Summary of Legislative Bills Significant to Healthcare Risk Managers Pursuant to the 2017 Legislative Session in Annapolis, Maryland

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2017 Bills Summarized

- HB 152 **Budget Reconciliation and Financing Act of 2017 (also known as** Maryland's All-Payer Model (Medicare Waiver) Spend down)
  (Passed, Effective June 1, 2017) (Pages 4-5)

- HB 188 **Public Health - Advance Directives – Witness Requirements, Advance Directives Services, and Fund**
  (Passed, Effective July 1, 2017) (Page 6)

- HB 233 **Disclosure of Medical Records – Guardian Ad Litem – Victims of Crime or Delinquent Acts**
  (Passed, Effective October 1, 2017) (Page 7)

- HB 352/SB1106 **Health Care Practitioners – Use of Teletherapy**
  (Vetoed) (Page 8)

- HB370/SB 354 **Richard E. Israel and Roger "Pip" Moyer End-of-Life Option Act**
  (Unfavorable report; withdrawn) (Pages 9-10)

- HB 581 **Maryland Medical Practice Act – Individuals Exempt from licensure, Repeal of Criminal History Records**
  (No further action) (Page 11)

- HB 604 **Courts and Judicial Proceedings – Venue – Health Care**
  (Unfavorable report; withdrawn) (Page 12)

- HB 777 **Patient Safety Early Intervention Programs**
  (Died in House Judiciary Committee) (Page 13)

- HB 909/SB571 **Maryland Health Insurance Coverage Protection Act**
  (Passed, Effective June 1, 2017) (Page 14)

- HB 1347/SB 877 **Maryland No-Fault Birth Injury Fund**
  (Stayed Senate Judicial Proceedings Committee) (Pages 15-16)

- SB 27 **Child Abuse and Neglect – Substance-Exposed Newborns Reporting**
  (Unfavorable report) (Page 17)

HB 152 *cross-filed with SB 172*
Budget Reconciliation and Financing Act of 2017
Sponsored by: The Speaker at the request of the Administration

Major Points:
Background: The Maryland Constitution requires the Governor to submit, and the General Assembly to pass, a balanced budget. The General Assembly cannot add spending to the budget introduced by the Governor, nor can general funds be used to restore reductions made by the General Assembly after adoption of the budget, except through an approved deficiency appropriation in the following year's budget.

In general, HB152/SB172 actions enhance revenues and transfer funds, provide mandate relief, require fund swaps and cost shifts, and implement cost control and other administrative measures in addition to establishing new mandates in a variety of forums throughout the State. Those actions which specifically relate to healthcare in Maryland include:

- Delays to fiscal 2019 the ongoing requirement that the Governor reduce the Medicaid Deficit Assessment on Maryland Hospitals to $25.0 million below the assessment level for the prior year; increases, for fiscal 2019 and 2020 only, the required reduction to $35.0 million; and specifies the amount that the budgeted assessment must be for fiscal 2018 through 2020.

- Reduces the Core Public Health Services funding formula to the fiscal 2017 level for fiscal 2018 and rebases the formula beginning in fiscal 2019.

- Authorizes the Maryland Community Health Resources Commission Fund, in fiscal 2018 only, to be used for mental health services for the uninsured under specified circumstances.

- Allows excess funds from the Senior Prescription Drug Assistance Program Fund to be used, in fiscal 2018 only, for the benefit of the Kidney Disease Program or community mental health services to the uninsured and without authorization by budget amendment.

- Authorizes the Department of Health and Mental Hygiene to charge the Maryland Health Care Commission (MHCC) and the Health Services Cost Review Commission (HSCRC) an indirect cost assessment of up to 30.5% of salaries.

- Increases the user fee caps for both MHCC and HSCRC from $12.0 million to $16.0 million.

- Expands existing legislative review of any programmatic change that results from a federal block grant; adds a time-limited provision requiring additional review of specified programmatic changes to Medicaid and the Supplemental Nutrition Assistance Program.

- Requires the Comptroller to administer the Maryland Emergency Medical System Operations Fund, including accounting for all transactions and performing year-end reconciliation.

- Alters the amount of mandated operating grants to the University of Maryland Medical System for the Prince George's County Regional Medical Center; requires the Governor to include an annual appropriation of $10.0 million for additional operating grants in fiscal 2022 through 2028; and restructures mandated capital appropriations that the Governor must include in the capital or operating budget bill for the construction of the center in fiscal 2018 through 2020.

Significance of Bill to Risk Managers:

- The bill takes effect June 1, 2017
- It is beneficial for Risk Managers to have a general awareness of legislation which affects healthcare from a State Budgetary perspective and may ultimately have an impact on healthcare facilities' resources (staffing, budgetary constraints, equipment, programs etc.).

Current Bill Status:

- Enacted; effective June 1, 2017

HB 188
Public Health – Advance Directives – Witness Requirements, Advance 2 **Directives Services, and Fund**
Sponsored by: Delegates Kipke, Lam, Oaks, K. Young, and Morhaim

Major Points:
Alters the witness subscription requirement for electronic advanced directives; requires the Maryland Health Care Commission to establish regulations specifying how a declarant's identity may be verified without a witness subscription; clarifies that the Maryland Department of Health and Mental Hygiene (DHMH) may contract with multiple electronic advanced directive services; establishes requirements for the Advanced Directives Program Fund; and amending provisions of law regarding the State Board of Spinal Cord Injury Research and funding for the Spinal Cord Injury Research Trust Fund, specifically:

