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**Spotlight On...Dr. Mike Bond**

Michael Bond, MD, FACEP

1. MD ACEP Position

*I am currently the Treasurer of Maryland ACEP.*

2. Where do you practice?

*University of Maryland Medical Center - Downtown Campus*



3. What drew you to Maryland?

*Medical School and then fell in love with Baltimore*

4. What is your EDC (Every Day Carry) for a shift?

- *Littman Electronic 3200 Stethoscope*
- *Leatherman Trauma Shears Raptor*
- *A cup for continuous cold water*
- *In my bag I have portable pulse oximetry, 2 point discrimination tool, and some Vicks Vapor Rub to cover those offensive odors*

5. What's on your ED playlist?

*Pandora 80s or Classic Rock*

6. What's your favorite thing about EM?

*Variety of patient complaints, always a challenge. No two days are ever the same. I especially enjoy teaching.*

7. Interesting fact about you

*I worked throughout medical school and have been an EMT, Phlebotomist and patient care teacher*

8. Goal in leadership

*Leave the organization better than when I joined it, and to improve its educational offerings*

### **Resuscitation 2019 - June 26-28 - University of Maryland**

The national *Resuscitation* conference is coming to Baltimore on **June 26-28, 2019** in Leadership Hall at the University of Maryland. It is an amazing conference, with all-star educators Amal Mattu, Rich Cantor, Peter DeBlieux, Sara Gray, Teresa Wu, Tom Scalea, Haney Mallemat, Anand Swaminathan, Rory Spiegel, Laura Bontempo, George Willis, John Greenwood, and so many more. The main conference will be held on Wednesday, June 26th and Thursday, June 27th and is designed to cover the critical topics needed to save the life of your dying patient. The critical care bootcamp will be held on Friday, June 28th and is designed to cover important topics in the care of your ICU boarding patient. There are also preconference cadaver and ultrasound labs that will be held on Tuesday, June 25th. There are just a few spots left in the Emergency Airway Cadaver Lab directed by Ken Butler.

To review the conference line up, register for the conference, watch a sample lecture from last year's conference, and listen to the free resuscitation podcasts go to [Resus](#).

**Congratulations to Dr. Gregory Jasani, the Residents Competition winner at the MD ACEP 2019 Annual Educational Conference held on March 14, 2019 - the first recipient of the Linder Cup!**



## Legislative Update

Danna Kauffman, Esq  
Schwart, Metz and Wise, PA



### **IN MEMORIAM**

***Michael E. Busch (January 4, 1947-April 7, 2019)***

On Sunday, April 7th, Speaker of the House Mike Busch passed away. He represented Anne Arundel County and the City of Annapolis in the General Assembly since 1986. He became Chairman of the Economic Matters Committee in 1994, where he oversaw health insurance and other aspects of the health care industry. He always had an open door to hear physician concerns, even once he became Speaker in 2003. He was a friend to all members of our law firm, and we know too many of you as well. He will be missed as a legislator, but even more so as a good and decent man who was always ready with a smile and handshake. Please keep his family and friends in your prayers in the days ahead.

### **FINAL 2019 SESSION REPORT**

The 439th Session of the Maryland General Assembly began at noon on Wednesday, January 9th and concluded at 11:30 PM on Monday, April 8th when it held a joint session to honor Speaker Busch. This was the first year of the new term (2019-2023). With nearly 60 new legislators and new committee leadership, especially in the Senate, this Session was marked by uncertainty. Typically, the first session of a term is relatively quiet. However, this was not the case this Session. Major policy issues were discussed this Session, including increasing the minimum wage, implementing the Kirwan Commission recommendations (school funding), debating end-of-life options and much more.

The General Assembly considered approximately 2,497 bills and resolutions. As a comparison, the General Assembly considered 3,127 during the 2018

Session; 2,876 in 2017; and 2,832 bills in 2016. While there were almost 600 fewer bills this Session than last, the major difference was that almost half of the bills were introduced at the deadline during the week of February 4th. As such, it was an extremely busy Session.

