everyone he could. Please keep his family and friends in your prayers in the days ahead.

MEDCHI FINAL 2019 SESSION REPORT

The 439th Session of the Maryland General Assembly began at noon on Wednesday, January 9th and concluded its legislative work at 11:30 PM on Monday, April 8th when it held a joint session to honor Speaker Busch. This was the first year of the new term (2019-2023). With nearly 60 new legislators and new committee leadership, especially in the Senate, this Session was marked by uncertainty. Typically, the first session of a term is relatively quiet. However, this was not the case this Session. Major policy issues were debated, including increasing the minimum wage, implementing the Kirwan Commission recommendations (school funding), debating end-of-life options and much more.

The General Assembly considered approximately 2,497 bills and resolutions. As a comparison, the General Assembly considered 3,127 during the 2018 Session; 2,876 bills and resolutions in 2017; and 2,832 bills and resolutions in 2016. While there were almost 600 fewer bills this Session than last, the major difference was that almost half of the bills were introduced at the deadline during the week of February 4th. MedChi's Legislative Policy Council reviewed over 215 bills, not including cross-files. Consequently, it was an extremely busy but also very successful Session for MedChi.

Budget – Fiscal Year 2020

As introduced, the Fiscal Year 2020 budget did not contain additional monies for Medicaid E&M rates, resulting in a percentage decline to 92.5% of Medicare. MedChi strongly lobbied the Governor and the members of the General Assembly and was successful in having an additional $4.76 million added in the supplemental budget. As such, Medicaid E&M rates will be at 93% of Medicare in the Fiscal Year 2020 budget.

With regard to the Maryland Primary Care Program (MDPCP), the Health Services Cost Review Commission (HSCRC) introduced legislation that would have transferred the remaining $10 million from the Maryland Health Insurance Plan Fund to the MDPCP to be used for administrative purposes – ***Senate Bill 1045/House Bill 1423: Maryland Health Insurance Plan Fund – Use of Remaining Balance***. However, the budget committees preempted the legislation and instead, through budgetary action, transferred the monies from the Plan Fund to Medicaid to be used in general for provider reimbursements. As such, Senate Bill 1045/House Bill 1423 failed. However, this action has NO effect on physician compensation under the MDPCP but only limits the administrative support that can be provided by the HSCRC under the MDPCP. MedChi continues to encourage physicians to enroll in the MDPCP.

It is important to note that, while the Fiscal Year 2020 budget is balanced the Department of Legislative Services (DLS) is projecting a structural deficit beginning in Fiscal Year 2021 in the amount of $829 million. By Fiscal Year 2024, it is projected to increase to $1.22 billion. According to DLS, "the existing structural imbalance in the budget and costs added for Kirwan (school funding) will likely result in a need for additional revenues and/or existing programmatic change. Given the size of Medicaid, any programmatic changes could mean significant changes to how services are currently delivered."

The Fiscal Year 2020 budget also requires several reports to be submitted and/or actions to be taken by various State agencies.

- Beginning September 30, 2019, the Maryland Department of Health (MDH) and the Opioid Operational Command Center are required to submit quarterly reports on the spending plan for the use of the funds contained in the Opioid Crisis Fund.
- The Maryland Institute for Emergency Management Services Systems (MIEMSS) and the HSCRC are required to report by November 1, 2019, on the strategies for addressing the increasing emergency department overcrowding in the State.
- The MIEMSS, HSCRC and the Maryland Health Care Commission (MHCC) are required to report on the development of new models of care delivery that will improve emergency department overcrowding by treating low-acuity patients in settings other than the emergency department, such as mobile integrated health services, emergency medical services (EMS) without transport, and EMS with transport to an alternative destination.
- The Behavioral Health Administration (BHA) is required to plan and create a statewide bed registry for all inpatient psychiatric beds, including total, operational, and vacant inpatient psychiatric beds in all State-run psychiatric facilities, acute general hospitals, and private psychiatric hospitals in Maryland.
- The BHA is required to conduct and report by December 1, 2019, on an analysis of existing scientific research and evidence surrounding the safety and efficacy of ibogaine (a psychoactive substance found in the root bark of the iboga plant) treatment for individuals with opioid-use disorders and the feasibility of future scientific research within existing institutions and research facilities.
- Based on interest in the behavioral health outcomes in the MDPCP, MDH, and the HSCRC are to submit a report on the process for evaluating the behavioral health provision in primary care practices and the impact that MDPCP has on Medicare and dually eligible Medicaid and Medicare enrollees with behavioral health needs, including those with serious mental illness.
- MDH and HSCRC are also required to submit a report on the projected operating expenses for MDPCP and the funding sources that will be used to support the MDPCP beginning in Fiscal Year 2020.

