

**SB506.POCT.MPhA.MPC.pdf**

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Position: FAV



**Date:** February 17, 2026

**To:** The Honorable Pamela Beidle, Chair, Senate Finance Committee

**From:** Aliyah N. Horton, FASAE, CAE, Executive Director, 240-688-7808

**Cc:** Members, Senate Finance Committee

**Re:** **FAVORABLE – SB5 06 Health Occupations – Pharmacists – Minor Conditions and HIV Prevention and Treatment**

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The Maryland Pharmacists Association (MPHA) and the Maryland Pharmacy Coalition (MPC) recommend a **FAVORABLE report on SB 506 Health Occupations – Pharmacists – Minor Conditions and HIV Prevention and Treatment.**

Approximately 14 of Maryland’s 24 counties are federally designated Health Professional Shortage Areas (HPSAs), and another 8 are partial HPSAs — meaning 22 of 24 counties are affected by provider shortages.<sup>1</sup> Maryland does not have enough primary care access points. Utilizing pharmacists is one of the fastest ways to responsibly expand capacity without building new clinics or significantly increasing state spending.

Many Maryland counties have appointment delays exceeding weeks and emergency room wait times are some of the highest in the country. Our primary care shortages are real. Whether they are staffing a community or ambulatory care pharmacy or embedded in a clinic, pharmacists can extend physician capacity without competing in complex patient care.

CMS Administrator Dr. Mehmet Oz emphasized workforce expansion and enabling clinicians — including pharmacists — to practice at the top of their license as an important part of the Rural Health Transformation Program.<sup>2</sup> Maryland can take lessons learned of more than 30 states that authorize pharmacists to utilize point-of-care tests to diagnose minor conditions and dispense medications. Evidence reviews and international evaluations show pharmacist prescribing for minor ailments and pharmacy-based test-and-treat programs provide safe, clinically appropriate care without increased adverse outcomes.<sup>3</sup>

Point-of-care tests (POCT) proposed in this bill are:

- CLIA-waived
- Low risk
- High specificity
- Protocol-driven
- Paired with clear inclusion/exclusion criteria
- Backed by referral requirements for red flags.

Additional provisions in the bill include authorization for pharmacists to provide HIV testing and prescribing of HIV PEP and PrEP because they represent safe, evidence-based strategies to expand timely access to prevention services. Maryland continues to see hundreds of new HIV diagnoses each year, with disproportionate impact in

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<sup>1</sup> Cicero Institute, “Maryland Physician Shortage Facts,” *Cicero Institute*, accessed February 10, 2026, <https://ciceroinstitute.org/research/maryland-physician-shortage-facts/>

<sup>2</sup> Centers for Medicare & Medicaid Services (CMS). *Rural Health Transformation (RHT) Program Overview* (describing workforce development and providers practicing at the top of their license). CMS.gov. <https://www.cms.gov/priorities/rural-health-transformation-rht-program/overview>.

<sup>3</sup> Ali A\*, Mishra S\*, Waddell K, Ciurea P, Cura J, Dass R, Sivanesanathan T, Alam S, Goodale G, Grewal E, MacLean Y, Phelps A, Bhuiya AR, Whitelaw H, Bustamante D, Wilson MG. Rapid evidence synthesis: Impacts of pharmacist prescribing on the equity-centred quadruple-aim outcomes. Hamilton: McMaster Health Forum, 24 July 2025.



jurisdictions such as Baltimore City and Prince George’s County. Pharmacists are often available evenings and weekends without an appointment and are well-positioned to initiate post-exposure prophylaxis within the critical 72-hour window and to expand access to ongoing PrEP prevention. CDC clinical guidance clearly outlines protocols for screening, testing, and follow-up. Department of Health protocols will ensure appropriate referral and continuity of care.

Authorizing pharmacists to conduct HIV testing and to provide PEP and PrEP does not replace physicians; it creates another access point that helps close prevention gaps. Evidence from pharmacist-led programs demonstrates strong safety outcomes, high patient engagement, and increased uptake of prevention services. This is another opportunity to leverage pharmacists, as existing, highly trained professionals, to reduce new infections and improve public health outcomes.

### **Do Pharmacists want this? YES!**

375 pharmacies in Maryland currently hold CLIA-waivers to perform these tests. This is not a novel concept. The goal is to enable pharmacists to fully use the tools they already have. National surveys of pharmacists show overwhelming professional support for expanding clinical services like point-of-care testing — with more than 80% agreeing POCT advances the profession and improves patient care, and roughly three-quarters of pharmacy professionals say they want to expand their clinical role.<sup>4</sup>

Clinical service expansion often increases professional satisfaction. Pharmacists know that practice expansion means disruption and workflow redesign. It requires scope change, regulatory updates, practice and process transformation. Maximizing resources for better health outcomes requires the legislature to be forward-thinking and recognize that pharmacists, patients, and payors must evolve together to expand access, improve equity, and deliver care closer to where people live.

Attached to my testimony, please find the following additional materials:

#### **A. Infographic - Pharmacist Provide Access to Care – Test and Treat**

#### **B. Fact Sheet - Myth vs. Fact: Pharmacy-Based Test and Treat**

This document expounds upon the following topics from a national perspective with research/study citations.

- Pharmacists training
- Studies on pharmacist testing and treatment services
- Diagnostic integrity of point-of-care testing
- Public support and interest in pharmacy-based clinical services
- Pharmacist/pharmacy accessibility
- Insurance coverage
- Pharmacist capacity
- Fragmented care
- Patient privacy

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<sup>4</sup> Gallimore CE, Porter AL, Barnett SG, Portillo E, Zorek JA. A state-level needs analysis of community pharmacy point-of-care testing. *J Am Pharm Assoc.* 2021;61(3):e93-e98. doi:10.1016/j.japh.2020.12.013



## **Maryland Pharmacists Association**

The Maryland Pharmacists Association (MPhA), established in 1882, is the only state-wide professional society representing all practicing pharmacists, student pharmacist and pharmacy technicians. Our mission is to strengthen the profession of pharmacy, advocate for all Maryland Pharmacists and promote excellence in pharmacy practice.

