Maryland Society of Otolaryngology (MSO)
2018 Legislative Session Report

The 2018 Session of the Maryland General Assembly adjourned at 12 midnight April 9th bringing to a close a frenetic 90 days of bill hearings, budget briefings and committee workgroups. This ending at the same time rings a new beginning of the "Pre-Primary Election" rush. With the State's primary elections being held on June 26th incumbents and candidates alike will be pressing hard to get their message out and secure supporters. The next few weeks and months are a great opportunity to get involved, build relationships and lay the ground work for the Sessions to come.

The predominant issue in health care today is the State's advancement towards Phase 2 of Maryland's Hospital All-Payer demonstration model. The key principles that we fought to secure in the Term Sheet between the State of Maryland and CMS played a role in a number of bills this Session, as you will see later on in this report.

The movement towards Phase 2 and controlling "Total Cost of Care" has implications for all of healthcare, particularly physicians, who are not afforded the same financial safety net as the hospitals.

We continue to focus our efforts at the highest levels to keep these issues at the forefront and develop solutions to preserve physician autonomy, fair payment and reduce financial risk. Here is a quick update of where things are and where things are going with the All-Payer Model.

Maryland All-Payor Demonstration Model – Phase 2:

At the beginning of the year the Sate and CMS jointly announced a 1-year extension of Phase 1 of the State's Hospital All-Payer Demonstration Model. This pushes the beginning of Phase 2 from January 1, 2019 to January 1, 2020.

The Health Services Cost Review Commission and the Maryland Department of Health anticipate final approval of the formal agreement for Phase 2 in the coming months. At that time, we will learn when implementation of Phase 2 will officially commence.

The next phase will see how well hospitals will be able to achieve cost savings and better health outcomes as Total Cost of Care comes to encompass care delivered by physicians, health care providers and health care facilities outside of hospital settings.

Hospitals continue to be incentivized to stay under their global ceilings and more and more volume is being pushed to outpatient settings. With that push Maryland's health care costs outside of the hospital are increasing above the national average. While hospital spending is decreasing, it raises questions as to how much is due to cost shifts to health care settings outside of the global budgets purview. Information on nonregulated outpatient settings is not well documented by the HSCRC, making it that much more challenging to quantify the true impact to the healthcare system.

As Total Cost of Care comes to include the fuller healthcare system in Maryland, it must be watched to see whether increasing outpatient costs will undermine hospital cost reductions. If they do, the paradigm will then shift to controlling costs outside the hospitals. This might have unforeseen repercussions on

patient safety, challenging the Model's goal of patient-centered care. Furthermore, the issue of how physician autonomy and fair payment are impacted will continue to be a challenge and a principal issue of concern.

Our participation on key workgroups in the State is ongoing as the HSCRC, the Administration and General Assembly continues to develop its plans and policies to transition from Phase 1 to Phase 2. We are meeting with members of Maryland's Congressional Delegation and State policy and decision makers central to this process. It is essential that physician expertise, leadership and intervention is part of the process.

Health Insurance Coverage Protection

House Bill 1795/Senate Bill 1267: Maryland Health Benefit Exchange - Establishment of a Reinsurance Program
House Bill 1782/Senate Bill 387:Health Insurance – Individual Market Stabilization (Maryland Health Care Access Act of 2018)
All Passed and Signed into law by the Governor.

- These two pieces of legislation are the end-product of the House ACA Workgroup. This workgroup met throughout the session, along with various stakeholders, to study ways to stabilize the individual health insurance market in the Maryland Health Benefits Exchange in both the short and long-term.
- Health insurance premiums for the individual market are expected to increase between 30%-50% in the next year. Such a jump would be catastrophic to the market and would lead to greater population pool attrition and the exit of CareFirst from the individual market.
- Ultimately the Workgroup decided to implement a reinsurance program. Such a program would try to reduce rate volatility in the individual pool by covering a significant portion of high-cost claims and allowing carriers to offer lower premiums.
- Funding for this program would come from state and federal funds. State funds would be derived from an assessment on carriers equal to what carriers would have paid in Health Insurance Tax in 2019 had a moratorium on said tax had not been instituted by the federal government. This amount will be approximately $380 million.

House Bill 1782/Senate Bill 387 establish the carrier assessment and create a commission to study different policymaking options to stabilize the individual market on a long term basis, such as the merging of the individual and the small group markets, the creation of a single-payer system, a Medicare buy-in program, etc.

- Originally, House Bill 1782 aimed to establish a penalty to enforce the individual mandate and a hospital assessment. The penalty was dropped for concerns of "bipartisanship." The Secretary of Health testified against the hospital assessment since such an assessment would increase Total Cost of Care and risk endangering negotiations with CMS over the Model.
- Federal funding will come from federal pass through funding equal to the Advanced Premium Tax Credits (APTC) subsidies the federal government would save thanks to the reinsurance program. The amount of pass-through funding would be approximately $200-300 million.
- In order to receive these federal funds the state has to apply for a 1332 Innovation Waiver. Such waivers allow states to be exempt from certain provisions of the Affordable Care Act to establish

innovative healthcare programs they believe will address rising premiums while retaining the basic protections of the ACA.

