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## MedChi Final Report

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### INTRODUCTION

The 431st Session of the Maryland General Assembly concluded at midnight on Monday, April 8<sup>th</sup> with its usual confetti release. In this Session, the General Assembly considered 2,619 legislative bills and resolutions.

It was a particularly notable Session for Governor O'Malley who saw repeated successes in enacting controversial proposals including passage of major gun control legislation, the repeal of the death penalty and an increase in the gasoline tax.

Less controversial was the Administration's successful passage of health care legislation including Senate Bill 274/House Bill 228 (*Maryland Health Progress Act of 2013*). This legislation was the third and final legislative step in implementing the Affordable Care Act and provided multiple details relating to the new Exchange (the Maryland Health Connection) which will be the "marketplace" for uninsured individuals to obtain coverage. Of particular interest to MedChi in this legislation was the "continuity of care" provisions which provided that a patient shifting from one insurance product to another would be allowed to continue to see his or her doctor for up to 90-days with the new insurance company being responsible for compensating the doctor. A MedChi amendment was added to this legislation specifying that Maryland's "Assignment of Benefits" law would apply even after the 90-days meaning that, in certain circumstances, the patient could continue with his or traditional doctor by "assigning" the new insurance benefits.

In the last week of the Session there was a considerable dust up concerning the Medicare Waiver filing by the state with the federal CMS Agency. In the final days, Senate bills were filed calling for legislative oversight of any proposal to change and alter the existing Waiver. Maryland is the only state in the nation which enjoys a Medicare Waiver with the result that the federal government pays the hospital rates determined by the Maryland Health Service Cost Review Commission. This has the effect of pumping hundreds of millions of additional federal dollars into Maryland hospitals every year. However, there is considerable anxiety that the Waiver will not be continued because Maryland's control of hospital rates has not been as successful in the last few years as at prior times. Secretary Joshua Sharfstein made it clear to the Senate Finance Committee in the last week of the Session that he will continue to work with all stakeholders in making adjustments and in attempting to secure approval of the new application from CMS. Maryland hospitals have objected to the new application but it contains several new measures which are favorable to physicians (e.g., no bundled payments of professional fees for at least the next five years and the possibility of gain sharing by physicians from facility fees).

## MedChi MAJOR ISSUES: A GOOD YEAR

Naturopaths: For the third year MedChi's effort to defeat the initiative of so called "naturopathic" doctors was successful. Senate Bill 783/House Bill 1029 (*State Board of Physicians - Naturopathic Doctors*) did not receive a favorable vote and, indeed, the Senate Bill was withdrawn on the day of its hearing given the effectiveness of the opposition. MedChi had offered to support the legislation provided that a physician would be the "collaborator" with any "naturopathic" doctor. The naturopaths do not want physician involvement and this refusal once again doomed their legislative proposal.

Physician Dispensing: The assault on physician dispensing by the workers' compensation insurance industry was also defeated. This is a continuation of a fight which began in 2011 and came in the form of two separate proposals in the General Assembly. Senate Bill 247/House Bill 174 (*Workers' Compensation – Payment for Physician-Dispensed Prescriptions - Limitations*) would have allowed a workers' comp insurance company to refuse reimbursement for physician dispensed medication after an initial 30-day supply. Senate Bill 914/House Bill 1389 (*Workers' Compensation – Reimbursement for Drugs – Fee Schedule and Requirements*) would have imposed a draconian fee schedule so that workers' comp insurance companies would have reimbursed most doctors less for their dispensed medicines than the doctors had paid to obtain the medicines. This legislation was considered by the two standing committees, an "ad hoc" group of 10 Delegates who studied the issues as well as several meetings with Leadership of the Senate Finance Committee attended by MedChi CEO Gene Ransom and lobbyist Jay Schwartz. In the end, the decision was made to forego passage of this legislation with the expectation that the issue will be back again in 2014.

