

SCHWARTZ, METZ & WISE, P.A.

ATTORNEYS

20 WEST STREET
ANNAPOLIS, MARYLAND 21401

TEL: 410-244-7000

FAX: 410-269-5443

MedChi Final 2020 Session Report

March 19, 2020

Amidst the COVID-19 pandemic, the General Assembly adjourned Sine Die three weeks early on Wednesday, March 18, 2020. In the final days, several actions were taken to assist the Governor and his Administration in addressing the pandemic. The Governor's Fiscal Year 2021 budget contains \$10 million for the pandemic and the General Assembly passed and the Governor already signed ***Senate Bill 1079 (Chapter 12): State Budget – Revenue Stabilization Account Transfers – Coronavirus (passed)***, which allocates an additional \$50 million from the Rainy Day Fund to assist in the fight against the virus.

The General Assembly has also passed ***Senate Bill 1080/House Bill 1663: State Government – State of Emergency and Catastrophic Health Emergency – Authority of Governor and Unemployment Insurance Benefits (COVID-19 Public Health Emergency Protection Act of 2020) (passed)***, which is an emergency bill that authorizes the Governor, for the duration of the emergency, to take specified actions, including:

- Prohibiting cost-sharing by carriers for COVID-19 testing (and associated costs) conducted based on testing protocols recommended by the Secretary of Health.
- Ordering the Maryland Department of Health (MDH) to cover the cost of COVID-19 testing and associated costs if the costs would not otherwise be paid for by a carrier or another third-party.
- Requiring carriers and Medicaid to cover a COVID-19 immunization (should one be determined to prevent the disease) and any associated costs, without cost-sharing, if the patient belongs to a category of individuals to whom MDH has determined cost-sharing should not apply.
- Establishing or waiving telehealth protocols for COVID-19, including authorizing health care professionals licensed out-of-state to provide telehealth to patients in the State.
- Ordering MDH to reimburse synchronous and asynchronous telehealth services for COVID-19 provided to a patient, without regard to whether the patient is at a clinical site, if the service is covered by Medicaid, provided by a participating Medicaid provider, and authorized under the health care provider's scope of practice.
- Consulting, as appropriate, with MDH, the Maryland Insurance Commissioner, and the Maryland Health Benefit Exchange (MHBE) to develop and implement orders relating to

COVID-19 to minimize disruption in enrollment in health insurance and Medicaid, facilitate reimbursement by carriers of telehealth services provided to patients in the State, and facilitate reimbursement of essential services to minimize the risk to public health.

- Prohibiting a retailer from increasing the sale or rental price of any good or service to a price that increases the retailer's value of profit by more than 10%, including food, fuel, water and ice, medicine, medical supplies and equipment, cleaning products, building supplies and equipment, energy sources, and storage space (will be prosecuted under Commercial Law as an unfair, abusive and deceptive trade practice).
- Prohibiting an employer from terminating an employee solely on the basis that the employee has been required to be isolated or quarantined.
- Ordering the MDH to authorize an alternative work week for an employee of a health care facility that is owned or operated by the MDH and open 24 hours a day and 7 days a week or is subject to the Memorandum of Understanding with the American Federation of Teachers. If the Governor orders MDH to authorize an alternative work week the alternative work week may allow the employee to work hours or shifts that are not typical for State employees and work less than 40 hours in a week. An employee who is authorized to work an alternative work week is considered a full-time employee of the State, notwithstanding any other provision of law; and is entitled to compensation for overtime work in accordance with § 8-305 of the State Personnel and Pensions Article. For the purposes of § 8-305 of the State Personnel and Pensions Article, the time worked by an employee who is authorized to work an alternative work week includes only the hours actually worked and does not include paid leave hours taken by the employee during the work week.

The bill also states that the Secretary of Labor may determine that an individual, who need not separate from the individual's employment, is eligible for benefits if: (1) the individual's employer temporarily ceases operations due to COVID-19, preventing employees from coming to work; (2) the individual is quarantined due to COVID-19 with the expectation of returning to work after the quarantine is over; or (3) the individual leaves employment due to a risk of exposure or infection of COVID-19 or to care for a family member due to COVID-19.

House Bill 448/Senate Bill 402: Health Care Practitioners – Telehealth and Shortage (passed) is an example of how changing circumstances can alter the path of a bill in a hurry. As introduced, the bill was opposed by MedChi and others as being an overreach due to the bill changing current regulations that require an in-person visit. Under the bill, an in-person visit would no longer be required to allow asynchronous interaction alone, subject to the standard of care. MedChi expressed caution about moving too quickly in allowing medicine to be practiced solely using apps and other electronic means. However, with the onset of COVID-19, the use of telehealth became more urgent. MedChi and the other parties' concerns regarding asynchronous communications were quickly cast aside as a result. The General Assembly not only passed the bill but made it an emergency bill, which will go into effect upon the Governor's signature. The bill was amended, however, to prohibit the use of telehealth in prescribing a Schedule II opiate

unless there is a declared catastrophic emergency or the individual who is prescribed the opiate is a patient in a certain health care facility.

