MedChi General Assembly Sine Die Report
April 7, 2025

Executive Summary

The Maryland General Assembly began the 447th Session at noon on Wednesday, January 8th, and concluded its legislative work at midnight on Monday, April 7th. The challenges of this Session included, but were not limited to, an unprecedented $3.3 billion deficit and uncertain federal policies and their effect on Maryland. Despite these challenges, MedChi had a successful Session, including preserving Medicaid Evaluation and Management (E&M) payment rates at current funding levels, receiving $3 million in funding for the Physicians' Loan Assistance Repayment Program (LARP), and maintaining $15 million in grants for cancer research by Statewide Academic Health Centers.

MedChi also successfully opposed legislation that would have repealed the cap on non-economic damages in non-medical malpractice negligence cases (***House Bill 113/Senate Bill 584***) and that would have allowed naturopaths to prescribe prescription drugs and controlled dangerous substances, including opioids (***House Bill 867***). In addition, MedChi continued its fight to strengthen laws related to utilization review and prior authorization policies used by health insurance carriers by providing the Maryland Insurance Commissioner with greater enforcement authority, increasing consumer transparency related to denials of care (***House Bill 848/Senate Bill 474***), and establishing guardrails around the use of artificial intelligence (***House Bill 820***).

Fiscal Year 2026 Budget

Maryland began the 2025 Legislative Session with a budget deficit of $3 billion, which quickly increased to $3.3 billion. Governor Moore's initial budget proposal (***House Bill 350***) and the Budget Reconciliation and Financing Act (***House Bill 352***) combined spending cuts and revenue generators (i.e., taxes and fees) to close the budget gap. Most notable among the revenue provisions were income tax increases on "high-wage" earners, the adoption of combined reporting, a raise in the sports wagering tax, an increase in the cannabis tax, and the implementation of a 0.75-cent tax on deliveries to raise transportation trust fund revenue.

After the introduction of the budget by Governor Moore, the General Assembly began its review. The General Assembly rejected just as much of the Governor's budget as it accepted and introduced bills to address the revenue shortfall. Legislative leadership introduced a bill (***House Bill 1554/Senate Bill 1045***) in late February that would have imposed a 2.5% business-to-business tax on services, such as accounting, marketing, public relations, IT, and other related services. However, hundreds of Maryland businesses, ranging from McCormick & Company to smaller employers, lined up to oppose this tax. MedChi also opposed this newly created tax at the hearing and issued alerts to our membership to contact the Legislature.

After much back and forth, by Session's end, the Legislature enacted a plan that cut over a billion dollars from the budget and also raised revenue in the following ways:

- Adding a new 3% sales tax on data and IT services, expected to raise nearly $482 million, which was narrowed significantly from a much broader tax and mitigated the effect on physician offices.
- Adding a 2% surcharge on capital gains exceeding $350,000, expected to raise $367 million, with 40% of the proceeds allocated to the Transportation Trust Fund.
- Imposing higher income tax brackets on higher earners – those earning between $500,000 and $1 million will pay 6.25%, while those earning above $1 million will pay 6.5%.
- Increasing the cannabis tax rate to 12% from 9%, resulting in $39 million in additional revenue.
- Increasing the tax rate on sports wagering to 20% from 15%, expected to raise $32 million.
- Enabling local governments to increase the maximum local piggyback tax rate to 3.3% from 3.2%.

Despite the deficit, MedChi successfully prevented any reduction in Medicaid E&M payment rates, thus maintaining current funding levels. According to the Maryland Department of Health (MDH), as of October 2024, E&M payment rates are 99% of Medicare rates. For perspective, during the "Great Recession" of 2008 under Governor O'Malley, the State experienced a $1 billion deficit, and E&M payment rates were reduced to 87% of Medicare. Maintaining rates at 99% in this even more challenging fiscal environment is a significant achievement. Separately, the Fiscal Year 2026 budget allocates $3 million for LARP and $15 million for cancer research by Statewide Academic Health Centers.

Boards and Commissions

House Bill 113/Senate Bill 584: Civil Actions – Noneconomic Damages – Personal Injury and Wrongful Death (failed) would have repealed the cap on non-economic damages in cases other than medical malpractice. MedChi strongly opposed the bill and met with legislators over the last two years to educate them on the issue, knowing that whatever the outcome of this legislation, a separate medical malpractice cap would likely follow, either through future legislation or litigation. MedChi joined the insurance industry and other business interests in successfully opposing this bill.

A combination of effective lobbying by MedChi, businesses, and property and casualty insurers against the bill, as well as outside economic factors such as the likelihood that this would increase car insurance costs on top of other rising consumer expenses, derailed the bill for 2025.

House Bill 776/Senate Bill 423: Maryland Medical Practice Act and Maryland Physician Assistants Act – Revisions (passed) makes numerous revisions to the statutes governing physicians, physician assistants, and allied health professions, with most of the changes being technical. MedChi supported the bill with several amendments. After weeks of negotiating with the Board of Physicians, MedChi was able to not only address most of our concerns but also obtain several beneficial provisions for physicians. These include: 1) allowing specific disciplinary measures to be addressed administratively, thereby avoiding reporting to the National Practitioner Databank, 2) speeding up the peer review process in disciplinary cases, and 3) raising the threshold for placing malpractice judgments on a physician's Board Profile to $1 million. We also tried to raise the disciplinary standard from "preponderance of the evidence" to "clear and convincing" evidence, but that long-standing issue will have to wait for another day.

