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## MedChi Final 2018 Session Report

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The 438<sup>th</sup> Session of the Maryland General Assembly began at noon on Wednesday, January 10<sup>th</sup> and concluded at midnight on Monday, April 9<sup>th</sup> when it adjourned “Sine Die” with the traditional confetti release in both the Senate and House chambers. In between, the General Assembly considered 3,127 bills and resolutions. By comparison, in 2017, the General Assembly considered 2,876 bills and resolutions and in 2016, considered 2,832 bills and resolutions. Why the sharp increase? Simply stated, 2018 is an election year and election year equals more bills to respond to constituent issues.

Below is a comprehensive review of the issues advocated on by MedChi this Session.

### Medical Liability Reform Legislation

After many years of relative quiet on the medical liability reform front, ***Senate Bill 30/House Bill 1581: Health Care Malpractice Qualified Expert – Limitation on Testimony in Personal Injury Claims (failed)***. As introduced, this bill proposed to repeal the “20% Rule”, which limited standard of care experts who sign the certificate of qualified expert or testify at trial to using no more than 20% of their time testifying as expert witnesses. This longstanding rule prevented the use of “professional witnesses”. The Senate passed the bill as introduced by a vote of 29-16. The House amended both the Senate and House bills to address the problem raised by the plaintiff’s lawyers—that an expert could become disqualified under the 20% Rule during the pendency of the case due to retirement, illness, or changes in his/her practice. As amended by the House, once the expert qualifies, he/she remains qualified for the entire case.

The Senate refused to accept these amendments, and a conference committee was appointed in the closing days of the Session. The conference committee met and recommended returning the bill to its original form—a full repeal of the 20% Rule. Under intense lobbying by MedChi, the bill passed by only 1 vote in the Senate. However, the House voted it unfavorable on the floor (41-89). **The bill died!**

Other bills that failed included: ***House Bill 289/Senate Bill 36: Civil Actions – Noneconomic Damages (failed)***, which would have tripled noneconomic damages; ***Senate Bill 5: Civil Actions – Punitive Damage Awards (failed)***, which would have allowed certain civil cases to be subject to punitive damages; and ***House Bill 909/Senate Bill 862: Maryland No-Fault Birth Injury Fund (failed)***, which would have created a birth injury fund in Maryland.

### Fiscal Year 2019 Budget and Physician Payments

MedChi successfully maintained the additional \$17.6 million provided in the Governor’s Fiscal Year 2019 budget to fund Medicaid physician rates. The Fiscal Year 2019 budget also provides \$150,000 for the

development of continuing medical education courses (developed in collaboration with a Maryland-based nonprofit accredited by the Accreditation Council for Continuing Medical Education) on: 1) medical best practices for individuals with sickle-cell disease; 2) opioid use disorder with a focus on addiction treatment, and 3) medical best practices and treatment for Lyme disease.

The Fiscal Year 2019 budget also requires the Maryland Department of Health (MDH) to submit reports on:

- A broad-based plan to address Hepatitis C in Maryland (submitted by July 1, 2018);
- The impact of data matching cost containment initiatives as well as MDH's proposed mail return policy under Medicaid, including tracking the number of individuals removed from the Medicaid program each month after implementation; if, and when, those individuals returned to the Medicaid program; and the number of individuals who are re-categorized but remain on the Medicaid program (submitted by September 1, 2018 and final December 1, 2018);
- The progress for implementing the technology program – Maryland Total Human-Services Information Network (MD THIINK) (submitted on a quarterly basis).

### **Fighting Opioid Abuse and Addressing Substance Use and Behavioral Health Disorders**

For the third straight session, the General Assembly and the Governor made Maryland's opioid crisis a top priority. MedChi worked hard to educate the legislators on the improvements and efforts initiated by MedChi on this important public health crisis as well as to ensure that physicians continue to have the flexibility to treat each patient's health care needs. In the end, that balance was again achieved.

- ***Funding***

The Hogan Administration proposed additional money for the Opioid Crisis Fund (OCF), raising the appropriation from \$10 million in fiscal year 2018 to \$13 million for fiscal year 2019. However, the Administration advised that \$5.3 million of these fiscal year 2019 funds have already been designated to support the 2% rate increase for providers, in response to both the HOPE and Treatment Act as well as budget language that prioritized new initiatives within the HOPE Act when it came to making decisions on OCF funding. Given the slow, bureaucratic release of OCF funding by the Opioid Operational Command Center (OOCC) to the Opioid Intervention Teams in fiscal year 2018, the budget now requires the OOCC to provide quarterly reports on OCF spending.