- Adds a provision allowing an Advanced Directive executed by the declarant without the need for a witness
- Requires the Maryland Health Care Commission to adopt regulations specifying the manner in which the declarant's identity may be verified without a witness.
- Provides that the DHMH can contract with multiple electronic advanced directives services
- The State–designated health information exchange may accept as valid an unwitnessed electronic advance directive in the form of a video record or file to state the declarant's wishes regarding health care for the declarant or to appoint an agent if the video record or file is dated; and is stored in an electronic file by an electronic advance directives service recognized by the Maryland Health Care Commission.
- Establishes requirements for DHMH in administering the Advanced Directives Fund including providing that the fund is nonlapsing and money in the fund may only be used to carry out the purposes of the Advanced Directive Program; money earned as interest from the fund must be credited to the fund; and, the State Treasurer shall hold the fund separately and account for the fund.
- Repeals the requirement that the fund is administered and funded through the Spinal Cord Injury Research Trust Fund

Significance of Bill to Risk Managers:

- Would allow advanced directives to be entered and signed electronically without a witness and under regulations to be established by the Maryland Health Care Commission

Current Bill Status:

- Passed enrolled 4/6/2017; Approved by the Governor – Chapter 667 5/25/2017
- Will take effect July 1, 2017

HB 233
Disclosure of Medical Records – Guardian Ad Litem – Victims of Crime or 2 **Delinquent Acts**
Sponsored by: Delegates Barron, West, Fennell, and Hettleman

Major Points:
Requires a health care provider to disclose a medical record without certain authorization to a court appointed guardian ad litem for a minor, disabled, or elderly individual who is a victim of a crime or certain act; authorizing the guardian ad litem to redisclose the medical record under certain circumstances; and prohibiting the health care provider from charging a fee to the guardian ad litem, specifically:

- Adds a provision allowing a health care provider to disclose the medical record to a guardian ad litem appointed by the court.

- Requires the guardian ad litem to redisclose the medical record if it is necessary to another party designated in the statute to carry out the guardian ad litem's official function to protect the best interests of a minor or disable or elderly individual in a criminal or juvenile delinquency court proceeding.

- Prohibits the health care provider from charging the guardian ad litem a fee for producing the medical record.

Significance of Bill to Risk Managers:

- Would require Risk managers to instruct medical records administrators and health care providers that medical records can be disclosed to a court appointed guardian ad litem for a minor, disabled, or elderly person involved in a criminal court or juvenile delinquency case.

Current Bill Status:
- 4/18/2017 Approved by Governor – Chapter 166
- Will take effect October 1, 2017

HB352/SB1106
Health Care Practitioners – Use of Teletherapy
Sponsored by: Delegates Reznik, Dumais, C. Howard and Krebs; Senator Zucker.

Major Points:

- Authorizing health care practitioners, who provide clinical behavioral health services and are licensed by the State boards of Nursing, Physicians, Professional Counselor and Therapists, Psychologists, and Social Workers to use "teletherapy."
- "Teletherapy" means the use of interactive audio, video or other telecommunications or electronic technology by a health care practitioner to deliver behavioral health services at a site other than the site at which the patient is located.
- Proposing that the board must adopt regulations for the use of teletherapy, including guidelines over the technology, informed consent, and information required before the first teletherapy session, and otherwise establishing safety and emergency protocols. During the drafting there was a dispute as to the language on whether the board should adopt clinical versus nonclinical guidelines.
- Identical to prior bill HB1103, which was withdrawn in 2016. Providers also found the bill overly prescriptive and potentially allowing individuals who are not health care practitioners to provide teletherapy services and amendments were passed.
- Modifications included removal of obligation of health care practitioner to obtain training in the technology and removal of statutory provisions governing the technology, thus stripping the bill. There were concerns that the bill would create separate standards of care delivery based on whether the care was provided in-person or via telehealth. (see http://www.mhaonline.org/docs/default-source/position-papers/2017/house-bill-352-health-care-pracitioners-use-of-teletherapy-final.pdf)

Significance of Bill to Risk Managers:

- The use of telecommunications technologies in the provision of mental health therapy has increased in recent years due to ongoing development of new technologies and the expansion of payment for telemedicine services. Industry associations, such as the American Psychological Association and American Telemedicine Association, have developed guidelines for the provisions of such services. These guidelines address such issues as the competence of practitioners, patient safety, standards of care, informed consent, confidentiality/security/disposal of data and information, testing and assessment, and interjurisdictional practice.
- Bills governing telemedicine and teletherapy are gaining traction.
- Consider development of policies and procedures to address teletherapy and telemedicine.

Current Bill Status:

- Hearing held on February 8, 2017 in House Health and Government Operations with favorable report and third reading passed; Senate Education, Health and Environmental Affairs Committee with favorable vote pending amendments.
- Overwhelmingly favored bill and passed unanimously by the legislature.
- Governor Hogan vetoed the bill.

HB 370/SB354
Richard E. Israel and Roger "Pip" Moyer End-of Life Option Act
Sponsored by: 42 Delegates and 14 Senators

Major Points:

