SCHWARTZ, METZ & WISE, P.A.
ATTORNEYS

20 WEST STREET
TEL: 410-244-7000 ANNAPOLIS, MARYLAND 21401 FAX: 410-269-5443

MDAAP Final Legislative Report

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Pam Kasemeyer- chapter lobbyist

The 435th Session of the Maryland General Assembly concluded at midnight on Monday, April 13th. In this Session, the General Assembly considered 2,248 legislative bills and resolutions, several hundred less than typically introduced. In large measure, the reduction in the number of bills was reflective of the significant number of new legislators in both the House and the Senate, as well as a new Administration. The changes affected the flow of the Session, as new members became oriented to the process while House and Senate leadership learned the new dynamics of their respective chambers. Ultimately, the pace resembled a typical Session with a flurry of activity in the final days. The dynamics of change were most notable in the budget process, where the bipartisan tenor between Governor Hogan and the General Assembly became strained as budget negotiations reached the final days of the Session.

Wrangling over the State Budget continued on Sine Die with Republican Governor Larry Hogan facing off with the Democratically-controlled General Assembly, which cut Governor Hogan's Budget and wanted to have the deleted monies used for: (1) increased education aid; (2) healthcare expenditures, including an improvement to the Medicaid reimbursement rate for doctors; and (3) State employee COLA increases. Governor Hogan was more interested in conserving budgetary monies and providing certain targeted tax relief. In the end, the General Assembly passed the Fiscal Year 2016 budget, but Governor Hogan has the right to fund (or not) the General Assembly's priorities. To the extent that these programs are not funded by the Governor, the monies will remain unspent.

Issues of specific interest to MDAAP are summarized below.

Medicaid Budget: In the last weeks of Governor O'Malley's administration, he reduced Medicaid reimbursement for E&M Codes from 100% of Medicare to 87% of Medicare in order to balance the 2015 Budget (July 1, 2014 to June 30, 2015). The reduction took effect on April 1st. At the start of this Session, the physician community hoped that the 87% figure – given budget expectations in January – would not be further reduced. Due to an aggressive advocacy effort, the final agreed Budget raised the reimbursement for E&M codes to 92% of Medicare. A return to 100% of Medicare is the desired path going forward, but physicians should believe that the proverbial rabbit came out of the hat, as an actual increase was secured. The Budget also restored funding back to 250% of FPL for pregnant women. However, whether the Governor decides to fund these priorities, and at what level, remains to be seen.

Sterile Compounding: Senate Bill 69/House Bill 181 (*State Board of Pharmacy – Sterile Compounding – Compliance by Nonresident Pharmacies and Repeal of Permit Requirement*) repeals the 2013 Maryland law regulating "sterile compounding." From its initial enactment, the 2013 legislation became problematic for physicians due to the fact that the Maryland Board of

Pharmacy determined that the definition of compounding included the routine mixing of medicines in a physician's office. After the enactment of 2013 law, a federal law was enacted which, in fact, properly regulated sterile compounding facilities and included an exemption for the mixing of medicines in a physician's office. The passage of the federal law illustrated the problems with the Maryland law, which was contradictory to the federal statute and harmful to real medical practices. In 2014, certain specialties were exempted from the Maryland Sterile Compounding law and, with the passage of Senate Bill 69/House Bill 181, all medical practices will now be relieved as soon as Governor Hogan signs the bill, which is expected. On a related note, the Maryland Board of Pharmacy has repeatedly delayed the enactment of regulations following the 2013 law, including the latest delay until July 1st. With the full repeal, it is anticipated that the Board will also repeal the regulations.

Direct Entry Midwives: House Bill 9 (*Maryland Licensure of Direct-Entry Midwives Act*) was successfully enacted into law. The historic opponents to this legislation, which included MDACOG, MedChi, the Department of Health and Mental Hygiene (DHMH) and the Maryland Hospital Association, continued to voice their concerns about the safety of home birth, however, the momentum for passage was mounting and MDACOG, in conjunction with other similarly minded stakeholders, took the opportunity to amend the legislation to dramatically limit the practice of direct-entry midwifery and the conditions under which they may attend a home birth.