In addition, the General Assembly statutorily mandated additional funds to fight the opioid crisis through ***House Bill 1092/Senate Bill 703: Behavioral Health Crisis Response Grant Program – Establishment (passed)***, which provides funds to local jurisdictions to establish and expand community behavioral health crisis response systems. The Governor must include the following appropriations in the State operating budget for the program: (1) \$3 million for fiscal 2020; (2) \$4 million for fiscal 2021; and (3) \$5 million for fiscal 2022.

- ***Opioid Initiatives***

***House Bill 88/Senate Bill 1083: Public Health – Prescription Drug Monitoring Program – Revisions (failed)*** was the opioid-related legislation that was the primary focus of MedChi's advocacy. As introduced, the legislation would have allowed direct referral of a provider to both law enforcement and the licensing boards. The House passed an amended bill that removed law enforcement and reflected other changes acceptable to MedChi, but also authorized direct referral to the Office of Controlled

Substances Administration (OCSA) which MedChi opposed. The Senate amended the bill with the acceptable provisions reflected in the House bill and authorized referral to the professional boards, as opposed to OCSA, only if reviewed and recommended for referral by the Technical Advisory Committee (TAC). The Senate and House did not resolve the differences and the bill failed in the final hours of the Session.

***House Bill 922: Maryland Department of Health – “Pill Mill” Tip Line and Overdose Report (passed).*** Supported by MedChi, it establishes a hotline allowing citizens to report suspected over-prescribing by licensed health professionals, and those reports are forwarded to the professional licensing board with jurisdiction. To identify ways to better address the epidemic, the bill was amended to require a multi-departmental analysis of the prescription and treatment history, including court-ordered treatment or treatment provided through the criminal justice system, of individuals who have suffered fatal overdoses involving opiates and other controlled dangerous substances in the preceding 4 calendar years. The additional language is based on a Massachusetts initiative referred to as the Chapter 55 Project. The bill also includes a study of the “Hub and Spoke” model of behavioral health care service delivery, which has been implemented in Vermont.

The Administration’s initiative ***House Bill 359: Health – Reporting of Overdose Information (passed).*** Supported by MedChi, the bill enables EMS personnel and law enforcement to enter information related to the location of overdoses into a multijurisdictional database. The information in the database does not contain individualized data and is to be used to better focus resources for prevention, intervention, and enforcement. A law enforcement agency may not publish the exact location of an overdose unless there is a valid public safety concern. The bill also requires the OOC to provide a comprehensive report regarding the reporting of overdoses to the multijurisdictional database.

***House Bill 653/Senate Bill 522: Health Care Providers – Opioid Prescriptions – Advice Regarding Benefits and Risks (passed)*** deletes all the originally proposed language. As amended, the bill essentially restates existing direction for patient communication that is already incorporated in all evidenced-based guidelines for prescribing, which is to advise the patient of the benefits and risks associated with the opioid. The bill also addresses patient communication related to co-prescribing of opioids and benzodiazepines.

***House Bill 1452/Senate Bill 1223: Controlled Dangerous Substances Registration – Authorized Providers – Continuing Education (passed)*** requires a provider to attest to having taken 2 hours of continuing education related to prescribing or dispensing opioids at the time a provider registers for a Controlled Dangerous Substance (CDS) certificate, or at the first renewal of the registration after the implementation of the law. It is a one-time requirement that is linked to the provider’s CDS registration and not to their medical license.

***House Bill 517: Prescription Drug Monitoring Program – Data Request Exemption – Surgical Procedures (passed)*** strengthens and clarifies the current exemption for surgical procedures from the requirement to query the Prescription Drug Monitoring Program (PDMP). Under current law a prescriber is not required to request data from PDMP when prescribing or dispensing an opioid or benzodiazepine to treat or prevent acute pain, for a period of up to 14 days, following a surgical procedure in which general anesthesia was used. The bill removes the reference to general anesthesia in recognition of the fact that the type of anesthesia associated with a surgical procedure is not indicative of the need to address acute pain.

**House Bill 1716: Prescription Drug Monitoring Program – Prescription Monitoring Data – Insurance Carriers (failed)** would have required the PDMP to disclose prescription drug monitoring data to insurance carriers for determining the medical necessity of a prescription drug claim, enhancing or coordinating patient care, or assisting the treating provider's clinical decision making. Strongly opposed by MedChi, the bill failed.

**House Bill 601/Senate Bill 1255: Public Health – Opioids – Dispensing Requirement (failed).** As introduced the bill would have required all prescribers when prescribing an opioid to also provide the patient with a product designed to deactivate the opioid for purposes of disposal. The Senate amended the bill to be permissive, not mandatory and to only apply to pharmacists, however the House took no action on the legislation.

Though introduced and refined over three successive legislative sessions, **House Bill 326/Senate Bill 288: Public Health – Overdose and Infectious Disease Prevention Supervised Drug Consumption Facility Program (failed)**, which proposed providing a place for the consumption of pre-obtained drugs with sterile needles, failed.