**Maryland Pharmacy Coalition (MPC)** provides a forum for discussion and understanding between Maryland's professional pharmacy associations on issues impacting the practice of pharmacy and the public's health.

## **Full Members**

- American Society of Consultant Pharmacists – Maryland Chapter
- Maryland Pharmaceutical Society
- Maryland Pharmacists Association
- Maryland Society of Health System Pharmacists
- University of Maryland Baltimore School of Pharmacy Student Government Association
- University of Maryland Eastern Shore School of Pharmacy Student Government Association
- Notre Dame of Maryland University School of Pharmacy Student Government Association

## **Affiliate Members (non-voting)**

- University of Maryland Baltimore School of Pharmacy
- University of Maryland Eastern Shore School of Pharmacy
- Notre Dame of Maryland University School of Pharmacy
- Maryland Association of Chain Drug Stores



## Myths vs. Facts: Pharmacy-Based “Test and Treat”

**Myth:** Pharmacists are not sufficiently trained to administer point-of-care tests, conduct patient assessments, nor initiate treatment for common health conditions.

**Fact:** Pharmacists are clinically trained healthcare professionals who, in addition to serving as medication experts, are educated to order and administer tests and manage treatments for common conditions.

Since 2004, all entry-level pharmacists graduate with a Doctor of Pharmacy degree, completing a robust curriculum that prepares pharmacists to provide direct patient care, clinical assessments, and evidence-based treatment and management of a wide variety of health conditions.<sup>i</sup> In fact, more than half of the national licensing exam for entry-level pharmacists is focused on obtaining, interpreting, and assessing medical data and patient information, and developing and managing treatment plans.<sup>ii</sup> Additionally, point-of-care tests are often used in both medical offices and pharmacies, and these tests, by definition, are so simple that there is little risk of error.<sup>iii</sup> In initiating any treatments based on test results, pharmacists strictly adhere to evidence-based protocols that reflect the latest clinical guidelines, and as medication experts, are well prepared to manage drug therapy, including any drug interactions.

**Myth:** Pharmacist testing and treatment services have not been previously studied or implemented.

**Fact:** For more than a decade, pharmacists in the United States have increasingly provided testing and treatment services.<sup>iv,v</sup>

In fact, the use of CLIA-waived tests in pharmacies has grown by 140% since 2019, given the essential need for more accessible testing services during the recent public health emergency where pharmacies provided more than 42 million COVID-19 tests.<sup>vi,vii</sup> Further, a wide array of pharmacy-based testing and treatment or referral services have been proven safe and effective, including for influenza, strep throat, blood glucose, HIV, hepatitis C, latent tuberculosis, and more.<sup>viii,ix,x,xi</sup> For example, a study analyzing community pharmacist testing and treatment services tested 273 patients for strep throat, of which 46 patients tested positive and received the appropriate treatment. At follow-up, almost 94% of patients that tested positive reported feeling better, and patients that reported feeling worse were referred to additional care. Also, of those tested, more than 43% did not have a primary care provider.<sup>xii</sup>

**Myth:** Allowing pharmacists to initiate treatment based on test results could lead to misdiagnosis and mistreatment.

**Fact:** Pharmacists administer the same high-quality tests used across healthcare settings with robust quality control measures, low user error, and simple-to-read results.<sup>iii</sup>

Pharmacists closely follow the testing manufacturer’s instructions for administering tests and reading the results. When initiating treatment based on test results, pharmacists adhere to current, evidence-based clinical guidelines that reflect the most appropriate treatment. In fact, research indicates that pharmacists more strictly follow clinical prescribing guidelines compared to other healthcare providers.<sup>xiii</sup>

In addition to performing a test, pharmacists often conduct other assessments to ensure the most appropriate treatment or referral is provided. These assessments may include a patient interview about their symptoms, a brief physical exam, or a vital signs check. In fact, when a pharmacist’s assessment indicates that something more serious may be going on, the pharmacist will refer the patient to higher levels of care, such as the emergency room or their medical provider, as appropriate.

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**Myth:** The public would not seek testing and treatment of common health conditions at pharmacies.

**Fact:** The public has become even more accustomed to receiving clinical care from their local pharmacist in recent years, including testing and treatment services.

In fact, 58% of Americans are likely to visit a pharmacy first when faced with a non-emergency medical issue and 81% say they trust a pharmacist to diagnose minor illnesses and prescribe medications to treat them.<sup>xiv</sup> Also, more than 70% of Americans believe that it is important for pharmacists to test and treat common illnesses and minor conditions like flu and strep throat.<sup>xv</sup> For example, in a study of people who received testing and treatment services from a pharmacist, 98% were satisfied with the care provided and stated they would use it again.<sup>xvi</sup> Research indicates that when pharmacists offer testing and treatment, over a third of people who utilize the service may not have access to a primary care provider, and almost 40% visit the pharmacy outside of usual medical office hours.<sup>xvii</sup>

Today, more than 100 million Americans do not have a primary care provider, nearly a third of the U.S. population. Without sufficient access to primary care, people may forgo evaluation and treatment for common conditions, which threatens the health of communities, and ultimately contributes to worse health outcomes and higher healthcare costs. Pharmacists providing testing and treatment services can help extend the reach of primary care to close access gaps, while also supporting effective referrals and linkages to primary care and follow-up.

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**Myth:** Pharmacists are not as accessible as other healthcare providers for testing and treatment services.

**Fact:** With 60,000+ community-based pharmacies across the country, nearly half of Americans live within 1 mile of pharmacy, while 89% live within 5 miles, and 97% live within 10 miles.<sup>xviii</sup>

Pharmacies frequently offer extended hours beyond the typical nine-to-five weekday schedule, providing additional care opportunities after work and school hours. In fact, pharmacies are visited 10 times more frequently than the average patient's primary care provider.<sup>xix</sup> Additionally, 85% percent of adults in the U.S. say pharmacists are easy to access.<sup>16</sup>

Pharmacies are sometimes the only healthcare provider within reach in some rural and underserved communities and allow for more accessible care for those who may have limited mobility or face transportation challenges, such as seniors. Studies show that Medicare patients visit pharmacies significantly more often than primary care providers – 13 visits per-year compared to seven visits per-year. In rural communities, the difference is more significant – 14 visits compared to five visits annually.<sup>xx</sup> By providing "Test-and-Treat" services in pharmacies, people can more easily receive timely care. Also, pharmacy-based testing and treatment services streamline access for people to receive both testing and treatment in one place, instead of going to one healthcare location for the test and then to the pharmacy to pick up their treatment.