The amendments, which in many respects reflect some of the most restrictive provisions of any such law in the nation, include but are not limited to the following: a prohibition on an at home vaginal birth after cesarean (VBAC); detailed scope of practice limitations that delineate conditions that trigger mandatory transfer and consultation provisions (the scope of practice provisions are based on Vermont statute); increased education and training requirements from the originally proposed the North American Registry of Midwives standards that more closely reflect the standards for midwifery that are being developed through the American College of Nurse-Midwives process following the adoption of international standards for midwifery; transition of newborn care within 72 hours when most other States allow six weeks; and required uniform informed consent and transfer forms that will be developed by a stakeholder workgroup that includes MDACOG.

Additionally, the new law will require extensive data and outcome reporting to determine the efficacy of the new law. The data reporting requirements are based on California's reporting requirements and do not rely on Midwives of North America stats.

While vicarious liability language, stronger than current law, was proposed in the initial version of the bill, it was amended through the insertion of the word "solely" to essentially reflect current law such that liability protection is afforded only if the basis of the action is for injuries based solely on the acts or omissions of the midwife. However, the bill does clarify that a physician-patient relationship is not established as are result of consultation, referral, notice of birth, or receipt of medical records unless a physician actually examines or treats the patient of a midwife.

One further note regarding the substance of the legislation: while VBAC is prohibited – a critical requirement for stakeholder acquiescence – the bill does allow for a reassessment of VBAC annually and for the Department of Legislative Services to study outcome statistics from other

jurisdictions. Despite these provisions, VBAC will only be permitted if there is a change in statute in the future – it cannot be done by regulation.

Nurse Practitioners: Senate Bill 723/House Bill 999 (*Certified Nurse Practitioners – Authority to Practice*) changes the present law which requires an "attestation" by the Nurse Practitioner (NP) to identify a doctor who is available to the NP. As a practical matter, the doctor's name is placed on paperwork, but there is no actual legal requirement that there be actual collaboration. Given the ineffectiveness of the current attestation requirement, there seemed little point to insisting on its provision and, hence, amendments were offered to require: (1) that new NPs be required to have a mentoring relationship with a doctor or experienced NP for at least eighteen months, and, (2) that NPs who did not collaborate in the appropriate case would be subject to discipline for their failure to do so. Ultimately, these amendments were accepted and the legislation was enacted.

Child Maltreatment: Two bills supported by MDAAP that provide enhancements to the accountability and effectiveness of the child welfare system were enacted. House Bill 386 (*Child Abuse and Neglect – Centralized Database)* repeals references to a central registry and instead defines a "centralized confidential database" as DHR's confidential computerized data system that contains information regarding child abuse and neglect investigations and assessments. The bill establishes that SSA may maintain a centralized confidential database and that each local department must enter and have access to information in the database related to reports, investigations, and assessments of suspected abuse and neglect. The bill specifies that the information in the centralized confidential database is accessible only to the protective services staff of SSA and local departments and individuals or entities specifically authorized by law to access the information.

The bill also establishes that, unless an individual has been identified as responsible for abuse or neglect in the centralized confidential database, information in the database may not be provided in response to any request for background information for employment or voluntary service. The bill repeals prohibitions against a central registry, including information from a local department case file, until any individual found responsible for indicated or unsubstantiated child abuse or neglect has been found guilty of any criminal charge arising out of the alleged abuse or neglect and has unsuccessfully appealed the finding or failed to exercise the appeal rights within specified timeframes. The bill also repeals prohibitions against a central registry containing identifying information relating to an investigation of abuse or neglect if the abuse or neglect has been ruled out (a finding that abuse, neglect, or sexual abuse did not occur) or if the finding has been expunged in accordance with statutory provisions.

The bill repeals a requirement for DHR to remove from the name of such an individual the designation as responsible for abuse and neglect if no entry has been made for that individual for seven years after the entry of the individual's name in a registry. Finally, the bill establishes that the centralized confidential database may not contain any information that is required to be expunged in accordance with statutory provisions.

Also enacted, Senate Bill 567/House Bill 643 (*Department of Human Resources – State Child Welfare System – Report)* requires the Department of Human Resources (DHR), by December 1

of each year, to report the following information regarding children and foster youth in the State child welfare system: (1) the number of child abuse and neglect reports, alternative responses, investigative responses, and findings for completed investigations; (2) the number of children and foster youth receiving in-home services; (3) the number of new out-of-home placements by placement type; (4) the number of exits from the child welfare system by exit type; (5) the number of exits to reunification and reentries within 12 months after exit; (6) the number of exits to reunification and reentries within 24 months after exit; (7) the stability of out-of-home placements, including the number of placement changes; (8) the stability of school placements; (9) the number who graduate from high school; (10) the number who qualify for a high school diploma by examination; and (11) the number who receive tuition waivers.