House Bill 1795/Senate Bill 1267 authorize and require the Maryland Health Benefits Exchange to apply for the 1332 waiver (legislation authorizing the application is part of the application process for these waivers) as well as define the parameters for the reinsurance program.

MSO Specific Issues and Legislation of Note:

Insurers Actions Regarding Hearing Aid Devices

Over the years MSO leadership has been actively engaged in efforts to prevent and roll back efforts by insurers to limit patient choice of hearing devices and prohibit patients paying for the difference out of pocket even if that is their desire. Please note in the Appendix at the end of this document a brief history of these issues.

Currently we are hearing of a renewed effort by United to direct patients to a 3rd party provider of hearing devices. If you are learning of similar efforts by insurers, please let your MSO leadership know. The concern is that insurers will enact policies as cost saving measures that will negatively impact a patient's choice of hearing device.

House Bill 168- **State Board of Examiners for Audiologists, Hearing Aid Dispensers, and Speech Language Pathologists - Inactive Status of Licenses – *Signed into Law***
This legislation establishes an "inactive status" classification for licensees of the State Board of Examiners for Audiologists, Hearing Aid Dispensers, and Speech-Language Pathologists. The board must place a licensee on inactive status if the licensee submits an application and pays the inactive status fee.

A licensee on inactive status may not practice audiology, hearing aid dispensing, or speech-language pathology or assist in the practice of speech-language pathology while the license is on inactive status. The board may not place a licensee on inactive status for more than two years, though a licensee may renew the inactive status for up to two consecutive additional terms. The board must provide a licensee who has applied for inactive status with specified written notification, including the consequences of not reactivating his or her license. A licensee on inactive status may reactivate the license at any time by paying the reactivation fee and complying with any other requirements.

If a licensee fails to renew the inactive status or reactivate the license, the license must be placed on nonrenewed status. A licensee whose license has been placed on nonrenewed status may apply to reinstate the license if the licensee (1) meets the requirements for the waiver of specified licensing requirements pertaining to audiologists and speech-language pathologists or (2) meets the current requirements for obtaining a new license, as well as the continuing education requirements.

Tort Reform:

House Bill 1581/Senate Bill 30 **- Health Care Malpractice Qualified Expert - Limitation on Testimony in Personal Injury Claims – Repeal – *Opposed - Failed on House Floor***

This legislation sought to repeal the longstanding "20% rule" which prohibited professional experts in medical malpractice cases to devote more than 20% of their professional time to activities which directly involve testimony. This law ensures that parties in a medical malpractice case must use practicing medical professionals rather than witnesses whose main source of income is derived from testifying in medical malpractice cases. The repeal of the law would have led to an increase in frivolous claims. We, along with MedChi and many other medical institutions heavily opposed the bill.

The Health Services Cost Review Commission (HSCRC) testified in opposition, on account of the potential negative impact it would have on the All-Payer Model by increasing malpractice litigation spending. Its opposition letter included language we drafted for inclusion in the Model's Term Sheet.

Amendments were offered in the House which addressed the problems of the legislation's advocates - that an expert could become disqualified during the pendency of the case due to retirement, illness or other changes in his or her practice by assuring that once an expert qualifies as such he or she would remain so for the entirety of the case.

The Senate did not assent to these changes and the legislation went to a joint conference committee between representatives of each chamber, which decided to strip the amendments out.

The legislation was defeated on the floor of the House literally during the 11th hour (approximately 15 minutes before midnight and the end of session) by 41 to 89 vote. It was a remarkable vote and a meaningful victory for the medical community, since it is extremely rare for legislation agreed to in conference to fail on the floor.

Opioids:

Similarly, to last year, the current opioid crisis has been an important driver behind many of this Session's legislative priorities. Although few bills concerning opioid use and prevention dealt with physicians and hospitals directly, two pieces of note which passed are below:

House Bill 1452/Senate Bill 1223: Controlled Dangerous Substances Registration – Authorized Providers – Continuing Education – *Passed*
This legislation requires an authorized provider of controlled dangerous substances to attest that the authorized provider has completed two credit hours of continuing education relating to the prescribing or dispensing of CDS to the MDH in order to qualify for an initial or renewed registration to dispense CDS. This attestation needs to occur only once. Originally the attestation was meant to happen in every renewal.

House Bill 653/Senate Bill 522: Health Care Providers - Opioid and Benzodiazepine Prescriptions - Discussion of Benefits and Risks – *Passed*
This legislation mandates healthcare providers to discuss the benefits and risks involved in opioid usage with a patient when prescribing an opioid. Additionally, an amendment was added to require a physician to hold the same kind of discussion when giving a co-prescription of benzodiazepines (e.g. Xanax). Failing to hold this conversation is grounds for disciplinary action by the appropriate health occupation board.