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**Myth:** Insurance covers healthcare services provided by pharmacists.

**Fact:** Unlike services provided by other healthcare professionals, clinical services provided by pharmacists, like testing and treatment, are rarely a covered benefit by health plans, despite evidence on the safety and effectiveness of pharmacist-provided care.

Lacking insurance coverage for pharmacist services ultimately limits public access to receive essential and timely care services at their local pharmacy. Importantly, a significant majority of Americans (71%) support insurers paying pharmacists adequately for testing and initiating treatment for various health conditions, recognizing the importance of these services for improved public health, and the need for sustainable reimbursement.

In alignment with the goals of health plans to facilitate cost-effective healthcare, pharmacist-provided clinical services have been proven to reduce downstream, preventable healthcare costs.<sup>xxi,xxii</sup> Pharmacy interventions provided during the recent public health emergency alone averted more than 1 million deaths, prevented more than 8 million hospitalizations, and saved \$450 billion in healthcare costs.<sup>xxiii</sup> When it comes to pharmacist testing and treatment for common conditions, early and timely treatment of these conditions can shorten the duration of symptoms and reduce the risk of additional health complications, preventing unnecessary and costly hospitalizations.<sup>xxiv</sup>

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**Myth:** Pharmacists do not have enough time to offer more services, like testing and treatment.

**Fact:** Many pharmacists are eager to engage more directly with patients, in fact, a recent survey found that 81% of pharmacists want to expand their clinical services.<sup>xxv</sup>

Notably, a majority of the respondents said the biggest barrier to offering more clinical services beyond the traditional pharmacy care services is due to the lack of payment for these services – not a lack of capacity to take on additional responsibilities. Also, pharmacies have continued to update their systems and processes, where possible, to free up pharmacists’ time to provide clinical services. This includes shifting more prescription dispensing responsibilities to remote pharmacy teams, utilizing new technology solutions, and leveraging the expertise of pharmacy technicians to perform more tasks that do not require the clinical skills of pharmacists. In fact, research on expanded technician duties, such as final product verification, has demonstrated meaningful opportunity to distribute more pharmacist time to providing more clinical services.<sup>xxvi, xxvii</sup>

**Myth:** One-off visits with a pharmacist don’t provide an opportunity for follow-up care nor collaboration with the patient’s other healthcare providers.

**Fact:** People visit pharmacies 10 times more often than other healthcare providers,<sup>22</sup> providing ample opportunities for follow-up care. In published examples of pharmacist testing and treatment, follow up is a common practice, typically within 24-48 hours.<sup>xxviii, xxix</sup>

Also, when providing testing and treatment services, pharmacies often share information with the patient’s medical provider, if the patient has one. In fact, while the majority of people (60%) use only one pharmacy,<sup>xxx</sup> the average person sees 18 different doctors in their lifetime<sup>xxxi</sup> and about 30% of seniors see 5 or more doctors.<sup>xxxii</sup> Therefore, in some instances, the pharmacy may have the most comprehensive understanding of the patient’s medical picture based on the medications being prescribed by different prescribers. This is especially true because there are documented gaps in communication between specialists and primary care providers.<sup>xxxiii</sup> In fact, challenges with data interoperability and communication are prevalent across healthcare in general, and are not unique to pharmacy-based care.

Further, research supports pharmacists’ ability to identify health care needs and provide successful referrals and linkage to care when additional care is needed.<sup>xxxiv, xxxv, xxxvi</sup> For example, in a study of 55 community pharmacies providing testing and treatment for flu, pharmacists performed 75 tests and among them, 8 people (11%) tested positive and were provided appropriate treatment. At the initial visit, 4 patients were instructed to seek additional care based on the pharmacist’s assessment and clinical judgement. These patients were successfully reached at follow-up and reported the following: one diagnosis of pneumonia, one diagnosis of bronchitis, and two antiviral prescriptions for flu. The patients also reported feeling better due to the pharmacist’s referral. In addition, pharmacists successfully followed up with 79% of all tested patients within 48 hours of the initial visit and 78% of those reached reported feeling better.<sup>xxxvii</sup>

**Myth:** Pharmacies do not offer the privacy necessary to provide testing and treatment services.

**Fact:** Pharmacies have long adhered to strict privacy rules required since 2003 under the Health Insurance Portability and Accountability Act (HIPAA) regulations to protect patient health information.

In implementing “test-and-treat” programs, pharmacies ensure that test results and patient assessments are conducted in a private manner and that patient data is securely stored and shared only in accordance with healthcare privacy laws. Increasingly, pharmacies are designating space for private rooms near the pharmacy to conduct patient assessments, tests, vaccinations and other healthcare services. For example, in a study evaluating a pharmacist-led HIV pre-exposure prophylaxis (PrEP) program, patients who completed the 6-month visit survey indicated a high level of satisfaction (>95% very satisfied) with the privacy of conversation with the pharmacist.<sup>xxxviii</sup>

<sup>i</sup> Accreditation Standards and Key Elements for the Professional Program in Pharmacy Leading to the Doctor of Pharmacy Degree. Accreditation Council for Pharmacy Education. February 2015. <https://www.acpe-accredit.org/pdf/Standards2016FINAL.pdf>

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<sup>ii</sup> Competency Statements | North American Pharmacist Licensure Examination. National Association of Boards of Pharmacy.

<https://nabp.pharmacy/programs/examinations/naplex/competency-statements/>

<sup>iii</sup> Clinical Laboratory Improvement Amendments (CLIA) How to Obtain a CLIA Certificate of Waiver. <https://www.cms.gov/regulations-and-guidance/legislation/clia/downloads/howtoobtaincertificateofwaiver.pdf>

<sup>iv</sup> Klepser ME, Klepser DG, Dering-Anderson AM, Morse JA, Smith JK, Klepser SA. Effectiveness of a pharmacist-physician collaborative program to manage influenza-like illness. *Journal of the American Pharmacists Association* (2003). 2016 Jan;56(1):14-21. doi: 10.1016/j.japh.2015.11.008. PMID: 26802915.