Step Therapy: As with any Legislative Session, there were certain MedChi supported initiatives which were not successful. Perhaps most disappointing was the failure to obtain a vote on Senate Bill 746/House Bill 1015 (*Health Insurance – Step Therapy – Fail-First Protocol*) in either the Senate Finance Committee or the House Health & Government Operations Committee. Leadership in the House HGO Committee decided to put the bill "in the drawer" and not bring it up for a vote. Consequently, the Senate Finance Committee did not vote on the bill. **However, there may be light at the end of the tunnel. In the last few days, MedChi was successful in persuading the Presiding Officers (Senate President Thomas V. "Mike" Miller, House Speaker Michael E. Busch, Senate Finance Chair Thomas "Mac" Middleton and House HGO Chair Peter A. Hammen) to direct a letter to the Maryland Health Care Commission asking them to convene a meeting of stakeholders to consider the Step Therapy issue and to recommend a solution to the General Assembly by December 15, 2013. Hence, while the bill did not receive a vote, the issue is moving forward.**

This is important legislation which will be back in 2014 as it is important to establish that a physician's clinical judgment needs to override insurance protocols when necessary for a patient's clinical improvement.

## BOARD OF PHYSICIANS

Perhaps the most significant set of bills for physicians was the legislation relating to the Maryland Board of Physicians ("Board"). The Board has been under heavy criticism for any

number of years in various “Sunset” reviews conducted by the Legislature. Legislation reauthorizing the Board was delayed in 2012 pending a further, independent review by Dr. Jay Perman of the University of Maryland Medical School at the request of Health Secretary Joshua Sharfstein. The result of the Sunset reviews and the Perman Report were that significant changes were proposed, and these took the form of numerous pieces of legislation introduced by the Board as well as legislation introduced at the request of MedChi (SB 550/HB 899) - *Disciplinary and Licensure Procedures-Revision*. While the MedChi proposal was not adopted, substantial aspects of it were adopted via the other bills summarized below. Lobbyist Steve Wise managed these bills.

House Bill 1096/Senate Bill 672 (*Board of Physicians—Sunset Extension and Program Evaluation*) was the principal bill that “reauthorized” the Board. The bill:

- Expands the Board to 22-members, which for purposes of disciplinary proceedings will be divided into two 11-person panels with complaints being considered by one panel or the other. This will accelerate the disposition of cases; already with the appointment of Dr. Andrea Mathias as the new Chair of the Board (along with Carole Catalfo, the new Executive Director), the backlog of cases has been significantly reduced. MedChi was able to partially address its concern over what constitutes a quorum on the 11 member panels by raising that number from 6 to 7.
- Maintains 1 osteopath on the Board which was a principal objective of MedChi.
- Maintains 2 peer reviewers. This achieved another principal objective of MedChi, despite the recommendation of the Perman report to reduce the number of peer reviewers to one.
- Prohibits the Board from administering the physician rehabilitation program, and requires that it continue to be run by a non-profit organization such as the current one, the Center for Healthy Maryland.
- Allows physicians to earn up to 5 CMEs for doing pro bono volunteer work in the State. This was one of the proposals contained in SB 550/HB 899 which was successfully added to the Board bill.

House Bill 1296/Senate Bill 981 (*Board of Physicians-Quasi-Judicial Powers-Revision*) provides physicians some relief from the summary suspension process, which was a principal goal of MedChi’s as noted above in Senate Bill 550/House Bill 899. In an effort to move the Board *away* from Summary Suspension and toward more targeted disciplinary action (the minimum necessary to protect the public), this language permits the board to address the narrow area where the physician has acted inappropriately (prescribing, for example) through a Cease and Desist Order, rather than suspending a license entirely through Summary Suspension. This way, in some circumstances, the physician can continue to practice while the specific issue is addressed.

The bill also eliminates from the disciplinary process the time-consuming yet unnecessary step of going to the Department of Health and Mental Hygiene’s Board of Review after the Board of Physician’s has issued a Final Order. A physician can now proceed directly to court

after the Board rules rather than waiting perhaps another 180 or more days for the Board of Review to act, which is particularly helpful in summary suspension cases. This was another aspect of MedChi's proposed legislation that was adopted via another bill.

House Bill 1313 (*Consultation, Qualification for Licensure, Renewal and Representation to the Public*) affected physicians principally by allowing for a 60 day "late" period for renewing licenses without penalty. MedChi put forth an amendment that was adopted allowing renewal to occur within that timeframe without any fine, either. Another MedChi amendment allows physicians to continue to receive written renewal forms upon request rather than strictly online, which will be the default method of renewal going forward.

While not contained in any legislation, MedChi also made some headway in addressing the Board's plans to raise license fees in 2014. Chairman Hammen has committed to writing a letter to the Governor after Session, asking that he directly fund in the next fiscal year the programs which are currently funded through license fees. If the Governor will do so, 12% of license fees would stay with the Board and thus reduce the need or at least the amount of any increase.