In reporting the information, DHR must maintain the confidentiality of children and foster youth and ensure that no personally identifiable information is disclosed. DHR must disaggregate the information by county, age, gender, race, and ethnicity. The report is to be provided to the General Assembly and DHR must also publish each report on its website within 30 days of submission to the General Assembly.

Senate Bill 571/House Bill 856 (*Child Abuse and Neglect – Failure to Report – Penalties and Training)* and Senate Bill 525/House Bill 1146 (*Child Abuse and Neglect – Failure to Report)* failed to pass. Both bills approached the recurring concern that there are insufficient penalties for failure to report child abuse and neglect that are undermining the effectiveness of the child welfare system. The bills this year were much more limited than in previous years and in fact SB 525/HB 1146 did not create penalties but rather created reporting requirements by the Department of Social Services to the professional boards. Nonetheless, the implications for falsely assuming that failure to report was knowingly and/or willfully done resulted in the defeat of both bills. Similarly, House Bill 780 (*Task Force on the Prevention of Child Abuse and Neglect)* which has been proposed in previous Sessions was not successful

Senate Bill 12/House Bill 7 (*Family Law - Child Abuse and Neglect – Expungement of Reports and Records – Time Period*) would have extended the length of time which the Department of Human Resources (DHR) is required to maintain records related to child abuse and neglect even if abuse or neglect were "ruled out" or found "unsubstantiated. The Senate and House failed to agree on the final language of the bill and it died in the final days of Session.

Newborn Screening Program: House Bill 5 (*Department of Health and Mental Hygiene - Newborn Screening Program Fund*-Establishment), legislation that failed in the waning hours of the 2014 Session was enacted. House Bill 5 establishes the Newborn Screening Program Fund, which will administered by the Secretary of the Department of Health and Mental Hygiene (DHMH), and is intended to cover the administrative, laboratory, and follow-up costs associated with performing newborn screening tests. The fund will assist the State in more timely implementation of new screening tests recommended to be added to the program by the State Advisory Committee for Hereditary and Congenital Disorders such as SCID.

Dental Services: Senate Bill 431/House Bill 355 (*Public Health – Dental Services for Adults – Coverage and Access)* would have expanded coverage under Medicaid for dental services for women during the six week postpartum period wherein they remain eligible for medical services.

Senate Bill 141/House Bill 858 (*Maryland Medical Assistance Program – Former Foster Care Adolescents – Dental Care)* would have extended dental benefits under Medicaid to former foster care adolescents to age 26 consistent with coverage for youth under the ACA. Unfortunately, the fiscal note for both of these expansions could not be supported given the existing budget challenges. These are initiatives that will be revisited in future Sessions.

Immunizations: House Bill 687 (*Public Health – Religious Exemptions from Immunization Requirements – Repeal*) would have repealed the exemption allowing for individuals to refuse vaccinations based on religious reasons. The bill was withdrawn by the sponsor before the hearing in large part due to a concern by proponents of the repeal that a hearing would give "anti-vaccine" advocates a platform to advance their perspective when Maryland's vaccination rate remains high and the anti-vaccine sentiment has not taken hold in the State. Consequently, a well-intended bill could have had unintended consequences.

Senate Bill 598 (*Public Health – Vaccination Reporting Requirements – ImmuNet*) was Departmental legislation that would have made it mandatory for every health care provider to report all vaccines administered to ImmuNet. While MDAAP supports a vibrant registry with full participation, mandating participation given remaining technical challenges with Immunet could not be justified. MDAAP is however committed to working with DHMH to achieve the objectives of the legislation.

School Based Health Centers: Senate Bill 403/House Bill 375 (*Maryland Council on Advancement of School-Based Health Centers)* replaces the Maryland School-Based Health Center Policy Advisory Council at the Maryland State Department of Education (MSDE) with the Maryland Council on Advancement of School-Based Health Centers. The Council has 15 voting members and five ex-officio members. One of the voting members is a pediatrician to be nominated by MDAAP.

The purpose of the council is to improve the health and educational outcomes of students who receive services from school-based health centers (SBHC) by advancing their integration into both the health care system and educational system at the State and local levels. By December 31 of each year, the Council must report findings and recommendations to the Department of Health and Mental Hygiene (DHMH), MSDE, and the General Assembly on improving the health and educational outcomes of students who receive services from SBHC.

