Department of Legislative Services

Maryland General Assembly
2010 Session

FISCAL AND POLICY NOTE
Revised

Senate Bill 279 (The President, *et al.*) (By Request - Administration)
Judicial Proceedings and Finance Appropriations and Judiciary

Maryland False Health Claims Act of 2010

This Administration bill (1) prohibits a person from making a false or fraudulent claim for payment or approval by the State or the Department of Health and Mental Hygiene (DHMH) under a State health plan or program; (2) authorizes the State to file a civil action against a person who makes a false health claim; (3) establishes civil penalties for making a false health claim; (4) permits a private citizen to file a civil action on behalf of the State against a person who has made a false health claim; (5) requires the court to award a certain percentage of the proceeds of the action to the private citizen initiating the action; and (6) prohibits retaliatory actions by a person against an employee, contractor, or grantee for disclosing a false claim or engaging in other specified false claims-related activities.

Fiscal Summary

State Effect: Potential significant increase in general fund revenues from civil penalties and damages awarded in cases involving the cause of action created by the bill. Potential decrease in special fund revenues if the State pursues recovery for false claims using the cause of action created by the bill (resulting in general fund revenues) rather than methods for recovery under the current law (in which recoveries are classified as special fund revenues).

General fund expenditures may increase beginning in FY 2011 for additional staff at the Office of the Attorney General (OAG) and to replace potential loss of special fund recoveries for Medicaid. The Governor's proposed FY 2011 budget includes $20 million in Medicaid expenditures reductions ($9 million general funds, $11 million federal funds) contingent on enactment of the Maryland False Claims Act of 2010. Any increase in actions filed in the District Court can be handled with existing resources.

Local Effect: Any increase in actions filed in the circuit courts can be handled with existing resources.

Small Business Effect: The Administration has determined that this bill has minimal or no impact on small business (attached). Legislative Services concurs with this assessment. (The attached assessment does not reflect amendments to the bill.)

Analysis

Bill Summary:

Definitions

A "claim" is a request or demand, under contract or otherwise, for money or property, regardless of whether the State has title to the money or property, that is (1) presented through a State health plan or a State health program to an officer, employee, or agent of the State; or (2) made to a contractor, grantee, or other recipient, if the money or other property is to be spent or used on the State's behalf or to advance a State interest through a State health plan or State health program and the State provides or reimburses any portion of the money or property. A "State health plan" is the State Medicaid program or a private health insurer, health maintenance organization (HMO), managed care organization, or health care cooperative or alliance that provides or contracts to provide health care services that are wholly or partly reimbursed by or are a required benefit of a health plan established under the federal Social Security Act or by the State. A "State health program" is Medicaid, the Cigarette Restitution Fund Program, the Mental Hygiene Administration, the Developmental Disabilities Administration, the Alcohol and Drug Abuse Administration, the Family Health Administration, the Infectious Disease and Environmental Health Administration, or any other unit of DHMH that pays a provider for a service rendered or claimed to have been rendered to a recipient. "Knowing" or "knowingly" is defined to mean, with respect to information and without requiring proof of specific intent to defraud, that a person (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information. "Knowing" or "knowingly" does not mean, with respect to information, that a person acts in a manner that constitutes mistake or negligence.

Prohibited Activities

The bill prohibits a person from (1) knowingly presenting or causing to be presented a false or fraudulent claim for payment or approval; (2) knowingly making, using, or causing to be made or used a false record or statement material to a false or fraudulent claim; (3) conspiring to commit a violation of the false claims statute; (4) having possession, custody, or control of money or other property used by or on behalf of the

State under a State health plan or program and knowingly delivering or causing to be delivered to the State less than all of the money or property; (5) being authorized to make or deliver a receipt of money or property used or to be used under a State health plan or program and, intending to defraud the State or DHMH, making or delivering a receipt knowing that the information contained in it is not true; (6) knowingly buying or receiving publicly owned property from an officer, employee, or agent of a State health plan or program who may not lawfully sell or pledge the property; (7) knowingly making, using, or causing to be made or used a false record or statement material to an obligation to pay or transmit money or other property to the State; (8) knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or other property to the State; or (9) knowingly making any other false or fraudulent claim against a State health plan or program.