<sup>v</sup> Grabenstein JD. Essential services: Quantifying the contributions of America's pharmacists in COVID-19 clinical interventions. *Journal of the American Pharmacists Association*. 2022;62(6):1929-1945.e1. doi:https://doi.org/10.1016/j.japh.2022.08.010

<sup>vi</sup> Zalupski B, Elroumi Z, Klepser DG, Klepser NS, Adams AJ, Klepser ME. Pharmacy-based CLIA-waived testing in the United States: Trends, impact, and the road ahead. *Res Social Adm Pharm*. 2024;20(6):146-151. doi:10.1016/j.sapharm.2024.03.003.

<sup>vii</sup> Grabenstein JD. Essential services: Quantifying the contributions of America's pharmacists in COVID-19 clinical interventions. *Journal of the American Pharmacists Association*. 2022;62(6):1929-1945.e1. doi:https://doi.org/10.1016/j.japh.2022.08.010

<sup>viii</sup> Buss VH, Deeks LS, Shield A, Kosari S, Naunton M. Analytical quality and effectiveness of point-of-care testing in community pharmacies: A systematic literature review. *Research in Social and Administrative Pharmacy*. 2019;15(5):483-495. doi:10.1016/j.sapharm.2018.07.013

<sup>ix</sup> Kugelmas M, Pedicone LD, Lio I, Simon S, Pietrandoni G. Hepatitis C Point-of-Care Screening in Retail Pharmacies in the United States. *Gastroenterol Hepatol (N Y)*. 2017;13(2):98-104.

<sup>x</sup> Jakeman B, Gross B, Fortune D, Babb S, Tinker D, Bachrycz A. Evaluation of a pharmacist-performed tuberculosis testing initiative in New Mexico. *Journal of the American Pharmacists Association*. 2015;55(3):307-312. doi:https://doi.org/10.1331/japha.2015.14141

<sup>xi</sup> Klepser DG, Klepser ME, Smith JK, Dering-Anderson AM, Nelson M, Pohren LE. Utilization of influenza and streptococcal pharyngitis point-of-care testing in the community pharmacy practice setting. *Research in Social and Administrative Pharmacy*. 2018;14(4):356-359. doi:10.1016/j.sapharm.2017.04.012

<sup>xii</sup> Klepser DG, Klepser ME, Dering-Anderson AM, Morse JA, Smith JK, Klepser SA. Community pharmacist-physician collaborative streptococcal pharyngitis management program. *Journal of the American Pharmacists Association*. 2016;56(3):323-329.e1. doi:https://doi.org/10.1016/j.japh.2015.11.013

<sup>xiii</sup> Klepser ME, Adams AJ, Klepser DG. Antimicrobial Stewardship in Outpatient Settings: Leveraging Innovative Physician-Pharmacist Collaborations to Reduce Antibiotic Resistance. *Health Security*. 2015;13(3):166-173. doi:https://doi.org/10.1089/hs.2014.0083

<sup>xiv</sup> Rebelo A. Wolters Kluwer's Pharmacy Next survey shows 58% of Americans likely to first seek non-emergency healthcare at pharmacies. [www.wolterskluwer.com](http://www.wolterskluwer.com). Published May 17, 2023. <https://www.wolterskluwer.com/en/news/survey-shows-americans-likely-to-first-see-non-emergency-healthcare-at-pharmacies>

<sup>xv</sup> Morning Consult. Public Support for Pharmacist-Provided Services. Published 2023. <https://www.nacds.org/pdfs/Opinion-Research/NACDS-OpinionResearch-National.pdf>

<sup>xvi</sup> Kirby J, Mousa N. Evaluating the impact of influenza and streptococcus point-of-care testing and collaborative practice prescribing in a community pharmacy setting. *Journal of the American Pharmacists Association*. 2020;60(3S):S70-S75. doi:https://doi.org/10.1016/j.japh.2020.03.003

<sup>xvii</sup> Klepser DG, Klepser ME, Smith JK, Dering-Anderson AM, Nelson M, Pohren LE. Utilization of influenza and streptococcal pharyngitis point-of-care testing in the community pharmacy practice setting. *Research in Social and Administrative Pharmacy*. 2018;14(4):356-359. doi:10.1016/j.sapharm.2017.04.012

<sup>xviii</sup> Berenbrok LA, Tang S, Gabriel N, et al. Access to community pharmacies: A nationwide geographic information systems cross-sectional analysis. *Journal of the American Pharmacists Association*. 2022;62(6). doi:https://doi.org/10.1016/j.japh.2022.07.003

<sup>xix</sup> Hemberg N, Huggins D, Michaels N, Moose J. Innovative Community Pharmacy Practice Models in North Carolina. *North Carolina Medical Journal*. 2017;78(3):198-201. doi:https://doi.org/10.18043/ncm.78.3.198

<sup>xx</sup> Berenbrok LA, Gabriel N, Coley KC, Hernandez I. Evaluation of Frequency of Encounters With Primary Care Physicians vs Visits to Community Pharmacies Among Medicare Beneficiaries. *JAMA Network Open*. 2020;3(7):e209132. doi:https://doi.org/10.1001/jamanetworkopen.2020.9132

<sup>xxi</sup> Milosavljevic A, Aspden T, Harrison J. Community pharmacist-led interventions and their impact on patients' medication adherence and other health outcomes: a systematic review. *International Journal of Pharmacy Practice*. 2018;26(5):387-397. doi:https://doi.org/10.1111/ijpp.12462

<sup>xxii</sup> Lee JK, Grace KA, Taylor AJ. Effect of a Pharmacy Care Program on Medication Adherence and Persistence, Blood Pressure, and Low-Density Lipoprotein Cholesterol. *JAMA*. 2006;296(21):2563. doi:https://doi.org/10.1001/jama.296.21.joc60162