## **Budget-Fiscal Year 2020**

As you know, a priority of ACEP has been the issue of emergency room boarding and the lack of inpatient and community services for behavioral health services, especially for the pediatric and geriatric patients. This Session, members of ACEP met with Vice-Chair Joseline Pena-Melnyk and Chair Shane Pendergrass (House Health and Government Operations Committee) to discuss these issues. Also participating in the meeting were representatives from the Maryland Department of Health (MOH), the Maryland Institute for Emergency Management Services Systems (MIEMSS), the Health Services Cost Review Commission (HSCRC), the Maryland Hospital Association (MHA) and other community stakeholders. Another meeting of this informal workgroup is scheduled for the beginning of May.

Irrespective of this workgroup, the Fiscal Year 2020 budget contains three relevant provisions.

- \* The MIEMSS and the HSCRC are required to report by November 1, 2019, on the strategies for addressing the increasing emergency department overcrowding in the State.
- \* The MIEMSS, HSCRC and the Maryland Health Care Commission (MHCC) are required to report on the development of new models of care delivery that will improve emergency department overcrowding by treating low-acuity patients in settings other than the emergency department, such as mobile integrated health services, EMS without transport, and EMS with transport to an alternative destination.
- \* The Behavioral Health Administration (BHA) is required to plan and create a statewide bed registry for all inpatient psychiatric beds, including total, operational, and vacant inpatient psychiatric beds in all State-run psychiatric facilities, acute general hospitals, and private psychiatric hospitals in Maryland.

## **Addressing Substance Abuse and Behavioral Health Initiatives**

### ***\* Prescription Drug Monitoring Program***

The General Assembly picked up where it left off in 2018. ***Senate Bill 195/House Bill 25: Public Health Prescription Drug Monitoring Program - Revisions*** (passed) is a reintroduction of the House version of legislation considered in 2018, which would have made several changes to the Prescription Drug Monitoring Program (PDMP). While most of the changes were acceptable to the provider community, such as requiring rather than authorizing the PDMP to review prescription monitoring data for indications of possible misuse or abuse of a monitored prescription drug or a possible violation of law or breach of professional standards by a prescriber or dispenser, the provider community remained opposed to allowing direct referral of cases to the Office of Controlled Substance Administration (OCSA) without prior review by the Technical Advisory Committee (TAC). The provider community worked with MDH to determine how best to enhance the PDMP without creating a chilling effect on legitimate prescribing. Amendments were ultimately agreed to that retain TAC involvement in all cases that the Program is considering for referral to the OCSA for further investigation. The amendments also include a requirement for the inclusion of additional data in the Program's

annual report on the number of prescribers and dispensers identified for further outreach and education as well as referral for further investigation. Finally, the bill directs the Program to continue to work with the TAC to improve the effectiveness of its data analysis.

**Senate Bill 342/House Bill 466: Prescription Drug Monitoring Program - Program Evaluation** (passed) reflects the recommendations of the Department of Legislative Services (DLS) relative to its review of the PDMP. Most importantly, the bill removes the termination date of July 1, 2019, to allow the Program to operate in perpetuity.

Once again, insurers tried to unsuccessfully gain access to the PDMP. **Senate Bill 498/House Bill 847: Prescription Drug Monitoring Program - Disclosure of Data - Managed Care Organizations** (failed) would have allowed the Medicaid managed care organizations (MCOs) access to PDMP data, purportedly only for purposes of compliance with two required Medicaid utilization review programs. The provider community opposed the legislation, again citing the need to maintain the PDMP as a health care tool for prescribers and dispensers and to prohibit the unfettered access to data by any entity other than a prescriber or dispenser without a subpoena or in furtherance of a bona fide investigation.

\* **Substance Use Disorder and Behavioral Health Initiatives**

**House Bill 116: Public Health - Correctional Services - Opioid Use Disorder Examinations and Treatment** (passed) establishes specified programs of "opioid use disorder" screening, evaluation, and treatment in local correctional facilities and in the Baltimore Pre-trial Complex. The program will begin in four counties and phases in to include all counties and the Baltimore Pre-trial Complex. The State must fund the programs of opioid use disorder screening, examination, and treatment of inmates, and the bill establishes requirements for screening and treatment. By November 1, 2020, and annually thereafter, the Governor's Office of Crime Control and Prevention must report data to the General Assembly from local correctional facilities.

