LAW OFFICES
SCHWARTZ, METZ & WISE, P.A.
A PROFESSIONAL ASSOCIATION

10 WEST MADISON STREET
BALTIMORE, MARYLAND 21201
www.schwartzmetz.com

BALTIMORE
TELEPHONE: 410-244-7000
FACSIMILE: 410-332-4505

ANNAPOLIS
TELEPHONE: 410-269-1618
FACSIMILE: 410-269-5443

MedChi Final Report

April 13, 2009

The 426th General Assembly Session adjourned *Sine Die* at midnight on Monday, April 13th. MedChi's Legislative Agenda was extremely aggressive and resulted in the passage of several significant pieces of legislation and the demise of several adverse proposals.

Two years ago, MedChi persuaded the O'Malley Administration to file a bill creating the Governor's Task Force on Health Care Access and Reimbursement (dhmh.maryland.gov/hcar/). That Task Force met from the fall of 2007 until the early winter of 2008 and made a number of significant proposals to improve the status of Maryland's physicians. Those proposals were contained in the final report and recommendations of the Task Force (December 2008 – dhmh.maryland.gov/hcar/html/reports) and resulted in the initiation of several legislative initiatives including the following:

1. Senate Bill 627 / House Bill 714 (*Loan Assistance Repayment and Practice Assistance for Physicians*) was enacted which provides for the creation of a state specific loan assistance program for physicians who will practice in a state defined shortage area. The legislation is particularly directed toward primary care which is broadly defined as including family medicine, internal medicine, obstetrics, pediatrics, geriatrics, emergency medicine and psychiatry. There currently exists a federal program for loan assistance repayment but it is extremely limited with respect to the practice type and geographical areas covered as well as the monies dispensed. The intent of the Task Force legislation was to create a well-funded state program by the assessment on all hospital bills in Maryland of .1% to fund the program. **It is estimated that such an assessment will raise between $10-13 million per year (as opposed to the present $500,000 received from the federal program in 2008).** While Senate Bill 627 / House Bill 714 have established the legal vehicle for the new program, it will be up to Health Secretary John Colmers to persuade Federal CMS officials that an assessment on hospital rates for these purposes is acceptable in light of the rules regarding Maryland's unique Medicare waiver with respect to its hospital rate setting system. In essence, Secretary Colmers will have to demonstrate that assisting primary care physicians will be beneficial to controlling the hospital costs in Maryland. As Chairman of the Governor's Task Force, he is firmly dedicated to this goal and, hopefully, Maryland will have this assistance program up and running in short order.

2. Senate Bill 380 / House Bill 255 (*Health Maintenance Organizations - Payments to Nonparticipating Providers*) establishes a new payment methodology for non-par doctors treating Maryland HMO patients. Since doctors are not allowed to "balance bill" HMO

patients, the Legislature has required HMOs to pay charges according to a statutory formula. The Governor's Task Force "increased" this statutory formula in order to arrive at what it felt was a fair reimbursement schedule. **It was projected by the Task Force that the additional compensation to doctors will be between $17-25 million annually as a result of the new formula.** Essentially, for certain codes (evaluation and management), the new formula requires the HMO to pay the greater of 140% of Medicare or 125% of the average rate paid to a contracting doctor. For all other codes, the new formula requires HMOs to pay 125% of the average paid to contracting doctors. While the 125% calculation existed in the past, most HMOs would figure the 125% on the basis of the lowest contract and not on the basis of the average contract. Experience indicates that the change from "lowest" to "average" will increase reimbursement by approximately 10% over present levels.

3. Senate Bill 661 / House Bill 526 (*Health Insurance - Use of Physician Rating Systems by Carriers*) was enacted and provides that insurance carriers who use "rating systems" of physicians will be required to observe detailed guidelines and to provide and pay for an "independent ratings examiner" to determine whether a rating is correct or not. The legislation provides detailed guidelines requiring a carrier to disclose clearly to enrolling physicians what portion of a physician's rating results from "cost efficiency" as opposed to "quality of performance." Moreover, "quality of performance" must be based on recognized evidence-based or consensus-based clinical guidelines. A physician will be entitled to receive detailed information as to how his or her "ranking" was determined and a ranking must make appropriate risk adjustments to account for patient population.