- Authorizing an individual to request aid in dying by making specified requests; prohibiting another individual from requesting aid in dying on behalf of an individual; requiring a written request for aid in dying to meet specified requirements; establishing specified requirements for witnesses to a written request for aid in dying; requiring a written request for aid in dying to be in a specified form; etc.
- "AID IN DYING" MEANS THE MEDICAL PRACTICE OF A PHYSICIAN PRESCRIBING MEDICATION TO A QUALIFIED INDIVIDUAL THAT THE QUALIFIED INDIVIDUAL MAY SELF–ADMINISTER TO BRING ABOUT THE QUALIFIED INDIVIDUAL'S DEATH.
- A qualified individual is an adult who has the capacity to make medical decisions, is a resident of Maryland, has a terminal illness (prognosis that will likely result in death within 6 months), and has the ability to self-administer medication.
- An individual who meets the qualifications may request aid in dying from their attending physician. No other individual, including an agent under an advanced directive, a guardian, or an attorney-in-fact, may request aid in dying on behalf of an individual. The request must be signed and dated by the individual and witnessed by at least two other individuals who, in the presence of the person requesting aid, attest that to the best of their knowledge, the person is of sound mind, acting voluntarily, and not being coerced to sign the written request. Only one of those individuals may be a relative by blood, marriage or adoption or, at the time the written request is signed, entitled to any benefit on the person's death.
- A form "Maryland Request for Medication in Aid of Dying" is provided. The form acknowledges that after taking the medication most deaths occur within three hours but that death may take longer and that the attending physician has counseled about this possibility.
- If in the opinion of the attending physician an individual has impaired judgment or does not have the capacity to make medical decisions, the physician shall refer the individual to a licensed mental health professional for an assessment. The physician may not provide medication in aid of dying until the mental health professional determines that the individual has the capacity to make medical decisions and communicates this in writing.
- The failure to notify next of kin is not a basis for denial of the request for aid in dying.
- Actions taken in accordance with the subtitle do not constitute suicide, assisted suicide, mercy killing or homicide. NOTE: How will life insurance companies handle? Legislation states that a provision in an insurance policy, annuity, contract, or any other agreement, issued on or after 10/1/17, is not valid to the extent that the provision would attach consequences to or otherwise restrict or influence an individual's decision to make or rescind a request for aid in dying. An obligation under a contract existing on 10/1/17 may not be conditioned on or affected by the making or rescinding of a request for aid in dying.

Significance of Bill to Risk Managers:

This bill creates a number of questions regarding how risk management will deal with patients who request aid in dying; attending physicians who will need to be trained on these requirements; attending physicians who do not want to participate in assisting the death of a patient; how to establish protocols that will ensure that the numerous requirements are met to avoid potential litigation.

Current Bill Status:

- Unfavorable Report by Judicial Proceedings; Withdrawn.
- SB354: On March 9, 2017 a hearing was held before the Judicial Proceedings Committee and the bill received an unfavorable report and was withdrawn by the sponsor.
- HB370: On February 16, 2017, a hearing was held before the Health and Government Operations Committee, but no further action was taken.

HB 581
Maryland Medical Practice Act – Individuals Exempt from Licensure, Repeal of Criminal History Records
Sponsored by: Delegates Terri Hill and Clarence Lam

Major Points:
Generally relating to individuals exempt from licensure under the Maryland Medical Practice Act:

- Repeals the requirement that, in order to practice medicine without a license while performing specified duties, a medical student or an individual in a postgraduate medical training program approved by the Maryland Board of Physicians must submit to a criminal history records check (CHRC) in accordance with a specified provision of law.

Significance of Bill to Risk Managers:

- Would begin on October 1, 2017.
- Medical students and individuals in approved post-graduate medical training programs would no longer have to submit to criminal history records checks.
- The Maryland Board of Physicians registers or re-registers approximately 2,500 Unlicensed Medical Practitioners per year, and the MBP has been requiring such practitioners to undergo CHRC since October 2016. If this bill is approved, it would be easier for the MBP to register and re-register Unlicensed Medical Practitioners.

Current Bill Status:
On 02/22/17, the second reading passed with amendments (amended to note that this is an "emergency" measure for the immediate preservation of public health and safety) and is effective immediately. Cross-filed with SB 0633. On 02/23/17, the SB 0633 went to the Senate Education Health and Environmental Affairs Committee. On 2/24/17, the third reading passed in the House (136-0). The first reading in the Senate (Education Health and Environmental Affairs Committee) was on 2/27/17. No further outcome was noted.

HB 604
Courts & Judicial Proceedings – Venue – Health Care
Sponsored by: Delegates Sydnor, Morhaim, and Rosenberg

Major Points: This bill stipulates that the venue for an action due to an injury arising out of or resulting from an alleged negligent act or omission specifically with respect to the provision of health care, as opposed to a civil action generally, is the county in which the alleged negligent act or omission occurred. It further specifies that if an alleged negligent act or omission occurred in more than one county, the plaintiff may bring the action in any of those counties. In addition, any other party may seek a change of venue in accordance with the Maryland Rules.

> Notably, under current law , a civil action must be brought in the county where the defendant (1) resides; (2) carries on a regular business; (3) is employed; or (4) habitually engages in a vocation. A corporation may also be sued where it maintains its principal offices in the State. If there is more than one defendant, and there is no single venue applicable, all of the defendants may be sued in a county in which any one of them could be sued or in the county where the cause of action arose.

Significance of Bill to Risk Managers:
In addition to the general provisions that a defendant may be sued where he resides or carries on business, the current venue framework provides that tort actions based on negligence may be brought where the cause of action "arises," a term of art capturing the moment when all elements of a negligence claim come into being (including the injury). HB 604 specifically proposes that actions due to an injury arising or resulting from the rendering or failure to render heath care may be brought where the alleged negligent act or omission occurred. The bill could potentially provide additional venue options for medical negligence lawsuits.

Current Bill Status:
- The bill received an unfavorable report by the judiciary and was withdrawn.