**House Bill 1271: Family Law – Opioid-Exposed Newborns and Parents Addicted to Opioids – Mobile Application (I'm Alive Today App) (failed).** The bill required a court to make a referral to the local social services department for an assessment of the risk of harm to and safety of a child if the child's parent has been found guilty of possession of an opioid. The bill would have also required the Department of Human Services to develop a mobile application to track parents who had been referred to the Courts.

- **Behavioral Health Initiatives**

**House Bill 772/Senate Bill 765: Maryland Department of Health – Reimbursement for Services Provided by Certified Peer Recovery Specialists – Workgroup and Report (passed).** The bill requires the Secretary of MDH to convene a stakeholder workgroup to make findings and recommendations regarding the reimbursement of certified peer recovery specialists, including whether a Medicaid State Plan Amendment is required.

**House Bill 1652/Senate Bill 704: Maryland Medical Assistance Program – Telemedicine – Assertive Community Treatment and Mobile Treatment Services (passed).** The bill requires that, if MDH specifies by regulation the types of health care providers eligible to receive reimbursement for Medicaid telemedicine services, the types of providers must include psychiatrists providing assertive community treatment (ACT) or mobile treatment services (MTS) in a home or community-based setting. The bill also specifies that ACT and MTS, for purposes of reimbursement and any fidelity standards established by MDH, are equivalent to the same health care service when provided through in-person consultation. Expansion of telehealth services under Medicaid has historically been opposed by MDH based on fiscal concerns. Consequently, the bill sunsets in 2 years and MDH is required to report to the Senate Finance and House Health and Government Operations Committee by September 1, 2020 on the costs associated with psychiatrists providing ACT or MTS via telehealth.

**House Bill 1682/Senate Bill 835: Maryland Medical Assistance Program – Collaborative Care Pilot Program (passed)** The bill establishes a Collaborative Care Pilot Program. MDH must apply for an amendment to the State's § 1115 HealthChoice Demonstration Waiver, if necessary, to implement the pilot program, which is to be developed by MDH in collaboration with stakeholders. MDH will administer the pilot program and select up to three sites at which a collaborative care model must be established over a four-year period. The sites selected must be adult or pediatric non-specialty medical practices or health

systems that serve a considerable number of Medicaid enrollees. To the extent practicable, one of the sites must be in a rural area of the State. The pilot program has a four-year sunset and by November 1, 2023, MDH must report to the Governor and the General Assembly on its findings and recommendations. For fiscal 2020 through 2023, the Governor must include in the annual budget an appropriation of \$550,000 for the pilot program.

### **Scope of Practice and Physician Licensure**

For the second year in a row, the optometrists attempted to broaden their scope of practice but were unsuccessful. After the failure of a bill to pass during the 2017 Session, the Chairs of the House Health and Government Operations Committee and the Senate Education, Health and Environmental Affairs Committee requested that the Maryland Society of Eye Physicians and Surgeons (MSEPS), MedChi and the Maryland Optometrist Association (MOA) meet over the interim to develop consensus legislation. Over a dozen meetings were held but an agreement was not achieved. Regardless, Delegate Karen Young introduced *House Bill 1296: Health Occupations – Practice of Optometry – Therapeutically Certified Optometrists (failed)*, which favored the optometrists. However, before a hearing could even be scheduled on the bill, Senator Joan Carter Conway announced that she would not support a bill that could not be supported by MSEPS. Consequently, Delegate Young withdrew her bill. It is expected that MOA will once again introduce a bill during the next term.

*House Bill 591/Senate Bill 549: Health Occupations – Physician Assistants – Dispensing of Drugs Under a Delegation Agreement (passed)*. MedChi supported these bills, which allow a physician assistant to dispense drugs, if allowed by the physician under the delegation agreement. The physician thus retains control over whether a physician assistant can dispense at all, and if so, which drugs.

*House Bill 596/Senate Bill 234: Interstate Medical Licensure Compact (passed)*. These bills make Maryland a member of the Interstate Medical Compact. Per the MedChi House of Delegates Resolution, MedChi supported this bill. For those who choose, effective in July of 2019, they can obtain a Compact license through the Maryland Board which will allow them to also obtain a license in other Compact member states. The Compact should simplify the licensure process, in that the principal state of licensure verifies the credentials of the physician, and the other Compact states are then required to license that physician. The physician remains subject to the particular requirements of each state following licensure through the Compact.

*House Bill 857: Health Occupations – Physicians – Specialty Certifications (failed)*. This bill would have prohibited hospitals and insurers from requiring physicians to *maintain* their specialty certifications through the American Board of Medical Specialties. MedChi supported this bill, as many physicians have expressed frustration with the costs and time commitment required to maintain their certification. The hospitals and insurers all opposed it. However, MedChi did secure a letter from Chairman Shane Pendergrass of the House Health and Government Operations Committee, directing the Maryland Health Care Commission (MHCC) to study the issue over the interim, and MedChi will be involved in that study.