Awards/Damages

A person who violates the bill's prohibitions is liable to the State for a civil penalty of up to $10,000 and up to triple the State's damages resulting from the violation. However, the total amount of a violator's liability to the State may not be less than the amount of the actual damages the State health plan or State health program incurred as a result of the false claims violation. These penalties are in addition to any criminal, civil, or administrative penalties provided under any other State or federal law. The State may file a civil action against an alleged violator seeking civil penalties, court costs, and attorney's fees. Any remedy provided under the bill is in addition to any other appropriate legal or equitable relief provided under any other applicable statute or regulation. Any civil penalties or damages assessed are deposited in the general fund.

When determining the appropriate amount of civil penalties and damages awarded for a false claims violation, a court must consider the following factors: (1) the number, nature, and severity of the person's current and past false claims violations; (2) the degree of loss suffered by the State health plan or State health program as a result of the false claims; (3) the person's history of billing compliance and whether the person has a compliance program in place; (4) the extent to which the person has taken steps to address and correct the false claims violations since becoming aware of them; (5) the extent to which the violation caused harm or detriment to patients or consumers of the State health plan or State health program; (6) funds previously returned to the State in compliance with federal overpayment requirements, to the extent the funds represented losses to the State health plan or State health program caused by the violation; (7) whether the person self-reported the violation, the timeliness of the self-reporting, the person's cooperation with the investigation of the violation, and the extent to which the person had prior knowledge of the investigation or other action relating to the violation; and (8) any other factor as justice requires. When weighing these factors, the court must give special consideration, where appropriate, to the extent to which the person's size, operations, or financial condition may have affected each of the specified factors and the

extent to which these attributes may affect the person's ability to provide care and continue operations after payment of damages and fines.

The awarding of court costs and attorney's fees in a false claims case is discretionary. When determining the amount of court costs and/or attorney's fees to be awarded, the court must consider the amount of any penalties and damages recovered in the action and any other factor as justice may require.

Causes of Action by Private Parties on Behalf of the State ("Qui Tam" Actions)

The bill authorizes a private party to bring an action on behalf of the State (often referred to as a "*qui tam*" action), in which the private party may seek the civil penalties and damages previously mentioned, as well as court costs and attorney's fees. If the State intervenes and proceeds with an action and prevails, the court must award the private party not less than 15% and not more than 25% of the proceeds, and in certain circumstances not more than 10% of the proceeds, proportional to the amount of time and effort that the party contributed to the final resolution of the action.

The court may reduce any share of the proceeds on a finding that the party who brought the civil action deliberately participated in the violation on which the action was based. If a person who initiated a civil action is convicted of criminal conduct arising from a violation of this bill prior to a final determination of the action, the person will be dismissed from the action and not receive any share of the proceeds. If a person who was awarded proceeds is later convicted of criminal conduct arising from a violation of the bill's provisions, the person will be ordered to repay the proceeds previously awarded.

Procedural Requirements

If a civil action is initiated by a person on behalf of the State, the person must serve on the State a copy of the complaint and a written disclosure of substantially all material and information that the person possesses in accordance with the Maryland Rules. A complaint is to be filed *in camera* and must remain under seal for at least 60 days or until the court orders the complaint to be served on the defendant. The State may request that the court grant an extension of the 60-day period during which the complaint is sealed for good cause shown. During the period in which the complaint is under seal, the State must notify the defendant as soon as practicable of an ongoing alleged violation, unless notification would compromise the investigation.

The State may intervene in and proceed with the civil action that has been initiated on its behalf by another person. The State must proceed with the civil action or notify the court that it will not proceed within the 60-day period or before any applicable extension period expires. If the State decides to intervene, the State may elect to withdraw from the case at any time. The court must dismiss the case if the State declines to intervene or decides to withdraw from the case after intervening.

If the State elects to proceed with a civil action, it has the primary responsibility for proceeding with the action and is not bound by any act of the person who initiated the action. However, the person who initiated the action may continue as a party to the action. If the court determines after a hearing that a proposed settlement is fair, adequate, and reasonable, the State may settle a civil action, regardless of the objections of the person who initiated the action.

A court may impose limitations on the participation of the person who initiated the civil action if the State can show that unrestricted participation would (1) interfere with or unduly delay the State in its pursuit of the civil action; or (2) be repetitious, irrelevant, or harassing to the person allegedly in violation of the bill's provisions. Such limitations can include restricting the number of witnesses the person may call to testify, limiting the person's cross-examination of witnesses, or limiting the person's participation in the litigation. A court may impose these limitations on the motion of the State or the defendant or on the court's own motion.