HB 777
Patient Safety Early Intervention Programs
Sponsored by: Del. Dumais

Major Points:

- Similar to 2016 HB 606
- Allows (but does not require) hospitals, related institutions and health care liability insurers to establish a 'patient safety early intervention program' with the following required features:
    - Must provide for timely investigation of each report of an adverse event to determine if harm to the patient occurred and if the care provided deviated from the standard of care.
    - When an investigation reveals that substandard care did result in harm to the patient, the program shall have a process so the following occur timely:
        -Obtaining input from the patient/patient's family about the adverse event;
        -Disclosing to the patient/patient's family the findings of the investigation;
        -Apologizing to the patient for the care provided;
        -Advising the patient/patient's family of their right to legal representation;
        -Allowing the patient/patient's family to participate in efforts to identify and implement system improvements designed to prevent a recurrence of the adverse event;
    - Patients shall be provided a written summary of the hospital's program.
    - Services or support, including financial support, to the patient/patient's family does not affect the right of the patient to fair and reasonable compensation for damages associated with the adverse event available under State law.
- If a hospital, related institution, or health care liability insurer establishes such a program, statements made by a party during a discussion in accordance with this program are not admissible in evidence as an admission of liability or an admission against interest.
- Significant objection by the Plaintiff's bar regarding involvement of counsel for representation of patient's interests and exclusion of evidence as an admission of liability or admission against interest during a malpractice claim proceeding or civil action.

Significance of Bill to Risk Managers:

- Risk managers would likely be called upon to play an important role in the implementation of any such program, and all of the processes described above.
- For example, risk managers may be required to give a Miranda-like warning to patients, letting them know they have a right to a lawyer.
- Though the bill is intended to provide protection for these discussions from admission at trial, the language employed leaves many avenues for manipulation by inventive plaintiffs' attorneys.

Current Bill Status:

- HB606 was introduced on February 3, 2017 - 25% progression. Hearing on 3/8/17. No report and no further action taken.

HB 909/SB571
Maryland Health Insurance Coverage Protection Action
Sponsored by: Senator Middleton, Deleegate Pena-Melnyk

Major Points:
Preamble of the bill notes that the repeal of the Affordable Care Act ("ACA") may result in 22 million individuals becoming uninsured in the United States, more than 350,000 people in Maryland or one in five of the nonelderly population. Acknowledges that a repeal or weakening of the ACA, Medicaid, or Medicare could more than double the number of individuals without health insurance.

Establishing the Maryland Health Insurance Coverage Protection Commission to monitor and assess the impact of potential and actual federal changes to specified health care programs and to provide recommendations for State and local action to protect the access of residents of the State to affordable health coverage; providing for the composition of the Commission; authorizing the Commission to convene specified workgroups; requiring the Commission to report *annually* to the Governor and General Assembly by December 31; etc.

Significance of Bill to Risk Managers:

- Would pass monitoring of the federal ACA provisions to a commission with annual reporting.

Current Bill Status:
- Favorable reports with amendments.
- Will take effect June 1, 2017

Other Noteworthy Provisions:
- See Maryland Defense Act of 2017 (February 15, 2017). Resolution providing the Attorney General with the directive and the resources to engage in offensive or defensive action to protect citizens of Maryland from "harmful" federal efforts. Outlines steps for the Attorney General to follow and allocates $3 million a year including five staff members in the Attorney General's Office to take the necessary actions.
- See also Senate Joint Resolution 7 and House Joint Resolution 9, urging the Governor of Maryland and the Congressional Delegation to strongly oppose and resist the repeal of the ACA.

HB 1347/SB 877
Maryland No-Fault Birth Injury Fund
Sponsored by: 7 Senators; 32 Delegates

Major Points:

- The sponsors of the bill want to provide fair and equitable compensation, on a no-fault basis, for a limited class of catastrophic injuries that result in unusually high costs for custodial care and rehabilitation. The purpose is to establish a system for adjudication of prospective birth-related claims involving permanent neurological injury.
- The Office of Administrative Hearings will determine on the basis of evidence presented in a contested hearing, eligibility, the nature and amount of compensation and benefits. An infant may be awarded actual lifetime expenses for qualified healthcare costs, limited to reasonable charges prevailing in the same community for similar treatment of injured persons when the treatment is paid for by the injured person; up to $500,000 payable in periodic payments or as a lump sum to the injured infant or parents or legal guardians of the injured infant for the benefit of the injured infant; loss of earnings to be paid in periodic payments beginning on the eighteenth birthday of the infant (alternatively, a funeral payment of $25,000 if the infant dies before age 18); funding for reasonable expenses incurred in connection with the filing and prosecution of the claim (including reasonable attorneys' fees on an hourly basis subject to approval and award of the ALJ).
- Birth-related neurological injury means an injury to the brain or spinal cord of a live infant born in a Maryland hospital that (1) is caused by oxygen deprivation or other injury that occurred or could have occurred during labor, delivery, or in the resuscitative period after delivery and (2) renders the infant permanently neurologically and physically impaired.
    - does NOT include disability or death caused by genetic or congenital abnormality.
- The rights and remedies under this statute would supplant all other rights and remedies of the infant, PR of the infant, and parents, dependents or next of kin of the infant arising out of or related to a birth-related neurological injury to the infant, including claims of emotional distress related to the infant's injury. However, it does not exclude other rights and remedies available to the mother of the infant arising out of or related to a physical injury, separate and distinct from a birth-related neurological injury to the infant, suffered by the mother of the infant during the course of delivery. Further, a civil action is not prohibited against a HCP or Hospital if there is clear and convincing evidence that the HCP or Hospital *maliciously intended* to cause a birth injury and the claim if filed before and instead of payment of an award under this subtitle.
- The limitations period for a civil action that may be brought by or on behalf of an injured infant for damages allegedly arising out of or related to a birth-related neurological injury are tolled by the filing of a claim under the bill. The claim may be filed by a legal representative on behalf of an injured infant.
- The Fund is capitalized by annual premiums from Maryland hospitals. Each fiscal year, based on an annual statement of actuarial opinion, the board must determine the amount required to finance and administer the Fund. The methodology of determining rates for hospitals must account for geographic differences among hospitals, differences among

hospitals' historical claims experience involving births in each hospital, and distinguish between hospitals that provide OB services and those that do not