*House Bill 863: State Board of Nursing – Advanced Practice Registered Nurses – Certification and Practice (passed)*. As introduced, this bill codified certain existing scope of practice functions of nurse anesthetists, but also altered their scope. MedChi opposed the bill. Through amendments, the bill was limited to codifying the scope as it currently exists in regulation.

*House Bill 1008/Senate Bill 1087: State Board of Physicians – Invasive Cardiovascular Professionals (failed)*. These bills would have established a licensure process for those who assist in heart procedures,

but was poorly defined and encroached on other already licensed professionals' scopes of practice. MedChi was asked to support the bill by the cardiologists, but ultimately took no position because of these concerns.

***House Bill 1063: Physicians – Dispensing Permit Exemption – Prepackaged Topical (failed).*** This legislation would have exempted certain prepacked creams, lotions or solutions used in plastic surgery from the requirement of having a dispensing permit. MedChi supported the measure with an amendment to clarify that any such product containing an opioid still required a permit.

***House Bill 1193: Physicians – Discipline – Procedures and Effects (failed).*** Introduced in response to a disciplinary proceeding before the Board of Physicians, this legislation sought to address several issues related to the process. The bill would have established that when two peer reviewers do not agree on the standard of care, that this would end the inquiry, rather than obtaining a third review. It would also prohibit insurers from keeping physicians off their networks for periods that exceed any probationary period set by the Board. MedChi will continue to work on these issues through a panel set up by our Board of Trustees.

***House Bill 1194/Senate Bill 1023: Health – Drug Cost Review Commission (failed).*** This legislation, would have, among other things, established a Commission to conduct a review of certain drug costs, and in some circumstances been authorized to set reimbursement levels. The Attorney General would have been authorized to act against manufacturers who failed to comply with those levels. MedChi sent a letter of information stating support for transparency, but expressed concern regarding how the measure interacted with Maryland's unique All Payer Model. As amended by the House, the bill still established a Commission, but its role is limited to accessing public data on pharmaceutical pricing, or accessing public and non-public data through memoranda of understanding with other states which already review pricing information.

***House Bill 1266/Senate Bill 950: Health Occupations – Treatment of Lyme Disease and Other Tick-Borne Diseases – Disciplinary Actions (failed).*** Frustrated by physicians who are unwilling to prescribe certain treatments for Lyme Disease for fear of disciplinary action, the advocates for this measure sought to exempt those willing to do so from board discipline. MedChi opposed the measure because exempting those physicians from discipline who use unproven treatments for any disease undermines adherence to the established standard of care. However, MedChi did work with Delegate Carey to secure \$50,000 in Board funding for continuing medical education on new treatments for Lyme Disease in an effort to better educate the physician community.

***House Bill 1416: Drugs and Devices – Electronic Prescriptions – Requirements (failed).*** This bill would have required that prescriptions be handled electronically rather than in writing, except under certain identified exceptions. While prescription data is moving in that direction, MedChi opposed the bill because not all providers are in a position to write every prescription electronically, and because of other factors related to effective implementation of the bill.

***House Bill 1430: Health Occupations – Podiatric Physicians (failed).*** This bill would have allowed podiatrists to refer to themselves as “physicians”. MedChi strongly opposed this bill because this term has been reserved under Maryland law for those who have M.D's or D.O's, and so that patients can distinguish among those already calling themselves “doctor”.

***Senate Bill 531/House Bill 718: Insurance Law – Application to Direct Primary Care Agreements – Exclusion (failed)*** would have defined a “direct primary care agreement” and specifies that such an

agreement is not health insurance, a health benefit plan, or long-term care insurance, nor is it subject to provisions governing health insurance or nonprofit health benefit plans. The bill also would have exempted a primary care provider (or agent) that provides primary care services in accordance with a “direct primary care agreement” from insurance producer licensing requirements. The bill was introduced by the Academy of Family Physicians.

## **Public Health**

- ***Maternal and Child Health***

***House Bill 994/Senate Bill 774: Maryland Medical Assistance Program – Family Planning Services (passed).*** The bill requires MDH to apply to CMS for a State Plan amendment that expands eligibility for family planning services, subject to the State Budget, to individuals whose income is at or below 250% of poverty and does not impose a limit on the age of an individual able to receive family planning services. The bill also requires Medicaid and the Children’s Health Program to expand coverage of a single dispensing of prescription contraceptives from 6 months to 12 months. Finally, the bill requires MDH in conjunction with the Maryland Health Care Exchange to develop a presumptive eligibility and enrollment program that will ultimately be offered on the Health Care Exchange. A workgroup of stakeholders is to be convened to advise the Department on implementation.