   This legislation basically codifies the Consent Agreement reached between the Attorney General of the State of New York and various national insurance carriers which was the result of complaints from the New York Medical Society that ratings were unfair and slanted toward "cost" as opposed to "quality" indices.

4. Senate Bill 646 / House Bill 526 (*Credentialing of Health Care Providers by Managed Care Organizations, Insurance Carriers, and Hospitals*) was enacted and designed to assist the speed of credentialing activities by recognizing certain uniform credentialing forms to be used by insurers (including managed care organizations) and hospitals. Major challenges with respect to credentialing remain because of the different requirements applicable to hospitals as opposed to insurance intermediaries and, further, because of the requirement of primary source verification where there is no accepted repository for primary source information.

While the Governor's Task Force formed the predicate for most of MedChi's positive Legislative Agenda, other initiatives were actively promoted, including Senate Bill 852 / House Bill 1647 (*Health Insurance - Assignment of Benefits - Notice and Report*). The principal reason that this legislation was not successful was the concern of legislators that the bill will encourage doctors to become non participating (because they will receive an insurance check whether they are participating or not) and, as a non participating doctor, will "balance bill" patients for the amount of their bill which is not covered by the assigned insurance benefit. It appears that very few assignment of benefits laws have passed in the 50 states. **When it became clear that the**

legislation would not be favorably enacted, MedChi persuaded Thomas "Mac" Middleton, the Chair of the Senate Finance Committee, and Peter A. Hammen, Chair of the House HGO Committee, to write a joint letter requesting that the issue be studied over the interim leading up to the 2010 Session by the Joint Committee on Health Care Delivery & Financing. This is the same committee that studied the Maryland small group insurance market last year and came up with legislative reform of that market which is described below. We believe that the interim study will serve as a springboard for success in 2010.

The subject of electronic health records was addressed by Senate Bill 744 / House Bill 706 (*Electronic Health Records - Regulation and Reimbursement*) which was enacted and provides the development of regulations by the Maryland Health Care Commission directing insurance payers to provide "incentives" (increased reimbursement) to physicians to develop electronic health records. The Maryland Health Care Commission and various elected officials recognize the "cost" of electronic health records is borne by physicians with considerable benefits to health insurance carriers. The purpose of Senate Bill 744 / House Bill 706 is to provide a process by which the various insurance payers recognize and pay for the benefits they receive from electronic health records and further, a deadline for all physicians who participate with insurance carriers to switch to interchangeable electronic health records. The state initiative will be coordinated with the recent federal legislation. MedChi added amendments to this legislation to "exempt" physicians who do not participate with insurance companies and, further, to delay any implementation of a state only system until the federal law mandates are effective.

<u>The "Bad Ones" That Didn't Get Away</u>

MedChi's Legislative Agenda is historically the most aggressive agenda of any interest group in the General Assembly in that MedChi's lobbyists are annually directed to "pass" a significant number of bills. Most interest groups are happy to report that no "bad" bills passed and rarely report the passage of a significant piece of legislation.

The "bad" bills were many in 2009 but none was more significant than the #1 priority of the Maryland Trial Lawyers Association which was House Bill 237 / Senate Bill 505 (*Health Care Malpractice - Noneconomic Damages*). These proposals would have doubled the allowable cap on noneconomic damages in a wrongful death case (the cap in wrongful death actions is presently $825,000 and it would have been doubled to $1,750,000 if this legislation passed). The trial lawyer argument is that in all other wrongful death actions – except those arising from medical malpractice – the higher dollar amount applies. The successful MedChi argument was that "medical malpractice" cases deserved special treatment because there had been special problems over the years with the latest iteration being the Special Session on medical malpractice called by Governor Ehrlich in 2004/2005. That Special Session resulted in the passage of House Bill 2 which **reduced** the wrongful death amount from the higher level to the present level. Indeed, this was one of the principal "tort reforms" in House Bill 2 and the trial lawyers were seeking to undo it. House Bill 237 had a number of sponsors including 10 members of the 22 member House Judiciary Committee and seemed poised for passage.