Fiscal 2021 Budget

Despite extreme pressure from other budgetary demands (e.g., Kirwan funding, COVID-19 and the forecasted structural deficit), MedChi successfully secured an additional \$4 million in funding to maintain E&M Codes at the current level of 93% of Medicare. This success is particularly notable given that the General Assembly completely eliminated any further reductions to the hospital Medicaid Deficit Assessment after Fiscal Year 2021, setting it at \$294,825,000 for this fiscal year and each year moving forward. Previously, the agreement was to phase-out the Assessment by \$25 million each fiscal year. Other notable funding was the restoration of the Community Health Resources Commission (CHRC) budget. The CHRC currently is funded at \$8 million. The Administration proposed to reduce that amount to \$4 million in *House Bill 152/Senate Bill 192: The Budget Reconciliation and Financing Act (passed)*. The General Assembly rejected the reduction and restored the amount to the original \$8 million but requires that \$1 million be used to support Local Health Improvement Coalitions.

In addition to funding, several reporting requirements were included in the budget, including:

- Requiring the MDH and each managed care organization to provide information on the results of the change that removed fibrosis restrictions for accessing new Hepatitis C therapies – Report due January 15, 2021.
- Requiring the Health Services Cost Review Commission (HSCRC) to report on the effectiveness of the Maryland Primary Care Program given its role in transforming care under the Total Cost of Care Model. The evaluation should focus on cost-savings from the Program reducing unnecessary utilization or hospitalization for patients participating in the Program over the increased expenditures from provider incentives – Report due October 1, 2020.
- Requiring the HSCRC to report on how it intends to manage hospitals that are generating excessive operating profits under regulated rates under the Total Cost of Care Model. The report should detail its policy on the appropriate level of hospital profits, detail tools available to regulate hospital profits and outline future plans to employ these strategies to contain regulated profits – Report due October 1, 2020. On a related note, *Senate Bill 42: Health Services Cost Review Commission – Duties and Reports – Revisions (passed)* modifies the timing and required information in the HSCRC reports. MedChi had the bill amended to require a report on the partnerships formed between hospitals and community-based physicians, community organizations and post-acute care providers under the Total Cost of Care Model.

- Requiring the University of Maryland Medical System to submit a report to the budget committees and the Joint Audit and Evaluation Committee detailing specific responses to findings and recommendations contained in the March 2020 Office of Legislative Audits Special Review of Board of Directors Activities and the December 2019 Special Committee of the Board of the University of Maryland Medical System internal forensic audit report undertaken with advice by Latham and Watkins, LLP – Report due October 1, 2020.
- Requiring the HSCRC to fund an independent actuarial analysis of the State’s hospital medical liability market, including: (1) the cost of hospital self-insurance programs including the availability, adequacy and affordability of hospital reinsurance in the State; (2) an examination of hospital reinsurance climates in other states and the ability of states to maintain adequate access to hospital reinsurers; (3) the impact on Maryland’s medical liability climate of implementing each of the provisions of California’s Medical Injury Compensation Reform Act; and (4) recommendations on how to stabilize the hospital liability market in the State to ensure both continued access to essential services and success under Maryland’s Total Cost of Care Model – Report due September 15, 2020.

Boards and Commissions

Board of Physicians

MedChi spent a substantial amount of time addressing efforts by the Maryland Hospital Association (MHA) and the University of Maryland-Baltimore (UMB) to increase the amount of physician license fees used to fund the Maryland Physician and Physician’s Assistant Loan Program (LARP). LARP provides loan assistance to physicians and physician’s assistants who agree to work in underserved areas for a minimum of 2 years, and all State monies up to \$1 million receive a federal match. MedChi has always supported the annual transfer of \$400k in license fees to LARP, and further supports additional monies going to the program because the need is clearly there, but the funding source should not be physician license fees alone. With the majority of LARP recipients working in hospitals, they along with the medical schools also have a funding role to play.

MHA and UMB mounted a two-front effort: 1) They pushed for another \$400k to be taken from the Board of Physicians Fund Balance through *House Bill 152/Senate Bill 192: Budget Reconciliation and Financing Act*, and 2) sought a statutory change through *House Bill 998/Senate Bill 501: Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants – Administration and Funding (passed)* that would permanently take \$1 million in license fees every year for LARP. After hours of negotiations and meetings, the House Appropriations Committee helped us amend the legislation, limiting the increase to \$1 million to FY 2022. In the meantime, a workgroup is established under the bill to examine ways to fund LARP at a higher level. MedChi has a seat on the workgroup.