#### THE PHYSICIAN FEE INCREASES THAT DID NOT HAPPEN

MedChi was successful in its efforts to stop a number of critical fee increases. In July 2012, DHMH proposed significant fee increases for ambulatory surgical facilities, assisted living facilities and "letters of exception" for CLIA-waived laboratory tests. Despite MedChi's strong objections to the proposed increases, DHMH issued a "30 day" letter in November indicating their intent to finalize the proposed regulations implementing the increases. MedChi began an aggressive campaign to prevent their implementation. In January, Senator Robey and Delegate Dulaney-James, who chair the Health and Human Resources subcommittees of the Senate Budget and Taxation and House Appropriations Committee respectively, wrote a joint letter to Secretary Sharfstein requesting the fee increases be tabled pending collaborative dialogue with stakeholders to address funding issues the Office of Health Care Quality faces in meeting its regulatory oversight responsibilities. DHMH has not implemented the fee increases and it is anticipated that the stakeholder dialogue will occur before DHMH takes further action.

Just prior to the beginning of the Legislative Session, a proposal was floated which would have imposed a fee on physicians (and others) to fund the Exchange (the Maryland Health Connection) which is designed to be the marketplace for individuals seeking insurance coverage under the Federal Affordable Care Act. MedChi's objections were swift and decisive. The subsequent legislation on the Exchange and related issues contained no reference to an assessment on physicians.

MedChi also averted a licensure fee increase rumored to be proposed by the Board of Physicians. MedChi's early intervention in the dialogue regarding Board funding delayed consideration of licensure fee increases pending further study of Board funding that is diverted for other uses. It is an issue that will undoubtedly be the subject of conversation during the interim.

## SCOPE OF PRACTICE

As is the case every year, non-physician groups regularly seek to expand their scope of practice through legislative enactment. The principal initiative this year was by the so-called “naturopaths” but, as previously noted, that was unsuccessful.

Senate Bill 541/House Bill 746 (*Health Occupations – Licensed Podiatrists – Scope of Practice*) was legislation initiated by podiatrists to permit them to perform “acute ankle surgery.” The bill was turned down by the Senate EHE Committee which sealed its fate in the House HGO Committee. This is the second year that this legislation has been defeated by the orthopedic community.

Psychologists, over the objection of the psychiatric community, initiated Senate Bill 121/House Bill 67 (*Health Care Decisions Act – Incapacity to Make Informed Decision – Certification by Psychologist*). This legislation would have allowed psychologists to make incapacity decisions now entrusted to physicians. The legislation was given an unfavorable report by the House HGO Committee which determined its fate in the Senate.

House Bill 630 (*Rules of Interpretations – Interpretation of ‘Physician’ – Inclusion of Advanced Practice Nurse and Physician Assistant*) was given an unfavorable report by the House HGO Committee. This bill was remarkable in that it sought to have the word “physician” interpreted to mean advance practice nurses and physician assistants in any reference in the Annotated Code of Maryland. This “across the board” approach received short shrift.

House Bill 1356/Senate Bill 512 (*Health Care Practitioners-Identification Badge*) was also passed. This was a MedChi initiative that began in 2012 as part of the “Truth in Advertising” legislation. The bill requires that licensed practitioners wear badges displaying their name and license in medical offices (but not in solo practices), ambulatory care and urgent care facilities. The Boards governing the practitioners can carve out situations where provider safety or the need for a sterile environment weighs against requiring display of a name badge.

Lay midwife and home birth related issues are likely to become the next major scope of practice issue for the physician community and will continue to be managed by MedChi lobbyist Pam Kasemeyer. There is a strong and growing “grassroots” demand for home births by a small but well-educated and vocal group of Maryland women and their families. The demand for accessible home birth options is further exacerbated by Maryland’s large Amish population which relies on home birth. 2011 legislation resulted in a DHMH workgroup that met extensively over the interim. The workgroup did not reach consensus on a single issue and its report was essentially an outline of options. Absent policy direction from the workgroup, several bills related to certified nurse midwives (CNM) and “lay midwives” were introduced this year. Senate Bill 760/House Bill 1151 (*State Board of Nursing – Certified Nurse Midwives – Standards and Practice Guidelines*) eliminated the requirement for CNMs to file collaborative plans that include an attestation identifying a physician with whom they collaborate. Senate Bill 1293/House Bill 647 (*Higher Education and Health Occupations – Nurse Midwifery Program – Study*) required a study of barriers to nurse midwifery training programs and options to expand training in the State. House Bill 1202 (*Health Occupations – Certified Professional Midwives – Pilot Program*) proposed a two year pilot program that would have enabled lay midwives to

practice under a loose regulatory structure prior to determining if they should be permanently authorized to practice. All three proposals were withdrawn by their sponsors at the request of House and Senate Committee leadership. However, the House and Government Operations Committee has requested DHMH to convene two separate interim workgroups to look at (1) certified midwifery practice and (2) home birth options and the regulation of lay midwives. These issues will return in 2014.