**While House Bill 139/Senate Bill 135: Public Health - Overdose and Infectious Disease Prevention Site Program** (failed) was received more favorably by the Committees than in past years, in part due to continued efforts to identify new and innovative approaches to address the continued escalation of the opioid crisis, the bill still failed to advance this Session. This Session's initiative was a more narrowly defined pilot program that would have authorized a community-based organization to establish an Overdose and Infectious Disease Prevention Site Program to provide a supervised location where drug users could consume pre-obtained drugs, as well as receive other services, education, and referrals.

**House Bill 427/Senate Bill 403: Behavioral Health Administration - Outpatient Civil Commitment Pilot Program - Revisions** (passed) requires the BHA within MDH to allow an eligible individual to request enrollment in, and allow an immediate family member of an eligible individual to request voluntary enrollment for the individual in an existing authorized pilot program for outpatient civil commitment. BHA must include specified information in its annual report for individuals admitted into the program both voluntarily and involuntarily.

Two bills were requested this Session by the Maryland Parity Coalition to address issues with network adequacy as it relates to mental health parity and

addition equity. **House Bill 599/Senate Bill 631: Health Insurance - Coverage for Mental Health Benefits and Substance Use Disorder Benefits - Treatment Criteria** (passed) was heavily amended by the committees. Initially, the bill required carriers to submit two extensive reports to the Maryland Insurance Administration on how the carrier complied with federal mental health parity and addiction equity laws and on the carrier's data for mental health benefits, substance use disorder benefits, and medical/surgical benefits by parity act classifications. The committees amended the bill to only require carriers to use the American Society of Addiction Medicine criteria for all medical necessity and utilization management determinations for substance use disorder benefits. The bill also repeals the limitation on a carrier charging a copayment for methadone maintenance treatment that is greater than 50% of the daily cost for methadone maintenance treatment.

The companion bill to **House Bill 599/Senate Bill 631, House Bill 837/Senate Bill 761: Health Insurance - Payments to Noncontracting Specialists and Noncontracting Nonphysician Specialists** (failed) addressed access to and payment for out of network services for behavioral health by enacting balanced billing and assignments of benefit provisions for behavioral health programs as a mechanism for incentivizing carriers to expand their provider panels. While the bill was well-received by each respective committee, there was strong resistance from the carriers and the bill ultimately failed.

Several study bills were introduced on the issue of behavioral health. Given the number of resources already dedicated to examining this issue, the committees did not act upon the bills. **House Bill 783/Senate Bill 993: Task Force to Study Behavioral and Mental Health in Maryland** (failed)' would have created a Task Force to examine the availability of services in schools as well as at-large. Similarly, **House Bill 852: Task Force on the Premature Discharge of Patients with Substance Use Disorders** (failed) also not acted upon and was withdrawn by the sponsor. Lastly, **House Bill 506: Maryland Department of Health -Mental Health and Substance Use Disorder Services-Needs Assessment Study** (failed) would have required the MOH to conduct a study to determine the existing capacity and estimated unmet needs for mental health and substance use disorder services by region. The bill required \$5 million to be allocated for the study.

Two other bills aimed at increasing access to behavioral health providers, especially in the more rural areas of the State, were **House Bill 829: Health Insurance - Provider Panels - Graduate Providers** (passed) and **Senate Bill 944: Behavioral health Programs - Outpatient Mental Health Centers - Medical Directors** (passed). House Bill 829 prohibits a carrier from rejecting a provider who provides community-based health services for an accredited program for participation on the carrier's provider panel solely because the provider is a licensed graduate social worker, a licensed master social worker, a licensed graduate alcohol and drug counselor, a licensed graduate marriage and family therapist, a licensed graduate professional art therapist, or a licensed graduate professional counselor. **Senate Bill 944** requires regulations governing behavioral health programs to include a provision authorizing a psychiatric nurse practitioner to serve as a medical director of an accredited outpatient mental health center, including the use of telehealth.