In the report due by December 31, 2016, the council must include recommendations on the establishment of a process for the review and approval of new SBHCs and the expansion of the scope of existing SBHCs by MSDE and DHMH; the identification and elimination of barriers for managed care organizations to reimburse for services provided by SBHCs; and health reform initiatives under the Maryland Medicare Waiver and patient-centered medical home initiatives. It must also include information on the number and location of school-based health centers that are co-located with behavioral health services.

Network Adequacy: Senate Bill 834/House Bill 990 (*Maryland Health Benefit Exchange – Qualified Health Plans – Standards*) was a comprehensive bill to address issues related to network adequacy and prescription coverage under Qualified Health Plans under the Exchange.

While the bill did not pass, the Exchange is in the process of convening a workgroup to study and make recommendations related to network adequacy, an issue that the Executive Director of the Exchange acknowledged in her testimony on the bill. MDAAP is seeking to have a member appointed to the workgroup.

Behavioral Health: Senate Bill 469/House Bill 367 (*Public Health – Maryland Behavioral Health Crisis Response System)* changes the name of the Mental Health Crisis Response System to the Behavioral Health Crisis Response System (BHCRS) and expands services that a local crisis response system may include, such as clinical crisis walk-in services, crisis residential beds, and mobile crisis teams operating 24 hours a day and 7 days a week to provide behavioral health services. The bill also requires the Behavioral Health Administration (BHA) to collect specified data related to individuals with behavioral health diagnoses that seek services through the BHCRS. Finally the bill clarifies that financial support of the crisis response system could be considered a "community benefit" for hospitals and other nonprofits that must provide community benefit contributions.

Senate Bill 157/House Bill 662 (*Consultation, Diagnosis, and Treatment of Mental and Emotional Disorders – Consent by Minors)* expands the current ability for a minor to consent to treatment of mental and emotional disorders to include consent to care by any licensed health care provider working within their scope of practice. Current law only included physicians and psychologists.

Senate Bill 74/House Bill 739 (*Task Force to Study Maternal Mental Health)* was enacted. The Task Force will be staffed by the Maryland Mental Health Association and is charged with: (1) identifying vulnerable populations and risk factors in the State for maternal mental health disorders; (2) identifying and recommending effective, culturally competent, and accessible prevention screening and identification and treatment strategies, including public education and awareness, provider education and training, and social support services; (3) identifying successful postpartum mental health initiatives in other states and recommending programs, tools, strategies, and funding sources that are needed to implement similar initiatives in the State; (4) identifying and recommending evidence–based practices for health care providers and public health systems; (5) identifying and recommending private and public funding models; and (6) making recommendations on legislation, policy initiatives, funding requirements and budgetary priorities to address maternal mental health needs in the State. Task Force membership reflects a broad array of stakeholders which includes a representative from MDAAP. The Task Force Report is due December 1, 2016.

Foster Youth and Unaccompanied Homeless Youth: Senate Bill 225/House Bill 297 (*Higher Education – Unaccompanied Homeless Youth Tuition Exemption – Modification)* clarifies the requirements for Unaccompanied Homeless Youth to qualify for the same Tuition Exemption that is provided for foster youth. Its passage will improve the accountability of the program and therefore provide a better basis for its continuation.

Senate Bill 685/House Bill 439 (*Family Law – Information and Services for Foster Children and Former Foster Children)* was passed. The legislation establishes a number of requirements for DSS to provide a range of support services to foster children who are approaching emancipation

including, but not limited to: enrolling the child in health insurance before the child is emancipated; screening the child for eligibility for public benefits and assisting with applications for public benefits before the child is emancipated; working with appropriate individuals to establish a plan for stable housing that is reasonably expected to remain available to the child for at least 12 months after the date of emancipation; and working with appropriate individuals to engage the child in education, training, and employment activities that will prepare the child to have appropriate and sufficient income to live independently after emancipation. It also requires that regulations be adopted that ensure that all children in foster care who are at least age 18 have a birth certificate, a Social Security card, health insurance information, medical records, and a driver's license or State-issued identification card at emancipation. The bill also requires that DHR include in its annual report descriptions of existing efforts to address the housing and employment needs of former foster youth; new strategies to provide job opportunities for former foster youth; projections regarding the number of youth expected to exit foster care at age 21 each year for the next four years; and the proposition of potential partnerships with specified entities to support the placement of foster youth into safe and stable housing.