House Bill 560/Senate Bill 395: State Board of Physicians and Allied Health Advisory Committees – Sunset Extension and Program Evaluation (passed) ensures that the Board

remains statutorily authorized for 10 more years. This bill stems from a review of the Board ordered last year by the General Assembly. MedChi effectively used this review to address several longstanding issues with Board disciplinary matters. First, we reached agreement with Board leadership to evaluate an expungement program in coordination with MedChi for physicians with minor infractions. Second, the Board is required to evaluate and report back to the General Assembly on the use of a third peer reviewer when the two initial reviewers do not agree. Other changes were made to the Board's governing statutes as well, though most of these were to update it and make it more efficient.

House Bill 259/Senate Bill 103: Health Occupations – Diagnostic Evaluation and Treatment of Patients – Disciplinary Actions (The Patient's Access to Integrative Healthcare Act of 2020) (passed) had substantial amendments worked out between the integrative medicine advocates (which included physicians), MedChi and the Board of Physicians. This legislation originally proposed to establish a separate disciplinary process for those who practice integrative medicine, but that term was undefined, and the alternative disciplinary process was full of holes through which purely bad actors could escape. The amendments simplified the bill to state that a professional board cannot act against a practitioner “solely” because they use integrative methods, and that the standard of care must still be observed.

Scope of Practice

House Bill 428: Health Occupations – Podiatric Physicians (failed) would have allowed podiatrists to use the term “podiatric physician”, as is done in numerous other states. MedChi opposed the bill and argued that the term “physician” should be reserved to M.D.'s and D.O.'s. In the end, we were able to hold the bill off this year. But, in a letter from the House Health & Government Operations Committee (HGO) Chair Shane Pendergrass to MedChi CEO Gene Ransom, it was made clear that 2021 will produce a different result, barring new or additional information that weighs against passing the bill.

While MedChi was successful in narrowing the scope of this bill, ***House Bill 656/Senate Bill 545: Pharmacists – Administration of Self-Administered Medications and Maintenance Injectable Medications (The Christopher King Access to Treatment Act) (failed)*** did not emerge from the Senate Committee. In addition to limiting the bill's scope, MedChi amendments would have required the prescriber administer the initial dose in order to guard against bad outcomes from adverse reactions.

House Bill 1594/Senate Bill 440: Pharmacists – Aids for the Cessation of Tobacco Product Use (failed), as introduced, would have allowed pharmacists to prescribe tobacco cessation products. The Senate amended the bill to reduce this authority to nicotine replacement therapies. The House took no action on the Senate Bill, and the House Bill never emerged from the Rules Committee where it was sent due to late introduction.

House Bill 937: Naturopathic Doctors – Formulary Council Membership, Formulary Content, and Scope of Practice (failed) also died in the HGO Committee. MedChi opposed this legislation and argued that naturopaths, with no residency and limited pharmacology background

should not be prescribing, and that prescription drugs are essentially anathema to their scope of practice.

House Bill 1040/Senate Bill 763: State Board of Physicians – Genetic Counselors – Licensing (failed) would have licensed genetic counselors in Maryland, as numerous other states have done. MedChi supported the bill but with amendments to make clear that genetic counselors would have to refer patients as needed to other providers and clarifying that they could not diagnose or treat an illness, disease or condition. Senator (and Doctor) Clarence Lam was the Senate sponsor and readily accepted these amendments. The bill passed the Senate but died in the House.

House Bill 935/Senate Bill 728: Freestanding Ambulatory Care Facilities – Administration of Anesthesia (passed), which was aimed at ensuring that proper levels of anesthesia are available for the procedures being performed in ambulatory surgery centers. With the advent of the Total Cost of Care Model, more procedures are being performed in ambulatory surgery centers. The operating rooms in these centers are now more heavily utilized, and this has also increased the volume of cases being managed in procedure rooms, which are not designed for the same level of procedures as an operating room. After significant amendments to the bill to clarify the language, this legislation passed, and regulations will be developed.

House Bill 1461: Behavioral Health Programs – Outpatient Mental Health Centers – Medical and Clinical Directors (failed) would have established the roles of Medical Directors and Clinical Directors in outpatient mental health centers and required that the medical director of an outpatient mental health center be a licensed and appropriately trained physician. This legislation was in response to a bill passed in 2019 that allowed nurse practitioners to serve as “medical directors”. House Bill 1461 died in the House Committee.