<sup>xxiii</sup> Grabenstein JD. Essential services: Quantifying the contributions of America's pharmacists in COVID-19 clinical interventions. *Journal of the American Pharmacists Association*. 2022;62(6):1929-1945.e1. doi:https://doi.org/10.1016/j.japh.2022.08.010

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# Written Testimony SB506.pdf

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The Honorable Chair Beidle  
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Finance Committee  
Senate of Maryland

February 17th, 2026

**SB506: Health Occupations – Pharmacists – Minor Conditions and HIV Prevention and Treatment**

Chair Beidle, Vice Chair Hayes, and members of the Finance Committee,

Senate Bill 506: Health Occupations – Pharmacists – Minor Conditions and HIV Prevention and Treatment would allow pharmacists to treat conditions that either: 1) do not require a new diagnosis, 2) are minor and or naturally recoverable, or 3) have a test that’s used to guide diagnosis or clinical decisions. Additionally, pharmacists will be able to test for and treat minor conditions such as cold sores, strep throat, the flu, lice, COVID-19, urinary tract infections, skin conditions such as athlete's foot, and other emerging health challenges as authorized by the Board of Pharmacy.

Pharmacists have increasingly become front-line public health providers since 2020, having safely administered over 12.6 million vaccinations to Maryland residents. Across the State, there are fewer than 80 primary care providers for every 10,000 residents.<sup>1</sup> In 2024, more than 40% of children in Maryland are without a “medical home.”<sup>2</sup> They do not have a consistent relationship with a healthcare provider for well-child visits and checkups. As of this year, 1,170,262 Maryland residents live in a Health Professional Shortage Area for primary care physicians.<sup>3</sup>

This legislation will help address Maryland’s existing gaps in access to health services. By creating a new treatment access point in rural and historically underserved urban areas, Senate Bill 506 will increase provider availability. Moreover, pharmacists are open in the evening and on weekends, making them the most accessible health professionals in many communities. Many primary care physicians are open only during business hours, causing a significant access barrier to workers without paid medical leave. Pharmacists are also the primary point of healthcare for the uninsured and underinsured, and the expanded services proposed in Senate Bill 506 would create increased access for

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<sup>1</sup> Miller, H., & Cohn, M. (2023, March 27). *Why it's hard to find a doctor in Maryland right now*. The Baltimore Banner. Massachusetts

<sup>2</sup> Kaiser Family Foundation. (2026, January 23). *Percent of children with a medical home: KFF State Health Facts*. KFF.

<sup>3</sup> Ngyuen, A. (2025, July 15) *Mapping Healthcare Deserts: Over 80% of the Country Still Lacks Adequate Access to Healthcare*. GoodRX.emergency

those patients. Often patients are not choosing between different types of providers, but whether they seek care at all.

Senate Bill 506 will also help relieve some of the strain on the state's overburdened healthcare system. Maryland has some of the highest emergency department wait times in the country, sometimes extending beyond 12 hours. By diverting care for minor conditions, states that have expanded pharmacist services have seen measurable reductions in emergency department utilization for minor illness. Pharmacists can address the minor conditions outlined in this bill and refer patients to appropriate providers for more serious concerns, reducing the need for emergency departments to serve as the only option. Recent data shows 90% of patients treated by pharmacists for minor conditions would have otherwise gone to a general practitioner or emergency room.<sup>4</sup>

There is statewide and national precedence for this legislation. Maryland has previously authorized and successfully implemented other expanded services for Maryland pharmacists, including vaccines, other testing services, and access to contraception. Additionally, more than 30 other states allow pharmacists to conduct point-of-care tests for minor conditions and then dispense the appropriate medication directly to that patient. The majority of those states give pharmacists the independent authority — Senate Bill 506's scope is narrower, requiring pharmacists to operate under a statewide protocol or standing order developed by their regulating agency.

I respectfully urge a favorable report.

Sincerely,



Senator Karen Lewis Young

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<sup>4</sup>Little, J., Bluml, B., Ambegaonkar, A., & Revanth, D. (2025). Project impact: Test and treat. increasing access to test and treat services through community pharmacy. *INNOVATIONS in Pharmacy*, 16(2).

# **SB506\_MDBoardofPharmacy\_FWA**

Uploaded by: State of Maryland (MD)

Position: FWA



Wes Moore, Governor · Aruna Miller, Lt. Governor · Meena Seshamani, M.D., Ph.D., Secretary

**Maryland Board of Pharmacy**  
Kristopher Rusinko, PharmD, Board President  
Deena Speights-Napata, M.A., Executive Director  
4201 Patterson Avenue  
Baltimore, MD 21215-2299

February 12, 2026

The Honorable Pamela Beidle  
Chair, Senate Finance Committee  
3 East Miller Senate Office Building  
Annapolis, Maryland 21401

**RE: Senate Bill 506 – Health Occupations – Pharmacists – Minor Conditions and HIV Prevention and Treatment**

Dear Chair Beidle and Committee Members:

The State Board of Pharmacy (Board) respectfully submits this letter of support with amendments for Senate Bill (SB) 506 – Health Occupations – Pharmacists – Minor Conditions and HIV Prevention and Treatment.

SB 506 expands the scope of practice for licensed pharmacists to enable them to test, diagnose and treat certain diseases, such as influenza and COVID, that ostensibly may be detected through CLIA-waived laboratory tests. SB 506 also expands the ability of licensed pharmacists to prescribe HIV pre-exposure and post-exposure prophylaxis medications without the need to participate in the Department’s Nonoccupational Postexposure Prophylaxis (nPEP) Standing Order Program.

The Board recognizes and is supportive of the integral role pharmacists serve in providing direct patient care. Indeed, pharmacists were central in the provision of vital vaccines during the COVID pandemic and continue to provide Maryland citizens with access to necessary vaccines today. However, the Board has concerns that certain proposed provisions in the bill are not in the interest of public health. In addition, certain provisions lack clarity and may result in confusion to pharmacists regarding the scope of the expanded authority.

Based on the above-mentioned concerns, the Board recommends the following amendments:

**Amendment 1**

As SB 506 intends to eliminate the requirement that pharmacists participate in the Department's nPEP Standing Order Program in order to prescribe HIV prophylaxis medications, the enabling statutes for the Program should also be deleted at Health Gen. Art. Sec.13-5301 through 13-5303.