Assignment of Benefits: Senate Bill 92/House Bill 230 (*Health Insurance – Assignment of Benefits and Reimbursement of Nonpreferred Providers – Repeal of Termination Date*) has now made permanent the AOB law first passed in 2010, over the strenuous objection of the insurance industry. By the terms of the 2010 law, there was a five year "sunset," which would cause the bill to terminate on September 30, 2015. Senate Bill 92/House Bill 230 removed the "sunset" and made the law permanent.

Misuse and Abuse of Prescription Drugs/Heroin: The growing incidences of drug abuse and overdose deaths have garnered significant public attention. In February, Governor Hogan created the *Heroin and Opioid Emergency Task Forc*e and a separate *Inter-Agency Coordinating Council*. Both groups will work to support efforts to address Maryland's growing heroin and opioid crisis. In addition, there were a number of legislative initiatives passed this Session to combat the misuse and abuse of prescription drugs, the increasing incidence of overdose deaths attributed to heroin, and other related issues associated with drug abuse.

a. Senate Bill 607/House Bill 896 (*Joint Committee on Behavioral Health and Opioid Use Disorders)* is the most important of these initiatives. It creates a standing Joint Legislative Committee comprised of five senators and five delegates who shall have oversight over: the prescription drug monitoring program (PDMP); state and local programs to treat and reduce behavioral health disorders; and state and local programs to treat and reduce opioid use disorders. The Committee is also charged with reviewing the extent to which health insurance carriers in the State are complying with federal and State mental health and addiction parity laws. The Joint Committee has a six year sunset.

b. Senate Bill 516/House Bill 745 (*Public Health – Overdose Response Program*) expands the Overdose Response Program within DHMH by authorizing an advanced practice nurse with prescribing authority or a licensed physician to prescribe and dispense Naloxone to a certificate holder either directly or, under specified circumstances, *under a standing order*, as well as authorizing any licensed health care provider with prescribing authority to prescribe Naloxone to a patient who is believed to be at risk of experiencing

an opioid overdose or in a position to assist an individual at risk of experiencing an opioid overdose. This legislation includes critical liability protections for physicians who prescribe or dispense Naloxone under the program.

c. Senate Bill 757 (*Public Health – Prescription Drug Monitoring Program – Required Disclosures)* is a departmental bill which expands the entities to which the PDMP must disclose prescription drug monitoring data, to include: the State Child Fatality Review Team or a Local Child Fatality Review Team; a Local Drug Overdose Fatality Review Team; the Maternal Mortality Review Program; or a medical review committee appointed by or established in DHMH or a local health department. The information is only provided on approval of the Secretary of Health and Mental Hygiene and for the purpose of furthering an existing bona fide individual case review and includes the protections on information disclosure which MedChi insured were included in the program when originally created. The bill also clarifies that PDMP must disclose data to the State Board of Physicians (MBP), on issuance of an administrative subpoena voted on by a quorum of a disciplinary panel of the board, for the purposes of furthering an existing bona fide investigation of an individual.

d. Senate Bill 546 (*Immunity From Liability – Emergency Medical Care for Drug Overdose)* extends civil immunity under the Good Samaritan Act for acts of ordinary negligence to specified rescue and emergency care personnel administering medications or treatment in response to an apparent drug overdose. The bill applies prospectively to causes of action arising on or after the bill's October 1, 2015 effective date.

e. Senate Bill 654/House Bill 1009 (*Criminal Procedure – Immunity – Alcohol or Drug-Related Medical Emergencies)* expands the current "Good Samaritan" protection enacted in 2014 that provided immunity from prosecution if a person sought emergency medical care for themselves or another because the person reasonably believed they were experiencing an overdose. The law was expanded to include "arrest" and "charges," as prosecution alone still left individuals concerned they would be arrested and charged even if not prosecuted. The bill also provides that seeking emergency medical care in these circumstances cannot be considered a violation of parole or probation. In all instances the immunity only applies if seeking emergency services is the sole basis for the arrest, charges, etc.

f. Senate Bill 606/House Bill 887 (*Health Insurance – Abuse-Deterrent Opioid Analgesic Drug Products – Coverage*) will require insurance companies to cover two brand abuse deterrent opioid drug products and two generic abuse deterrent opioid drug products at equivalent cost sharing levels as non-abuse deterrent opioids. Abuse deterrent opioids are new formulations whose physical characteristics deter manipulation of the product.

g. House Bill 971 (*Public Health – Substance Abuse Treatment Outcomes Partnership Fund*) expands the scope of the Substance Abuse Treatment Outcomes Partnership (S.T.O.P.) Fund in DHMH to include "eligible functions" that may be funded under S.T.O.P., including transportation to and from treatment services; treatment, prevention, or coordination staff; data sharing services among counties and other appropriate

treatment providers; education or outreach programs and materials; in-community emergency behavioral health services or crisis stabilization units; and behavioral health programs in schools.