***House Bill 1518: Public Health – Maternal Mortality Review Program – Report and Stakeholder Meetings (passed).*** The bill, as amended, makes no changes to the composition of the Mortality Review Committee but rather creates a stakeholder engagement process twice a year to review the work of the Committee and to make recommendations for addressing the findings of the Committee. A summary of the stakeholder meetings and their recommendations will be included in the annual report.

***House Bill 716/Senate Bill 266: Maryland Health Care Commission – Mortality Rates of African American Infants and Infants in Rural Areas – Study (passed).*** The bill requires MHCC, in consultation with the Office of Minority Health and Health Disparities, the Maternal and Child Health Bureau, the Vital Statistics Administration, and interested stakeholders, to conduct a study on the mortality rates of African American infants and infants in rural areas. The study is to examine several factors relative to infant mortality and means to address those factors. The Commission is to report its findings and recommendations by November 1, 2019.

***House Bill 1685/Senate Bill 912: Maryland Prenatal and Infant Care Coordination Services Grant Program Fund (Thrive by Three Fund) (passed).*** This bill establishes a Maryland Prenatal and Infant Care Coordination Services Grant Program Fund to provide grants to counties and municipalities for care coordination services to low-income pregnant and postpartum women and to children from birth to age three. The Secretary of Health must award grants from the fund and, in coordination with members of the Children’s Cabinet, establish procedures to distribute money to local jurisdictions according to specified priorities. The bill does not provide for mandated funding and therefore will be funded in accordance with whatever revenues are included in the budget.

***House Bill 1744: Child Abuse and Neglect – Substance-Exposed Newborns – Reporting (passed).*** The bill reflects changes that were required to be made to Maryland’s current reporting framework for State compliance with the federal Child Abuse Prevention and Treatment Act (CAPTA) and Comprehensive Addiction and Recovery Act (CARA) to ensure the State did not lose more than \$700 million in annual federal grant funding, which is distributed to all 24 local departments of social services to support child protective services programs that benefit at-risk families and children.

- ***Environmental Health***

***House Bill 116/Senate Bill 500: Pesticides – Use of Chlorpyrifos – Prohibition (failed)***. As originally proposed the bill prohibited the use of chlorpyrifos before it was amended in the Senate into a workgroup to study the idea. Nevertheless, it was recommitted to committee on the Senate floor, where the bill ultimately died. It is an issue that will undoubtedly be revisited in 2019.

***House Bill 304/Senate Bill 801: Environment – Reduction of Lead Risk in Housing – Elevated Blood Lead Levels (failed)***. The bill would have reduced from 10 micrograms per deciliter to 5 micrograms per deciliter the elevated blood lead level that initiates certain case management, notification, and lead risk reduction requirements. The proposed change would have been in line with current Centers for Disease Control and Prevention recommendations. Both the Department of the Environment and MDH supported the lower level but indicated a need for the development of protocols for investigations and remediation of the lower threshold levels given current limitations in local health departments' protocols for investigation. While the legislation failed, the Chair of the House Committee has indicated it is an issue that will be given consideration during the interim in anticipation for further work towards the objectives in the 2019 Session.

***House Bill 852/Senate Bill 524: Landlord and Tenant – Repossession for Failure to Pay Rent – Lead Risk Reduction Compliance (failed)***. It would have addressed lead risk reduction compliance certification in eviction cases for failure to pay rent. The bill passed the House but was not acted upon in the Senate.

- ***Rural Health Initiatives***

Following the recommendation of the Rural Health Care Delivery Workgroup for a rural health collaborative, Senator Steve Hershey introduced ***Senate Bill 1056: Rural Health Collaborative Pilot (passed)***. As a participant of the workgroup, MedChi successfully lobbied passage of the bill, which will provide the State an opportunity to explore creative mechanisms to ensure that rural areas of the State are able to establish comprehensive, integrated and responsive health care delivery systems that can provide appropriate access to high quality, cost effective health care services to the residents of their region.

***Senate Bill 682: Emergency Medical Services Providers – Coverage and Reimbursement of Services – Reports and Plan (passed)*** as originally introduced would have allowed reimbursement to emergency medical services providers even when transport does not occur and would have allowed reimbursement to alternative locations (other than a hospital). Heavily opposed by the insurance carriers and the Maryland Health Care Commission, the bill was amended to require MHCC and the Maryland Institute for Emergency Medical Services Systems, in consultation with specified entities, to jointly (1) develop a statewide plan for the reimbursement of services provided by emergency medical services providers to Medicaid recipients; (2) identify a process for obtaining Medicare reimbursement for such services; (3) study and make recommendations regarding the desirability and feasibility of reimbursement for such services provided to privately insured individuals; and (4) submit reports to the Governor and General Assembly. MedChi is a named stakeholder in the bill.