### **Amendment 2**

On page 3, strike lines 27 – 28 beginning with “DO NOT REQUIRE” and ending with “SELF-LIMITING.”

The bill language states that a licensed pharmacist may not prescribe for a condition that “requires a new diagnosis.” However, in order to perform a lab test, interpret the test results, and prescribe accordingly, a pharmacist must determine a diagnosis. Such language creates confusion and arguably negates the expanded authority intended.

Similarly, the bill's language limits a pharmacist's ability to test and prescribe to conditions that are “minor and self-limiting”. These terms are overly ambiguous and thus, arguably unenforceable. In addition, the bill specifically lists eligible conditions (p.4, lines 11-21) obviating the need for this language.

### **Amendment 3**

On page 4, line 11, strike “COLD SORES”; line 14, strike “LICE”; line 17, strike “SKIN CONDITIONS, INCLUDING RING WORM AND ATHLETE'S FOOT”; and line 18, strike “URINARY TRACT INFECTION”.

The Board does not believe that treatment of such conditions is uniformly included in the core curriculum of school of pharmacy programs. In addition, certain conditions, such as “cold sores” or “skin conditions” may be an indication of a serious condition that requires medical treatment.

### **Amendment 4**

On page 5, line 5, strike “PHARMACY STUDENT” and insert “REGISTERED INTERN.”

The Board requires pharmacy students who are working in a pharmacy, as well as foreign pharmacy graduates who are fulfilling their experiential requirements, to be registered interns in accordance with Health Occ. Sec. 12-6D-02, *et seq.*

### **Amendment 5**

Honorable Pamela Beidle  
February 12, 2026  
Page 3

On page 5, lines 5-6, strike “AN INDIVIDUAL ENGAGED IN A BOARD-APPROVED TECHNICIAN TRAINING PROGRAM UNDER THE SUPERVISION OF THE PHARMACIST.”

The Board does not have jurisdiction over pharmacy technician trainees and has no ability to monitor them. The Board does not feel it is in the interest of public health and safety to permit such individuals, who have no consistent or verifiable training or experience, to perform testing.

With the proposed amendments above, the Board respectfully requests a favorable report on SB 506.

If you would like to discuss this further, please do not hesitate to contact Deena Speights-Napata, MA, Executive Director, at [deena.speights-napata@maryland.gov](mailto:deena.speights-napata@maryland.gov) or (410) 764-4753.

Sincerely,

*Deena Speights-Napata -MDA-*

Deena Speights-Napata, MA  
Executive Director  
State Board of Pharmacy

**SB0506\_UNF\_Patient First\_Health Occs. - Pharmacist**

Uploaded by: Danna Kauffman

Position: UNF



February 17, 2026

Senate Finance Committee  
3 East Miller Senate Office Building  
Annapolis, Maryland 21401

Re: Comments from Patient First regarding *Senate Bill 506: Health Occupations – Pharmacists – Minor Conditions and HIV Prevention and Treatment*

Dear Chair Beidle and Members of the Senate Finance Committee:

As a Maryland physician with more than 30 years of experience in primary and urgent care, I am writing on behalf of Patient First’s physicians to express our concerns regarding Senate Bill 506.

Patient First provides primary and urgent care medical services at 25 locations in the State of Maryland. Our medical centers are open 365 days of the year on a walk-in, non-appointment basis from 8 a.m. to 8 p.m. In Maryland, Patient First employs more than [100] physicians, who are board certified in family practice and internal medicine, and over [100] additional physician assistants and nurse practitioners. In 2025, we treated Maryland patients in more than 1 million visits for many of the same conditions that are addressed in SB 506. Over 20% of our visits were from Medicaid patients and the uninsured.

While we support efforts to expand access to care, SB 506 would do so in a manner that is inconsistent with existing state law governing patient care by physicians. Specifically, the bill would permit pharmacists to diagnose, determine treatment, and prescribe medications for illness including influenza, streptococcus, and COVID-19. Pharmacists have neither the training nor the facilities necessary to perform these tasks safely. While the bill suggests that such conditions are “minor [and] self-limiting,” **they are not**. Flu, strep and COVID kill many Maryland residents each year and pose acute threats to public health.

Under Maryland law, a physician may not prescribe drugs to a patient without first (i) obtaining a medical history; (ii) performing an appropriate examination; and (iii) initiating additional interventions and follow-up care, if necessary. These requirements promote the safe and effective treatment of patients by requiring basic medical examination and care as a precursor to drug therapy. Pharmacists lack both the medical training and the facilities necessary to perform or document any of these services required by law of physicians.

For the public health reasons set forth above, we strongly oppose SB 506 and request that you do the same. Thank you.

Sincerely,

Isaac Yoon, M.D.  
Chief Medicaid Director  
Patient First Neighborhood Medical Centers

**2026 SB506 NAPNAP.docx.pdf**

Uploaded by: JD Murphy

Position: UNF



February 13, 2026

Maryland Senate  
Finance Committee  
3 East Miller Senate Office Building  
Annapolis, Maryland 21401

Dear Honorable Chair, Vice-Chair, and Members of the Committee:

On behalf of the pediatric nurse practitioners (PNPs) and fellow pediatric-focused advanced practice registered nurses (APRNs) of the National Association of Pediatric Nurse Practitioners (NAPNAP) Maryland Chesapeake Chapter, we are writing to express our **opposition of Senate Bill 506 Health Occupations - Pharmacists - Minor Conditions and HIV Prevention and Treatment.**

We greatly support initiatives that aim to increase access to healthcare services; however, we have significant concerns regarding this proposed expansion of pharmacists' scope of practice. While essential partners in the healthcare system, pharmacists are not equipped with the comprehensive clinical training necessary to assess and manage a wide spectrum of minor conditions effectively. Conditions that are often deemed "minor" can present with complexities requiring a nuanced and thorough medical evaluation. Relying solely on pharmacists for diagnosis and treatment may lead to misdiagnosis or inadequate management. Many of the listed "minor" conditions can have underlying issues that require deeper investigation, such as UTIs being due to sexual abuse, or frequent skin infections being due to an immunodeficiency. Pediatric healthcare providers are trained to evaluate not just the presenting symptoms but also the broader context of a child's health, including growth and development, family history, and psychosocial factors. Pharmacists may not have the necessary tools or training to conduct these comprehensive assessments effectively. Additionally, children and adolescents are particularly vulnerable populations that benefit significantly from continuity of care. When pediatric patients present with minor conditions, their care should be integrated with their overall health management. This bill risks fragmenting this continuity, potentially compromising the quality of care that pediatric patients receive and leaving gaps in their ongoing treatment plans.