- Virginia (1987), Florida (1988) and New York (2011) have birth-related neurological injury compensation plans.
- In 2015, the Workgroup to Study Access to Obstetric Services was established. The workgroup, convened by the Maryland Hospital Association, consisted of 17 organizations, including medical professional organizations and hospitals. In its December 2015 final report, the workgroup recommended the establishment of a No Fault Birth Injury Fund to stabilize medical liability costs and provide an incentive for hospitals to continue to provide obstetric services.
- Looking at DHMH's Vital Statistics Report, approximately seven qualifying infants are born each year.
- SB513 of 2016, a similar bill, received a hearing in the Senate Judicial Proceedings Committee but no further action was taken. Its cross-filed HB, HB 377, received a hearing in the House Health and Government Operations Committee and in the House Judiciary Committee but no further action was taken.

Why this bill is important to Risk Managers:

This bill creates a strict liability system for birth injuries that would purportedly mitigate the liability risk of what has been traditionally considered the highest risk services to insure, decrease the potential for highest jury awards and preserve access to Obstetrics services in Maryland while enabling all birth injured babies to receive the care that they need.

Current Bill Status:

- SB877: A hearing was held on February 23, 2017 before the Judicial Proceedings Committee, with no further action taken.
- HB1347: A hearing was held on March 6, 2017 before the Judicial Proceedings Committee, with no further action taken.

SB 27
Child Abuse and Neglect – Substance Exposed Newborns - Reporting
Sponsored by: Chair, Judicial Proceedings Committee

Major Points:
This emergency departmental bill repeals a provision that **exempts** health care practitioners from making a required report regarding a substance-exposed newborn if the health care practitioner has verified that, at the time of delivery (1) the mother was using a controlled substance as currently prescribed for the mother by a licensed health care practitioner or (2) the presence of a controlled substance was consistent with a prescribed medical or drug treatment administered to the mother of the newborn.

A newborn, child younger than the age of 30 days who is born or receives care in the State, is "substance-exposed" if the newborn displays (1) a positive toxicology screen for a controlled drug as evidenced by any appropriate test after birth; (2) the effects of controlled drug use or symptoms of withdrawal resulting from prenatal controlled drug exposure as determined by medical personnel; or (3) the effects of a fetal alcohol spectrum disorder. A newborn is also substance-exposed if the newborn's mother had a positive toxicology screen for a controlled drug at the time of delivery.

A health care practitioner involved in the delivery or care of a substance-exposed newborn must make an oral report to the local department of social services as soon as possible and make a written report to the local department not later than 48 hours after the contact, examination, attention, treatment, or testing that prompted the report. If the substance-exposed newborn is in the hospital or birthing center, a health care practitioner must instead notify and provide the information to the head of the institution or that person's designee.

After receiving report, the local department must assess the risk of harm to and the safety of the newborn to determine whether any further intervention is necessary. If the local department determines that further intervention is necessary, the local department must (1) develop a plan of safe care; (2) assess and refer the family for appropriate services, including alcohol or drug treatment; and (3) as necessary, develop a plan to monitor the safety of the newborn and the family's participation in appropriate services. A report made under these provisions does not create a presumption that a child has been or will be abused or neglected.

Amendments were proposed by interested groups to ensure that dependent funding provisions were followed. (See https://www.acy.org/wp-content/uploads/2017/01/sb-27-Subst-Exp-Newborns-Supp-w-Amend.pdf)

Significance of Bill to Risk Managers:
- Would relinquish reporting requirements and minimize involvement of local department.

Current Bill Status:
- Unfavorable report by Senate Judicial Proceedings

SB 38
Department of Mental Health & Hygiene ("DHMH") – Updating Advisory Boards and Councils
Sponsored by: Finance Committee Chair (Governor's bill)

Major Points:
This bill would consolidate three currently existing State advisory councils (physical fitness, arthritis, heart disease and stroke) into one State Advisory Council on Health and Wellness in the DHMH. The aforementioned Council's purpose would be to continue to advise DHMH in an effort to establish guidelines, promote evidenced-based program development, educational and reporting mandates with respect to chronic disease prevention, health and wellness. Rather than continue to have three independent advisory councils, this bill would allow the council members to collaborate their efforts improve their effectiveness, efficiency and cost-saving.

The bill also expands the membership of the Advisory Board on Prescription Drug Monitoring. Additionally, the bill makes several technical changes, including repealing obsolete entities, updating outdated references, streamlining certain appointment processes, and clarifying membership of the State Child Fatality Review Team.

Significance of Bill to Risk Managers:
-Will become effective October 1, 2017.

Current Bill Status:
Senate and House passed each with minor amendments. Approved by the Governor on 4/11/17.

SB 47
Reporting Abuse to the Long-Term Care Ombudsman Program and the Office of Health Care Quality
Sponsored by: Finance Committee Chair (by request)

Major Points:
Alters the State mandatory reporting requirement for cases of alleged or suspected abuse of a vulnerable adult.