- ***School Based Initiatives***

There were several bills geared toward school-aged youth. ***House Bill 427/Senate Bill 217: Public Schools – Student Sunscreen Use – Policy (passed)*** was passed and requires local school boards to adopt a written policy authorizing a student to possess and use sunscreen on school property or at a school-

sponsored activity without written permission from a health care provider and to educate parents on the policy and the use of sunscreen.

***House Bill 315/Senate Bill 740: State Department of Education – Breakfast and Lunch Programs – Funding (Maryland Cares for Kids Act) (passed).*** The Maryland Cares for Kids Act passed and makes the State responsible for the student share of the costs of reduced-price breakfasts provided under the federal School Breakfast Program and reduced-price lunches provided under the National School Lunch Program by fiscal year 2023, and phases in this responsibility beginning with fiscal year 2020.

***House Bill 1110: Public Schools – Health and Safety Best Practices – Digital Devices*** passed and requires the State Department of Education in conjunction with MDH to develop health and safety best practices, for the use of digital devices in classrooms, which will then be provided to the local boards of education for consideration and adoption.

### **Pharmaceuticals and Pharmacies**

In an overwhelming show of support, the General Assembly supported ***House Bill 736/Senate Bill 576: Pharmacy Benefits Managers – Pharmacies and Pharmacists – Information on and Sales of Prescription Drugs (passed)***, which prohibits “gag clauses” and allows pharmacists to discuss the retail price of a prescription versus the patient’s cost. The bill maintains current law regarding the dispensing of generics and biologics.

***House Bill 115/Senate Bill 13: Maryland Health Care Commission – Electronic Prescription Records System – Assessment and Report (passed)***, a bill advocated for by Delegate Dan Morhaim, M.D., requires MHCC to convene interested stakeholders to assess the feasibility of developing an electronic system to allow health care providers to access a patient’s prescription medication history. By January 1, 2020, MHCC, in consultation with interested stakeholders, must report its findings and recommendations to the Governor and the General Assembly. The bill was originally opposed by MedChi because it would have required all prescriptions, not just controlled dangerous substances, to be transmitted through the PDMP. While MedChi could support the intent of the legislation, the larger concern was the use of the PDMP as the “pipes” before the PDMP is fully operational and the mandatory query (July 1, 2018) takes effect. MedChi supported the workgroup and subsequent report.

***House Bill 1283: Health Insurance – Prescription Contraceptives – Coverage for Single Dispensing (passed)*** requires carriers that provides coverage for contraceptive drugs and devices to provide coverage for a single dispensing of up to a 12-month supply of prescription contraceptives. The bill may not be construed to require a provider to prescribe, furnish, or dispense 12 months of contraceptives at one time.

***House Bill 1558: Pharmacists – Dispensing of Prescription Drugs – Single Dispensing of Dosage Units (passed)*** authorizes a pharmacist to dispense, in a single dispensing and exercising the professional judgment of the pharmacist, a quantity of a prescription drug that (1) is up to the total number of dosage units authorized by the original prescription and any refills and (2) does not exceed a 90-day supply of the drug. For a contraceptive dispensed on or after January 1, 2020, the single dispensing cannot exceed a 12-month supply of the drug. The authorization does not apply to a CDS or the first prescription or change in a prescription for a patient. A pharmacist may not dispense, in a single dose, a quantity of a prescription drug that exceeds the limit prescribed if the prescriber has indicated that the prescription be dispensed only as prescribed.

## Health Insurance

- *Stabilizing the Individual Health Insurance Marketplace and the Use of Health Savings Accounts*

Perhaps the most time sensitive issue affecting health insurance this Session was the need to stabilize the individual health insurance market. After years of double-digit premium increases and the reduction of insurance carriers in the individual health insurance marketplace, the General Assembly feared a collapse of this product. Therefore, a special committee in the General Assembly was formed to discuss options, which lead to the passage of two bills. ***House Bill 1782/Senate Bill 387: Health Insurance – Individual Market Stabilization (Maryland Health Care Access Act of 2018) (passed)*** and ***House Bill 1795/Senate Bill 1267: Maryland Health Benefit Exchange – Establishment of a Reinsurance Program (passed)*** seek to stabilize the individual health insurance market. The bills authorize the State to apply to the federal government to develop a Section 1332 reinsurance program under the Affordable Care Act (ACA), which would be primarily funded through the recoupment of the 2.75% health insurance provider fee that would have otherwise been assessed under the ACA but was suspended earlier this year, which is estimated to be approximately \$375 million. Additional monies will be available from the federal government under an approved 1332 waiver program. To expedite the process needed to file the application with the federal government, the Governor signed House Bill 1795/Senate Bill 1267 into law on April 5<sup>th</sup>.