Addressing Substance Abuse and Behavioral Health Initiatives

- ***Prescription Drug Monitoring Program***

The General Assembly picked up where it left off in 2018. ***Senate Bill 195/House Bill 25: Public Health – Prescription Drug Monitoring Program – Revisions (passed)*** is a reintroduction of the House version of legislation considered in 2018, which would have made several changes to the Prescription Drug Monitoring Program (PDMP). While most of the changes were acceptable to MedChi such as requiring rather than authorizing the PDMP to review prescription monitoring data for indications of possible misuse or abuse of a monitored prescription drug or a possible violation of law or breach of professional standards by a prescriber or dispenser, MedChi remained opposed to allowing direct referral of cases to the Office of Controlled Substance Administration (OCSA) without prior review by the Technical Advisory Committee (TAC). MedChi, in conjunction with the Maryland Hospital Association (MHA), Maryland Dental Society, and the Maryland Nurses Association worked with MDH to determine how best to enhance the PDMP without creating a chilling effect on legitimate prescribing. Amendments were ultimately agreed upon to retain TAC involvement in all cases that the PDMP is considering for referral to the OCSA for further investigation. The amendments also include a requirement for the inclusion of additional data in the PDMP's annual report on the number of prescribers and dispensers identified for further outreach and education as well as referral for further investigation. Finally, the bill directs the PDMP to continue to work with the TAC to improve the effectiveness of its data analysis.

House Bill 466: Prescription Drug Monitoring Program – Program Evaluation (passed) reflects the recommendations of DLS relative to its review of the PDMP. Most importantly, the bill removes the termination date of July 1, 2019, to allow the PDMP to operate in perpetuity.

Once again, insurers tried to unsuccessfully gain access to the PDMP. ***Senate Bill 498/House Bill 847: Prescription Drug Monitoring Program – Disclosure of Data – Managed Care Organizations (failed)*** would have allowed the Medicaid managed care organizations (MCOs) access to PDMP data, purportedly only for purposes of compliance with two required Medicaid utilization review programs. MedChi, in conjunction with the dental and nursing provider communities, opposed the legislation again, citing the need to maintain the PDMP as a health care tool for prescribers and dispensers and to prohibit the unfettered access to data by any entity other than a prescriber or dispenser without a subpoena or in furtherance of a bona fide investigation.

- ***Substance Use Disorder and Behavioral Health Initiatives***

House Bill 116: Public Health – Correctional Services – Opioid Use Disorder Examinations and Treatment (passed) establishes specified programs of "opioid use disorder" screening, evaluation, and treatment in local correctional facilities and in the Baltimore Pre-trial Complex. The program will begin in four counties and phases in to include all counties and the Baltimore Pre-trial Complex. The State must fund the programs of opioid use disorder screening, examination, and treatment of inmates, and the bill establishes requirements for screening and treatment. By November 1, 2020, and annually thereafter, the Governor's Office of Crime Control and Prevention must report data to the General Assembly from local correctional facilities.

While ***House Bill 139/Senate Bill 135: Public Health – Overdose and Infectious Disease Prevention Site Program (failed)*** was received more favorably by the Committees than in past years, in part due to continued efforts to identify new and innovative approaches to address the continued escalation of the opioid crisis, the bill still failed to advance this Session. This Session's initiative was a more narrowly

defined pilot program that would have authorized a community-based organization to establish an Overdose and Infectious Disease Prevention Site Program to provide a supervised location where drug users could consume pre-obtained drugs, as well as receive other services, education, and referrals.

House Bill 427/Senate Bill 403: Behavioral Health Administration – Outpatient Civil Commitment Pilot Program – Revisions (passed) requires the BHA within MDH to allow an eligible individual to request enrollment in, and allow an immediate family member of an eligible individual to request voluntary enrollment for the individual in an existing authorized pilot program for outpatient civil commitment. BHA must include specified information in its annual report for individuals admitted into the program both voluntarily and involuntarily.

Two bills were requested this Session by the Maryland Parity Coalition to address issues with network adequacy as it relates to mental health parity and addition equity. ***House Bill 599/Senate Bill 631: Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Treatment Criteria (passed)*** was heavily amended by the committees. Initially, the bill required carriers to submit two extensive reports to the Maryland Insurance Administration on how the carrier complied with federal mental health parity and addiction equity laws and on the carrier's data for mental health benefits, substance use disorder benefits, and medical/surgical benefits by parity act classifications. The committees amended the bill to only require carriers to use the American Society of Addiction Medicine criteria for all medical necessity and utilization management determinations for substance use disorder benefits. The bill also repeals the limitation on a carrier charging a copayment for methadone maintenance treatment that is greater than 50% of the daily cost for methadone maintenance treatment.

House Bill 837/Senate Bill 761: Health Insurance – Payments to Noncontracting Specialists and Noncontracting Nonphysician Specialists (failed) addressed access to and payment for out of network services for behavioral health by enacting balanced billing and assignments of benefit provisions for behavioral health programs as a mechanism for incentivizing carriers to expand their provider panels. While the bill was well-received by each respective committee, there was strong resistance from the carriers and the bills ultimately failed.

Another bill aimed at increasing access to behavioral health providers, especially in the more rural areas of the State, was ***House Bill 829: Health Insurance – Provider Panels – Graduate Providers (passed)***. This bill prohibits a carrier from rejecting a provider who provides community-based health services for an accredited program for participation on the carrier's provider panel solely because the provider is a licensed graduate social worker, a licensed master social worker, a licensed graduate alcohol and drug counselor, a licensed graduate marriage and family therapist, a licensed graduate professional art therapist, or a licensed graduate professional counselor.