There was considerable discussion around the bill's requirement that all employers report to the Board specific actions taken against physicians. Hospitals have long been required to do this, and the bill will

expand that obligation to other employers as well. However, after extensive negotiations, we were able to limit the trigger for a report to when specified employment actions are taken against a physician, *and* those actions are based on a disciplinary ground under the law. This is considerably narrower than first proposed. Moreover, in many other states, the reporting requirement is placed on other licensees, rather than the employer, so we avoided that more burdensome outcome with this solution.

House Bill 783: Health Occupations – Implicit Bias and Structural Racism Training (passed) adds structural racism to the subjects required for those licensed by a health occupation board. Many will recall the legislation passed years ago that required all health occupations to complete a one-time implicit bias training program following their next renewal, after April 2022. This legislation implements another one-time requirement to take such a course after 2026, but it would add subject matter related to "structural racism."

MedChi submitted a letter of concern on the bill because mandated training begins to undermine a principle that MedChi has long espoused – that training courses and CME should be chosen by the physician and tailored to their practice. However, in the interest of compromise, we suggested that either only NEW licensees only be required to take the program or that the training count toward CME requirements. The House agreed to the latter change. After considerable debate in the Senate Finance Committee over the necessity of this requirement on the heels of the implicit bias training requirement, the bill emerged on a 7-4 vote and subsequently passed.

House Bill 867: State Board of Physicians – Naturopathic Doctors – Prescriptive Authority and Administration of Medication (failed) would have proposed several changes related to naturopaths - eliminate the current Naturopathic Formulary Council within the Board of Physicians, allow naturopaths to administer natural medicines via intramuscular, subcutaneous, and intravenous routes, and allow the prescribing of "prescription drugs," including Schedule III, IV, and V controlled dangerous substances. In opposing the bill, MedChi argued that naturopaths do not have adequate training to prescribe these medications and certainly do not have the training to treat any complications from them.

After the hearing, the bill's sponsor, House Health and Government Operations (HGO) Committee Vice Chair Bonnie Cullison, requested that MedChi meet with her and representatives of the naturopaths, which we did on March 20th. The issue did not advance much after that, but it is expected that the HGO Committee will direct us to work on this issue during the interim.

House Bill 905/Senate Bill 720: Hospitals – Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2025) (failed) would have required hospitals to establish Clinical Staffing Committees that would implement data-based guidelines for adequate staffing within various departments of hospitals. MedChi supported the bill with amendments, making clear that a Resident Physician shall be a member of the committee if in a teaching hospital, and that in all hospitals a staff physician that is not a member of the administration shall be a member. The Senate Committee adopted a number of amendments and reported the bill to the Senate floor, but it was re-committed to the Committee at the request of the bill sponsor.

House Bill 1099: Civil Actions – Punitive Damage Awards – Surcharge (failed) proposed to lower the standard for an award of punitive damages from the current "actual malice" to, among things, a "pattern of repeated misconduct" or "acts or omissions that create a high degree or harm to others." This new standard arguably could have been applied in medical malpractice cases, prompting MedChi to oppose

the bill. Even more egregious, in cases where punitive damages are awarded, the bill imposes a surcharge of 50% of the amount of the punitives on top of the award, payable to the State and deposited into the Blueprint for Education Fund.

House Bill 1104: Maryland Department of Health – AHEAD Model Implementation – Electronic Health Care Transactions and Population Health Improvement Fund (passed) made changes necessary for implementing the AHEAD Model. MedChi requested amendments to the bill's structure regarding the Population Health Fund, aimed at ensuring proper governance and accountability. As passed by the House, the amendments require the MDH to annually submit to the General Assembly a report measuring the effectiveness of the funds, the impact on health outcomes and health disparities, and relevant components from hospital required reporting on population health improvements. The bill also requires regular audits by the Office of Legislative Audits.

We also advocated for an independent entity to administer the Fund, but as passed by the House, the Health Services Cost Review Commission (HSCRC) and the MDH will fill that role. In this challenging fiscal environment, the costs associated with establishing an independent entity likely precluded that outcome.

However, the Senate added amendments reflecting the uncertainty surrounding the AHEAD Model at the federal level, which further address MedChi's concerns regarding the accountability of the Fund. First, the reports that MDH must submit to the General Assembly must provide for a 30-day public comment period, which will allow interested parties to weigh in, and second, the House and Senate will each appoint three members to meet monthly with the HSCRC and MDH to monitor developments regarding the AHEAD Model over the next 18 months. This will provide MedChi with another avenue to address concerns as the AHEAD Model is implemented.

House Bill 1199: Physicians – Licensing – Internationally Trained Physicians (failed) was based on the results of a workgroup convened by the Board of Physicians, in which MedChi participated, and established a process for physicians who have previously been licensed and practiced for at least five years internationally to become licensed in the U.S. The bill died in the Senate after passing the House.

House Bill 1288/Senate Bill 658: Labor and Employment – Noncompete and Conflict of Interest Provisions (failed) did not advance in either chamber. MedChi successfully passed legislation last year that prohibits or limits non-compete clauses in health occupation employment agreements that extend beyond the termination of employment. However, this bill aimed to prevent employees from working for two employers at once. This affected emergency room physicians and others who often work for more than one hospital. For this reason, MedChi opposed the bill and it did not pass.