The bills also will require the current Maryland Health Insurance Coverage Protection Commission to study and make recommendations for individual and group health insurance market stability, including: (i) the components of one or more waivers under § 1332 of the ACA to ensure market stability that may be submitted by the State; (ii) whether to pursue a standard plan design that limits cost sharing; (iii) **whether to merge the individual and small group health insurance markets for rating purposes**; (iv) whether to pursue a basic health program; (v) whether to pursue a Medicaid buy-in program for the individual market; (vi) whether to provide subsidies that supplement premium tax credits or cost-sharing reductions described in § 1402(c) of the ACA; and (vii) whether to adopt a State-based individual health insurance mandate and how to use payments collected from individuals who do not maintain minimum essential coverage, including use of the payments to assist individuals in purchasing health insurance. MedChi will continue to monitor this Commission, especially the provision to study the merger of the individual and small group health insurance market.

On a related issue, the General Assembly passed legislation to ensure that health savings accounts connected with high deductible health plans (HDHP) can continue to be used in Maryland – ***Senate Bill 137/House Bill 135: Health Insurance – Coverage for Male Sterilization – High Deductible Health Plans (passed)***. The validity of health savings accounts arose because on January 1, 2018, Maryland implemented the Contraceptive Equity Act, which prohibited an insurer from imposing a copay or a deductible on vasectomies. The IRS does not allow the waiver of deductibles under the ACA on services that are not preventive. On March 5, 2018, the IRS provided further guidance on this issue by promulgating Notice 2018-12, which stated that a health plan that provides benefits for male sterilization before satisfying the minimum deductible for an HDHP does not constitute an HDHP, regardless of whether such coverage is required by state law. However, the notice provides transitional relief until calendar 2020. Senate Bill 137/House Bill 135 provides a long-term fix.

In addition, the General Assembly passed ***House Bill 1400: State Employee and Retiree Health and Welfare Benefits Program – Employees of County Boards (passed)***, advocated by Delegate Dan Morhaim, authorizes local boards of education, including the Baltimore City Board of School Commissioners, to participate as satellite organizations in the State Employee and Retiree Health and

Welfare Benefits Program (the State health plan). The bill also establishes a Task Force to Study Cooperative Purchasing for Health Insurance. In order to pool public employee health care purchasing by the State, counties, municipal corporations, and county boards to maximize value while maintaining a broad package of benefits and reasonable premiums, the Task Force is charged with: (1) studying models of cooperative purchasing of health insurance; and (2) recommending the health insurance benefit options that should be offered to: (i) nonprofit organizations that qualify and elect to participate in the State health plan; (ii) county, municipal corporation, and county board employees; (iii) a surviving spouse, child, or dependent parent of a county, municipal corporation, or county board employee who died while employed by the State; and (iv) a retired county, municipal corporation, or county board employee.

- ***Mandated Benefits/Coverage***

While MedChi typically does not take positions on mandated benefits, we do monitor the bills and several did pass this Session. ***House Bill 249/Senate Bill 33: Health Insurance – Coverage for Fertility Awareness-Based Methods (passed)*** requires carriers that provide hospital, medical, or surgical benefits to provide coverage for instruction by a licensed health care provider on “fertility awareness-based methods” to avoid pregnancy.

***House Bill 847: Health Insurance – Coverage for Lymphedema Diagnosis, Evaluation, and Treatment (passed)*** requires carriers that provides hospital, medical, or surgical benefits to provide coverage for the medically necessary diagnosis, evaluation, and treatment of lymphedema.

***House Bill 908/Senate Bill 271: Health Insurance – Coverage of Fertility Preservation Procedures for Iatrogenic Infertility (passed)*** requires carriers to provide coverage for “standard fertility preservation procedures” that are (1) performed on a policyholder or subscriber or on the covered dependent of a policyholder or subscriber and (2) medically necessary to preserve fertility due to a need for medical treatment that may directly or indirectly cause “iatrogenic infertility.” However, a carrier may not be required to provide this coverage to a religious organization that requests and receives an exclusion from specified in vitro fertilization (IVF) coverage. This bill was strongly supported by the Maryland DC Society of Clinical Oncologists.

\*\* Both House Bill 847 and House Bill 908/Senate Bill 721 were the subject of study and 2017 reports by MHCC on the costs of the mandates.

***Senate Bill 656/House Bill 86: Health Insurance – Coverage for Elevated or Impaired Blood Glucose Levels, Prediabetes, and Obesity Treatment (passed)*** expands the current health insurance mandate for coverage of medically appropriate and necessary diabetes equipment, supplies, and outpatient self-management training and educational services to apply to the treatment of (1) impaired blood glucose levels induced by pregnancy and (2) consistent with the American Diabetes Association’s standards, elevated or impaired blood glucose levels induced by prediabetes. The bill also authorizes specified reimbursement of services rendered by a licensed dietician or nutritionist for the treatment of prediabetes and obesity.