It is also important to note that the Fiscal Year 2020 budget provides a 3.5% increase to behavioral health providers as part of the 2018 initiative – *Keep the Door Open.*

<u>Scope of Practice and Physician Licensure</u>

For the last three years, the Maryland Society of Eye Physicians and Surgeons (MSEPS) and MedChi have been fighting against the unfettered expansion of the optometric scope of practice. Strong supporters of the expansion included Chair Shane Pendergrass (House Health Government and Operations Committee) and newly appointed Chair Paul Pinsky (Senate Education, Health, and Environmental Affairs Committee). At the request of the Maryland Optometric Association, ***House Bill 471/Senate Bill 447: Health Occupations – Requirements for the Practice of Optometry – Miscellaneous Revisions (passed)***

was introduced, which would have granted broad authority to optometrists to prescribe oral medications, remove foreign bodies, order tests and diagnose and treat all forms of glaucoma. MSEPS and MedChi successfully lobbied for appropriate safeguards around each measure to protect patient safety. As such, the bill was amended to reflect these concerns. Under the provisions of this bill, Maryland is still one of the more restrictive states for optometric practice. As amended, the bill prohibits the ability for optometrists to perform any acts that would qualify as "surgery." The bill, while authorizing the prescribing of pharmaceutical agents, prohibits the prescribing of a controlled dangerous substance (CDS) or any drug that needs to be injected or administered intravenously, as well as certain classes of pharmaceutical agents. The bill also prohibits the prescribing of oral pharmaceutical agents, except under limited circumstances, to those under the age of 18 years. Finally, the legislation allows for an optometrist to order limited tests after consulting with a physician and for an optometrist to diagnose and treat only open-angle glaucoma, provided that certain benchmarks related to clinical stability and intraocular pressure are satisfied.

Two bills that were introduced to expand the pharmacists' scope of practice failed. ***House Bill 419/Senate Bill 577: Pharmacists – Administering Injectable Medications and Biological Products (failed)*** would have allowed pharmacists to administer injectables and biologics. MedChi initially opposed this legislation, but we did try to work with the pharmacy association to develop consensus amendments. ***House Bill 1217/Senate Bill 497: Pharmacists – Aids for the Cessation of Tobacco Product Use – Prescribing and Dispensing (failed)*** would have allowed pharmacists to prescribe smoking cessation products. MedChi raised issues relating to the pharmacist's inability based on education and training to fully assess a patient before prescribing these treatments. But more importantly, we raised the issue that pharmacies should not sell cigarettes in the front of the store and then smoking cessation products in the back of the store, an issue not opposed by the pharmacy association. The Senate Committee voted the bill unfavorable. In the end, the bills failed to move forward.

As expected, the naturopaths were once again before the General Assembly requesting an expansion of their scope. ***House Bill 547/Senate Bill 900: State Board of Physicians – Naturopathic Doctors – Formulary Content and Scope of Practice (failed)*** would have allowed naturopaths to prescribe prescription drugs, subject to the authority of the Board of Physicians (BOP) to reject any drug being added to their formulary. MedChi argued that naturopaths do not complete a residency, the very training that makes an M.D. or D.O. qualified to prescribe prescription drugs, so why should a naturopath be considered qualified to do so? While the committees voted the bill unfavorable, much work needs to be done to educate the legislators on the education requirements of physicians versus other health care professions.

MedChi successfully crafted a narrow exemption for physicians in the dispensing of topical medications. ***House Bill 1288/Senate Bill 916: Physicians – Physician Permit Exemption – Topical Medication (passed)*** allows a physician to receive a special written permit for the dispensing of certain topical medications. Unlike the full dispensing permit, to qualify for this permit, the physician must pay $100 and take five CMEs (rather than the current ten hours).

On behalf of MedChi (Resolutions 38-19 and 39-19), ***House Bill 455/Senate Bill 372: Physicians – Discipline – Procedures and Effects (failed)*** was introduced which would have prohibited insurers from removing a physician from a provider panel for a longer period than the duration of any probation that the physician received from the Board. Ultimately, MedChi requested that the sponsors withdraw the bills due to mounting concerns raised by committee members and opposition by insurers coupled with a breaking story where another physician had been disciplined in the State for inappropriate contact with a patient. MedChi will revisit the issues we were attempting to remedy through this bill, and others, during

the interim. Of note, the BOP will be undergoing a Sunset Review and Performance Audit during this interim pursuant to House Bill 638.

Health Facility Regulation

Three certificate of need (CON) bills were considered this Session. All three passed. These bills were part of the discussions of the CON Modernization Workgroup that occurred this interim and were included in the recommendations put forth by the Workgroup.

House Bill 931/Senate Bill 940: Health Care Facilities – Certificate of Need – Modification (passed) changes the definition of ambulatory surgical center from having two operating rooms to three operating rooms and removes the capital threshold requirement for triggering a CON approval requirement.

House Bill 626: Health Care Facilities – Change in Bed Capacity – Certificate of Need Exemption (passed) exempts from the CON an increase or decrease in bed size within an existing intermediate care facility or a general hospice program.

House Bill 646/Senate Bill 597: Maryland Health Care Commission – State Health Plan and Certificate of Need for Hospital Capital Expenditures (passed) requires evaluation of the State Health Plan for hospitals and increases the hospital capital expenditure threshold.