This Session, there was a concerted effort by the Medicaid MCOs to carve-in behavioral health. As you know, behavioral health is carved-out of the MCOs and is administered through the Beacon, the State's administrative service organization (ASO). **House Bill 846/Senate Bill 482: Maryland Medical**

**Assistance Program - Managed Care Organizations - Behavioral Health Services** (failed) would have required Medicaid to provide reimbursement for medically necessary and appropriate "behavioral health services" and would have required each MCO, rather than the ASO, to provide or arrange for behavioral health services beginning January 1, 2021. As a counter to this bill, advocates who continue to support the carve-in introduced two bills. **House Bill 938/Senate Bill 975: Behavioral Health Transformation Act of 2019** (failed) would have introduced additional performance standards into the ASO contract. **House Bill 941/Senate Bill 976: Public Behavioral Health System - Implementation Plans to Improve Efficiency, Accountability, and Outcomes - Workgroup** (failed) would have required the Secretary of Health to convene a workgroup of specified stakeholders to develop implementation plans to improve efficiency, accountability, and outcomes of publicly funded behavioral health services. Given the sensitivity of this issue and the concerns raised by the advocates, the bills were both withdrawn. This issue is sure to garner additional discussions this interim.

It is also important to note that the Fiscal Year 2020 budget provides a 3.5% increase to behavioral health providers as part of the 2018 initiative - Keep the Door Open.

### **Health Facility Regulation**

Unfortunately, **House Bill 894: Criminal Law - Felony Second Degree Assault -Emergency Medical Care Workers** (failed) did not pass this Session. While there was strong support by several Committee members, others expressed concern that the bill could be unfairly prejudicial to individuals by increasing the penalty from a misdemeanor to a felony. It goes without saying that this did not go over well with the nurses and other emergency professionals that testified in support at the hearing.

**House Bill 971/Senate Bill 605: Hospitals - Emergency Departments - Identification, Treatment, and Rescue of Human Trafficking Victims** (failed) also did not advance due to concerns raised by MHA and ACEP regarding the need for a forensic nurse to be in each emergency department 24/7. The Senate sponsor attempted to amend the bill to a Task Force, but the committees did not believe the issue rose to the level of needing an independent Task Force. There is a Statewide workgroup in the Attorney General's Office examining human trafficking and there may be discussion on this issue moving forward within this Statewide workgroup.

At the request of University of Maryland Shock Trauma, **House Bill 607/Senate Bill 901: Maryland Trauma Fund - State Primary Adult Resource Center - Reimbursement of On-Call and Standby Costs** (passed) was introduced. This bill expands the purpose of the Maryland Trauma Physician Services Fund to include subsidizing the documented costs incurred by the State primary adult resource center to maintain trauma surgeons, orthopedic surgeons, neurosurgeons, and anesthesiologists on-call and on standby as required by the MIEMSS.

Continued concerns regarding the availability of health services on the shore prompted **Senate Bill 1010: Maryland Health Care Commission - Assessment of Services at the University of Maryland Shore Medical Center in Chestertown** (passed). This bill requires the MHCC, in conjunction with the Office of Health Care Quality, to assess the types, quality, and level of services provided at the University of Maryland Shore Medical Center in Chestertown (UMSMCC). The assessment must, at a minimum, (1) compare the services currently provided to the services provided in fiscal 2015; and (2)

identify whether, on or after July 1, 2015, any services from UMSMCC were reduced or transferred to the University of Maryland Shore Medical Center in Easton. The MHCC must report its findings to the General Assembly by January 1, 2020.

In the final two weeks of Session, due to controversy surrounding the University of Maryland Medical Systems, **House Bill 1428: University of Maryland Medical System Corporation -Board of Directors, Ethics, and Performance Audit** (passed) was introduced. This emergency bill alters the composition of, and the appointment process for, members of the Board of Directors of the University of Maryland Medical System Corporation, including reconstituting the board and prohibiting a member from being a State or local elected official.