***House Bill 1132/Senate Bill 858: Health Insurance – Access to Local Health Departments (passed)*** requires carriers that use a provider panel to ensure that all enrollees have access to local health departments (LHDs) and covered services provided through LHDs, including behavioral health care services, to the extent that LHDs are willing to participate on a carrier’s provider panel. A carrier that is a group model health maintenance organization is exempt from these requirements.

***House Bill 1344/Senate Bill 702: Health Insurance – Behavioral Health Assessments, Services, and Treatment for Patients Provided Opioids – Coverage (failed)*** would have required carriers to provide coverage for: (1) a behavioral health assessment to determine the risk for opioid misuse or opioid use disorder and (2) services provided by a comprehensive pain management program for opioid weaning or a substance use disorder treatment program under specified circumstances. The House later amended the bill to be a study, but the bill still failed to pass.

Often, it takes two Sessions to pass legislation affecting insurance requirements, which will be the case this Session. ***House Bill 1546: Pharmacy Benefits Managers – Requirements for Prior Authorization (failed)***, introduced by Delegate Terri Hill, M.D., would have made several exemptions to prior authorization laws, including no longer requiring prior authorizations for medications needed by patients for long-term or chronic conditions. ***House Bill 1070: Health Insurance – Retroactive Denial of Reimbursement to Health Care Providers (failed)*** would have allowed a health care provider the option to pay the amount of the denied reimbursement in lieu of retention by the carrier of an equivalent amount of funds from another claim for reimbursement submitted by the health care provider. While the bills did not pass, MedChi is committed and has told the House Health and Government Operations Committee that it will convene a stakeholder workgroup over the interim to examine the issues and make recommendations for legislation in 2019.

### **Other Bills of Interest**

***House Bill 787/Senate Bill 629: Correctional Facilities – Pregnant Inmates – Medical Care (passed)*** requires each State and local correctional facility to have a written policy in place regarding the medical care of pregnant inmates and to provide the policy to an inmate at the time of a positive pregnancy test result.

***House Bill 797/Senate Bill 598: Correctional Services – Inmates – Menstrual Hygiene Products (passed)*** requires the managing official of a correctional facility to ensure that the facility has a sufficient supply of menstrual hygiene products available, a written policy and procedure in place requiring the products to be provided at no cost, and to maintain records on the provision and availability of menstrual hygiene products to inmates.

***House Bill 786/Senate Bill 539: Correctional Services – Restrictive Housing – Limitations (failed)***, which would have required the Department of Public Safety and Correctional Services to adhere to the standards of the American Corrections Association for restrictive housing in State correctional facilities, failed.

***House Bill 1467/Senate Bill 574: Public Health – Sepsis Public Awareness Campaign Workgroup (passed)*** requires the Secretary of Health to establish a Sepsis Public Awareness Campaign Workgroup to develop a public awareness campaign on sepsis awareness and prevention. The Workgroup is to provide a report to the Senate Finance and House Health and Government Operations Committees by December 1, 2018.

Unfortunately, ***House Bill 1224/Senate Bill 1218: Ending Youth Homelessness Act of 2018 (failed)***, which would have established a grant program on preventing and ending youth homelessness, failed.

### ***Special Thanks***

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

MedChi also recognizes those physicians who came to Annapolis on behalf of MedChi to testify on various initiatives, including Dr. Gary Pushkin, Dr. Jeff Fernley, Dr. Larry Green, and Dr. Casey Humbyrd.

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

Doctors who staffed the First Aid Room this Session include:

Gene Ashe, M.D.  
George Bone, M.D.  
Richard Bruno, M.D.  
William Chester, M.D.  
Jane Chew, M.D.  
Richard Cirillo, M.D.  
Geoff Coleman, M.D.  
J. Ramsay Farah, M.D.  
Walter J. Giblin, M.D.  
John Gordon, M.D.  
Natasha Herz, M.D.  
Ben Lowentritt, M.D.  
Loralie Ma, M.D.  
George Malouf, M.D.

Sarah Merritt, M.D.  
Joseph Nichols, M.D.  
Michael Niehoff, M.D.  
Gary Pushkin, M.D.  
Padmini Ranasinghe, M.D.  
Anuradha D. Reddy, M.D.  
Stephen Rockower, M.D.  
Marc Scheiner, M.D.  
Ben Stallings, M.D.  
Rosaire Verna, M.D.  
Reed Winston, M.D.  
Jacqueline Wisner, M.D.  
H. Russell Wright, M.D.  
James York, M.D.