Continued concerns regarding the availability of health services on the shore prompted ***Senate Bill 1010: Maryland Health Care Commission – Assessment of Services at the University of Maryland Shore Medical Center in Chestertown (passed)***. This bill requires the MHCC, in conjunction with the Office of Health Care Quality, to assess the types, quality, and level of services provided at the University of Maryland Shore Medical Center in Chestertown (UMSMCC). The assessment must, at a minimum, (1) compare the services currently provided to the services provided in fiscal 2015; and (2) identify whether, on or after July 1, 2015, any services from UMSMCC were reduced or transferred to the University of Maryland Shore Medical Center in Easton. The MHCC must report its findings to the General Assembly by January 1, 2020.

In the final two weeks of Session, due to controversy surrounding the University of Maryland Medical Systems, ***House Bill 1428: University of Maryland Medical System Corporation – Board of Directors, Ethics, and Performance Audit (passed)*** was introduced. This emergency bill alters the composition of, and the appointment process for, members of the Board of Directors of the University of Maryland Medical System Corporation, including reconstituting the board and prohibiting a member from being a State or local elected official.

Medical Malpractice Liability

After killing a bill in 2018 on the final night of the Session that would have completely repealed the 20% Rule, MedChi, MHA and Med Mutual were asked by Speaker Mike Busch to try and reach a compromise with the trial lawyers that retains the Rule, but fixes certain issues with its application. These talks continued through the final week of Session when agreement was reached. As agreed, ***Senate Bill 773: Health Care Malpractice Qualified Expert – Qualification (passed)*** defines the term "professional activities", increases the amount of time one can spend as an expert to 25%, provides for the time period during which the 25% is computed, establishes that once the expert is qualified in the case they remain qualified, and sets rules for when and whether the case can be re-filed if the expert is determined to not comply with the Rule.

As a result of agreement reached on the qualified expert, no other bill related to medical malpractice passed this Session. These bills included ***Senate Bill 813: Personal Injury or Wrongful Death – Non-Economic Damages (failed)***, which would have raised the cap based on the number of beneficiaries in wrongful death cases, in some cases by as much as 300% of the existing cap. ***House Bill 1323/Senate Bill 784: Civil Actions – Health Care Malpractice Claims (Life Care Act 2019) (failed***) would have specified the method by which an award or a verdict for future medical expenses must be calculated. ***Senate Bill 322: Medical Malpractice – Notice of Intent to File Claim (failed)*** would have required a claimant to send a health care provider written notice of the claimant's intent to file a medical injury claim against the health care provider at least 90 days before filing the claim. ***Senate Bill 323: Medical Malpractice – Discovery (failed)*** sought to clarify that the discovery available as to the basis of a certificate of a qualified expert in a health care malpractice action includes a deposition of the attesting expert.

Public Health

- ***Maternal and Child Health***

MedChi opposed ***House Bill 247/Senate Bill 445: Maryland Health Care Commission – Surgical Birth Rate – Study (failed)***, which would have required MHCC to study surgical births. Prior to the hearing, MedChi and the proponents defined an alternative approach to the study that was acceptable to all interested parties. As such, the bill was withdrawn in favor of the Patient Safety Center, which conducted a two-year collaborative on reduction of primary c-sections in conjunction with all of Maryland's birth hospitals, agreeing to continue its collaborative efforts with stakeholders to further study surgical births.

With respect to maternal mortality review, two bills were introduced to address the issue. ***Senate Bill 356/House Bill 583: Health – Maternal Mortality Review Program – Recommendations and Reporting Requirement (passed)*** requires the Maternal Mortality Review Program, in consultation with the Office of Minority Health and Health Disparities, to make recommendations to reduce any disparities in the maternal mortality rate, including recommendations related to social determinants of health. The program must also include in its annual report a section on racial disparities that contains specified information. ***House Bill 796: Public Health Maternal Mortality Review Program – Establishment of Local Teams (passed)*** became a much more problematic bill. While notable, Baltimore City was interested in creating its own maternal mortality review team but the bill, as drafted, raised potential negative repercussions for the State program. Fortunately, under MedChi's leadership, the stakeholders were able to resolve the potential unintended consequences of the bill as introduced. As amended, the bill not only authorizes the establishment of local maternal mortality review teams but also strengthens the provisions of the State program.

Senate Bill 970/House Bill 506: Maryland Department of Health – Special Supplemental Nutrition Program for Women, Infants, and Children – Reports (passed) requires MDH to work with stakeholders, including MedChi, to review and address barriers to enrollment in the WIC program. MDH is to produce a report annually through 2021 that includes data on the WIC program as well as any identified mechanisms to increase participation.

Senate Bill 406/House Bill 520: Prenatal and Infant Care Coordination – Grant Funding and Task Force (passed) increases, from $50,000 to $100,000, the amount of funding the Governor must provide for the Maryland Prenatal and Infant Care Coordination Services Grant Program Fund beginning in Fiscal Year 2021. The bill also establishes the Task Force on Maryland Maternal and Child Health, to be jointly staffed by MDH, the Department of Human Services, and HSCRC. The task force must study and make

recommendations on how the policies of MDH can be used to incentivize early intervention and prevention of key adverse health outcomes; how State policies and payment mechanisms can support community- and school-based models of care; encourage partnerships under the all-payer model to improve child care; assist in collaborations with public health care; and use specified Medicaid data to monitor improvements and programs that Medicaid should implement. By November 1, 2019, the task force must report its findings and recommendations to the General Assembly.