House Bill 1298/Senate Bill 919: Health Occupations – Practice of Audiology – Definition (failed) was introduced at the request of MedChi to address legislation adopted last year. The 2024 bill contained some scope expansions that needed to be limited. The Governor agreed with us and did not sign the 2024 bill, but he did allow it to become law. We invested substantial time in resolving this issue, including some very frustrating negotiations with the audiologists and their lobbyist. However, despite our efforts, the bill sponsors also grew frustrated and decided not to move forward with the bill this year. We will reassess the matter during the interim and proceed accordingly after doing so.

House Bill 1437: Catastrophic Health Emergency – Immunity for Health Care Providers – Repeal (failed) would have repealed the good faith immunity that is triggered for providers when the Governor of the State declares a catastrophic health emergency. MedChi was opposed, and shortly before the hearing, the bill was withdrawn.

House Bill 1493/Senate Bill 539: Health Occupations – Prescriptions for Children Subject to Shared Custody or Visitation Schedules (failed) did not emerge from either chamber before crossover. It would have required a prescriber who is given a child custody order with shared visitation to issue two prescriptions for the child, one to be filled by each parent, proportional to the amount of time that each parent spends with the child. It further requires the prescription to be dispensed accordingly.

MedChi opposed these bills because they put prescribers between parents and require a prescriber to determine whether a child custody order is still valid or has been superseded. They further create insurance problems by dividing quantities into two prescriptions that might otherwise be eligible for lower co-pays or discounts if prescribed as a single dose.

House Bill 1510: Medical Records – Notice of Destruction – Method (passed) was introduced at the request of MedChi to allow for notice of the planned destruction of medical records to be provided by either first-class mail or e-mail, rather than by both methods as required by current law. In addition to the costs of providing notice by first-class mail, the current law can result in other members of a household learning of a patient's relationship with a physician when the patient does not want them to know. Amendments to the bill require that delivery (but not receipt) of the email be confirmed. If delivery is not successful, then the notice must be sent by first-class mail.

Health Insurance

As amended, ***House Bill 11/Senate Bill 902: Health Insurance – Access to Nonparticipating Providers – Referrals, Additional Assistance, and Coverage (passed)*** specify that a health insurance carrier must ensure that mental health and substance use disorder (SUD) services are provided for the duration of the treatment plan at no greater cost to the covered individual than if a participating provider provided the services. Furthermore, if a member cannot access mental health or SUD services through the referral procedure, the carrier must assist the member in identifying and arranging coverage for mental health or SUD services with a nonparticipating specialist or nonphysician specialist. MedChi successfully advocated for the removal of the provision requiring the Maryland Health Care Commission (MHCC) to set rates for nonparticipating providers.

House Bill 424/Senate Bill 357: Prescription Drug Affordability Board – Authority and Stakeholder Council Membership (Lowering Prescription Drug Costs for All Marylanders Now Act) (passed) expand the ability of the Prescription Drug Affordability Board (PDAB) to establish a process for setting upper payment limits (UPLs) for all purchases and payor reimbursements of prescription drug products in the State that, in the Board's determination, have led or will lead to an affordability challenge. The Senate amendments add a representative from the rare disease community, an oncologist, and a representative from a patient advocacy organization to the Stakeholder Council; add information that must be reported in the annual report if the PDAB sets a new UPL; and require the PDAB to consider 340B and the impact on rare diseases in examining UPLs.

House Bill 459/Senate Bill 374: Counties – Cancer Screening for Professional Firefighters – Required Coverage (James "Jimmy" Malone Act) (passed), as amended, rather than requiring coverage by health insurance carriers, the bills require counties that offer a self-insured plan to provide each firefighter employed by the county for preventative cancer screenings under the latest screening guidelines issued by the International Association of Firefighters.

As amended, ***House Bill 553/Senate Bill 94: Maryland Medical Assistance Program – Maternal Health Self-Measured Blood Pressure Monitoring (passed)*** require Medicaid, beginning January 1, 2026, to provide coverage for self-measured blood pressure monitoring to recipients who (1) are pregnant, (2) are postpartum, or (3) have been diagnosed with chronic kidney disease, diabetes, heart disease, or a cardiometabolic disease. Coverage must include (1) the provision of validated home blood pressure monitors and (2) reimbursement of health care provider and other staff time, specifically for patient training, the transmission of blood pressure data, interpretation of blood pressure readings and reporting, remote patient monitoring, and the delivery of co-interventions, including educational materials or classes. Due to the fiscal note, the education campaign was removed from the bill.

House Bill 666/Senate Bill 60: Maryland Medical Assistance Program and Health Insurance – Required Coverage for Calcium Score Testing (passed) require health insurance carriers, as well as the Maryland Medicaid program, to cover calcium score testing following the most recent guidelines issued by the American College of Cardiology (ACC) that expand the scope of preventive care services for the benefit of consumers. As successfully advocated by MedChi, the specific conditions (diabetes, high blood pressure, high cholesterol, and family history) were removed from the bill and replaced with the ACC reference.

House Bill 718: Maryland Health Insurance Coverage Protection Commission – Established (passed) establishes the Maryland Health Insurance Coverage Protection Commission to (1) monitor potential and actual federal changes to the federal Patient Protection and Affordable Care Act (ACA), Medicaid, the Maryland Children's Health Program (MCHP), Medicare, and the Maryland All-Payer Model; (2) assess the impact of such changes; and (3) provide recommendations for State and local action to protect access to affordable health coverage. By December 31st of each year, the Commission must submit a report on its findings and recommendations. MedChi has a named seat on the Commission.