Senate Bill 401/House Bill 179 (*Pharmacists – Administration of Vaccinations – Expanded Authority and Reporting Requirements*) was successfully enacted but with important reporting requirements requested by MedChi. The legislation enables pharmacists to administer CDC recommended vaccines to adolescents with a physician’s prescription and CDC recommended vaccines and international travel vaccines to adults pursuant to vaccine specific protocols to be developed in regulation. Pharmacists that administer a vaccine are required to report the administration to the prescribing physician or if there is not a prescribing physician to the patient’s primary care physician or facility where the patient receives regular medical care. The pharmacist is also required to report the administration to the Immunet registry.

### MEDICAID AND PUBLIC HEALTH ISSUES

MedChi was successful in a number of public health and Medicaid related initiatives. With respect to Medicaid, MedChi supported DHMH’s effort to resist two critical cuts recommended by the Department of Legislative Services (DLS) budget analysts. DLS proposed eliminating the “early takeover” of the newly designed MMIS system by the new contractor. This proposal would have negatively impacted the implementation of the new MMIS system which MedChi has strongly supported and which CRISP has played an important role. MedChi also opposed the recommendation that the eligibility requirements for pregnant woman be reduced from 250% to 185% of poverty over a two year period. This proposed reduction was based on the implementation of the ACA and presumed coverage of these women through the Exchange. DHMH, with MedChi’s support, was successful in resisting the recommended cuts. Language was also added to the budget to require DHMH to study reimbursement for anesthesia services under the Medicaid pediatric dental program.

Sterile Compounding: Senate Bill 896/House Bill 986 (*State Board of Pharmacy – Sterile Compounding - Permits*) was an initiative of Dr. Joshua Sharfstein, the Secretary of the Department of Health and Mental Hygiene, to more closely regulate compounding pharmacies in response to the scandal related to the facility in Massachusetts which produced adulterated steroids causing injuries and death. The Massachusetts facility was closed in the fall of 2012 when the problems came to light. Under the legislation, a sterile compounding facility operating in Maryland must obtain a permit and facilities located outside of Maryland must also obtain a permit before the sterile compounded preparations are dispensed in the state. The Board of Pharmacy continues to have regulatory authority and, in response to issues raised by MedChi and the Maryland Society of Eye Physicians and Surgeons (Eye Society), a “waiver” provision was added to the bill. The “waiver” provisions may be utilized where “...there is a clinical need, as determined by the Board with input from health care providers in the state.” The Board is given the authority to waive any requirements of the new law “in exigent circumstances that...otherwise prevent health care providers from obtaining, in the size and strength

needed,...”sterile drug products. Doctors using such products under the waiver must document the lot number or other mechanism for identifying the sterile drug product for the purpose of tracking back to the person that prepared it. Significantly, the bill provides that a sterile drug product “...is not required to be prepared in response to a patient’s specific prescription.” This definition changes existing Maryland law and was requested by the Eye Society so that, for example, a retina specialist could order in advance medications which he or she knows will be needed for emergency applications even though they do not know the name of the patient in advance.

Cosmetic Surgery: House Bill 1009 (*Cosmetic Surgical Facilities-Regulation*), as proposed, would have regulated “medispas” after a 2012 death of a patient due to infection. DHMH also proposed legislation, Senate Bill 509/House Bill 1116 (*Cosmetic Surgery-Regulation*) on this subject. In the end, MedChi’s concern over altering a carefully crafted definition of “cosmetic surgery” was addressed, allowing procedures commonly done in physician offices to continue to be done there. However, under House Bill 1009, as amended, the Secretary of DHMH now has authority to carve out certain of those procedures by regulation if public safety so warrants.

Cell Phones/Driving: Senate Bill 339/House Bill 753 (*Motor Vehicles – Use of Wireless Communication Device – Prohibited Acts – Enforcement, Penalties*) was enacted on the last day as the result of a Conference Committee agreement between the House and the Senate. As enacted, the bill makes it a “primary” offense to use a cell phone to call or text while driving.