- Creates an exception for the State Long-Term Care (LTC) Ombudsman or an individual designated as an ombudsman.
    - An ombudsman is not required to disclose, and is prohibited from disclosing, the identity of a resident or complainant unless specified consent is given as required under Federal Law.
        - *Conforms the State reporting requirement to confidentiality requirements included in federal law and regulation.*
- Alters reporting requirements to clarify the entities to which a person is required to report suspected abuse of a resident of a certain related institution.
    - A person who believes a resident of a facility has been abused must report the alleged abuse to:
        - The Office of Health Care Quality (OHQC), instead of the Secretary of Health and Mental Hygiene; and
        - An appropriate law enforcement agency.
    - *Must report both instead of just one.*

Significance of Bill to Risk Managers:

- Begins October 1, 2017.
- **Imposes a penalty: An employee of a related institution who is required to report alleged abuse and who fails to do so within 3 days after learning of the alleged abuse is liable for civil penalty of not more than $1,000. [note that this is already current law, but the reporting requirements would change (they must report to a new entity, plus the appropriate law enforcement agency)**

Current Bill Status:

- **Passed** in both House & Senate, approved by Governor 4/18/17

SB 51 (Cross file HB 559)
Worker's Compensation – Permanent Total Disability – Survival of Claim
Sponsored by: Senator Klausmeier

Major Points:
This bill generally relates to the survivability of rights to compensation for permanent total disability due in part to accidental personal injury or resulting from an occupational disease. If the permanent total disability was either due in part to an accidental personal injury (in conjunction with a preexisting condition or an occupational disease) or resulted from an occupational disease, then the total amount of compensation still due at the time of death remains payable to the rightful survivors.

Under current law, there is no right of survivorship to any residual compensation if the permanent disability was due solely to an accidental personal injury and compensation of greater than or equal to $45,000 has already been paid; if less than $45,000 has been paid, the survivors received the benefit equivalent to the cap of $45,000. In sum, if an injured worker is receiving worker's compensation benefits for permanent total disability and dies from a cause not related to that worker's compensation claim, this bill would allow the employee's surviving beneficiaries to recover the remaining previously awarded worker's compensation award beyond the $45,000 cap.

Significance of Bill to Risk Managers:
- While expenditures on a State and local level, as well as those of insurers would increase under this bill, the situation addressed by this bill is predicted to be narrow enough that it would be rare in occurrence and as such, would have minimal financial impact.
- Had this bill passed, would have been effective October 1, 2017**.**

Current Bill Status:
Senate Finance Committee Hearing on 2/21/17; Died in the Senate.

SB 110
Public Health – Expedited Partner Therapy – Pharmacist Dispensing (to dispense antibiotic therapy)
Sponsored by Senator Joan Conway (Democrat, District 43, Baltimore City)

Major Points:

- Authorizing, notwithstanding any other provision of law, a licensed pharmacist to dispense antibiotic therapy to a specified partner of a patient diagnosed with trichomoniasis without making a personal physical assessment.
- The purpose of the expedited partner therapy is to provide antibiotic therapy to any partner of a patient diagnosed with a STD identified as chlamydia, gonorrhea or trichomoniasis, contain the spread of infection and reduce the likelihood of reinfection in the diagnosed patient.
- Health Care providers (physician, APRN, PA-C, Health Department RN) may, prescribe, dispense or provide antibiotic therapy without making a personal physical assessment of the patient's partner.

Significance of Bill to Risk Managers:

- The bill adds Trichomoniasis to the STD infections for which antibiotic therapy may be prescribed by physicians, APRN's, PA-C's and Health Department RN's. Under the Bill, pharmacists are not given prescriptive authority.
- A potential issue for risk managers would be the writing of a prescription for an individual whom the provider has not made a physical assessment. While it is prudent to treat the patient's partner, it would also be prudent to examine the patient's partner to assess for any other clinical issues or concerns as STDs and UTI can often present with the same symptomatology.

Current Bill Status:

- Enacted under Article II, Section 17(c) of the Maryland Constitution – Chapter 82
- Effective October 1, 2017

SB 144
Civil Actions – Prelitigation Discovery of Insurance Coverage
Sponsored by: Senator Zirkin

Major Points:

- The bill extends prelitigation discovery of certain insurance coverage information from vehicle accidents only to any tort.

- The proposed bill replaces references to "a vehicle accident" with "an alleged tort" in Sections 10-1101 to 10-1105 of the Courts and Judicial Proceedings article of the Maryland Code.

- With respect to discovery of reports, the proposed language replaces "A copy of the vehicle accident report, if available," with "A copy of <u>any vehicle accident report or police report concerning the alleged tort</u>, if available."

- **<u>Amendments:</u>** The original text was amended to require a claimant to provide an insurer with a letter from an attorney certifying the claim is not frivolous. The insurer would be required to provide the claimant documentation of coverage limits in an automobile insurance policy, home insurance policy, or renter's insurance policy.

Significance of Bill to Risk Managers:

- This bill would allow claimants / plaintiffs in medical negligence actions, including wrongful death claims, to obtain from the insurer the documentation of applicable limits of coverage.

- The information would be discoverable after a claim is filed but before litigation has formally begun.

- Risk managers may be confronted with these requests and compelled to disclose limits of liability coverage with only the most basic information about a claim.

- Of note, the proposed language solely covers "police reports" of the alleged tort, not incident reports or other records.

Current Bill Status:

- Favorable with amendments report by Judicial Proceedings
- April 10, 2017 – Unfavorable report by Judiciary

SB 193
Physicians-Professional Liability Insurance Coverage-Notification and Posting Requirements
Sponsored by: Senator Klausmeier

Major Points:

- The physician must provide written notification of lapses in liability insurance coverage and the lack of liability coverage at every encounter with the patient.
- The patient must sign a document acknowledging their awareness of the provider's lack or laps in liability coverage, which would be place in the patient's medical record.
- If the provider does not have liability coverage there must a be a sign in a noticeable area.

Significance of Bill to Risk Managers:

- The logistics of placing a signed document that acknowledges laps or lack of liability coverage in a patient's record would be a challenge.
- Most providers do not understand their liability coverage to be able to explain it to a patient.

Current Bill Status:

- On February 9, 2017 the bill was withdrawn.