House Bill 813: Maryland Insurance Administration and Maryland Department of Health – Workgroup to Study Pharmacy Benefits Managers (passed) was amended to be a study by the House. As amended, the bill requires the convening of a workgroup of interested stakeholders, including community pharmacies from both chain and independent settings, pharmacy services administrative organizations, pharmacists, pharmacy benefit managers (PBMs), managed care organizations, and third-party experts in the field of drug pricing in Medicaid, to review reimbursement for pharmacists.

House Bill 820: Health Insurance – Utilization Review – Use of Artificial Intelligence (passed), requested for introduction by MedChi, requires a health insurance carrier, PBM, or a private review agent that uses "artificial intelligence" (AI), algorithms, or other software tools for utilization review (including working through an entity that uses such tools) to ensure that such tools are used in a specified manner, such as ensuring that any utilization review decisions are still based on an enrollee's specific medical or other clinical history and that the final decision must be made by a physician in the same specialty with clinical experience as the medical condition being reviewed. The bill also alters the information a carrier

must submit in its quarterly adverse decisions and grievances report, including whether an AI, algorithm, or other software tool was used to make an adverse decision.

House Bill 848/Senate Bill 474: Health Insurance – Adverse Decisions – Notices, Reporting, and Examinations (passed), requested by MedChi, provides the Maryland Insurance Administration (MIA) with greater enforcement authority and adds additional transparency requirements to denials. The bills require health insurance carriers to provide information to the MIA if the number of adverse decisions issued by a carrier for a type of service has grown by more than 10% in the immediately preceding calendar year or 25% in the immediately preceding three years. The information must include (1) a description of any changes in medical management contributing to the rise in adverse decisions for the type of service; (2) any other known reasons for the increase; and (3) a description of the carrier's efforts and actions taken to determine the reason for the increase. The bills also require more information to be provided to the consumer on the first page of the adverse decision regarding appeal information and rights.

House Bill 956: Consumer Protection – Workgroup on Artificial Intelligence Implementation (passed) establishes a broad-based 39-member Workgroup on Artificial Intelligence Implementation to monitor issues and make recommendations related to AI, including (1) the regulation of AI used in decisions that significantly impact the livelihood and life opportunities of individuals in the State; (2) deployer and developer obligations related to labor and employment and protection of individual privacy rights; (3) protection of consumer rights; (4) current private sector use of AI; (5) general AI disclosures for all consumers; and (6) enforcement authority for the Office of the Attorney General's Consumer Protection Division. Of the membership, three are from the healthcare sector, with one having clinical experience.

House Bill 970/Senate Bill 646: Health Insurance – Insulin – Prohibition on Step Therapy or Fail-First Protocols (passed), as amended, prohibits health insurance carriers from imposing a step therapy or fail-first protocol for insulin or insulin analog approved by the U.S. Food and Drug Administration (FDA) and used to treat Type 1, Type 2, or gestational diabetes.

House Bill 974: Health Insurance – Preventive Services – High Deductible Health Plans and Enforcement Authority (passed), as amended, the bill requires the Insurance Commissioner to enforce requirements on health insurance carriers to cover preventative services consistent with the recommendations and guidelines in effect on December 31, 2024, set by the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the Health Resources and Services Administration, and Related Federal Rules or Guidance.

House Bill 995/Senate Bill 776: Workgroup to Study the Rise in Adverse Decisions in the State Health Care System – Establishment (passed) establishes a workgroup to study the rise in adverse decisions in the state health care system. As amended, the Workgroup must (1) review existing State adverse decision reporting requirements for all health payers in the State and include specified information in its final report; (2) make recommendations to improve State reporting on adverse decisions, including specified standardized definitions, methods, and processes; (3) develop strategies for, and make recommendations to reduce, the number of adverse decisions; and (4) develop recommendations for legislation to address the rise in adverse decisions and standardize State reporting requirements regarding adverse decisions across all payers. MedChi has a seat in the Workgroup and there are two additional physician members.

In response to a decision by a leading health insurer to limit payment of anesthesia services, which was later withdrawn, ***House Bill 1086: Maryland Medical Assistance Program and Health Insurance – Coverage for Anesthesia – Prohibiting Time Limitations (passed)*** requires health insurance carriers and Medicaid, if coverage for anesthesia delivery for a procedure for which a licensed provider issues an order is provided, to cover anesthesia delivery for the entire procedure. A time limitation may not be placed on the delivery of anesthesia.

House Bill 1087/Senate Bill 921: Health Insurance – Step Therapy or Fail-First Protocols – Drugs to Treat Associated Conditions of Advanced Metastatic Cancer (passed) prohibits health insurance carriers from imposing a step therapy or fail-first protocol for a prescription drug approved by the U.S. FDA that is prescribed by a treating physician to treat a symptom or side effect of stage four advanced metastatic cancer.

After nearly six years, ***House Bill 1243/Senate Bill 975: Health Insurance – Coverage for Specialty Drugs (passed)*** has finally passed in a limited manner. The bill prohibits a health insurance carrier (including a PBM) from excluding coverage for a covered specialty drug administered or dispensed by a provider if the carrier determines that (1) the provider is an in-network provider of covered oncology services and complies with State regulations for the administering and dispensing of specialty drugs and (2) the drug is infused, auto-injected, or an oral targeted immune modulator or an oral medication that requires complex dosing based on clinical presentation or is used concomitantly with other infusion or radiation therapies. MedChi successfully advocated for removing the term "medical" from the description of oncology services to ensure that all physicians who treat cancer can benefit from this bill, rather than only "medical oncologists." MedChi also collaborated with other advocates to ensure that physicians could continue to negotiate drug payments with insurers.