Senate Bill 355/House Bill 530: Health Occupations – Pharmacists – Administration of Vaccinations (failed) would have permitted pharmacists to administer vaccines to minors age 9 and older without a physicians’ prescription. It was opposed by MedChi as it would have fragmented the delivery of comprehensive primary and preventative health care services to adolescents. Ironically, MedChi was joined in its opposition by the anti-vaccine community, particularly the anti-HPV activists.

Tort Bills

House Bill 684 and Senate Bill 187: Civil Actions – Health Care Malpractice Claims (failed) though not cross-filed, sought to accomplish the same goal. Both were supported by MedChi and would have adopted the *Daubert* standard for expert witness testimony, which is followed by federal courts and is generally regarded as providing a sounder and more reliable basis for expert testimony than the current Frye/Reed standard used in Maryland. In sum, the *Daubert* standard requires that parties and experts work harder to ensure that expert opinions are grounded in reliable science or demonstrable relevant experience. Both bills failed.

House Bill 1037: Civil Actions – Noneconomic Damages – Personal Injury or Wrongful Death (failed) which died in Committee, would have lifted the statutory limits on non-economic

damages if the plaintiff proved that the damages resulted from “willful, wanton, malicious, reckless or grossly negligent acts or omissions.” MedChi, MHA and other groups all opposed this legislation because these standards would produce inconsistent results, be unclear to juries and result in “limitless” avoidance of the cap. We argued that the cap was put in place to ensure medical liability remains affordable and that patients have access to care, and House Bill 1037 would undermine both policy goals.

Senate Bill 879/House Bill 1563: Public Health – Maryland Infant Lifetime Care Trust Funded by HSCRC and Maryland Patient Safety Center Duties (failed), which was the initiative by Maryland hospitals to address the marketplace implications of the \$200+million malpractice award against Johns Hopkins. It was a variation of the birth injury fund legislation that had been introduced in previous Sessions. The bill provided for attorney’s fees and addressed other issues raised by the opposition with respect to prior birth injury fund legislation. Despite these new provisions, the trial bar vigorously opposed the legislation and it failed in both Houses.

Taxes

MedChi supported ***Senate Bill 523: Income Tax – Pass-Through Entities and Corporations (passed)*** per a MedChi House of Delegates Resolution because it would help provide tax relief to many physician practices. The bill passed on the final day of the Session. The bill was necessary because the federal “Tax Cuts and Jobs Act of 2017” (TCJA) imposed a new \$10,000 limitation on the deductible amount of state and local taxes paid by an individual, resulting in individuals who are small business owners paying more than \$10,000 per year in combination of state income tax, property tax and other related taxes having a federal income tax payment higher than in prior years when these taxes were fully deductible on the federal return. This legislation essentially restores the federal tax deduction that previously existed, a tremendous benefit to these physician practices.

Health Insurance

A big relief this year, but an area for concern in the future was the withdrawal of ***Senate Bill 776: Health Insurance, Health Care Facilities, and Providers – Balance Billing – Limitations (failed)***. This bill would have significantly altered Maryland’s successful balance billing protections and, in their place, implemented provisions being considered at the federal level. The bill was withdrawn prior to a hearing.

Mandated Benefits/Coverage

The General Assembly passed three mandated benefit bills.

House Bill 781/Senate Bill 988: Health Insurance – In Vitro Fertilization – Revisions (passed) alters the requirements for a married patient to qualify for IVF benefits by (1) reducing the length of required involuntary infertility for the patient and the patient’s spouse from at least two years’ duration to at least one year’s duration and (2) for same sex couples, reducing the

number of required attempts of artificial insemination from six attempts over the course of two years to three attempts over the course of one year.

House Bill 852/Senate Bill 661: Health Insurance – Prostate Cancer Screening Services – Prohibiting Cost-Sharing (passed) prohibits carriers from applying a deductible, copayment, or coinsurance to coverage for preventive care screening services for prostate cancer, which must include a digital rectal exam and a prostate-specific antigen blood test.

Senate Bill 475/House Bill 447: Health Insurance – Pediatric Autoimmune Neuropsychiatric Disorders – Coverage (passed) requires carriers to provide coverage for a 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. A carrier is also prohibited from imposing annual deductibles, copayments, or coinsurance on the required coverage if they are not greater than those imposed by the carrier for similar coverage under the same health insurance policy or contract.

The uncertainty of rising drug costs was the demise for ***House Bill 134: Health Insurance – Prescription Insulin Drugs – Limits on Copayment and Coinsurance (failed)***. This bill would have placed a cap on an insured's cost sharing however, legislators and the insurers expressed concern regarding the high cost of insulin and were reluctant to take this step. ***Senate Bill 183: Health Insurance – Health Benefit Plans – Special Enrollment Period for Pregnancy (failed)*** never made it out of the Senate committee. This bill would have removed the requirement that a woman's pregnancy had to be confirmed by a health care practitioner for the woman to apply for benefits.