### **Medical Malpractice Liability**

After killing a bill in 2018 on the final night of the Session that would have completely repealed the 20% Rule, MedChi, the Maryland Hospital Association and Med Mutual were asked by the Speaker Mike Busch to try and reach a compromise with the trial lawyers that retains the Rule, but fixes certain issues with its application: These talks continued through the final week of Session when agreement was reached. As agreed, Senate Bill 773: Health Care Malpractice Qualified Expert - Qualification (passed) defines the term "professional activities", increases the amount of time one can spend as an expert to 25%, provides for the time period during which the 25% is computed, establishes that once the expert is qualified in the case they remain qualified, and sets rules for when and whether the case can be re-filed if the expert is determined to not comply with the Rule.

As a result of agreement reached on the qualified expert, no other bill related to medical malpractice passed this Session. These bills included Senate Bill 813: Personal Injury or Wrongful Death - Non Economic Damages (failed), which would have raised the cap based on the number of beneficiaries in wrongful death cases, in some cases by as much as 300% of the existing cap. **House Bill 1323/Senate Bill 784: Civil Actions -Health Care Malpractice Claims (Life Care Act 2019)** (failed) would have specified the method by which an award or a verdict for future medical expenses must be calculated. **Senate Bill 322: Medical Malpractice - Notice of Intent to File Claim** (failed) would have required a claimant to send a health care provider written notice of the claimant's intent to file a medical injury claim against the health care provider at least 90 days before filing the claim. **Senate Bill 323: Medical Malpractice - Discovery** (failed) sought to clarify that the discovery available as to the basis of a certificate of a qualified expert in a health care malpractice action includes a deposition of the attesting expert.

### **Public Health**

**House Bill 1183/Senate Bill 251: Public Health - Treatment for the Prevention of HIV- Consent by Minors** (passed) clarifies current law with respect to a minor's right to consent to prevention for HIV or PReP. The highest incidences of new HIV cases are in individuals between the ages of 13-24 and access to prevention is essential to addressing the growing public health implications associated with this resurgence of HIV cases.

After years of being voted unfavorable, **House Bill 124/Senate Bill 299: Tanning Devices - Use by Minors** (passed) has finally made it to the Governor's desk. This bill prohibits individuals under the age of 18 from using a



tanning bed, like the current requirement in Howard County.

In continuing to protect youth, **House Bill 1169: Business Regulation - Tobacco Products and Electronic Smoking Devices -Revisions** (passed), among other provisions, increases the minimum age for tobacco products and electronic smoking devices to 21 years of age, except for military personnel.

**House Bill 911: Workgroup to Study Shelter and Supportive Services for Unaccompanied Homeless Minors** (passed) establishes a Workgroup to Study Shelter and Supportive Services for Unaccompanied Homeless Minors, which is to be staffed by the Joint Committee on Ending Homelessness. An unaccompanied homeless minor is a minor who is not in the physical custody of a parent or guardian and lacks a fixed, regular, and adequate nighttime residence or whose status or circumstances indicate a significant danger of experiencing homelessness in the near future. By December 1, 2019, the workgroup must report its findings and recommendations to the Governor and the General Assembly.

**Senate Bill 981: Vehicle Laws - Protective Headgear Requirement for Motorcycle Riders - Exception** (failed) would have exempted, from the requirement to wear specified protective headgear while operating or riding on a motorcycle, an individual age 21 or older who (1) has been licensed to operate a motorcycle for at least two years; (2) has completed an approved motorcycle rider safety course; or (3) is a passenger on a motorcycle operated by a rider who meets either of these criteria. Similar legislation has been introduced for at least the last four years.