After several years, ***Senate Bill 773: Health Benefit Plans – Calculation of Cost-Sharing Contribution – Requirements (passed)*** finally passed. Better known as the "accumulator bill," the bill requires health insurance carriers (including PBMs), when calculating an insured's or enrollee's cost-sharing contributions, to include any discount, financial assistance payment, product voucher, or other out-of-pocket expense made by or on behalf of the insured or enrollee for prescription drugs.

House Bill 1292: Health Insurance – Provider Directory – Required Updates (passed) replaces the term **"**network directory" with "provider directory" to conform with the federal No Surprises Act. Additionally, it shortens the period during which a health insurance carrier must update the online provider directory after receiving notification from a participating provider of a change in applicable information, from 15 working days to two working days.

House Bill 1301: Maryland Medical Assistance Program, Maryland Children's Health Program, and Health Insurance – Transfers to Special Pediatric Hospitals – Prior Authorizations (passed), as amended, this bill prohibits health insurance carriers, Medicaid, and the MCHP from requiring prior authorization to transfer to a State "special pediatric hospital."

House Bill 1315: Vaccinations by Pharmacists and Health Insurance Coverage for Immunizations (passed) requires health insurance carriers to cover vaccines as part of child wellness services, as recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices, as of December 31, 2024. The corresponding language is also added for adult vaccines provided by pharmacists.

House Bill 1355/Senate Bill 641: Health Insurance – Required Coverage – Hearing Aids (passed) requires health insurance carriers to cover hearing aids for adults if they are ordered, fitted, and dispensed by a licensed hearing aid dispenser.

Below are other health insurance bills that failed to pass this Session.

House Bill 381/Senate Bill 508: Maryland Medical Assistance Program and Health Insurance – Required Coverage for Aesthetic Services and Restorative Care for Victims of Domestic Violence (Healing Our Scars Act) (failed) would have required health insurance carriers to provide coverage to victims of domestic violence for aesthetic services and restorative care determined to be medically necessary for the treatment of physical injuries caused by domestic violence.

House Bill 382/Senate Bill 111: Maryland Medical Assistance Program and Health Insurance – Step Therapy, Fail-First Protocols, and Prior Authorization – Prescription to Treat Serious Mental Illness (failed) would have prohibited Medicaid and commercial insurers from applying step therapy protocols to treat serious mental illnesses. The fiscal note was $77 million for Medicaid and up to $1 million for the State Employees Health Benefit Plan.

House Bill 383/Senate Bill 406: Maryland Medical Assistance Program and Health Insurance – Coverage for Orthoses (So Every Body Can Move Act) (failed) would have required Medicaid and commercial insurers to provide coverage related to orthoses, effective January 1, 2026. The fiscal note was $1.19 million for Medicaid, but negligible for the State Employees' Health Benefit Plan, as the State already covers it.

House Bill 418/Senate Bill 437: Health Maintenance Organizations – Payments to Nonparticipating Providers – Reimbursement Rate (failed) would have altered the reimbursement rate paid by health maintenance organizations to non-participating providers. According to an MHCC report, concerns were raised that the bill's language would create a disparity between specialties.

House Bill 659/Senate Bill 475: Health Insurance – Utilization Review – Exemption for Participation in Value-Based Care Arrangements (failed) would have prohibited a health insurance carrier from applying prior authorization, step therapy, or quantity limits when the provider and carrier have entered into a two-sided incentive agreement. MedChi requested the introduction of this legislation. The legislation was favorably received, but further discussion is needed to address implementation issues that will arise during the interim.

House Bill 665/Senate Bill 328: Maryland Medical Assistance Program and Health Insurance – Annual Behavioral Health Wellness Visits – Coverage and Reimbursement (failed) would have required health insurance carriers to provide coverage and reimbursement for annual behavioral health wellness visits. Concerns regarding the content of this visit and who would be able to bill insurers were not resolved.

Senate Bill 306: Workers' Compensation – Prescription Drug and Pharmaceutical Services – Reimbursements (failed) would have required the Workers' Compensation Commission (WCC) to regulate all fees and other charges for reimbursing prescription drugs and pharmaceutical services provided through the workers' compensation system. Any such reimbursement would have been limited to an index or indices based on acquisition cost, calculated on a per-unit basis, as of the date of dispensing, and included reasonable dispensing fees and any other increases or decreases in reimbursement as

determined by the WCC. Early in the negotiations, after discussions with Chair Beidle (sponsor), MedChi successfully had dispensing physicians exempted from the bill. The bill also required a PDAB study on compounding and other topical prescription drugs.

Senate Bill 411: Health Insurance – Postpartum Depression Screening – Required Coverage and Authorized Cost Sharing (failed) would have required health insurance carriers to provide coverage for "postpartum depression screening" (defined as the administration, review, or discussion of the Edinburg Postnatal Depression Scale or any similar method used to screen for postpartum depression). It was noted that, under the ACA, most health plans are required to cover preventive services without cost-sharing, including depression screenings for mothers during well-baby visits. The U.S. Preventive Services Task Force recommends screening for depression in adults (including pregnant and postpartum persons).

