

2006 General Assembly Wrap-Up

April 11, 2006

Prepared by MedChi Lobbying Team
Schwartz & Metz, P.A.
Joseph A. Schwartz, III
Pamela Metz Kasemeyer
J. Steven Wise

One of the most contentious sessions of the General Assembly in at least a generation adjourned *Sine Die* at midnight Monday, April 10th. The partisan divide in the Legislature was palpable as the 90-day Session began with repeated overrides of Governor Ehrlich's 2005 vetoes including the Wal-Mart health bill. The 90-day Session ended with repeated overrides of the Governor's vetoes of 2006 legislation including bills dealing with the Baltimore City school system, disallowing political fundraising by members of the Board of Regents of the University of Maryland and establishing early voting procedures for the upcoming 2006 election.

MedChi's ambitious legislative agenda was remarkably successful given the daunting odds and the level of opposition to MedChi initiatives, particularly from the health insurance industry. Four of the six MedChi "payment bills" were enacted. One of the most significant was **workers' compensation reform** (SB 555/HB 868) which was directed at curbing the practice of United Healthcare in "assigning" its network of physicians to workers' compensation carriers such as the Injured Workers Insurance Fund (IWIF). On the final day of the Session, the Assembly enacted a bill which allows a physician to "opt out" of that provision in the physician's contract with a health insurer which allows that insurer to assign that physician's contract for workers' compensation claims. After July 1st of this year, a physician may "opt out" at any time although contracts entered into on or before June 30th will not be affected until the current term of the contract expires. (Note: Practices presently negotiating with United Healthcare may wish to take this into consideration.)

Another MedChi payment initiative was legislation to require **network adequacy** (SB 686/HB 1003) which was enacted and will, in the future, not only guarantee that health insurers maintain accurate information regarding their networks of participating physicians but also charges the Maryland Insurance Administration with developing regulations to define what constitutes an adequate network. The legislation also requires an insurer to limit a member's or enrollee's cost sharing requirements to "in network" levels if it is determined that they cannot reasonably access an in-network provider and must see a non-participating provider.

Also enacted was legislation referred to as the **most favored nation** (SB 1086/HB 897) law which outlaws CareFirst's present practice of requiring contracting physicians to reduce their charges to CareFirst in the event that the physician agrees to a lesser amount with another insurer. Finally, **credentialing reform** (SB636/HB 574) was enacted that will prohibit recredentialing of already credentialed physicians who switch practice settings or change their corporate structure. It will assure that those physicians will continue to be reimbursed without delay.

Two other MedChi payment initiatives will be considered next year. The first is the **assignment of benefits** (SB448/HB 1169) legislation and the second is the reform of the **non-contracting physician statutory reimbursement formula** (125% of contract rule [SB 839/HB 896]). There remains

April 11, 2006

considerable legislative interest in the assignment of benefits legislation which would require a health insurer to recognize a voluntary assignment of benefits from a patient to a doctor and to pay the doctor directly. Legislative Leadership in both the Senate and the House indicated to MedChi representatives a continuing interest in this issue but wanted more time to study it. MedChi's legislation to reform the HMO statutory reimbursement formula for non-participating physicians fell victim to MedChi's inability to have all specialties agree on the proper substitute formula. However, efforts will be made over the summer to reach consensus within the medical community for a replacement formula.

As expected, the MedChi **malpractice reform** (HB 936) agenda was not successful with the principal reason being that Legislative Leadership is not interested in moving forward with more malpractice reform until there is some track record with respect to the enactment of House Bill 2 approximately 15 months ago. House Bill 2 was the result of the Special Session on malpractice issues which resulted in (1) extraordinarily significant subsidy (a 4 year \$600 million package) to Maryland's physicians in the form of malpractice premium relief and dramatic Medicaid reimbursement increases as well as (2) various malpractice reforms, such as a four-year freeze on the "cap" for non-economic damages and new rules relating to expert witnesses and certificates of merit in malpractice cases.

Some of the reforms of House Bill 2 such as the "freezing" cap on non-economic damages will expire in four years and the subsidies (which are in the second year) will similarly be reduced and expire at the end of four years. This means that the most opportune time for further malpractice reform will be in the second and third year of the next General Assembly (2008 and 2009).