For these reasons, the Maryland Chesapeake Chapter of NAPNAP extends their **opposition to SB506 Occupations - Pharmacists - Minor Conditions and HIV Prevention and Treatment and requests an unfavorable report.**

The pediatric advanced practice nurses of your state are grateful to you for your attention to these crucial issues. The Maryland Chapter of NAPNAP membership includes over 200 primary and acute care pediatric nurse practitioners who are committed to improving the health and advocating for our state's pediatric patients. If we can be of any further assistance, or if you have any questions, please do not hesitate to contact the Maryland Chapter legislative chair, Dr. JD Murphy, at [mdchesnapnapleg@outlook.com](mailto:mdchesnapnapleg@outlook.com).

Sincerely,

Dr. Jessica D. Murphy DNP, CPNP-AC, CPHON, CNE  
Maryland Chapter Legislative Chair

Dr. Evgenia Ogorodova DNP, CPNP-PC  
Chapter Legislative Co-Chair

Dr. Yvette Laboy DNP, CPNP-AC, CCRN, CPN; Chapter President

Ms. Lindsay Ward MSN, CPNP-PC, IBCLC; Immediate Past-President

Dr. Samantha Hoffman DNP, MS, CPNP-PC; Chapter President-elect

# **Incidences of coercion by fraud.2026.pdf**

Uploaded by: Laura Bogley

Position: UNF

## **Reported Incidents of men drugging their pregnant partners with abortion-inducing drugs**

**Ohio:** December, 2025- Doctor Hassan-James Abbas

<https://www.fox26houston.com/news/ohio-surgeon-accused-forcing-abortion-pills-sleeping-girlfriend>

**Texas:** November, 2025: Marine Pilot

<https://www.kristv.com/news/local-news/in-your-neighborhood/corpus-christi/trial-date-set-for-woman-who-claims-marine-spiked-her-drink-with-abortion-pills>

**Illinois:** August 2025-- Emerson Evans

[https://www.telegraphherald.com/news/iowa-illinois-wisconsin/article\\_907fff98-76e8-4628-838a-dae2e1635f4e.html](https://www.telegraphherald.com/news/iowa-illinois-wisconsin/article_907fff98-76e8-4628-838a-dae2e1635f4e.html)

**Texas:** June, 2025-- Justin Anthony Banta

<https://www.bbc.com/news/articles/c0r1enk0x0eo>

**Washington State:** May, 2025 – Nurse Practitioner David Coots

<https://people.com/man-accused-sneaking-abortion-pills-into-womans-body-remove-ankle-monitor-11730927>

**United Kingdom:** October, 2024-- Stuart Worby

<https://www.cps.gov.uk/east-england/news/man-who-spiked-orange-juice-force-miscarriage-convicted>

**Massachusetts:** May 2024—Robert Kawada

<https://www.independent.co.uk/news/world/americas/massachusetts-abortion-pill-boyfriend-charged-robert-kawada-b2553243.html>

**Texas:** February, 2024-- Mason Herring

<https://www.nbcnews.com/news/us-news/texas-attorney-poisoned-pregnant-wife-abortion-medication-sentenced-18-rcna138065>

**Florida:** September, 2018: Jason Miller

<https://www.cbsnews.com/losangeles/news/report-former-trump-aide-accused-of-slipping-lover-abortion-pill/>

**Virginia:** May 2018—Doctor Sikander Imran

<https://abcnews.go.com/US/doctor-slipped-abortion-drug-girlfriends-tea-sentenced-years/story?id=55280357>

**New York:** March, 2014-- Shervaughn Remy

<https://nypost.com/2014/03/18/man-slipped-pregnant-girlfriend-abortion-pills-prosecutors/>

**Florida:** September, 2013-- John Andrew Welden

<https://www.cnn.com/2013/09/10/justice/girlfriend-abortion-case/index.html>

**UNFAVORABLE.SB506.LauraBogley.MDRTL.pdf**

Uploaded by: Laura Bogley

Position: UNF



## Unfavorable Statement

### SB506 – Health Occupations – Pharmacists – Minor Conditions and HIV Prevention Treatment

Laura Bogley-Knickman, JD

Executive Director, Maryland Right to Life

#### **We Oppose Taxpayer Funded Abortion by Pharmacists**

On behalf of the Board of Directors of Maryland Right to Life and our 200,000 followers across the state, we respectfully oppose SB506. This bill would revise the Health Occupations Article to allow pharmacists to “treat” for pregnancy and prescribe lethal chemical abortion drugs to women *and others* without a doctor’s examination or any other patient safeguards.

**Pregnancy is NOT a minor condition.** Improper healthcare before, during and after a woman’s pregnancy can have lifelong effects on both her health and the health of her child. Medical negligence can result in severe injury, infection, miscarriage, stillbirth, disability and even death. Prolonged disability can result in loss of income and homelessness. Maryland women deserve quality reproductive healthcare through a licensed obstetrician and the State should prioritize public funding for legitimate health services and providers that care for both mother and child - not elective abortion.

But public policy has failed to keep pace with the abortion industry’s rapid deployment of chemical abortion drugs, resulting in harm to women. **Pharmacists already are distributing dangerous abortion drugs with a prescription, but the abortion industry and their legislative advocates, intend for them to be certified prescribers of abortion drugs and be reimbursed through taxpayer-funded Medicaid.**

The state of Maryland has a duty to ensure that abortion is safe and must intervene on behalf of women and girls by adopting a protocol and standard of medical care for the use of chemical abortion drugs that must include an obstetrical examination and prescription by a licensed obstetrician.