House Bill 830/Senate Bill 476: Health Insurance – Genetic Testing and Cancer Imaging – Required Coverage (failed) would have required health insurance carriers to provide coverage for genetic testing to identify whether an individual with a personal or family history of cancer has an inherited mutation associated with an increased risk of cancer. Carriers would have also been required to cover follow-up evidence-based cancer imaging if the genetic testing determines the individual to be at increased risk of developing cancer. The bill passed the House but failed to advance in the Senate.

While ***House Bill 321/Senate Bill 303: Pharmacy Benefits Managers – Definition of Purchaser and Alteration of Application of Law (failed)*** passed the House, the Senate FIN Committee, for the third consecutive year, failed to act on the bill. As passed by the House, the bill would have extended Maryland's consumer protection provisions under the laws governing PBMs to self-insured plans that contract with a PBM. These important consumer protections include information on and sales of prescription drugs, the beneficiary's choice of pharmacy, reimbursement for pharmaceutical products or pharmacist services, requirements before entering into a contract, rebate sharing contract requirements, audits by PBMs, and internal review process requirements. Concerns persisted in the Senate regarding the application of state law to self-insured plans regulated by the federal government, as well as the associated cost implications.

While ***House Bill 1314: Health Care – Prior Authorizations – Prohibiting Fees (failed)*** passed the House, it did not move in the Senate. MedChi opposed the bill. To be clear, for covered, in-network services, physicians are already prohibited from charging fees for prior authorization. However, this bill fails to address the underlying issues that may lead physicians to consider, specifically the low payment levels by insurers.

Public Health

House Bill 421/Senate Bill 36: Public Safety – 9-1-1 Trust Fund – 9-8-8 Suicide Prevention Hotline (passed) expands the purpose of the 9-1-1 Trust Fund to include providing funds for costs related to the operation of the 9-8-8 suicide prevention hotline that may be shared with 9-1-1 activities, including software interfaces and joint training.

House Bill 869/Senate Bill 372: Preserve Telehealth Access Act of 2025 (passed) will permanently authorize audio-only telehealth on the same basis and at the same rate as if the healthcare service were delivered in person by the healthcare provider. This provision was initially set to expire on June 30, 2025. The bill also repeals the prohibition on health care practitioners prescribing a Schedule II opiate for the

treatment of pain through telehealth provided there is an established practitioner-patient relationship. Lastly, the MHCC is required to submit a report on telehealth every four years and report any findings or recommendations to the Governor and the Maryland General Assembly related to these developments.

House Bill 1066: Commission on Behavioral Health Care Treatment and Access – Workgroups (passed) requires the Commission on Behavioral Health Care Treatment and Access to establish an additional workgroup focused on improving health, social, and economic outcomes related to substance use. The workgroup must evaluate MDH regulations on patient discharge standards from substance use treatment programs, specifically assessing whether they adequately account for a patient's mental health or SUD diagnosis and the potential impact of discharge. Additionally, the workgroup must make recommendations to (1) mitigate the harms associated with the criminalization of substance use, with the goal of improving public health and safety, and (2) ensure that discharge and placement decisions are appropriate and supportive of the patient's ongoing needs.

House Bill 1146/Senate Bill 900: Maryland Behavioral Health Crisis Response System – Integration of 9-8-8 Suicide and Crisis Lifeline Network and Outcome Evaluations (passed) requires the Maryland Behavioral Health Crisis Response System to establish a State 9-8-8 Suicide and Crisis Lifeline in each jurisdiction, replacing the existing crisis communication centers. The system will coordinate with the national 9-8-8 network to provide support services like suicide prevention, crisis intervention, referrals to additional resources, mobile crisis teams, and crisis stabilization centers. The bill requires evaluation and reporting of outcomes from these services, including data on crisis resolution, response times, and service usage, with annual public reporting. MedChi supported the bill, which aims to improve crisis diversion and link individuals to appropriate community health services.

Introduced by Senator Lam, ***Senate Bill 448: Maryland Medical Assistance Program – Self-Directed Mental Health Services – Pilot Program (failed)*** would have established the Self-Directed Mental Health Services Pilot Program within MDH to enhance access to clinically appropriate, person-centered, culturally responsive, and trauma-informed mental health services within Medicaid. The program intended to enroll 100 individuals, prioritizing those who had been excluded from or unsuccessful in existing treatments, had multiple disabilities, severe mental illness with trauma-related disorders, unserved cultural needs, or were at risk of institutionalization. The pilot would have provided participants with individual-directed goods and services, support brokers to assist in creating and managing person-centered plans, and fiscal intermediary and administrative support. The bill ultimately failed due to its high budgetary note, which raised concerns about the cost of implementation and long-term funding. MedChi did not weigh in.

Substance Use & Overdose Response

House Bill 737: Public Health – Nonopioid Advance Directives (failed) would have permitted individuals to create a legally binding directive to refuse opioid medications, including during emergencies when they are unable to express their wishes. MDH would have been responsible for developing a model nonopioid advance directive form, posting it online, and creating and implementing regulations. MedChi opposed the bill, citing concerns that a separate non-opioid directive could lead to administrative confusion. There were also concerns that these directives could hinder emergency decision-making, where opioids might be the most clinically appropriate option. The bill ultimately stalled in its original committee.