Several bills were introduced related to sexual assault, sexual offense and rape. **House Bill 1248/Senate Bill 933: Criminal Procedure - Sexual Assault Evidence Kits - Privacy and Reimbursement** (failed) would have prohibited a physician, a qualified health care provider, or a hospital, when seeking compensation from the Criminal Injuries Compensation Board (with respect to services provided to a victim of an alleged rape or sexual offense or a victim of alleged child sexual abuse), from including in any request a narrative describing the alleged offense of a victim or a photograph of the victim. The bill passed the House but failed in the Senate Judicial Proceedings Committee. **House Bill 1311: Maryland Sexual Assault Evidence Kit Policy and Funding Committee - Voluntary Payment by Victim for Testing of Kit** (failed) would have allowed a process to be established for the insurer of a victim to pay for the sexual assault evidence kit. The bill was a late file and never made it out of Rules. Bills that did pass include **House Bill 1248/Senate Bill 933: Pilot Program - Alleged Rape, Sexual Offense, or Child Sexual Abuse - HIV Postexposure Prophylaxis** (passed) which establishes the Pilot Program for Preventing HIV for Rape Victims to HIV infection for victims of an alleged rape or sexual offense or victims of alleged child sexual abuse by providing a qualifying victim with a full course of treatment (free under specified circumstances) and follow-up care for postexposure prophylaxis for the prevention of HIV, at the victim's request, and as prescribed. **House Bill 1268/Senate Bill 569: Public Safety - Rape Kit Testing Grant Fund - Established** (passed) establishes a Rape Kit Testing Grant Fund to provide "law enforcement agencies" with funding for testing of sexual assault evidence collection kits by "forensic laboratories." On September 30, 2018, the U.S. Department of Justice awarded the Governor's Office of Crime Control and Prevention a \$2.6 million Sexual Assault Initiative Kit grant to implement a program over three years that creates, implements, and adapts a testing system for sexual assault evidence collection kits. ·

**House Bill 409/Senate Bill 469: Drugs and Devices-Electronic Prescriptions -Requirements** (failed) would have mandated that all prescriptions be prescribed electronically by October 1, 2019. Given the federal requirement that prescriptions under Medicare Part D for CDSs must be electronically submitted by January 1, 2021, MedChi worked with the bill sponsor and other stakeholders to conform the bill to the federal law by limiting it to CDS, extending the effective date and providing for additional exemptions for when a prescription could still be prescribed in writing or orally. Due to operational issues raised by MDH and the Attorney General's Office during the final days of Session, the bill did not pass. It is expected that, given the federal mandate, this bill will be reintroduced next Session.

Due to concerns raised that individuals, mainly children, were receiving duplicative vaccinations, **House Bill 316: Public Health - Vaccination Reporting Requirements - ImmuNet** (passed) will require all health care providers to report any vaccinations provided to the States ImmuNet system. Providers can either report directly through their electronic health record or through a separate State portal. The requirement will be effective October 1, 2019.

**House Bill 768: Health - Prescription Drug Affordability Board** (passed). In the final hours of the Session, House Bill 768 passed that establishes a Prescription Drug Affordability Board and Prescription Drug Affordability Stakeholder Council. The Board, in consultation with the Stakeholder Council, is charged with studying the complete supply chain as well as options to address drug affordability. The Board is to report its findings and recommendations to the General Assembly by December 31, 2020. Annually, beginning December 31, 2020, the Board is to submit to the General Assembly a report that includes price trends for prescription drug products, the number of drugs that were subject to review, and any recommendations the Board may have on further legislation needed to make prescription drug products more affordable in the State. The legislation also establishes a specific process for setting upper payments limits if recommended by the Board that includes the development of a plan that must be approved by either the Legislative Policy Committee or the Governor and Attorney General. The bill also includes language recommended by MedChi that would require the Board and the State Designated Health Information Exchange to study how the Exchange can provide de-identified provider and patient data to the Board.

**House Bill 920/Senate Bill 819: Health Insurance - Pharmaceutical Manufacturers - Transparency and Reporting** (failed) was introduced as an alternative to the Prescription Drug Affordability Board legislation. The bill required drug manufacturers, pharmacy benefit managers, and insurers to provide a range of information regarding the drug costs, rebates, the amount of funds returned to patients, and other factors that contribute to affordability and access to pharmaceuticals. The bill was never given serious consideration as the focus remained throughout on the Session on the creation of a Drug Affordability Board and the related provisions of that legislation.