While not a so-called "mandated benefit," concern over the fate of the federal Affordable Care Act (ACA) prompted legislators to pass ***House Bill 959/Senate Bill 872: Health Insurance – Consumer Protections (passed)***. The bill is an emergency bill which codifies the patient protections contained in the ACA rather than simply referencing them in a cross-reference to the federal statute. During the 2019 Session, the Maryland Health Insurance Coverage Protection Commission was required to establish a workgroup to (1) monitor the appeal of the decision regarding the ACA and the implications of the decision for the State; (2) monitor federal enforcement of the ACA; and (3) determine the most effective manner of ensuring that Maryland consumers can obtain and retain quality health insurance. This bill generally implements the recommendations of the workgroup.

Continued concern over network adequacy issues in behavioral health prompted ***House Bill 455/Senate Bill 334: Health Insurance – Mental Health Benefits and Substance Use Disorder Benefits – Reports on Nonquantitative Treatment Limitations and Data (passed)***. While significantly narrowed, this bill requires carriers to submit two reports (March 1, 2022 and March 1, 2024) to the Insurance Commissioner to demonstrate compliance with the federal Mental Health Parity and Addiction Equity Act (Parity Act) and provide information on benefits. With regard to the latter, this report is limited to the frequency, reported by number and rate, with which the health benefit plan received, approved, and denied prior authorization requests and the number

of claims submitted for mental health benefits, substance use disorder benefits, and medical and surgical benefits in each Parity Act classification during the immediately preceding calendar year.

House Bill 729: Health Insurance – Payment of Clean Claims – Time Limit (failed) would have changed the prompt pay rules from 30 days to 3 days. The sponsor did offer an amendment to change it to 15 days. The bill failed to advance on concerns raised by carriers that: 1) Ninety-six percent of claims were paid within 14 days; and 2) for those not paid, the 30-day timeframe was needed.

Technology in Health Insurance

House Bill 512/Senate Bill 166: Drugs and Devices – Electronic Prescriptions – Controlled Dangerous Substances (passed) was a reintroduction from the 2019 Session. This bill requires all controlled dangerous substances (CDS) to be transmitted by electronic prescribing. MedChi successfully maintained the exemptions negotiated last Session and delayed the effective date until January 1, 2022 to allow time for physicians and others to comply.

Senate Bill 99: Health Insurance Benefit Cards, Prescription Benefit Cards, and Other Technology – Identification of Regulatory Agency (passed) is a bill requested by the Maryland Insurance Administration and requires carriers, as well as Medicaid managed care organizations, to print on a health insurance benefit card or prescription benefit card the abbreviation of the name of the State agency that regulates the policy or contract. While seemingly a small change, this will add both physicians and consumers in determining whether their health plan is regulated under the State laws.

House Bill 905: Prescription Drug Benefits – Use of Real-Time Benefit Check Technology (failed) would have required health plans to make this technology available and would have mandated use by prescribers by January 1, 2021. Real Time Benefit Check is a software integration tool that provides information at the time of prescribing on the drug cost to the insured, alternative therapies and costs and whether a prior authorization is required. While MedChi supports the technology, it raised concerns that the technology is not widely available to mandate it, especially given the lack of information regarding costs and accuracy.

House Bill 1486/Senate Bill 752: Public Health – Non-Controlled Substance Prescription Record System Program (failed) would have required dispensers to report all non-CDS prescriptions into a prescription drug database to allow physicians and other health care providers access to a patient’s complete medication history. Because of the late hearing of the bill and the interruption from COVID–19, this bill did not receive full discussion in the committees. Additionally, many advocacy groups raised privacy concerns regarding certain medications being included in the database without a sufficient opt-out clause.

Access to Health Insurance and Providers

After years of rate increases in the individual health insurance market, the General Assembly continues efforts to ensure Maryland residents have access to affordable health insurance. As introduced, House Bill 196/Senate Bill 124 would have created a subsidy program

in the individual health insurance market. However, concerns regarding cost implications caused the committees to alter the bill to a study. Therefore, ***House Bill 196/Senate Bill 124: Maryland Health Benefit Exchange – Assessment Applicability and Report on State-Based Individual Market Health Insurance Subsidies (passed)*** requires the MHBE, by December 1, 2020, to report information to the respective committees as it relates to establishing State-based individual market health insurance subsidies in the State. On a related note, budgetary limitations caused ***House Bill 930/Senate Bill 977: Maryland Health Benefit Exchange – Funding for Small Business Insurance Subsidies and Outreach (failed)*** to fail. This bill would have required the Governor, beginning in fiscal 2022, to provide an annual general fund appropriation of \$17 million for the MHBE, including \$15 million to fund subsidies in the Small Business Health Options Program (SHOP) and \$2 million to fund small business outreach activities for the SHOP Exchange.