- ***Youth Protections***

House Bill 1183/Senate Bill 251: Public Health – Treatment for the Prevention of HIV – Consent by Minors (passed) clarifies current law with respect to a minor's right to consent to prevention for HIV or PReP. The highest incidences of new HIV cases are in individuals between the ages of 13-24. Access to prevention is essential to address the growing public health implications associated with this resurgence of HIV cases.

After years of being voted unfavorable, ***House Bill 124/Senate Bill 299: Tanning Devices – Use by Minors (passed)*** has finally made it to the Governor's desk. This bill prohibits individuals under the age of 18 from using a tanning bed, like the current requirement in Howard County.

In continuing to protect youth, ***House Bill 1169: Business Regulation – Tobacco Products and Electronic Smoking Devices – Revisions (passed)***, among other provisions, increases the minimum age for tobacco products and electronic smoking devices to 21 years of age, except for military personnel.

House Bill 911: Workgroup to Study Shelter and Supportive Services for Unaccompanied Homeless Minors (passed) establishes a Workgroup to Study Shelter and Supportive Services for Unaccompanied Homeless Minors, which is to be staffed by the Joint Committee on Ending Homelessness. An unaccompanied homeless minor is a minor who is not in the physical custody of a parent or guardian and lacks a fixed, regular, and adequate nighttime residence or whose status or circumstances indicate a significant danger of experiencing homelessness in the near future. By December 1, 2019, the workgroup must report its findings and recommendations to the Governor and the General Assembly.

House Bill 110: Public School Students – Daily Physical Activity (Student Health and Fitness Act) (failed), which has been supported by MedChi for several years and would have required a program of physical education for prekindergarten students, ultimately failed. The bill also would have established a goal that each public elementary school student be provided a daily program of developmentally and appropriately moderate to vigorous physical activity of at least 150 minutes per week, including recess and at least 90 minutes per week of physical education. While the bill passed the House of Delegates, it failed to advance in the Senate Education, Health, and Environmental Affairs Committee, where the Chair was reluctant to pass any bills that would place additional requirements on schools considering the passage of ***Senate Bill 1030: The Blueprint for Maryland's Future*** (recommendations of the Kirwan Commission on education funding).

- ***Environmental Health***

In the environmental health areas, several initiatives related to lead were introduced. The primary focus was on ***House Bill 1233: Environment – Reduction of Lead Risk in Housing – Elevated Blood Lead Levels and Environmental Investigations (Maryland Healthy Children Act) (passed)***, which redefines the elevated blood lead level as it applies to provisions of law that initiate case management, notification, and lead risk reduction requirements. The bill lowers Maryland's blood lead level threshold for

investigation to be consistent with national CDC standards. The Maryland Department of the Environment (MDE) must adopt regulations for conducting environmental investigations to determine lead hazards, as specified, and include a summary of the results of any environmental investigation conducted pursuant to the bill in its annual report on statewide childhood blood lead testing. The bill also modifies provisions regarding when an affected property owner is required to satisfy the modified risk reduction standard.

The other lead initiatives included, ***House Bill 1253: Drinking Water Outlets in School Buildings – Elevated Level of Lead and Grant Programs (passed)***, which redefines the "elevated level of lead" for the purposes of required lead water testing and remedial measures in public and nonpublic schools in the State. MDE, in consultation with the Maryland State Department of Education, would have been required to establish and administer a grant program to provide grants to local school systems to assist with specified remedial costs. ***House Bill 1068: Landlord Tenant – Repossession for Failure to Pay Rent – Lead Risk Reduction Compliance (failed)*** would have altered the procedures by which a landlord may repossess property for failure to pay rent in the State and in Baltimore City associated with properties that are not in compliance with lead abatement program requirements.

House Bill 275/Senate Bill 270: Pesticides – Use of Chlorpyrifos – Prohibition (failed) would have prohibited a person from using chlorpyrifos in the State, including insecticides that contain chlorpyrifos or seeds that have been treated with chlorpyrifos, beginning December 31, 2020.

Pharmaceuticals and Pharmacies

House Bill 409/Senate Bill 469: Drugs and Devices – Electronic Prescriptions – Requirements (failed) would have mandated that all prescriptions be prescribed electronically by October 1, 2019. Given the federal requirement that prescriptions under Medicare Part D for CDSs must be electronically submitted by January 1, 2021, MedChi worked with the bill sponsor and other stakeholders to conform the bill to the federal law by limiting it to CDS, extending the effective date and providing for additional exemptions for when a prescription could still be prescribed in writing or orally. Due to operational issues raised by MDH and the Attorney General's Office during the final days of Session, the bill did not pass. It is expected that, given the federal mandate, this bill will be reintroduced next Session.

Due to concerns raised that individuals, mainly children, were receiving duplicative vaccinations, ***House Bill 316: Public Health – Vaccination Reporting Requirements – ImmuNet (passed)*** will require all health care providers to report any vaccinations provided to the State's ImmuNet system. Providers can either report directly through their electronic health record or through a separate State portal. The requirement will be effective October 1, 2019.

In the final hours of the Session, ***House Bill 768: Health – Prescription Drug Affordability Board*** passed. As enacted, a Prescription Drug Affordability Board will be appointed as well as and Prescription Drug Affordability Stakeholder Council. The Board, in consultation with the Stakeholder Council, is charged with studying the complete supply chain as well as a number of options to address affordability. The Board is to report its findings and recommendations to the General Assembly by December 31, 2020. The Board is authorized to enter into a MOU with other States and to use the MOU information to identify drugs that may cause affordability issues and make a determination as to whether to do a cost analysis of an identified drug for potential affordability challenges. Annually, beginning December 31, 2020, the Board is to submit to the General Assembly a report that includes price trends for prescriptions drug products, the number of drugs that were subject to review, and any recommendations the Board may have on further legislation needed to make prescription drug products more affordable in the State.