Medical Marijuana: House Bill 1101 (*Medical Marijuana – Academic Medical Centers – Natalie M. LaPrade Medical Marijuana Commission*) was enacted. Rather than an open-ended allowance of “medical marijuana,” the legislation will allow for clinical trials at academic medical institutions in Maryland (the University of Maryland and Johns Hopkins). An academic medical center will make an application to the Fund set up by the legislation and it is anticipated that the implementation of the act will begin in July of 2014.

Lead Testing: House Bill 303 (*Task Force to Study Point-Of-Care Testing for Lead Poisoning*) was successfully enacted. This Task Force will study and make recommendations regarding the use of and reimbursement for point-of-care testing to screen and identify children with elevated blood-lead levels. The charge of this Task Force is consistent with MedChi’s House of Delegates Resolution 23-12 regarding CLIA-waivered lead testing.

Epinephrine: Senate Bill 815/House Bill 1014 (*Public and Nonpublic Schools – Epinephrine Availability and Use – Policy*) expands the use and availability of epinephrine to non-public schools and enhances the safety and training protections of the program for public schools enacted in the 2012. This issue was a primary initiative of the MedChi Alliance during the 2012 Session. The enhancement and application of the law to private schools advances the objectives of the Alliance.

Pesticide Use Reporting: The creation of a database to track the use of pesticides in the State was a priority for the environmental community and supported by MedChi. Senate Bill 675/House Bill 775 (*Maryland Pesticide Reporting and Information Workgroup*) creates a stakeholder workgroup comprised of relevant agency representatives and stakeholders to

comprehensively evaluate pesticide use reporting and data collection. The charge of the workgroup includes consideration of the public health aspects of pesticide, data collection and reporting.

### MISCELLANEOUS

Mental Health Parity: The mental health community was successful in enacting Senate Bill 581/House Bill 1216 (*Health Insurance – Federal Mental Health Parity and Addiction Equity Act – Notice and Authorization Forms*) and Senate Bill 582/House Bill 1252 (*Health Insurance – Federal Mental Health Parity and Addiction Equity Act – Utilization Review Criteria and Standards*). This legislation was supported by MedChi as being critical to the proper enforcement of the Federal Mental Health Parity and Addictions Equity Act (the Parity Law). The Parity Law will apply to all policies issued in Maryland by January 1, 2014.

Senate Bill 581/House Bill 1216 will require insurance entities to advise their enrollees of the existence of the Parity Law with information about the law. Senate Bill 582/House Bill will require private review agents, which are regulated by the Maryland Insurance Administration, to ensure that the criteria and standards used for Maryland policies are in compliance with the Parity Law.

Telemedicine: The Legislature made additional changes to the laws related to telemedicine, the most significant being Senate Bill 798/House Bill 1042 (*Hospitals – Credentialing and Privileging Process - Telemedicine*). This legislation deleted the requirement of “primary source” verification of a telemedicine consultant who was providing services at a hospital. Maryland law requires “primary source” verification which is an extremely time-consuming process. While primary source verification is appropriate for medical staff decisions at a hospital, such a requirement would impede the development of telemedicine where, for example, a specialist in Baltimore was consulted, via telemedicine with respect to a patient at a rural hospital. The legislation deleted the primary source verification and allowed a hospital to rely upon credentialing and privileging decisions already made by the distant site facility. However, in response to MedChi concerns, two important provisions were added. First, the telemedicine consultant must hold a Maryland license to practice medicine and, second, the credentialing and privileging decisions must be approved by the medical staff of the hospital. These amendments satisfied issues raised by MedChi radiology members.

In addition, Senate Bill 496/House Bill 931 (*Maryland Medical Assistance Program – Telemedicine*) was enacted. This legislation applied to the Medicaid program the current Maryland rule applicable to commercial insurers which requires the reimbursement for telemedicine services. As amended, the Maryland Medicaid Program will be required to reimburse telemedicine. Maryland Medicaid opposed the bill in its original form although it indicated that it thought telemedicine was appropriate for use in rural settings. As amended by the House of Delegates on the last day, telemedicine will be also required in any setting if it is deemed to be medically necessary, for the treatment of cardiovascular disease or stroke in an emergency department and where an appropriate specialist is not otherwise available.