House Bill 601: Health Insurance – Provider Panels – Providers of Community-Based Health Services (passed) provides that a carrier may not reject a provider who provides community-based health services for a program accredited for participation on the carrier's provider panel solely because the provider is a registered psychology associate. A similar bill, however, failed. ***House Bill 1165/Senate Bill 484: Health Insurance – Provider Panels – Coverage for Nonparticipating Providers (failed)*** would have required carriers to cover mental health or substance use disorder services provided by a nonparticipating provider at no greater cost to the member than if the services were provided by a participating provider, under specified circumstances.

As expected, bills that would have created a State mandated health plan or universal coverage failed – ***House Bill 188: Public Health – State-Provided Health Care Benefits (failed)***; ***House Bill 1648/Senate Bill 1064: Public Health – Healthy Maryland Program – Establishment (failed)***; and ***Senate Bill 228: Public Health – Commission on Universal Health Care (failed)***.

Prescription Drugs, Costs and Coverage

Two bills introduced on behalf of the Prescription Drug Affordability Board passed. ***House Bill 1095/Senate Bill 669: Public Health – Prescription Drug Affordability Board and Fund (passed)*** requires the board to assess and collect an annual fee on pharmacy benefit managers, carriers and wholesale distributors and manufacturers that sell or offer for sale prescription drug products to persons in the State to fund the board. All fees must be paid to the newly established Prescription Drug Affordability Fund. In addition, ***House Bill 1100: Prescription Drug Affordability Board – Meetings, Legal Advisor, Reports and Technical Changes (passed)*** requires the Board to meet four rather than six times a year, requires the Attorney General to provide legal counsel, and extends the timeframe for required reports by one year given the delay in start-up.

Issues related to reimbursement levels and insurance coverage caused ***House Bill 943/Senate Bill 871: Mail Order and Specialty Drugs – Physician Dispensing (failed)*** to be referred for additional study over the interim. Legislators requested physicians, pharmacy benefit managers and carriers to work together to resolve these issues. This bill would have allowed a physician with a dispensing permit to obtain specialty drugs directly through a distributor/manufacturer rather than from a specialty pharmacy.

Regarding specialty drugs, *House Bill 652/Senate Bill 931: Maryland Medical Assistance Program and Health Insurance – Specialty Drugs – Definition (passed)* became an emergency bill and alters the definition of specialty drugs to exclude drugs to treat diabetes, HIV, and AIDS. The bill was amended to prohibit a carrier from imposing a copayment or coinsurance requirement on a prescription drug prescribed to treat diabetes, HIV, or AIDS that exceeds \$150 for up to a 30-day supply of the drug, with an adjustment mandated each year.

Public Health

Minor Consent and Immunizations

There were a number of bills related to minor consent, which is always a challenging issue regardless of the basis for the legislation. *House Bill 87/Senate Bill 135: Public Health – Immunizations – Minor Consent (Access to Vaccines Act) (failed)* was supported by MedChi and would have granted minors age 16 and older the right to consent to vaccinations. The anti-vaccine community, especially those opposed to the HPV vaccine, coupled with parental rights advocates aggressively opposed the legislation and it was withdrawn without a vote.

House Bill 782/Senate Bill 611: Health – Mental and Emotional Disorders – Consent (Mental Health Access Initiative) (failed) would have reduced the age for minors to consent to behavioral health services from 16 years to 12 years failed, in large part due to issues related to parental rights. MedChi requested an amendment to prohibit consent to medication which was accepted by the sponsors and improved the support for the bill. However, despite the significant increase in behavioral health issues amongst minors, parental rights concerns prevented the bill from passing the House.

House Bill 53: Public Health – Contraceptive Devices – Minors (failed) would have prohibited a minor's ability to consent to long-acting reversible contraceptives (LARCs), the most effective contraceptive for young women, also failed. Minors are now authorized to consent to all family planning services and types of contraceptives. The defeat of this legislation was largely reflective of Maryland's historic "pro-choice" political environment and was not related to parental rights issues.

Maternal Mortality

Maternal and infant mortality will remain the focus of legislative activity beyond this Session and will provide the platform for continued advocacy for the extension of Medicaid to 12 months postpartum. Below are the following bills related to maternal mortality that were enacted.

House Bill 286: Public Health – Maternal Mortality Review Program – Stakeholders (passed) requires that the stakeholders convened by the Secretary of Health as part of the Maternal Mortality Review Program must include (1) families of women who have experienced a near maternal death, a high-risk pregnancy, other challenges during pregnancy, or a maternal death or (2) women who have experienced a near maternal death, a high-risk pregnancy, or other challenges during pregnancy.