Prescription Drug Monitoring Program: House Bill 3 (*Prescription Drug Monitoring Program – Prescribers and Dispensers – Required Query)* would have mandated a prescriber query the PDMP every time a controlled substance was prescribed. It was easily defeated given current technical capacity issues with the PDMP, but Chairman Hammen wrote DHMH, on behalf of the House Health and Government Operations (HGO) Committee, asking them to continue the dialogue with stakeholders to resolve technical issues and identify additional approaches to enhance the effectiveness of the program. Given the focus on substance abuse and the creation of the Joint Legislative Committee described previously, the PDMP is likely to continue to be a focus of policy debate.

Expedited Partner Therapy: Senate Bill 599 (*Public Health – Expedited Partner Therapy for Chlamydia and Gonorrhea)* was enacted. Expedited Partner Therapy (EPT) was authorized as a pilot program in Baltimore City in 2008. It has been a very successful program and passage of this legislation extends the authority for EPT statewide.

HIV Testing: House Bill 978 (*HIV Testing – Informed Consent and Pretest Requirements – Modification)* was enacted and brings Maryland HIV testing statute into full conformity with the Centers for Disease Control guidelines.

Electronic Cigarettes: Senate Bill 7/House Bill 489 (*Electronic Cigarettes –Sale to Minors – Components, Supplies, and Enforcement)* extends Maryland's current prohibition of the sale of e-cigarettes to minors to include component parts and supplies related to the use of e-cigarettes. It also expands enforcement authority to include designees of local health departments.

Statistical Sampling for Medicaid Overpayments: House Bill 1101 (*Department of Health and Mental Hygiene – Health Program Integrity and Recovery Activities*) was a late entry proposed by the Office of the Inspector General at DHMH. The legislation sought to: (1) give the Inspector General or his designee subpoena power; (2) allow the use of civil money penalties; (3) allow "overpayments" by the Medicaid program to be recouped from providers using extrapolation – statistical sampling; and (4) authorize DHMH to require providers/applicants to obtain a surety bond as a condition of participation in the Medicaid program. Danna Kauffman organized a coalition of opposition to the legislation which included twenty health provider groups in the State, including the Maryland Hospital Association, Johns Hopkins Medicine, the University of Maryland Medical System, MedStar, Pharma, the Maryland State Dental Association and the long-term care industry. In the end, the Chair of the HGO Committee, who had been promoting the bill, "put it in the drawer" with an expectation that the parties will consider the issues raised over the interim and address the matter in 2016.

There were a number of other bills, while supported by MDAAP, which did not pass. These include the following:

a. Senate Bill 152/House Bill 56 (*Tanning Devices – Use by Minors – Prohibition*) would have restricted the use of commercial tanning salons by those under the age of 18. This bill, which has been consistently introduced over the last number of years, attempts to make the law in Howard County, Maryland applicable throughout the State. It was voted down once again this year.

b. Senate Bill 37/House Bill 108 (*Tobacco Taxes – Healthy Maryland Initiative*) was a proposal to raise Maryland's tax on tobacco. The legislation has always been supported by MDAAP but, given the anti-tax message of the last election, it would appear that this proposal may have continued difficulties during Governor Hogan's administration.

c. Senate Bill 742/House Bill 1090 (*Public Health – Restaurants – Meals for Children*) would have required restaurants that market and serve "children meals" to include only bottled water, low-fat or non-fat milk or 100% fruit juice as part of the meal. Senate Bill 574/House Bill 261 (*Sales and Use Tax – Bottled Water – Exemption*) would have removed the Maryland sales and use tax on bottled water. These bills were initiatives introduced by Sugar Free Kids and sought to support parent's efforts to raise healthy kids by helping to combat childhood obesity and juvenile diabetes.

d. House Bill 995 (*Lawn Care Pesticides – Child Care Centers, Schools, and Recreation Facilities – Prohibition)* which would have prohibited the application of pesticides at a broad range of facilities where children could be exposed to the toxins.