If the State can show that certain actions of discovery by the private party who initiated the civil action may interfere with the State's investigation or prosecution of a criminal or civil matter arising out of the same facts, the court may stay the discovery for no more than 60 days. The bill provides for an extension of this period if the State can show that it has pursued the investigation or proceeding with reasonable diligence.

The bill permits the State to pursue alternative remedies, including any appropriate administrative proceeding to consider a civil money penalty. The person who initiated the civil action is afforded the same rights as the person would have had if the State had continued the action.

Retaliatory Actions

The bill prohibits retaliatory actions by a person against an employee, contractor, or grantee for (1) acting lawfully in furtherance of a false claim action; (2) disclosing or threatening to disclose the person's false claim; (3) providing information or testifying regarding a false claim; or (4) objecting or refusing to participate in a practice the employee, contractor, or grantor reasonably believes to be a false claim.

In general, an employee, contractor, or grantee who has experienced retaliation may file a civil action against the retaliator and may seek any relief necessary to make the employee whole, including reinstatement, two times the amount of back pay, interest on back pay, and compensation for other damages, including litigation costs, reasonable attorney's fees, and punitive damages. Remedies provided under the bill are in addition to any other remedy available under State or federal law or any collective bargaining agreement or employee contract.

Coordination with Federal Investigations

The State is required to make all reasonable efforts to coordinate any investigation of an alleged violation with any federal investigation involving the same violation. The State's objective must be to avoid duplication of effort on the part of the alleged violator and minimize the burden of the investigation on the alleged violator.

Statute of Limitations

The statute of limitations for any action brought under the bill is 6 years from the date of the violation or 3 years after the date when material facts were known or reasonably should have been known by the private party initiating the action on behalf of the State, the State's Inspector General, or the director of the State's Medicaid Fund Control Unit, but in no event more than 10 years after the date on which the violation is committed. A civil action may be filed for activity that occurred prior to October 1, 2010, if the limitations period has not lapsed. In any action, the State or the initiating complainant must prove all essential elements of the case by a preponderance of the evidence.

Reporting Requirements

Beginning October 1, 2010, the Inspector General of DHMH and the Director of the Medicaid Fraud Control Unit of OAG must report annually to the General Assembly on (1) the number of false claims civil actions filed; (2) the number of false claims civil actions in which a judgment was entered; and (3) the number of claims made by the State for alleged false claims violations that are settled without the filing of a civil action.

Current Law: As Medicaid program administrators, States are required under federal regulations to implement certain measures and procedures aimed at preventing fraud and abuse, including (1) verification of the eligibility of providers to participate in federal health care programs; (2) procedures to verify that recipients actually received billed services; (3) procedures to identify suspected fraud cases; and (4) methods for investigating fraud cases, including procedures for referring suspected fraud cases to law enforcement officials and state Medicaid fraud control units.

The Medicaid Fraud Control Unit investigates and prosecutes provider fraud in State Medicaid programs. In addition to any other penalties provided by law, a health care provider that violates a provision of the Medicaid fraud part of the Criminal Law Article is liable to the State for a civil penalty of not more than triple the amount of the overpayment. If the value of the money, goods, or services involved is $500 or more in the aggregate, a person who violates Medicaid fraud provisions is guilty of a felony and on conviction is subject to imprisonment for up to five years and/or a fine of up to $100,000. If a violation results in the death of or serious physical injury to a person, the violator is subject to enhanced penalties.

The federal False Claims Act (FCA), 31 U.S.C. § 3729, allows the bringing of a *qui tam* action by a private citizen (relator) on behalf of the federal government, seeking remedies for fraudulent claims against the government. If successful, the relator is entitled to a share of the recovery of federal damages and penalties, depending on the extent to which the relator substantially contributed to the case. Relators are not entitled to a share of a state's portion of recoveries. Many states have enacted state false claims acts under which they must share the damages recovered with the federal government in the same proportion as the federal government's share in the cost of the state Medicaid program.