SB195/HB957
Physicians-Licensure-Liability Coverage (Janet's law)
Sponsored by: Senator Klausmeier

Major Points:

- Resurrecting legislation from 2009 that would have required all physicians to carry specified levels of medical professional liability insurance.
- Requires the physician to maintain a minimum amount of liability coverage.
- The board of medicine can verify the physician's insurance coverage.
- The physician must notify the board of medicine of cancellation of liability coverage.
- Initiation, renewal and upon request the physician must provide the board of medicine proof of coverage.
- If the liability coverage is canceled the physician must notify the board of medicine ten days before the cancellation goes into effect.
- Those physicians *not* carrying professional liability insurance must post a sign in his/her office indicating that as well as to provide individual patients with this notification in writing as part of the informed consent process.

Significance of Bill to Risk Managers:

- Impacts the informed consent process.
- The responsibility for monitoring and maintaining insurance documentation will pass to Risk Managers, if not already handled.
- Ultimately, monitoring of compliance will ensure that providers have coverage and avoid potential lapses.
- Liability coverage will be listed on the public practitioner profile for each licensed physician in the State.

Current Bill Status:

- On March 10, 2017 the bill was passed in the Senate.
- On March 22, 2017 there was a hearing in the house health and government operations
- On April 10, 2017 the bill was passed.

SB 225 / SB 682
Civil Actions - Noneconomic Damages
Sponsored by: Senator Ramirez

Major Points:
This bill increases the maximum amount of noneconomic damages that may be recovered in any wrongful death or survival action, including a health care malpractice action, to 450% of the statutory limitation, which is from $845,000 to $3,802,500. The increase applies when there are two or more claimants. [Previously, when there were two or more beneficiaries, an award of non-economic damages could not exceed 150% of the applicable cap for general actions ($1,267,500) or 125% for health care malpractice actions ($981,250).]

The applicable limit on noneconomic damages in health care malpractice actions is the general cap of $845,000, as opposed to the prior, health care malpractice action cap of $785,000, for wrongful death or survival actions arising on or after October 1, 2017.

Further, a jury may be informed of the limits on noneconomic damages in specified civil actions, including that the award for noneconomic damages may not exceed 450% of the statutory limitation in a wrongful death or survival action.

Significance of Bill to Risk Managers:
For wrongful death and survival actions, the recoverable damages for pain and suffering would be substantially increased. Health care providers, particularly those in private practice, are more vulnerable to excess verdicts as the standard $1 million in coverage would not nearly cover the maximum exposure of about $3.8 million in noneconomic damages. It can be anticipated that hospitals, medical groups, and other entities that may have a principal-agent relationship with individual providers are more likely to be named and pursued to cover excess damages. Given the increased risk of a high dollar verdict for wrongful death and survival actions, early mediations may take a more prominent role in resolving disputes, particularly in challenging venues such as Baltimore City.

Current Bill Status:
SB 225 received an unfavorable report and was withdrawn on January 30, 2017. It was resubmitted as SB 682. *See also* HB 1459. Died in Committee.

SB 336
MD Tort Claims Act- Certain Claim Requirement
Sponsored by: Sen. Roger Manno (D)

Major Points:

- Repealing the requirement that a claimant make a specified motion and show good cause before a court may entertain a specified action under the Maryland Tort Claims Act; requiring a court to entertain an action under the Maryland Tort Claims Act even if a claimant fails to submit a specified written claim, under specified circumstances; and providing for the prospective application of the Act.
- In general, the State is immune from tort liability for the acts of its employees and cannot be sued in tort without its consent. Under MTCA, the State statutorily waives its own common law immunity on a limited basis. MTCA limits State liability to $400,000 to a single claimant for injuries arising from a single accident. In actions involving malice or gross negligence or outside the scope of public duties of the State employee, the State employee is not shielded by the State's color of authority or sovereign immunity and may be personally liable.
- MTCA also has certain notice and procedural requirements. Claim must be submitted to the State Treasurer or designee within one year after the injury, and an action must be filed within three years after the cause of action arises. The procedural requirement of submission of a written claim does not apply if within one year after the injury, the State has actual or constructive notice of the claimant's injury or defect or circumstances giving rise to the injury.
- Pursuant to legislation enacted in 2015, upon motion of a claimant who failed to submit a written claim within the one-year time period prescribed by MTCA, and for good cause shown, the court may entertain the claimant's action unless the State can affirmatively show that it has been prejudiced. While this was enacted in 2015, the Local Government Tort Claims Act (LGTCA) has contained a good cause requirement for several years.
- Retains statutory provision that a court is not required to entertain a cause of action if the State can affirmatively show that its defense has been prejudiced by the claimant's failure to submit a claim.
- Fiscal Impact: potential significant increase in State Insurance Trust Fund expenditures and increased litigation costs resulting from an increase in lawsuits involving older claims.
- According to the Treasurer's Office, one third of the estimated 5,000 claims received each year are denied on the basis of untimely notice.
- SB935 of 2016, a similar bill as amended by the Senate, received a favorable with amendments report by the House Judiciary Committee. No further action was taken on the bill.

Why this bill is important to Risk Managers:

This bill may impact risk management in the healthcare setting in rare instances where the state is a co-defendant in a premises liability action. As the law already contains a provision by which plaintiffs can seek an exception to the notice requirement for good cause and on filing of a motion, and because of the potential for significant increase in

litigation cost for the state, if it is introduced again in the 2018 legislative session we do not believe that it will go further than committee.

Current Bill Status:

- A hearing was held on February 27, 2017 before the Judicial Proceedings Committee and received an unfavorable report by a seven to four vote.