MedChi lobbyists approached House Speaker Michael E. Busch, who had been one of the principal architects of House Bill 2 and was committed to preserving the reforms. Because of his

direct intervention, House Bill 237 never received a vote as he indicated to the House Judiciary Committee leadership that he would be voting against the bill if it was reported to the floor favorably (it is an extremely unusual occurrence for the House Speaker to vote against a bill favorably reported by a House Committee).

House Bill 155 (*Physicians - Licensure - Liability Coverage*) and House Bill 1198 (*Physicians - Outpatient Surgical Services - Hospital Privilege*) were related "bad" bills. In its original form, House Bill 155 would have required all doctors in Maryland to secure medical malpractice insurance as a condition of licensure. House Bill 1198 would have required any doctor performing outpatient surgery to have hospital privileges. Both of these bills were generated by the activities of a plastic surgeon in Baltimore County which resulted in the death of a patient. It turned out that the plastic surgeon had neither hospital privileges nor malpractice insurance. It appears that House Bill 1198 also had an additional motive which was to discourage or limit certain physicians from performing certain procedures.

House Bill 1198 was withdrawn by its sponsor after a hearing in which MedChi raised numerous objections. House Bill 155 – despite MedChi's objection – passed the House of Delegates although in a substantially amended form. As passed by the House of Delegates, the malpractice insurance requirement would have only been applicable to those physicians performing surgery in an "ambulatory surgery center." Despite these amendments, MedChi's objections continued, particularly as passage of the bill would have resulted in a first time ever requirement for malpractice insurance as a condition of medical licensure. The Senate EHE Committee agreed with MedChi and turned thumbs down on the bill.

The same committee had also rejected Senate Bill 882 (*Physicians - Professional Liability Insurance Coverage - Notification and Posting Requirements*). Senate Bill 832 required a physician to disclose to patients the absence of medical malpractice insurance. MedChi preferred the disclosure approach to the approach promulgated by House Bill 155.

Finally, particularly "bad bills" were the Governor's False Claims bills (Senate Bill 272 / House Bill 304 - *Maryland False Health Claims Act of 2009*) as well as related, but even more expansive, measures (Senate Bill 830 / House Bill 915 - *Maryland False Claims Act*). These were a cluster of bills which would have allowed "whistleblower" lawsuits against hospitals, doctors and pharmaceutical companies for alleged fraud. Fraud, of course, is in the eye of the beholder and many "fraud" cases are really billing disputes between an insurance company and a physician's practice. The main entry in this debate was Senate Bill 272 which was part of Governor O'Malley's Administration package. It died on the floor of the Senate by a vote of 23 – 24 and was never resurrected. Perhaps in retribution, the Governor's budget reduced hospital payments by $10 million and physician Medicaid reimbursement by $4.5 million. While such amounts may seem substantial, these "cuts" will be for one year only and the defeated bill would have been forever.

Small Group Health Insurance Reform

The General Assembly enacted the most substantive reforms of the Maryland Small Group Market since it's creation in 1993.

The number of people insured in the small group market has been dropping. All bills were designed to increase flexibility in the Maryland Small Group Market for the purpose of attracting small employers who have either stopped providing or had never provided health insurance for their employees. The rationale for most changes was that there had to be lower premiums to attract these groups. It remains to be seen if these reforms will result in the desired participation and whether these reforms could make the insurance unaffordable for groups presently participating in the Small Group Market.

Senate Bill 637/House Bill 674 (*Small Group Market Regulation - Modifications*) established a number of changes including the following:

- The limitations on pre-existing conditions were fundamentally rewritten so that small group policies may limit coverage for all groups. In addition, pre-existing conditions (with the exception of pregnancy) could be imposed on a small group employer who is entering the market for the first time and had not offered a health benefit plan to its employees in the preceding 12 months;

- The current "rate bands" (plus or minus 40%) relate to the variation in premium which can occur because of age or geography in the small group market. The rate bands were increased to plus or minus 50% with plus or minus 55% in 2013. The new increased rate bans will still apply only to age and geography.