The General Assembly took a hard stand to protect independent pharmacies with the passing of **House Bill 754: Health Insurance and Pharmacy Benefits Managers - Cost Pricing and Reimbursement** (passed). House Bill 754, an emergency bill, prohibits a contract (or contract amendment) between a pharmacy benefits manager (PBM), a pharmacy services administration organization, or a group purchasing organization and a

pharmacy from becoming effective unless (1) the contract or amendment is filed with the Insurance Commissioner at least 30 days before it is to become effective; and (2) the Commissioner does not disapprove the filing within 30 days after the contract or amendment is filed. The bill's provisions also apply to MCOs that use a PBM. The bill also specifies requirements relating to appeals and disputes regarding maximum allowable cost and cost pricing and reimbursement. The bill repeals authorization for a PBM to retroactively deny or modify reimbursement to a pharmacy or pharmacist if the claim otherwise caused monetary loss to the PBM, provided that the PBM allowed the pharmacy a reasonable opportunity to remedy the cause of the monetary loss. Because this is an emergency bill, which will be effective on the day it is signed, there is speculation that the PBMs will be seeking a Governor veto of this bill due to the implications for current contracts.

Because of the passage of **House Bill 754, several other pharmacy bills failed, including House Bill 296: Health Occupations - Pharmacists - Disclosure of Price and Cost Share for Prescription Drugs** (failed), which would have required a licensed pharmacist, at the point of sale, to inform a retail consumer, to the best of the pharmacist's knowledge, of (1) the retail price for the prescription drug; and (2) if the consumer has insurance, the cost share for which the consumer is responsible. House Bill 545: Health Insurance - Freedom of Choice of Pharmacy Act (failed) would have, among other provisions, prohibited a carrier from allowing an enrollee from selecting a pharmacy of the enrollee's choice if the pharmacy participates as a contract provider in the health benefit plan offered by the carrier.

A related bill, **House Bill 759.; Pharmacy Benefits Managers - Pharmacy Choice** (passed) was voted favorable and prohibits a PBM from requiring that a beneficiary use a specific pharmacy or entity to fill a prescription if: (1) the PBM or a corporate affiliate of the PBM has an ownership interest in the pharmacy or entity; or (2) the pharmacy or entity has an ownership interest in the PBM or a corporate affiliate of the PBM. A PBM may require a beneficiary to use a specific pharmacy or entity for a specialty drug.

## Health Insurance

### \* **Insurance Coverage and Mandated Benefits**

As a result of Resolution 25-18 from the Fall House of Delegates, MedChi requested the introduction of **House Bill 435/Senate Bill 405: Health Insurance - Prescription Drugs - Formulary Changes** (passed). As introduced, the bill would have "frozen" the formulary, prohibiting any changes mid-year by an insurer as it related to removing a drug from the formulary or changing a prescription drug to a higher cost sharing tier. Because of concerns raised related to the recent spikes in pharmaceutical costs, legislators were concerned about limiting the ability of an insurer from making mid-year changes. MedChi worked with legislators and insurers to develop alternative language to address the issue. As amended, the bill builds on Maryland's current exemption process for addressing when a beneficiary needs a drug that is not on the carrier's formulary. Under the bill, if a carrier either removes a drug from the formulary or moves a drug to a higher cost tier, the beneficiary may be able to continue to access the drug or stay on the drug in the original cost sharing tier if the authorized prescriber states that there is no equivalent prescription drug in the entity's formulary or in a lower tier. In addition, if the carrier moves a drug from the formulary or shifts it to a higher cost sharing tier, the carrier must provide a beneficiary who is currently taking the drug and the member's health care provider with at least 30-day notice before the change is

implemented. The notice must include the process for requesting the exemption.

Continued concerns over the fate of the **Affordable Care Act (ACA)** prompted the introduction of **House Bill 697/Senate Bill 868: Health Insurance - Consumer Protections and Maryland Health Insurance Coverage Protection Commission** (passed), which would have codified in State law the requirements of the ACA. However, in the end, the bill extends the Maryland Health Insurance Coverage Protection Commission for an additional three years through June 30, 2023, and requires the Commission to establish a workgroup to monitor actions relating to the ACA and to determine the most effective manner of ensuring that Maryland consumers can obtain and retain quality health insurance, independent of any action or inaction on the part of the federal government or any changes to federal law or its interpretation. The Commission must include the findings of the workgroup in its 2019 annual report.