The bill's language reflects several changes to the FCA included in the Fraud Enforcement and Recovery Act of 2009 (FERA). FERA contains the most significant changes to the FCA since 1986. The most significant amendments to the FCA are listed below.

- *Intent* – Prior to FERA, FCA liability attached whenever a person "knowingly ma[de], use[d], or cause[d] to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government." Under FERA, a person is liable under the FCA if he/she "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim." The amendment is a response to the United States Supreme Court's ruling in *Allison Engine v. United States ex rel. Sanders*, 128 S. Ct. 2123 (2008). In *Allison Engine*, two former employees of a subcontractor to a navy contractor filed a *qui tam* action alleging that their former employer submitted false certificates of conformance in order to secure payment. The court held that it was insufficient for the plaintiffs to establish that the defendant's false statement resulted in payment of the claim or that the primary contractor used government money to pay the subcontractor. Instead, a plaintiff must prove that the false statement was made with the intent that it would result in the government paying the claim.

- *Presentment* – FERA defines a "claim" under the FCA to include requests or demands "made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest." This language expands the scope of the FCA by allowing claims made by subcontractors to private entities using government funds or advancing government interests to qualify as false claims. The FERA amendments reverse rulings by some federal courts requiring a false claim to have been presented to the government in order for the claim to qualify under the FCA. See *United States ex rel. Totten v. Bombardier Corp.*, 380 F.3ed 488 (D.C. Cir. 2004).

- *Reverse False Claims* – Prior to FERA, a person who knowingly made a fraudulent statement for the purpose of avoiding or decreasing an obligation to pay money to the government was liable to the government. FERA expanded this

"reverse false claim" provision by making a person liable for "knowingly conceal[ing] or knowingly and improperly avoid[ing] or decreas[ing] an obligation to pay or transmit money or property to the Government." Under FERA "obligation" includes "retention of an overpayment." Thus, knowingly retaining an overpayment by the government may result in a violation of the FCA.

Background: In 2003, the U.S. Government Accountability Office added Medicaid to its list of high-risk programs, noting that the program's size and growth, combined with insufficient federal and state oversight, put the program at significant risk for improper payments.

Federal Incentives: The federal Deficit Reduction Act of 2005 (DRA) established incentives for states to enact certain antifraud legislation modeled after the federal FCA. States that enact qualifying legislation are eligible to receive an increase of 10% in the share of recovered funds. The 10% increase in the state share of the recovery corresponds to a 10% reduction in the federal share.

To qualify, a state false claims act must provide (1) liability to the state for false or fraudulent claims; (2) provisions for *qui tam* actions to be initiated by whistleblowers and for the rewarding of those whistleblowers in amounts that are at least as effective as those provided by the federal FCA; (3) the placing of *qui tam* actions under seal for 60 days for review by the state Attorney General; and (4) civil penalties not less than those provided in the federal FCA, to be imposed on those who have been judicially determined to have filed false claims.

Other States: Twenty-three states and the District of Columbia have enacted state false claims acts with *qui tam* provisions, 14 of which qualify for increased recoveries under DRA (California, Georgia, Hawaii, Illinois, Indiana, Massachusetts, Michigan, Nevada, New York, Rhode Island, Tennessee, Texas, Virginia, and Wisconsin).

Some states have realized significant savings the year after enacting a state false claims act. However, given that false claims recoveries involve lengthy and complex litigation, it is unclear what portion of those increased recoveries is directly attributable to enactment of a state act rather than large recoveries from existing cases.

Current Medicaid Fraud Control Efforts: According to DHMH, approximately $300 million in fraudulent Medicaid claims are submitted each year. DHMH has an Office of the Inspector General (OIG) that works closely with the Medicaid Fraud Control Unit to maximize efforts to contain fraud, waste, and abuse in Medicaid and other departmental programs. Through its efforts under existing law, OIG and DHMH have recovered $78.2 million in fraudulent claims over the past four years, including $26.7 million in fiscal 2009.

Fiscal 2010 Budget: Language included in the fiscal 2010 budget authorized a $10 million general fund reduction to the Medicaid program to recognize savings from Medicaid Day Limits (MDLs) contingent on the failure of legislation implementing a Maryland False Claims Act (SB 272/HB 304 of 2009). Instead of implementing MDLs, the Health Services Cost Review Commission chose to finance the $10 million cut through a remittance on hospitals. Thus, hospitals alone will bear the cost of the reduction.