House Bill 837: Public Health – Maternal Mortality and Morbidity – Implicit Bias Training and Study (passed) provides for the creation of implicit bias training programs and requires perinatal facilities, including hospitals and birthing centers, to provide implicit bias to their employees who are involved in the provision of prenatal, delivery, and postnatal care and to encourage providers who are not employees to take the training. The legislation also directs MDH to work with relevant stakeholders to study how to incorporate severe maternal morbidity into the maternal mortality review program.

Behavioral Health

Senate Bill 441/House Bill 332: Mental Health – Confidentiality of Medical Records and Emergency Facilities List (passed) authorizes MDH, in the list of emergency facilities published annually related to emergency mental health evaluations, to include comprehensive crisis response centers, crisis stabilization centers, crisis treatment centers, and outpatient mental health clinics. The bill also alters the definition of “health care provider” as it pertains to the confidentiality of medical records to include a comprehensive crisis response center, a crisis stabilization center, and a crisis treatment center.

House Bill 1121: Maryland Mental Health and Substance Use Disorder Registry and Referral System (passed) establishes the Maryland Mental Health and Substance Use Disorder Registry and Referral System (System) in MDH. The purpose of this Registry is to provide a Statewide system through which health care providers can identify and access available inpatient and outpatient mental health and substance use services for patients in a seamless manner. It also creates an Advisory Committee to advise the Department on the development and implementation of the System.

House Bill 663: Prescription Drug Monitoring Program – Out-of-State Pharmacists and Discipline for Noncompliance (passed) is a departmental bill that alters the definition of “pharmacist” to include a pharmacist licensed by another state to dispense monitored prescription drugs for purposes of the Prescription Drug Monitoring Program (PDMP). The bill also adds failure to comply with the requirements of the PDMP to disciplinary grounds for dentists, physicians, and physician assistants by the appropriate health occupations board.

Senate Bill 710: Health – General – Prescription Drug Monitoring Program – County Health Officer (failed) would have provided County Health Officers access to PDMP data. MedChi strongly opposed this legislation as they have in previous years. MedChi continues to argue that the PDMP is a health care tool and should not be used as a tool for law enforcement or local health departments who are not able to appropriately review the raw data to which they would have access. It would create an unnecessary chilling effect on the prescribing community out of a fear of being stigmatized or unreasonably targeted for investigation. These arguments were well received by the Senate Finance Committee and the bill was easily defeated.

Senate Bill 990/House Bill 464: Public Health – Overdose and Infectious Disease Prevention Services Program (failed) would have authorized the establishment of an Overdose and Infectious Disease Prevention Services Program. A large body of evidence-based, peer-reviewed studies demonstrate that people who utilize these facilities take better care of themselves;

use their drugs more safely; and have better access to medical, social, and drug treatment services. While the receptivity of legislators to this concept has increased as the overdose statistics continue to escalate, it remains controversial and was not voted on in either Committee.

Environmental Health

House Bill 229/Senate Bill 300: Pesticides – Use of Chlorpyrifos – Prohibition (passed) was enacted in the final hours of the Session. Banning the use of chlorpyrifos has been the subject of debate for the last two years. This bill generally prohibits the use of chlorpyrifos in the State, including insecticides that contain chlorpyrifos and seeds that have been treated with chlorpyrifos, beginning December 31, 2020. In addition, the bill establishes a Pesticide Transition Fund and Pesticide Transition Task Force to support Maryland farmers in the transition away from the use of chlorpyrifos and requires the Maryland Department of Agriculture to provide specified education and assistance. The bill takes effect June 1, 2020, and sunsets June 30, 2024.

Senate Bill 18: Environment – Lead Poisoning Prevention Commission (passed) makes changes to the current Commission’s charges by deleting responsibilities that are no longer relevant and adding new and more relevant responsibilities such as case management, lead paint abatement service provider education, and blood lead testing. The bill also changes the composition of the Commission. The changes enacted will ensure that the Commission continues to focus on the most critical and current elements of lead poisoning prevention.

Miscellaneous Public Health Issues

House Bill 206/Senate Bill 207: Unaccompanied Minors in Need of Shelter and Supportive Services (passed), which addresses the pressing need of ensuring that unaccompanied homeless minors have access to shelter services. The bill, which reflects the recommendations of a workgroup established pursuant to similar legislation considered in 2019, authorizes an “unaccompanied minor in need of shelter” to consent to shelter and supportive services under specified circumstances.

House Bill 1564: Public Health – Emergency Evaluations – Duties of Peace Officers and Emergency Facilities (passed) broadens the list of emergency facility personnel authorized to request that a peace officer stay with an emergency evaluatee. Previously the request had to come from a physician because the evaluatee is violent and often a physician was not immediately available. The list of emergency facility personnel now includes a physician, physician assistant, nurse practitioner or other advance practice professional. The bill also requires, to the extent practicable, that a peace officer notify the emergency facility in advance that the peace officer is bringing an emergency evaluatee to the facility.

