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Memorandum

To: MedChi Members
From: Joseph A. Schwartz, III
Pamela Metz Kasemeyer
J. Steven Wise
Date: April 12, 2004
Re: 2004 General Assembly Wrap Up

The 2004 General Assembly ended at midnight on April 12th with some pundits calling it a “do nothing” session. For the second year in a row, the dominant debate was over **slot machines** and, once again, slots lost. It appears that the 2005 General Assembly will deal with the same issues (slots and taxes) as the mandated increases in state spending (K-12 education) will continue to outstrip the state revenues available. Expect this impasse to continue through the next election in 2006.

The high hopes for **malpractice reform** raised by the 2500 physicians attending an Annapolis rally in January were dashed when the Senate Judicial Proceedings Committee defeated Governor Ehrlich’s malpractice reform package by a vote of 7-4. Since last fall, MedChi had been saying that it was necessary to persuade two of four undecided senators on the Senate Judicial Proceedings Committee (Senators Forehand and Garagiola of Montgomery County, Senator Giannetti of Prince George’s County and Senator Brochin of Baltimore County) in order to receive a favorable vote in the Committee (MedChi believed that there would be 4 in favor of reforms, 3 opposed and 4 undecided). In the end, all four “undecided” senators voted against the MedChi position.

Things were a little better in the House of Delegates due to the interest of House Speaker Michael E. Busch but, even then, only a very weak version of malpractice reform known as House Bill 1299 passed. House Bill 1299 had provisions requiring mandatory mediation and, most importantly, an enhanced certificate of merit provision for malpractice cases and a mandatory deduction of past medical expenses paid by third parties such as Blue Cross. However, even this watered down version was not accepted as the Senate Judicial Proceedings Committee turned thumbs down on the bill.

MedChi’s malpractice proposal sought to regulate payouts – reduction in the non-economic damages cap to \$350,000, payouts over time through structured settlements, future economic awards based on actual losses and regulation of attorney contingent fees so patients

would get a greater percentage of award. These proposals were countered by the Maryland Trial Lawyers Association. The principal “trial lawyer” bill was Senate Bill 545 filed by Senator Miller and its companion bill (House Bill 1300) filed by Delegate Hurson. This bill would “compress” the rates that MedMutual and other malpractice insurers may charge between specialties. The highest rated specialty could be charged no more than 6 times the lowest rated specialty. The effect of this bill would be to raise the rates of 90% of the doctors in order to decrease the rates of 10% of the doctors. No other state in the country mandates this. MedChi persuaded the Legislature that this legislation was the equivalent of rearranging the deck chairs on the Titanic. However, it is indicative of the debate to come.

The Governor has stated in the newspapers that he may call a “special session” to address malpractice reform; it appears more likely that he will establish a high level task force to study the issue and come up with solutions over the summer. However, the real stumbling block on malpractice reform is the Senate leadership starting with Senator Miller and including Senator Brian Frosh, the Chairman of the Judicial Proceedings Committee. While there is strong opposition to reform in the House of Delegates, it appears that a victory in the closely divided House Judiciary Committee is possible and a strong win in the full House of Delegates is probable.

Malpractice reform was the chief medical issue before the General Assembly although there were numerous health related bills. The **Community Health Care Access and Safety Net Act of 2004** (House Bill 1271) **failed in the final hours of the Session**. Introduced by Chairman of the House Health and Government Operations Committee John Hurson with a Senate crossfile (Senate Bill 715), this bill quickly became the health care access reform legislation of the session. The bill in its final form as amended by the Senate through the leadership of Chairman Middleton, provided for a number of significant initiatives to enhance access and coverage for the uninsured. House Bill 1271 would have been funded by a 2% premium tax on HMOs.

The revenues from this tax would have: 1) established a two year commission to look at a number of issues relative to enhancing access to care for the uninsured through community health resources; 2) dedicated \$20 million in new revenues in 2005 for increasing Medicaid reimbursement rates for specialty services with \$25 million dedicated in subsequent years to maintain that increase; 3) dedicated \$5 million per year in operating grants for community health resources; and 4) expanded Medicaid to the parents of MCHIP children up to 150% of poverty over three years. Community health resources as defined in the bill included Federally Qualified Health Centers, programs such as the REACH initiative in Anne Arundel County, community based clinics such as the Primary Care Coalition clinics in Montgomery County, and other community based programs and providers who historically serve the uninsured. Historic providers as defined in the Medicaid program were included as community based health resources.

Since the funding for the bill came from the imposition of a 2% premium tax on HMOs, it faced an almost certain veto from Governor Ehrlich who has expressed his opposition to increased taxes. However, it never reached his desk due to last day opposition in the Senate.

This bill was one legislative “answer” to the **Health Care for All** initiative which continues to lack significant legislative support. Given its failure, there seems little likelihood that legislation covering the uninsured will be successful in the near future.

Another “answer” to the issue of the uninsured was legislation directing the Maryland Health Care Commission to develop a **limited benefit** health insurance policy (Senate Bill 570) in the small group market (less than 50 employees). This limited benefit policy is designed for small employers who do not offer the Comprehensive Standard Health Benefit Policy (CSHPB) and would not exceed 70% of the cost of the CSHPB. The bill now awaits the Governor’s signature.

A full listing of all legislation is available on MedChi’s website. Below is a listing of other issues of interest.

There were “scope of practice” issues as in previous years but not the number previously seen. Once again, the **optometrists** tried to increase their “scope of practice” and, once again, were defeated by the **ophthalmologists** in the House Health and Government Operations Committee. **Pharmacists** will, however, be able to administer flu shots just as nurses and physician assistants are now permitted to do. **Podiatrists** will be paid the same as orthopedists for the same service (the Maryland Orthopedic Society agreed to this proposal).

A successful MedChi initiative was legislation to clarify that doctors are allowed to collect **Medicare copays** in spite of Maryland’s HMO law which prohibits balance billing of HMO patients. This legislation clarifies a longstanding dispute.

The **Prescription Drug Safety Act** (House Bill 433) – opposed by MedChi in its original form – passed in a greatly modified form; as enacted, the bill simply required prescriptions to be “legible.” It also directed the Health Department to convene a workgroup of interested parties for the purpose of making recommendations to the General Assembly by November 1, 2004 on the future regulation of prescriptions.

House Bill 86 awaits the Governor’s signature; it establishes the **Office of Minority Health and Health Disparities** in the State Health Department and requires the new office to direct efforts to reduce health disparities occurring in the minority community.

The **Indoor Air Act of 2004** (Senate Bill 140/House Bill 260) which would have stopped smoking in restaurants and bars died in the Senate Finance Committee by a 6-5 vote in February. However, Senator Thomas “Mac” Middleton, the Chairman of the Committee, vowed to change his vote next year unless there was significant voluntary compliance by the restaurant industry in offering non-smoking alternatives.

The **open-heart surgery** battle of prior years occurred again but in a different form. Three hospitals (St. Joseph’s, Sinai and Prince George’s) tried to pass a bill, which would stop a research trial being proposed by the Maryland Health Care Commission to allow angioplasty to be performed on certain patients having heart attacks in community hospitals. This was a reprise of the “have” vs. “have not” hospitals; on this occasion, the “have not” hospitals were victorious.

The Maryland Health Care Commission is therefore permitted to consider research into the expansion of angioplasty services in community hospitals.