Other Legislation of Note:

House Bill 857: Health Occupations - Physicians - Specialty Certifications – *Monitor – Withdrawn*
This bill would have authorized an entity that grants "physician privileges" to use an active certification of a physician by a specialty certification board as criteria to determine "physician privileges." However, an entity may not require specialty certification by a particular specialty certification board as a prerequisite for the granting of "physician privileges."

Senate Bill 234: Physicians - Licensure - Grounds for Discipline and Interstate Medical Licensure Compact – *Monitor - Passed*
This legislation enters Maryland into the Interstate Medical Licensure Compact for physicians, which provides an expedited and streamlined process to become licensed in the member states of the compact. As of March 2018 22 states have adopted the compact. Of these, West Virginia and Pennsylvania border Maryland.

The bill specifies that an expedited license authorizes a physician to practice medicine in the issuing state in accordance with the laws and regulations of the member state. Additionally, the compact is not intended to alter a state's Medical Practice Act; state medical boards retain the right to impose disciplinary action against individuals who obtain an expedited license to practice in their states.

The bill further specifies that it's provisions may not be construed to alter the ability of the board to license physicians or regulate the practice of medicine in the State.

House Bill 1574/Senate Bill 896: Maryland Health Care Commission - Health Record and Payment Integration Program Advisory Committee – *Monitor – Passed*
Administrative costs currently account for a significantly large amount of healthcare spending. Furthermore, healthcare billing, reimbursement and record sharing remain largely unintegrated nationwide – efforts in Maryland to counter this have been mixed so far.

This legislation addresses these issues by requiring the Maryland Heath Care Commission to create a committee to study the feasibility of providing an integrated, secured, online electronic records and insurance benefits and payments clearinghouse. This committee will present its findings on or before November 1, 2019 to the Governor and the General Assembly. If the committee recommends the creation of such an integration program it will also recommend statutory language and funding requirements.

Currently, the PDMP established by CRISP has succeeded to some extent, as it includes all 50 general hospitals in the State as well as various physician practices, there are still many non-affiliated providers. It is hoped that by incorporating administrative healthcare transactions into the HIE and integrating such information with the existing clinical information exchange, physicians will be incentivized to participate in sharing clinical information, as administrative efficiencies will lead to simplified and prompter payments, regardless of payment method.

As the Maryland health care system increasingly migrates toward adopting public health approaches to meet the performance goals of the All-Payer Model, it requires that population health improvement focus beyond the clinical space to address all factors that determine health. As physicians join for administrative efficiencies and share more clinical data, it is hoped the richer information environment will help in clinical decision making and help the accomplishment of the Model's goals in cutting costs and determine population health.

APPENDIX: Recent Hearing Aid Issues

Cigna/HearPO (2014):

- Cigna has entered into an exclusive contract with HearPo to supply digital and digitally programmable analog hearing aids and supplies
- Cigna will no longer reimburse providers for those supplies and services and prohibits providers from billing patients for excluded services
- HearPo assumes the costs for the devices and supplies and is responsible for billing Cigna directly
- HearPo will pay dispensing fee directly to the provider.

Conversation with Brenda Wilson at MIA:

- Most Cigna plans in Maryland are 3rd Party plans
- ERISA exempts them from Maryland law and regulation

United HealthCare (2011):

- The concern was United was no longer allowing balance billing for hearing aids and were including costs of the durable medical equipment (DMEs) as physician services.
- United was directing patients to EPIC, a 3rd party provider, for hearing aids. "EPIC was reimbursed directly by united and dealers are paid a modest fitting fee regardless of what was sold."
- EPIC is a company that has contracted with hearing aid dealers and audiologist to provide hearing aids to the dealer for a fixed fitting fee. The insurance pays EPIC directly. The dealer is paid a modest fitting fee regardless of what was sold. There is no incentive for the dealer to provide any sort of services for or spend any time with the patient.

CareFirst Issue (2009-10):

- Maryland CareFirst letter announcing the change in their reimbursement policy for hearing aid devices including a balance billing prohibition.
- This issue arose from the Federal Employee Benefits program. The FEB recently expanded coverage of hearing aids to adults, and they required CareFirst to change their policy to prohibit balance billing.
- CareFirst reviewed their policy in other areas and decided to implement that ban across all their business lines. They said they have been told that physicians are bundling into the charge for hearing aids prospective charges like additional office visits because many other insurance companies do not provide coverage for hearing aids. CareFirst does provide coverage for some of those services.
- We led discussions with Care First leadership and succeeded in getting CareFirst to return to their former policy (effective February 2, 2010) except for the Federal Employee Benefit (FEB) plan