Senate Bill 846/House Bill 126: Peace Orders – Workplace Violence (failed) would have authorized an employer to file a petition for a peace order that alleges the commission of specified acts against the petitioner’s employee at the employee’s workplace. With increasing violent acts occurring in emergency departments against emergency personnel, this bill would have provided an additional tool to protect emergency personnel. If there wasn’t an early adjournment, this legislation may have passed after a number of years of previous consideration.

House Bill 1079: Sickle Cell Trait Screening, Treatment, Education, and Public Awareness (Journeys Law) (failed) was not enacted in large part due to early adjournment. The bill would have required the development of a public awareness campaign on the importance of an individual knowing their sickle cell trait status; receiving screening for the sickle cell trait; and receiving counseling if they carry the sickle cell trait.

Senate Bill 477/House Bill 1462: Public Health – Emergency Use Auto-Injectable Epinephrine Program – Revisions (passed) renames the Emergency Use Auto-Injectable Epinephrine Program at Institutions of Higher Education to be the Emergency Use Auto-Injectable Epinephrine Program, and expands eligible participants to include any food service facility in the State that voluntarily participates in the program.

There were nearly a dozen bills introduced this session aimed toward reducing tobacco use by banning flavored products and increasing taxes on a broad range of tobacco products, including vaping and electronic smoking devices. Ultimately, the General Assembly passed **House Bill 732: Taxation – Tobacco Tax, Sales and Use Tax, and Digital Advertising Gross Revenues Tax (passed)**. The bill establishes a 12% sales and use tax rate on open electronic smoking devices and a 60% sales and use tax on vaping liquid sold in a container that contains 5 milliliters or less. It also creates a 30% tax rate for pipe tobacco. It raises the taxes to \$3.75 for every package of 20 cigarettes and provides that the tax rate for other tobacco products is 53% of the wholesale price. Though it prohibits a county or municipal corporation from imposing a tax on an electronic smoking device going forward, it allows one imposed prior to January 2020 to remain in effect. Starting in 2022 and each fiscal year thereafter, the bill requires the Governor to provide at least \$18,250,000 in the budget for activities aimed at reducing tobacco use, an 82.5% increase from current levels. The net revenue increase from these new tobacco taxes must be used for the Kirwan education reforms.

Miscellaneous Legislation

While MedChi did not take positions on these bills (listed under FYI), we wanted to make you aware of them. **Senate Bill 632: Health Facilities – Hospitals – Disclosure of Outpatient Facility Fees (Facility Fee Right-to-Know Act) (passed)** requires a hospital that charges an outpatient facility fee to provide a patient with a written notice containing information on the fee. A hospital may not charge, bill, or attempt to collect an outpatient facility fee unless the patient was given the notice. **House Bill 1169/Senate Bill 774: Health Services Cost Review Commission – Community Benefits – Reporting (passed)** requires the HSCRC to develop a Community Benefit Reporting Workgroup to make recommendations for the development of regulations on community benefit reporting. The bills also define “community benefit.”

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. Benjamin 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. Benjamin Lowentritt, Dr. Michael Niehoff, Dr. Greg Guyton, Dr. Jim Ficke, Dr. Allie Dunham, Dr. Gary Pushkin, Dr. Jacob Wosbeck, Dr. Walt Hembee, Dr. Richard Bruno, Dr. Joe Adams, and Dr. Jack Peng, and Dr. Enrique Oviedo.

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. and Cassandra Thomas, BSN, RN, CDNC for their dedication in staffing the First Aid Room for the Session.

Doctors who staffed the First Aid Room this Session include:

Renee Bovelle, M.D.
Richard Bruno, M.D.
Brooke Buckley, M.D.
Tyler Cymet, M.D.
J. Ramsay Farah, M.D.
Walter Giblin, M.D.
John Gordon, M.D.
Lawrence J. Green, M.D.
Laura Kaplan-Weisman, M.D.
Benjamin Lowentritt, M.D.
Loralie Ma, M.D.
George Malouf, M.D.
Sarah Merritt, M.D.

Michael Niehoff, M.D.
Algernon Prioleau, M.D.
Gary Pushkin, M.D.
Paul Quesenberry, M.D.
Padmini Ranasinghe, M.D.
Anuradha D. Reddy, M.D.
Stephen Rockower, M.D.
Gary Sprouse, M.D.
Benjamin Stallings, M.D.
Francisco Ward, M.D.
James Williams, M.D.
Mozella Williams, M.D.
H. Russell Wright, M.D.