- However, "health status" will be applied to a small employer who is not offered a health benefit plan to its employees in the 12 months prior to initial enrollment in the small group market. With respect to such employers, there may be an additional "health status" adjustment of 10% in the first year of enrollment, 5% in the second year and 2% in the third year with the "community rate" applying thereafter (subject to the new rate bans of plus or minus 50% for age and geography). It is likely that proposals in future years will include an expansion of the "health status" factor.

- The Maryland Health Care Commission (MHCC) was directed to maintain on its website comparison of premiums for those carriers issuing health benefit plans to small employers;

- In addition to these changes, Senate Bill 638/House Bill 610 (*Health Insurance - Bona Fide Wellness Programs - Incentives*) provided for increased wellness program incentives for up to 20% of the cost of coverage.

While the issue of increasing the "medical loss ratio" for insurance carriers was not favored, Senate Bill 79 (*Health Insurance Reform*) did create a formal study by the Maryland Insurance Administration, in consultation with the Maryland Health Care Commission and appropriate stake holders to study options to raise or define medical loss ratio requirements in the individual, small group and large group health insurance markets. The results of the study are to be reported to the appropriate committees of the General Assembly by December 1, 2009. It is expected that "medical loss ratio" reform will be a prominent and perhaps successful issue in 2010.

Other Items of Interest

House Bill 498 (*Professional Service Corporations - Corporate Names - Approval by Professional Organizations*) was introduced at MedChi's request. It repealed a requirement that MedChi approve of certain corporate names of physician groups. An amendment also relieved the Board of Physicians from this approval requirement, something MedChi did not believe was good policy but went along with in order to eliminate the legal liability imposed on MedChi in its approval capacity. This bill passed at 11:54 p.m., 6 minutes before adjournment due to the last minute efforts of MedChi lobbyist, Steve Wise.

House Bill 1150 (*Health Occupations – Anatomic Pathology Services Billing),* a controversial MedChi agenda item was resolved to the satisfaction of all interested parties. In 2008, legislation was passed that limited direct billing for anatomic pathology under certain circumstances. Direct billing for pap smears was affected and created the potential for an unintended increase in patient costs. Following a collaborative dialogue with all interested parties, a compromise was reached. Passage of the legislation will enable physicians to direct bill for pap smear testing provided they comply with Maryland's existing disclosure laws and AMA Ethics Guidelines for the direct billing of laboratory services.

House Bill 72/Senate Bill 98 *(Delegate John Arnick Electronic Communications Traffic Safety Act)* passed after a number of attempts in previous years. It prohibits sending a text message while operating a motor vehicle. MedChi has consistently supported this legislation and its passage fulfills a MedChi House of Delegates Resolution.

House Bill 250/Senate Bill 759 (*Pubic Health – Certificates of Death – Nurse Practitioners)* would have authorized nurse practitioners to determine incapacity, effectuate advance directions, and countermand MIEMSS DNR forms. The bill also provided a technical correction to nurse practitioners' authority to sign death certificates. MedChi opposed all provisions except the technical correction related to death certificates and only the death certificate correction was enacted.

House Bill 180/Senate Bill 160 (*Hereditary and Congenital Disorders – Newborn Screening)* would have negatively impacted Maryland's nationally recognized newborn screening program. The bill required compulsory testing for certain "treatable disorders" and consent for disorders for which there is no effective treatment. MedChi opposed this bill as it would have led to confusion, administrative complexity and resulted in fewer newborns being screened. The bill was defeated in the Senate and withdrawn in the House.

House Bill 1468 *(Public Health Surveillance – Confidentiality)* provides confidentiality protection to information gathered subsequent to an initial report by a physician under the communicable disease reporting requirements enacted last year. A stakeholder workgroup was held during the interim to address concerns about confidentiality. This legislation, supported by MedChi, provides subsequently gathered information the same confidentiality protection provided the initial report.