House Bill 798/Senate Bill 589: Opioid Restitution Fund – Interactive Dashboard (passed) mandates the Maryland Office of Overdose Response, in collaboration with MDH, to develop and maintain an interactive dashboard detailing the allocation and expenditure of funds from the Opioid Restitution Fund. This dashboard aims to enhance public transparency by providing information on payment schedules, spending plans, and funded initiatives related to opioid-related settlements, disaggregated by state, county, and municipality. Counties and municipalities receiving settlement funds are required to report specified information to MDH for inclusion, unless they fulfill reporting obligations through existing settlement agreements and share those reports with the appropriate state entity. To the extent possible, the dashboard should utilize existing platforms that provide data on opioid use and overdoses in the State. MedChi, along with behavioral health advocates, strongly supported the bill. It ultimately passed both chambers unanimously.

House Bill 1131: Public Health – Buprenorphine – Training Grant Program and Workgroup (passed) establishes the Buprenorphine Training Grant Program to help counties cover the cost of training paramedics to administer buprenorphine, a medication used to treat opioid use disorder. It allocates at least $50,000 from the Opioid Restitution Fund to support this initiative. Additionally, the bill mandates the Maryland Office of Overdose Response to convene a workgroup to study access to buprenorphine across the state, identify gaps in service, and explore long-term expansion strategies. The findings and recommendations of the workgroup must be reported to the Governor and legislative committees by December 31, 2025. The bill takes effect on July 1, 2025, with the training program lasting five years and the workgroup operating for one year. The bill passed both chambers unanimously and unamended. MedChi supported the bill and has offered to help facilitate future trainings.

House Bill 1502: Baltimore City – AIDS Prevention Sterile Needle and Syringe Exchange Pilot Program – Revisions (passed) updates the statute for Baltimore City's syringe service program at the request of the Baltimore City Mayor's Office. This well-established harm reduction initiative helps prevent the spread of HIV, hepatitis C, and other bloodborne diseases by reducing the sharing of contaminated needles. MedChi supported this bill as it reinforces Maryland's commitment to health equity and harm reduction.

Neither House Bill 556/Senate Bill 370 nor House Bill 1398/Senate Bill 604 passed. ***House Bill 556/Senate Bill 370: Drug Paraphernalia for Administration – Decriminalization (failed)***, aimed to decriminalize the possession of items used to inject, ingest, inhale, or otherwise consume a controlled dangerous substance. MedChi supported this bill, viewing it as a step toward harm reduction by reducing the criminalization of individuals struggling with substance use disorder. In contrast, ***House Bill 1398/Senate Bill 604: Criminal Law – Distribution of Heroin or Fentanyl Causing Serious Bodily Injury or Death (Victoria, Scottie, Ashleigh, and Yader's Law) (failed)***, i.e., "Drug-induced homicide" aimed to deter drug distribution through enhanced criminal penalties for drug distribution leading to a fatal overdose. Violations would carry felony charges with potential imprisonment for up to 20 years. MedChi strongly opposed this bill, as stricter criminal penalties have historically not been effective in addressing drug addiction.

HIV

After years of unsuccessful attempts to pass similar legislation, ***House Bill 39/Senate Bill 356: Public Health – Repeal of Prohibition on Transfer of Human Immunodeficiency Virus (Carlton R. Smith Act) (passed)*** has passed. It repeals the misdemeanor offense and associated penalties for knowingly

transferring or attempting to transfer HIV. This Act is named in honor of Carlton R. Smith, a Black LGBTQ+ and HIV/AIDS activist in Baltimore, whose advocacy was instrumental in advancing HIV decriminalization and health equity. MedChi consistently supported the bill over the years.

Youth

House Bill 962/Senate Bill 696: Public Health – Pediatric Hospital Overstay Patients (passed) requires MDH, in coordination with the Department of Human Services, to ensure that pediatric hospital overstay patients (youth under age 22 who remain hospitalized more than 48 hours after being medically cleared) are transferred to and treated in the least restrictive setting when clinically appropriate and feasible. These overstays occur due to gaps in community-based and residential services, highlighting the need for improved placement options. To support this, each agency must establish a pediatric hospital overstay coordinator responsible for advocating for patients, coordinating care across systems, reviewing policy barriers, and maintaining data. The bill also creates a Workgroup on Children in Unlicensed Settings and Pediatric Hospital Overstays, staffed by the State Council on Child Abuse and Neglect, which must assess the scope of the issue, develop a plan to expand licensed placement options, and submit findings and recommendations to the Governor and General Assembly by October 1, 2025. The Governor may include funding in the Fiscal Year 2026 budget for five additional beds at the John L. Gildner Regional Institute for Children and Adolescents. Additionally, the bill clarifies that Maryland's Mental Health and Substance Use Disorder Registry and Referral System includes both private and public inpatient and outpatient services.

Senate Bill 310: Education – Youth Suicide Prevention School Program – Revisions (passed) expands the educational programs authorized under the Youth Suicide Prevention School Program to include classroom instruction designed to increase pupils' awareness of the relationship between gambling and youth suicide. MedChi supported this bill.