Governor's Proposed Fiscal 2011 Budget: The Governor's proposed fiscal 2011 budget includes $20 million in reductions ($9 million in general funds, $11 million in federal funds), contingent on enactment of the Maryland False Claims Act of 2010. All of the reductions are in medical care provider reimbursements under Medicaid. DHMH indicates that these savings ($9 million in general funds) will result due to associated damages in the civil process that cannot be awarded under current law and additional volume of false claims cases. This figure is based on current fraud collection efforts in Maryland and increased recoveries in other states in the first year following enactment of a state false claims act.

Department of Health and Mental Hygiene

General fund revenues may increase from civil penalties and damages awarded against providers that defraud the State's health plans and programs and from additional volume of false claims filings in the State. While current law does provide for a civil penalty of not more than triple the amount of the overpayment for criminal violations of State Medicaid fraud statutes, it does not provide a civil cause of action for fraud against a defrauding provider. In order to collect the current civil penalty or court-ordered restitution, the State has to secure a criminal conviction, which requires proof of specific intent to defraud. The civil cause of action provided in this bill would not require proof of specific intent to defraud and would be subject to the "preponderance of the evidence" standard used in civil cases, rather than the "beyond a reasonable doubt" standard used in criminal cases. Typically, the State is only able to recover what it can prove as actual losses through currently available fraud recovery efforts.

The bill does not affect total Medicaid expenditures but may affect how the program is financed. The State's share of Medicaid recoveries is currently classified as special fund revenues and used to offset the State's portion of the Medicaid match. The State funds its share of Medicaid costs through a combination of special funds and general funds. Currently, when the State receives Medicaid recoveries, special fund revenues and expenditures for Medicaid increase, resulting in a corresponding decrease in general fund expenditures for Medicaid. However, this bill requires any civil penalties and damages awarded in cases involving the cause of action created by the bill to be deposited into the general fund, not a special fund dedicated to Medicaid.

General fund revenues generated from civil penalties and damages awarded under the cause of action created by this bill may correspond to a decrease in special fund revenues if the State opts to pursue false claims using the cause of action created by the bill rather than current law efforts which result in special fund revenues. It is assumed, however, that general fund revenues generated under the bill will exceed current law special fund revenues from Medicaid recoveries. The bill may also effectuate a contingent reduction in the Governor's proposed fiscal 2011 Medicaid budget as discussed below.

While general fund revenues may increase significantly due to an increased volume of false claims actions, revenues ***will not*** increase as a result of an enhanced share of Medicaid fraud recoveries under the provisions of the DRA. As previously stated, state false claims statutes that are approved by the federal government are eligible for increased fraud recoveries under the provisions of the DRA. Under current law, any recoveries must be split between the State and federal government at the applicable Medicaid matching rates (normally 50/50). An approved State false claims act would allow the State to retain an additional 10% share of recoveries. For example, in 2009, Pfizer, Inc. reached a settlement with the federal government and states over allegations of health care fraud contained in nine *qui tam* cases. Maryland received $5 million from the settlement at the normal 50% State Medicaid share. DHMH-OIG advises that, had the State had a federally approved false claims statute, the State would have received $6 million (60% of the $10 million settlement).

However, it is unlikely that the false claims statute included in this bill will be approved by the Office of the Inspector General at the federal Department of Health and Human Services. In order to secure approval, a state false claims statute must offer protections to whistleblowers that is equal to or greater than those provided under federal law. This bill prohibits a private party who files a *qui tam* action from continuing with the case if the State declines to intervene or withdraws from the case – an option available under federal law. In addition, the bill does not contain a minimum civil penalty of at least $5,000 per false claim, the minimum civil penalty under federal law.

Office of the Attorney General

To the extent that the bill generates additional referrals for false or fraudulent claims, additional personnel and resources may be required by OAG. OAG estimates that it will need to employ at least one additional assistant Attorney General in fiscal 2011, which would result in an increase in general fund expenditures of $70,864 in fiscal 2011, which accounts for the bill's October 1, 2010 effective date. However, the need for additional personnel at OAG will depend on the number of increased referrals and cases as a result of the bill. This increase in case activity cannot be reliably determined at this time. The Medicaid Fraud Control Unit handled 140 cases in fiscal 2008, including cases pending at the beginning of the fiscal year. However, most of the unit's complaints are of patient abuse, which is not the type of activity typically covered by this bill. In fiscal 2008, the

unit received 36 complaints of fraud and 537 complaints of patient abuse. Currently, the unit has 23 positions, including five attorneys.