The legislation establishes a specific process for setting upper payments limits if recommended by the Board that includes the development of a plan that must be approved by either the Legislative Policy Committee or the Governor and Attorney General. The bill also includes language recommended by MedChi that would require the Board and the State Designated Health Information Exchange to study how the Exchange can provide de-identified provider and patient data to the Board.

House Bill 920/Senate Bill 819: Health Insurance – Pharmaceutical Manufacturers – Transparency and Reporting (failed) was introduced as an alternative to the Prescription Drug Affordability Board legislation. The bill required drug manufacturers, pharmacy benefit managers, and insurers to provide a range of information regarding the drug costs, rebates, the amount of funds returned to patients, and other factors that contribute to affordability and access to pharmaceuticals. The bill was never given serious consideration as the focus remained throughout on the Session on the creation of a Drug Affordability Board and the related provisions of that legislation.

The General Assembly took a hard stand to protect independent pharmacies with the passing of ***House Bill 754: Health Insurance and Pharmacy Benefits Managers – Cost Pricing and Reimbursement (passed)***. House Bill 754, an emergency bill, prohibits a contract (or contract amendment) between a pharmacy benefits manager (PBM), a pharmacy services administration organization, or a group purchasing organization and a pharmacy from becoming effective unless (1) the contract or amendment is filed with the Insurance Commissioner at least 30 days before it is to become effective; and (2) the Commissioner does not disapprove the filing within 30 days after the contract or amendment is filed. The bill's provisions also apply to MCOs that use a PBM. The bill also specifies requirements relating to appeals and disputes regarding maximum allowable cost and cost pricing and reimbursement. The bill repeals authorization for a PBM to retroactively deny or modify reimbursement to a pharmacy or pharmacist if the claim otherwise caused monetary loss to the PBM, provided that the PBM allowed the pharmacy a reasonable opportunity to remedy the cause of the monetary loss. Because this is an emergency bill, which will be effective on the day it is signed, there is speculation that the PBMs will be seeking a Governor veto of this bill due to the implications for current contracts.

Because of the passage of House Bill 754, several other pharmacy bills failed, including ***House Bill 296: Health Occupations – Pharmacists – Disclosure of Price and Cost Share for Prescription Drugs (failed)***, which would have required a licensed pharmacist, at the point of sale, to inform a retail consumer, to the best of the pharmacist's knowledge, of (1) the retail price for the prescription drug; and (2) if the consumer has insurance, the cost share for which the consumer is responsible. ***House Bill 545: Health Insurance – Freedom of Choice of Pharmacy Act (failed)*** would have, among other provisions, prohibited a carrier from allowing an enrollee from selecting a pharmacy of the enrollee's choice if the pharmacy participates as a contract provider in the health benefit plan offered by the carrier. A related bill, ***House Bill 759: Pharmacy Benefits Managers – Pharmacy Choice (passed)*** was voted favorable and prohibits a PBM from requiring that a beneficiary use a specific pharmacy or entity to fill a prescription if: (1) the PBM or a corporate affiliate of the PBM has an ownership interest in the pharmacy or entity; or (2) the pharmacy or entity has an ownership interest in the PBM or a corporate affiliate of the PBM. A PBM may require a beneficiary to use a specific pharmacy or entity for a specialty drug.

Health Insurance

- **Insurance Coverage and Mandated Benefits**

As a result of Resolution 25-18 from the Fall House of Delegates, MedChi requested the introduction of ***House Bill 435/Senate Bill 405: Health Insurance – Prescription Drugs – Formulary Changes***

(passed). As introduced, the bill would have "frozen" the formulary, prohibiting any changes mid-year by an insurer as it related to removing a drug from the formulary or changing a prescription drug to a higher cost sharing tier. Because of concerns raised related to the recent spikes in pharmaceutical costs, legislators were concerned about limiting the ability of an insurer from making mid-year changes. MedChi worked with legislators and insurers to develop alternative language to address the issue. As amended, the bill builds on Maryland's current exemption process for addressing when a beneficiary needs a drug that is not on the carrier's formulary. Under the bill, if a carrier either removes a drug from the formulary or moves a drug to a higher cost tier, the beneficiary may be able to continue to access the drug or stay on the drug in the original cost sharing tier if the authorized prescriber states that there is no equivalent prescription drug in the entity's formulary or in a lower tier. In addition, if the carrier moves a drug from the formulary or shifts it to a higher cost sharing tier, the carrier must provide a beneficiary who is currently taking the drug and the member's health care provider with at least 30-day notice before the change is implemented. The notice must include the process for requesting the exemption.