Senate Bill 130: Education – Student Personal Electronic Device Use Policy – Required (failed) recognized the growing concerns about the impact of excessive screen time on academic performance, mental health, and social development, MedChi submitted a general letter of information in support of limiting cell phone use during instructional time, while not weighing in on specific implementation details. Senate Bill 130 required the Maryland State Department of Education, in collaboration with stakeholders, to develop statewide guidelines for the use of personal electronic devices (PEDs), including smartphones, tablets, laptops, and smartwatches, by students during school hours. Each local board of education would have then adopted a policy limiting the use of PEDs, developed in consultation with parents, teachers, students, and school staff. The policy included exemptions for students with documented needs in an individualized education program or a Section 504 plan, as well as health-related uses and instances where devices are used for instructional purposes as directed by staff. Policies would be included in student handbooks, shared with school personnel, and reviewed every two years.

Cannabis

MedChi opposed ***Senate Bill 215: Cannabis Reform – Revisions (passed)***, due to significant concerns about public health and safety. While the original bill included provisions for "cannabis events" allowing on-site consumption of cannabis products at temporary events, those provisions were removed through amendments. As passed, the law extends the authorization for social equity dispensary license holders to continue delivering medical cannabis until July 1, 2026, and requires on-site consumption establishments

to obtain all necessary approvals to operate a food service facility, including relevant building and mechanical code permits, a use and occupancy certificate, and any other applicable licenses. It also clarifies that cannabinoid beverages are subject to Maryland's sales and use tax.

MedChi strongly opposed House Bill 880 and House Bill 1377. Both bills aimed to loosen restrictions on cannabis advertising but approached the issue differently. ***House Bill 880: Cannabis – Prohibition on Outdoor Advertising – Repeal (failed)*** sought to remove existing advertising restrictions, including the ban on marketing to individuals under 21. In contrast, ***House Bill 1377*: Cannabis – Advertising – Prohibited Locations (Equity in Cannabis Advertising Act) (failed)** took a more measured approach by prohibiting cannabis advertising within 500 feet of substance use treatment facilities, schools, childcare centers, and other specified locations. It also included a provision allowing cannabis licensees to request advisory opinions from the Maryland Cannabis Administration (MCA) regarding compliance, with MCA required to respond within 30 days. Ultimately, neither bill advanced.

Miscellaneous

House Bill 930/Senate Bill 848: Public Health Abortion Grant Program – Establishment (passed) had strong support in both chambers. With the Chair of Budget and Taxation Committee as the Senate sponsor and an impressive 84 cosponsors in the House, this bill establishes the Public Health Abortion Grant Program (and Fund) in MDH to provide grants to improve access to abortion care clinical services. Excess funds in carriers' segregated accounts for abortion care clinical services under the federal Patient Protection and ACA must be used to support improving access to abortion care clinical services. MedChi supported the bill as it provides financial assistance to eligible organizations, helping them meet the operational needs of abortion care providers. These grants can be used to cover administrative costs and enhance service delivery, thereby strengthening the overall infrastructure and accessibility of abortion care across Maryland. Republicans attempted to amend the bill to limit its application to Maryland residents only; however, the amendment was rejected, ensuring broader access to care for all individuals seeking services in the state.

Senate Bill 253: Controlled Hazardous Substance Facility Permit – Research Facilities – Chemical Warfare Material Requirements (passed) was substantially amended to address some of MedChi's concerns. The revised bill has provisions intended to provide stronger oversight, enhanced safety measures, and increased transparency. The bill authorizes the Maryland Department of the Environment to issue research, development, and demonstration (RDD) permits and establishes specific requirements for such permits. Although MedChi opposed the bill, we successfully advocated for an amendment that focuses on emergency preparedness and response. With MedChi's input, the Department of Commerce worked on amendments that now require RDD applicants to demonstrate they have adequately planned and secured funding for an emergency preparedness strategy. This includes a plan for evacuating, sheltering, and protecting individuals in the largest area at risk during a maximum credible event, as determined by the Department.

Special Thanks

MedChi thanks those members who served on the MedChi Council on Legislation 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. Lawrence J. Green (Boards and Commissions), Dr. Karen M. Dionesotes (Public Health), and Dr. Anuradha D. Reddy

(Health Insurance), and to our Council on Legislation co-chairs Dr. Clement S. Banda and Dr. Kathleen D. Keeffe.

MedChi also recognizes those physicians who testified on behalf of MedChi for various initiatives, including Dr. James York, Dr. Deondre Asike, Dr. Padmini Ranasinghe, and Dr. Renee Bovelle.

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 would also like to thank Colleen White, RN, and Megan Wobbe, BSN, for their dedication in staffing the First Aid Room during the Session.

Doctors who staffed the First Aid Room this Session include:

Dr. Paul Barbera
Dr. Marie-Alberte Boursiquot
Dr. Bhawna Bahethi
Dr. Joy Baldwin
Dr. Anne Banfield
Dr. Randi Braman
Dr. Tyler Cymet
Dr. Sonny Goel
Dr. John Gordon
Dr. Pallavi Gowda
Dr. Benjamin Goldstein
Dr. Lawrence Green
Dr. Amit Kalaria
Dr. Kathryn Kelly
Dr. George Malouf
Dr. Erinn Maury
Dr. Sarah Merritt
Dr. Robin Motter-Mast
Dr. Dan Morhaim
Dr. Michael Murphy
Dr. Lane Neidig
Dr. J. Michael Niehoff
Dr. Kalpana Prakasa
Dr. Gary Pushkin
Dr. Padmini Ranasinghe
Dr. Anuradha Reddy
Dr. Stephen Rockower
Dr. Bernita Taylor
Dr. James Williams
Dr. H. Russell Wright, Jr.
Dr. James York