As previously noted, the exact number of additional personnel OAG would need to hire as a result of the bill cannot be reliably determined at this time and will depend on the increase in referrals and case activity. However, OAG advises that Virginia received 20 additional positions when it passed false claims legislation. Information regarding preexisting staffing levels and increases in case activity in Virginia could not be ascertained in time for inclusion in this note. When Washington State considered false claims legislation last year (SB 5144), the fiscal note for that bill estimated that it would need 25 new positions "to provide legal services in complex litigation pharmaceutical cases" at an estimated cost of $3.8 million annually.

Additional Comments: The Governor's proposed fiscal 2011 budget (SB 140/HB 150) contains a reduction of $9 million in general fund expenditures and $11 million in federal fund expenditures for Medicaid "contingent upon the enactment of the Maryland False Claims Act of 2010." However, the title of this bill is "Maryland False *Health* Claims Act of 2010." The title of SB 187, another false claims bill being considered this session, is "Maryland False Claims Act."

Maryland is currently receiving an enhanced federal Medicaid match (61.6% federal funds, 38.4% general funds) for the first half of fiscal 2011 under the federal American Recovery and Reinvestment Act of 2009. The Governor's proposed fiscal 2011 budget assumes that the enhanced match will continue throughout fiscal 2011.

As of March 2010, two pieces of Congressional legislation (H.R. 2847 and H.R. 3962) contain provisions to extend this enhanced match through June 30, 2011. H.R. 2847 passed both chambers and is in conference. Extension of the enhanced federal medical assistance percentage is anticipated to result in $389 million in additional federal funds for Maryland in fiscal 2011.

Additional Information

Prior Introductions: Similar bills have been introduced during the 2008 and 2009 sessions. SB 215 of 2008 and SB 272 of 2009 received favorable reports from the Senate Judicial Proceedings Committee, but failed on third reading in the Senate. HB 304 of 2009 received a hearing in the House Judiciary and Appropriations committees, but no further action was taken.

Cross File: HB 525 (The Speaker, *et al.*) (By Request - Administration) - Judiciary and Appropriations.

Information Source(s): National Conference of State Legislatures; United States Government Accountability Office; Washington State Legislature; Statehealthfacts.org; *Amendments to the False Claims Act Significantly Increase Exposure for Government Contractors and Service Providers,* Skadden, Arps, Slate, Meagher & Flom LLP & Affiliates; *Supreme Court's Allison Engine Decision Narrows the Scope of False Claims Act Cases That Can Be Brought Against Subcontractors,* Foley & Lardner LLP; *Congress Quickly Passes Significant FCA Amendments as Part of a Bill Funding Federal Law Enforcement,* Foley & Lardner LLP; *FERA Amendments To The False Claims Act May Have Serious Implications for Health Care Providers,* Jackson Walker LLP (martindale.com); *Newstand: Fraud Enforcement and Recovery Act of 2009 ("FERA"),* K&L Gates; California Mental Health Directors Association, *Baltimore Business Journal*; Office of the Attorney General; Department of Budget and Management; Maryland Health Insurance Plan; Department of Health and Mental Hygiene; Maryland Insurance Administration; Comptroller's Office; Judiciary (Administrative Office of the Courts); Department of Legislative Services

Fiscal Note History: First Reader - February 22, 2010
ncs/mwc Revised - Senate Third Reader - March 31, 2010

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ANALYSIS OF ECONOMIC IMPACT ON SMALL BUSINESSES

TITLE OF BILL: Maryland False Health Claims Act of 2010

PREPARED BY: SB 279

PART A. ECONOMIC IMPACT RATING

This agency estimates that the proposed bill:

__X__ WILL HAVE MINIMAL OR NO ECONOMIC IMPACT ON MARYLAND SMALL BUSINESS

OR

___ WILL HAVE MEANINGFUL ECONOMIC IMPACT ON MARYLAND SMALL BUSINESSES

PART B. ECONOMIC IMPACT ANALYSIS

The proposed legislation will have no impact on small business in Maryland.