MedChi was also successful in strengthening Maryland's prior authorization laws to provide greater continuity of care for patients and transparency. ***House Bill 751: Health Insurance – Prior Authorization – Requirements (passed)*** provides that a carrier must honor a prior authorization from a previous entity for at least the initial 30 days of the beneficiary's prescription drug benefit coverage during which time the carrier can initiate its own prior authorization review. The bill also requires that an entity honor a prior authorization when the beneficiary moves between health plans within the same carrier and when there is a dosage change (excluding opioids). The bill also requires carriers to electronically pre-populate forms with certain information and again requires that, at least 30 days prior to implementing a prior authorization change, a carrier must provide a beneficiary who is currently taking the drug and all health care providers with notice of the change. Another bill, ***House Bill 750: Health Insurance – Prior Authorizations – Medical Devices or Oxygen (failed)***, which would have prohibited carriers from applying a second or subsequent prior authorization for the use of a medical device or oxygen for a "chronic condition" met with opposition from the carriers and failed to advance.

After failing to pass for the last three years, ***Senate Bill 36/House Bill 127: Health Insurance – Health Benefit Plans – Special Enrollment Period for Pregnancy (passed)*** finally made it through the General Assembly. This bill requires small employer and individual health benefit plans to provide a special enrollment period (90 days and begins on the date the health care practitioner confirms the pregnancy) during which an individual may enroll in a health benefit plan. Coverage must become effective on the first day of the month in which the woman receives confirmation of pregnancy. By January 1, 2022, the Maryland Health Benefit Exchange must report to the General Assembly on the use of the special enrollment period.

Continued concerns over the fate of the Affordable Care Act (ACA) prompted the introduction of ***House Bill 697/Senate Bill 868: Health Insurance – Consumer Protections and Maryland Health Insurance Coverage Protection Commission (passed)***, which would have codified in State law the requirements of the ACA. However, in the end, the bill extends the Maryland Health Insurance Coverage Protection Commission for an additional three years through June 30, 2023, and requires the Commission to establish a workgroup to monitor actions relating to the ACA and to determine the most effective manner of ensuring that Maryland consumers can obtain and retain quality health insurance, independent of any action or inaction on the part of the federal government or any changes to federal law or its interpretation. The Commission must include the findings of the workgroup in its 2019 annual report.

Unlike in previous Sessions, there will be no mandated benefit bills that passed this Session. ***House Bill 15: Health Insurance – Pediatric Autoimmune Neuropsychiatric Disorders – Coverage (failed)*** would

have required carriers to provide coverage for medically necessary diagnosis, evaluation, and treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including the use of intravenous immunoglobulin therapy. ***Senate Bill 609: Maryland Medical Assistance Program and Health Insurance – Coverage – Treatment for Contagious Diseases (failed)*** would have required carriers to provide coverage for any medically appropriate and necessary drug or other treatment for the treatment of a contagious disease (undefined in the bill). ***Senate Bill 410: Health Insurance – Coverage for Insulin – Prohibition on Deductible, Copayment and Coinsurance (failed)*** would have prohibited a carrier from imposing cost sharing requirements on insulin. Despite MedChi's policy on not taking positions on mandated benefits, MedChi did write a letter to the Senate Finance Committee not only explaining our policy but sharing our strong concern regarding the health implications when an individual does not have access to affordable insulin. ***Senate Bill 867: Health Insurance – Coverage for Diagnostic Laboratory Tests for Lyme Disease (failed)*** would have required carriers to provide coverage for the expenses incurred in conducting a medically recognized diagnostic laboratory test for Lyme Disease.

- **Individual Health Insurance Market**

The General Assembly continued its efforts to stabilize the individual health insurance market. Last Session, the State established a health insurance provider fee assessment for Calendar Year 2019 to assist in the stabilization of the individual health insurance market after the participating carriers (CareFirst and Kaiser) announced soaring premium increases. The provider fee assessment was used to create a State Reinsurance Program, which has had the effect of decreasing premium amounts. ***House Bill 258/Senate Bill 239: Health Insurance – Individual Market Stabilization – Provider Fee (passed)*** continues the assessment through 2023. The bill also requires the State to seek clarification on whether the assessment can apply to MCOs. Lastly, the bill requires the Maryland Health Insurance Coverage Protection Commission to study and make recommendations on whether the State Reinsurance Program should be extended after Calendar Year 2023 and, if so, how it will be funded.

As introduced, ***House Bill 814/Senate Bill 802: The Maryland Easy Enrollment Health Insurance Program (passed)*** would have imposed a penalty on individuals who did not have insurance. The bill would have also implemented automatic enrollment in the individual market. Due to concerns surrounding the fairness of a penalty on individuals who still may not be able to afford insurance, the General Assembly amended the bills to provide individuals with additional assistance for how to enroll in health insurance by indicating so on their tax return. Specifically, an individual will indicate on their tax return whether the individual or a dependent claimed on the tax return lacked minimum essential coverage at the time the tax return is filed.

If the return indicates an uninsured individual wants the assistance of the Exchange, the return must also include additional information on the individual. The Comptroller will forward the information to the Exchange upon which the Exchange will determine if the individual is eligible for Medicaid. If the individual is eligible, the Exchange will contact the individual and ask them to pick a Managed Care Organization Plan by a specified date and notify the individual that if they do not pick a plan, the State will pick one and enroll them in it. If the individual does not pick a plan the individual will be given one more chance to opt out of the plan chosen by the State. If the Exchange determines that an individual does not qualify for Medicaid, the Exchange will determine the individual's eligibility for other insurance affordability programs or other insurance options and notify the individual.