SB 363
Pharmacists – Contraceptives – Prescribing and Dispensing
Sponsored by Senator Joan Conway (Democrat, District 43, Baltimore City)

Major Points:

- Authorizing a pharmacist who meets the requirements of State Board of Pharmacy regulations to prescribe and dispense specified contraceptives; requiring the State Board of Pharmacy, on or before September 1, 2018, and in consultation with the State Board of Physicians, the State Board of Nursing, and specified stakeholders to adopt regulations establishing the conditions under which pharmacists may prescribe and dispense contraceptives; etc.

- Pharmacists shall be required to complete a training program approved by the Board for Prescribing and Dispensing Contraceptives.

- A Self-Screening Risk Assessment tool will be developed and used by a patient before a pharmacist may prescribe contraceptives for the patient.

- The Bill requires written documentation and instructions for the patient to follow-up with their PCP or reproductive health provider.

- Pharmacists are prohibited from prescribing contraceptives before January 1, 2019.

Significance of Bill to Risk Managers:
Close follow-up will need to be done to ensure the requirement for the Board of Pharmacy to work with stakeholders in the development of the regulations, initial training, and continuing education takes place. Additionally, the process for documentation and patient referral to a health care provider will need to be established.

The risk is having incomplete regulations and/or training before the effective implementation date of January 1, 2019.

Current Bill Status:
- Enacted. Effective July 1, 2017.

SB 836
Civil Actions – Punitive Damages Awards
Sponsored by: Senators Norman & Smith

Major Points:
Under the current law, actual damages[1], also known as compensatory damages, are intended to make a plaintiff whole by returning the plaintiff to the position he or she was in prior to the alleged harm caused by the defendant. This bill (1) establishes that punitive damages, which are historically designed to punish and deter blameworthy behavior, may be awarded in a civil action only if the plaintiff proves by clear and convincing evidence that the defendant acted with wantonness, fraud, or malice; (2) requires a trier of fact to consider specified factors to determine the amount of punitive damages awarded; and (3) prohibits a jury from awarding punitive damages unless the jury reaches a unanimous decision regarding the defendant's liability and the amount of punitive damages to be awarded.

Significance of Bill to Risk Managers:
- The bill applies prospectively to actions for punitive damages filed on or after the bill's October 1, 2017 effective date.
- Potential for meaningful impact on employers of healthcare providers, that would have to pay or receive punitive damages for the actions of its employees.
- A plaintiff seeking punitive damages has already received full economic and, in some cases, non-economic damages.
- This is an opportunity for the Plaintiff's bar to elevate the value of cases and persecute healthcare providers in damages akin to criminal penalties.

Current Bill Status:
Died in the Senate.

[1] Actual damages include both economic damages – compensation for things like lost wages, medical expenses, and costs to repair or replace property – and noneconomic damages – compensation for things like pain, suffering, inconvenience, physical impairment, loss of consortium, or other nonpecuniary injury.

SB 1020
Maryland Health Care Regulatory Reform Act of 2017
Sponsored by: Senator Middleton

Major Points:
This bill would merge the current Maryland Health Care Commission and the Health Services Cost Review Commission into one agency to be named the Maryland Health Care and Cost Review Commission ("MHCCRC"), and would dictate how the agency would be organized and governed. Essentially, this bill would completely overhaul the two commissions that currently regulate Maryland hospitals and healthcare facilities by combining them into one agency to perform the duties that each currently perform as an independent agency in addition to adding some provisions within their scope of work. The bill would also transition the commissioners from part-time volunteer positions with a required level of expertise to state salaried positions, similar to the structure of the Public Service Commission.

Some of those additional provisions include biannual reporting by the MHCCRC to the Governor regarding the State's performance in limiting inpatient and outpatient hospitalizations; progress towards achieving savings in Medicare per Medicare beneficiary; cost shift performance from per-case rate to a population based revenue system; performance in reduction of hospital readmissions and hospital-acquired conditions. The MHCCRC would oversee designated work-groups to provide recommendations and advice to implement Maryland's All-Payer Model contract.

Significance of Bill to Risk Managers:
- This bill would impose additional reporting requirements and potential penalties for failure to report data pursuant to the aforementioned categories on Maryland hospitals and healthcare facilities.
- This bill is highly complicated, is not scheduled for a hearing until after the bill crossover deadline and does not have a House companion bill so is not likely to gain much traction.

Current Bill Status:
Died in the Senate.

The Patient Protection and Affordable Care Act Repeal and Replace
American Health Care Act 2017
Sponsored by: Congressional House Committees – Ways and Means and Energy and Commerce

Major Points:

- Promise to provide better and more affordable coverage than Obamacare.
- Kill the requirement that everyone buy insurance by eliminating the tax penalty for those who don't have coverage.
- Makes significant changes in the financial assistance people can receive to buy a health plan. Tax credits, not subsidies, refundable in advance to people with incomes below $75k.
- Permit insurers to charge a 30% penalty to people who let their insurance lapse and then try to buy a new policy.
- Tends to increase average premiums.
- Will not repeal provisions that allow children to stay on their parents' plans until they are 26 years old.
- Tax credits will not be available to pay for insurance policies if they include abortion coverage.
- The bill plans to defund Planned Parenthood.
- Congressional Budget Office issued a report that the proposed bill would result in an increase of 14 million more uninsured Americans by next year and 52 million uninsured people by 2026, an increase of 24 million compared to the Affordable Care Act. It would also result in lower average premiums and federal savings of $337 billion by 2026. https://www.cbo.gov/publication/52486

Significance of Bill to Risk Managers:

- Too early to tell.
- Perhaps loss of coverage for patients. The largest savings would come in part from reductions in outlays for Medicaid.

Current Bill Status:

- House approved legislation May 4, 2017.
- Will require approval by the full House and Senate before it goes to President Trump for signature.