#### \* **Individual Health Insurance Market**

The General Assembly continued its efforts to stabilize the individual health insurance market. Last Session, the State established a health insurance provider fee assessment for Calendar Year 2019 to assist in the stabilization of the individual health insurance market after the participating carriers (CareFirst and Kaiser) announced soaring premium increases. The provider fee assessment was used to create a State Reinsurance Program, which has had the effect of decreasing premium amounts. **House Bill 258/Senate Bill 239: Health Insurance - Individual Market Stabilization - Provider Fee** (passed) continues the assessment through 2023. The bill also requires the State to seek clarification on whether the assessment can apply to MCOs. Lastly, the bill requires the Maryland Health Insurance Coverage Protection Commission to study and make recommendations on whether the State Reinsurance Program should be extended after Calendar Year 2023 and, if so, how it will be funded.

As introduced, **House Bill 814/Senate Bill 802: The Maryland Easy Enrollment Health Insurance Program** (passed) would have imposed a penalty on individuals who did not have insurance. The bill would have also implemented automatic enrollment in the individual market. Due to concerns surrounding the fairness of a penalty on individuals who still may not be able to afford insurance, the General Assembly amended the bills to provide individuals with additional assistance for how to enroll in health insurance by indicating so on their tax return and a process then for obtaining the insurance.

#### \* **Single Payer Health Care**

Once again, bills that would have implemented a State-operated health care plan did not pass. **House Bill 378: Public Health - State-Provided Health Care Benefits** (failed) would have created an Office of Health Care Coverage within MDH to establish and carry out a new Healthcare Maryland Program where individuals were enrolled in health care plans through the State's MCOs. **House Bill 1087/Senate Bill 871: Public Health -Healthy Maryland Program -Establishment** (failed) would have established the Healthy Maryland Program as an instrumentality of the State, which by January 1, 2021, would provide comprehensive universal single-payer health care coverage to replace Medicaid, the Maryland Children's Health Program, Medicare, the ACA, and any other federal programs within the State.

## New Policy Statements, PREP and Information Paper

During their April 2019 meeting, the ACEP Board of Directors approved the following new or revised policy statements/PREP/information paper:

### **New Policy Statements:**

[Salary and Benefits Considerations for Emergency Medical Services Professionals](#)

[Small Motorized Recreational Vehicles](#)

[Violence Prevention and Intervention in Emergency Medical Services Systems](#)

### **Revised Policy Statements:**

[Crowding](#)

[Domestic Family Violence](#)

[Patient Support Services](#)

[Violence-Free Society](#)

### **Revised Policy Resource and Education Papers (PREPs):**

[Resource Utilization in the Emergency Department: The Duty of Stewardship](#)

### **New Information Paper:**

[Influenza Emergency Department Best Practices](#)

## **Articles of Interest in *Annals of Emergency Medicine* - Spring 2019**

Sam Shahid, MBBS, MPH

Practice Management Manager, ACEP

ACEP would like to provide you with very brief synopses of the latest articles and articles coming soon to *Annals of Emergency Medicine*. Some of these have not appeared in print. These synopses are not meant to be thorough analyses of the articles, simply brief introductions. Before incorporating into your practice, you should read the entire articles and interpret them for your specific patient population. [View synopses here.](#)

## **Point of Care Tools**

ACEP's point-of-care tools are transforming care at the bedside. We've recruited the field's top experts and thought-leaders to develop tools our members can trust and deploy in the clinical setting. The evidence-based, clinical content provided in these tools ensures that you are providing the best possible care to the patients in your emergency department. Tools can be found on topics:

- AFIB -Management of Atrial Fibrillation
- ADEPT - Confusion and Agitation in the Elderly
- BUPE - Use of Buprenorphine in the ED
- DART - Recognition and Treatment of Sepsis
- ICAR2E - Identification of Suicidal patients
- And more..

[Check out all of ACEP's point of care tools!](#)

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