- **Single Payer Health Care**

Once again, bills that would have implemented a State-operated health care plan did not pass. ***House Bill 378: Public Health – State-Provided Health Care Benefits (failed)*** would have created an Office of Health Care Coverage within MDH to establish and carry out a new Healthcare Maryland Program where individuals were enrolled in health care plans through the State's MCOs. ***House Bill 1087/Senate Bill 871: Public Health – Healthy Maryland Program – Establishment (failed)*** would have established the Healthy Maryland Program as an instrumentality of the State, which by January 1, 2021, would provide comprehensive universal single-payer health care coverage to replace Medicaid, the Maryland Children's Health Program, Medicare, the ACA, and any other federal programs within the State. At its Fall 2018 meeting, the House of Delegates passed Resolution 30-18 to create a Task Force to study the implications of implementing new payment systems in Maryland, including, but not limited to, a single payer health care system and a Maryland public option and report back to the House of Delegates during the 2019 Fall meeting.

Other Bills of Interest

This Session, there was a concerted effort by the Medicaid MCOs to carve-in behavioral health. As you know, behavioral health is carved-out of the MCOs and is administered through the Beacon, the State's administrative service organization (ASO). ***House Bill 846/Senate Bill 482: Maryland Medical Assistance Program – Managed Care Organizations – Behavioral Health Services (failed)*** would have required Medicaid to provide reimbursement for medically necessary and appropriate "behavioral health services" and would have required each MCO, rather than the ASO, to provide or arrange for behavioral health services beginning January 1, 2021. As a counter to this bill, advocates who continue to support the carve-in introduced two bills. ***House Bill 938/Senate Bill 975: Behavioral Health Transformation Act of 2019 (failed)*** would have introduced additional performance standards into the ASO contract. ***House Bill 941/Senate Bill 976: Public Behavioral Health System – Implementation Plans to Improve Efficiency, Accountability, and Outcomes – Workgroup (failed)*** would have required the Secretary of Health to convene a workgroup of specified stakeholders to develop implementation plans to improve efficiency, accountability, and outcomes of publicly funded behavioral health services. Given the sensitivity of this issue and the concerns raised by the advocates, the bills were both withdrawn. This issue is sure to garner additional discussions this interim.

For the fourth time, the bill to authorize end-of-life procedures failed to pass – ***House Bill 399/Senate Bill 311: End-of-Life Option Act (Richard E. Israel and Roger "Pip" Moyer Act)***. This Session, the bill passed the House of Delegates. However, it failed by one vote on the Senate floor. The Senate Judicial Proceedings Committee had amended the bill in such a manner that the advocates for the bill withdrew their support.

Special Thanks

MedChi thanks those members who served on the MedChi Legislative Council this Session for their efforts in promoting the practice of medicine in Maryland and strengthening the role that MedChi plays in shaping public policy in Maryland. A special thanks to our subcommittee chairs: Dr. Clement S. Banda (Boards and Commissions), Dr. Richard Bruno (Public Health), and Dr. Anuradha D. Reddy (Health Insurance) and to our Legislative Council co-chairs, Dr. Ben Lowentritt and Dr. Sarah Merritt.

MedChi also recognizes those physicians who came to Annapolis on behalf of MedChi to testify on various initiatives, including Dr. Richard Bruno, Dr. Justin Berk, Dr. Gwen DuBois, Dr. H. Russell

Wright, Dr. Gary Pushkin, Dr. Stephen Rockower, Dr. Larry Green, Dr. Michael Murphy, Dr. Michael Ichniowski, Dr. Lee Snyder, Dr. David Baranano, Dr. David Glasser, Dr. Sonny Goel, Dr. Renee Bovelle, Dr. Alan Robin, Dr. Elyse McGlumphy, Dr. Laura Green, Dr. Susie Lipton, Dr. Mona Kaleem, Dr. Megan Collins, Dr. Tyler Cymet, Dr. David Dao, Dr. Jill Allbritton, Dr. Valerie Calendar, and Dr. Kate Jacobson.

Lastly, MedChi extends its appreciation to the physicians who volunteered their time to staff the State House First Aid Room this Session. Staffing the First Aid Room is an honor for MedChi and one that cannot be taken for granted. Physicians who staff the First Aid Room have access to the legislators and are looked at not only as a resource for medical care but also as a resource on policy issues. MedChi also would like to thank Colleen White, R.N. for her dedication in staffing the First Aid Room for the full 90-days of Session.

Doctors who staffed the First Aid Room this Session include:

Heidi Abdelhady, M.D.
Renee Bovelle, M.D.
Richard Bruno, M.D.
Jane Chew, M.D.
Geoff Coleman, M.D.
Wiemi A. Douoguih, M.D.
J. Ramsay Farah, M.D.
Aaron George, M.D.
Walter J. Giblin, M.D.
John Gordon, M.D.
Clare Kelliher, M.D.
Alisa Kim, M.D.
Irene Kuo, M.D.
George Malouf, M.D.
Sarah Merritt, M.D.
Michael Murphy, M.D.
Michael Niehoff, M.D.
Gary Pushkin, M.D.
Padmini Ranasinghe, M.D.
Stephen Rockower, M.D.
Lee Snyder, M.D.
Benjamin Stallings, M.D.
Bernita Taylor, M.D.
Rosaire Verna, M.D.
Joseph Weidner, M.D.
Reed Winston, M.D.
H. Russell Wright, M.D.