Vision Services: Senate Bill 904/House Bill 1160 (*Health Insurance – Vision Services – Provider Contracts*) passed. This was an initiative of the Maryland Optometric Association and, in its amended form, provided that a vision insurance provider could not force a practitioner (an ophthalmologist or an optometrist) to limit their fees for a non-covered service although covered services would continue to be in accordance with the agreed fee schedule. This legislation essentially copied existing Maryland law applicable to dentist plans.

Malpractice Reform: Four bills initiated by Maryland hospitals were unsuccessful. Three of the bills did not receive a favorable report from either the Senate or House Committee. Senate Bill 771/House Bill 1316 (*Post Judgment Interest – Medical Injury*) would have limited the amount of post-judgment interest paid in a medical malpractice case (currently 10% per year); Senate Bill 835/House Bill 1265 (*Patient Safety Early Intervention Programs*) would have markedly improved the Maryland “Apology Law” by allowing hospitals to have early intervention programs after a medical injury; Senate Bill 836/House Bill 1114 (*Health Care Malpractice – Award and Judgments – Periodic Payments*) would have allowed large medical malpractice payouts to be paid out over time rather than immediately.

However, House Bill 1310 (*Health Care Malpractice Claims – Definition of “Health Care Provider”*) was passed by the House of Delegates only to die in the Senate Judicial Proceedings Committee without a vote. The legislation was amended so that nurses would be covered under the present medical malpractice law including the cap on non-economic damages. When the “cap” was first established in 1986, there were a number of current health care practitioners such as advanced practice nurses who were not licensed by the state. Hence, the situation can now arise where a physician is covered by the “cap” but a nurse practitioner collaborating with that physician is not covered. Nevertheless, the Senate Judicial Proceedings Committee did not enact the legislation.

Biosimilars: Senate Bill 781 (*Pharmacists – Biosimilar Biological Products – Substitutions*) would have set new rules for the coming surge of “generic” biologic medicines. These medicines are referred to as “biosimilars” because they are made from a live virus and are not “identical” in chemical composition as are current medicines. The legislation passed the Senate but was unsuccessful in the House HGO Committee due to the opposition of the Department of Health and Mental Hygiene, the State Board of Pharmacy and various “generic” makers of such biosimilars. Their principal argument was that the legislation was premature as the FDA has not yet determined the rules to govern the interchangeability of a biosimilar for a prescribed biologic medicine.

Hospital Outpatient Services on the Eastern Shore: Senate Bill 151/House Bill 373 (*Hospitals – Outpatient Services – Offsite Facility – Rate Regulation*) was enacted. This bill will allow the Shore Health System to sell to private physicians (and MedChi members) an endoscopy facility located in Easton. The legislation was necessary because the current facility as under the rate regulation protocol of the Health Services Cost Review Commission.

Power Outage Priority: House Bill 1159 (*Electric Companies – Service Restoration – Special Medical Needs Facility*) was enacted. This bill addresses electricity reliability issues for special medical needs facilities. While it does not specifically include physician offices, the charge of the workgroup that presently exists, pursuant to an order by the Public Service

Commission, was expanded to include a requirement to identify additional special medical need facilities that should be considered under this framework. Its passage provides an opportunity to MedChi to address its concerns regarding electricity reliability and restoration relevant to physician offices

### WORKS IN PROGRESS

Senate Bill 488 (*Tanning Devices – Use by Minors - Prohibition*) was unsuccessful in the Senate Finance Committee by a vote of 7-4.

Senate Bill 700/House Bill 683 (*Tobacco Taxes – Health Maryland Initiative*) would have significantly increased Maryland's tobacco taxes and was supported by MedChi. It was not surprising that this initiative was unsuccessful as it has always been conceived to be a multi-year effort and would probably be enacted after the next election. It is expected that candidates will “pledge” to raise tobacco taxes in the 2014 election and that those pledges will be collected in the next 4-year cycle of the General Assembly.

House Bill 1117 (*Motor Vehicle Liability Insurance – Mandatory Coverage – Medical and Hospital Benefit*) was a MedChi initiative to increase automobile insurance coverage for medical expenses arising from an automobile accident over that presently existing. The legislation was opposed by the automobile insurance industry and received an unfavorable report from the House Economic Matters Committee.

House Bill 1270 (*Health Care Facilities and Pharmacies – Sale of Tobacco Products – Prohibition*) would have outlawed the sale of tobacco in health care facilities including pharmacies. While the legislation was turned down by the House Economic Matters Committee, this point will be made in succeeding years when pharmacists try to further advance their entitlement to serve as a health care facility.