Consistent with the predictions of key legislators prior to the commencement of the 2006 General Assembly, no further malpractice reform measures were enacted. However, there were a number of surprises suggesting that the Legislature's appetite for malpractice reform has not gone away. Governor Ehrlich's bill to implement several substantive reforms only failed by one vote in the House Judiciary Committee (11-11 tie). Meanwhile, MedChi's bill to correct **Maryland's "apology law"** (HB 790) passed easily in the House of Delegates only to be defeated in the Senate Judicial Proceedings Committee, which has been the graveyard for most malpractice reform efforts over the last three years. MedChi's bill to **reform the "certificate of merit"** (HB 789) also failed on an 11-11 tie in the House Judiciary Committee and will be filed next year. This legislation requires a detailed certificate of merit at the beginning of every case as to the reasons why each doctor in the case is being sued. At the present time (as a result of House Bill 2) such a detailed certificate of merit is required prior to trial. However, doctors are still sued (and lose their claim-free discount) even though they are dismissed prior to the actual trial of the case because the plaintiff's attorney cannot secure a detailed certificate of merit.

Other MedChi initiatives (a modified health court proposal, structured settlements, and a gross negligence standard for emergency room doctors) were less favorably treated by the House Judiciary Committee. However, it appears that there remains an appetite in the House of Delegates for further reform but, as most said before the Session, this wasn't the year.

Other items of significant interest:

- The Attorney General's legislation to establish a **Prescription Drug Monitoring Program** (SB 333/HB 1287) was enacted but only after extensive MedChi amendments were added to the legislation. The MedChi effort was spearheaded by Trustee Robert Lyles, M.D. and included various safeguards including a provision that no fees could be charged physicians to support the new program, that a physician would have immunity in using or not using information from the program in his or her treatment of patients and a provision that law enforcement personnel could only review the data if they already were engaged in a bona fide and active investigation of a specific physician.

- Legislation dealing with the Board of Physicians was not enacted. This legislation was the result of a **Sunset Review of the Board of Physicians** (SB 398) which proposed over 20 improvements to the existing law. The legislation did not need to be enacted until next year and, since the Chairman of the House HGO Committee did not believe that the legislation dealt effectively with budgetary and personnel constraints on the Board of Physicians, the House elected not to take up the bill.
- Legislation dealing with **Board of Physician subpoenas** (SB 142), which arose out of the case of Dr. Harold Eist, was also unsuccessful. As originally filed (and supported by MedChi), the legislation would have required that a subpoena of a doctor's records on a specific patient must include a notice to the patient that the subpoena had been issued. However, as amended by the Senate, this requirement was deleted in two instances, one being when a pattern and practice review was being made of mental health records. As amended, the bill was forcibly opposed by MedChi which believed that it emasculated the present protection given to mental health patients in Maryland law. The bill received an unfavorable report from the House HGO Committee.
- The **Healthy Air Act** (SB 154/HB 189), which will require Maryland's power plants to significantly enhance emissions control technology, was enacted by the General Assembly and signed into law. The legislation will lead to reductions in mercury emissions as well as sulfur dioxide and nitrous oxide emissions. The bill also requires Maryland to join the Regional Greenhouse Gas Initiative.
- The **Clean Indoor Air Act** (SB 298/HB 375) failed in Committee but with the growing number of local jurisdictions considering local legislation, the pressure for its passage will only continue to grow.
- Several bills dealing with **Health Care Disparities** were introduced this legislative session. Of note is the passage of one bill (HB 58) that requires the Maryland Health Care Commission to include, to the extent feasible, indices of racial and ethnic variations in a number of the studies they are required to conduct. Passage of this legislation should provide additional data on the pervasiveness of health disparities in various sectors of our health care system.
- Medicaid coverage for **Legal Immigrant Women and Children** (HB 89) was not restored despite the coordinated advocacy of a number of organizations. Legislation was however enacted that ensures that \$3 million dollars will be appropriated in the next fiscal year for an Immigrant Health Initiative and the DHMH will study various access and cost factors related to that initiative. Restoration of coverage should remain the goal but at least there is some funding to enhance existing public health programs in local jurisdiction that currently provide care to immigrants.
- Legislation to require the use of **mercury-free vaccines** (SB 365/HB 394) was defeated in the last days of the Session. The Senate version of the legislation had been significantly amended to reflect language that realistically would not have affected current vaccine administration practices. However, the members of the House Health and Government Operations Committee remained concerned about the creation of a perception that vaccines and immunizations were unsafe and defeated the legislation.
- **Telemedicine** legislation (SB 728) passed. It creates a Task Force to study the "use and reimbursement for telemedicine.