#### **Maryland Abortion Care Access Act**

In 2022, the Maryland General Assembly repealed the final safeguard for women by enacting the Abortion Care Access Act, making it legal for non-physicians (**including any certified pharmacist**) to provide abortions and forcing taxpayers to pay to train abortion providers. The Act established the Abortion Clinical Care Training Program in the Maryland Department of Health (the Department), renamed as the Abortion and Reproductive Clinical Health Program, and established the Abortion Care Clinical Training Program Fund. In 2025, the State gave at least \$10.6 million in grants to abortion training providers.

#### **Bill Language We Oppose**

This bill would allow pharmacists, and possibly pharmacist technicians and pharmacy students, to “treat” for pregnancy. As written, it would allow these individuals to **prescribe** both prenatal vitamins and lethal chemical abortion drugs.

Under the **Clinical Laboratory Improvement Amendments of 1988 (CLIA)**, home pregnancy tests are commonly considered “waived” tests. “Waived” tests are those cleared by the FDA for home use or those that utilize methodologies so simple and accurate that the likelihood of erroneous results is negligible. They also should pose no reasonable risk of harm to the patient if the test is performed incorrectly.

The language we oppose and therefore seek your amendment to remove includes the following:

12–101. (a) In this title the following words have the meanings indicated. (x) (1) “Practice pharmacy” means to engage in any of the following activities:

(XIV) IN ACCORDANCE WITH § 12–515 OF THIS TITLE, **PRESCRIBING DRUGS OR DEVICES, EXCLUDING CONTROLLED SUBSTANCES, THAT ARE PRESCRIBED: 1. IN ACCORDANCE WITH THE PRODUCT’S U.S. FOOD AND DRUG ADMINISTRATION–APPROVED LABELING; AND 2. TO TREAT CONDITIONS THAT: A. DO NOT REQUIRE A NEW DIAGNOSIS; B. ARE MINOR AND GENERALLY SELF–LIMITING; OR C. HAVE A TEST THAT IS USED TO GUIDE DIAGNOSIS OR CLINICAL DECISION MAKING THAT IS CLASSIFIED AS WAIVED UNDER THE FEDERAL CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF 1988;**

**AND**

12–515. 7

B) (1) A PHARMACIST WHO ORDERS, TESTS FOR, SCREENS FOR, OR **TREATS** A HEALTH CONDITION UNDER THIS SECTION MAY USE ANY TEST THAT MAY GUIDE CLINICAL DECISION MAKING THAT IS CLASSIFIED AS **WAIVED UNDER THE FEDERAL CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF 1988**, THE FEDERAL RULES ADOPTED UNDER THE FEDERAL CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF 1988, OR ANY SCREENING PROCEDURE THAT IS ESTABLISHED BY STATEWIDE WRITTEN PROTOCOL.

### **Abortion Drugs Are Not “Safe”**

Chemical abortion drugs are harmful to women’s health, almost always result in the death of a fetal human being, and are often misused due to the reckless deregulation of these drugs by the Food and Drug Administration and State of Maryland. The incidence of abortion coercion and forced ingestion of abortion drugs against a woman’s consent are increasing nationwide as men can now easily order and be prescribed these lethal drugs without sufficient oversight. This bill would put Maryland women at greater risk of harm.

The profit-minded abortion industry claims that chemical abortion is safe and easy. The truth is that chemical abortions are **4 (four) times more dangerous than surgical abortions**, presenting a high risk of hemorrhaging, infection, and even death. While the abortion industry falsely reports complications for only .5% of women, new reports prove that at least 11% of women experience serious complications from abortion pills. **The true risk is 22 times higher than reported.** This is willful medical negligence by the abortion industry and abortion drug manufacturers that would not be tolerated by the State in any other area of “healthcare” practice. This false reporting is meant to keep

women in the dark about the true risks of abortion drugs, denying women their right to give informed consent.

Reducing the credentials of those who may perform or provide abortions, including reimbursing pharmacists who distribute abortion drugs, is increasing the number of preborn children being killed, subjecting more women to injury and death, and straining emergency room providers who must provide emergency interventions for botched abortions as abortion drug providers who routinely deny their customers care for abortion complications. With the indiscriminate distribution of chemical abortion pills, the demand on Emergency Room personnel to deal with botched abortion complications has increased 500%, exacerbating existing medical scarcity and undermining the conscience rights of medical providers. Maryland already has the longest emergency room wait times in the nation.

### **Adopt Reasonable Health and Safety Standards**

Chemical abortions now account for as many as 75% of all abortions. The growing reliance on chemical abortion underscores the need for a state protocol for the use of abortion drugs including informed consent specific to the efficacy, complications and abortion pill reversal therapy. Strong informed consent requirements manifest both a trust in women and a justified concern for their welfare.

Previously, the FDA required that abortion drugs be distributed only under the supervision of a qualified healthcare provider because of the drug's potential for serious complications. A physician's examination was deemed necessary to assess the duration of pregnancy, diagnose ectopic pregnancies, and provide any surgical intervention for failed chemical abortions.

While we oppose all abortion, we strongly recommend that the state of Maryland enact reasonable regulations to protect the health and safety of girls and women by adopting the previous FDA Risk Evaluation and Mitigation Strategies (REMS) safeguards that required that the distribution and use of mifepristone and misoprostol, the drugs commonly used in chemical abortions, and any generic forms of these drugs, to be under the supervision of a licensed physician because of the drugs' potential for serious complications including, but not limited to, uterine hemorrhage, viral infections, pelvic inflammatory disease, loss of fertility and death.

**By authorizing pharmacists to prescribe lethal abortion drugs without oversight by a physician, the State will be putting women's lives at risk and funding the mass destruction of preborn children.** The inevitable harm to women includes underestimation of gestational age may result in higher likelihood of failed abortion. Undetected ectopic pregnancies may rupture leading to life-threatening hemorrhages. Rh negative women may not receive preventative treatment resulting in the body's rejection of future pregnancies. **Men can order and pick up abortion drugs from a pharmacist and administer them to women without their consent.** Catastrophic complications can occur through telabortion, and emergency care may not be readily available in remote or underserved areas. With the remote distribution of chemical abortion drugs, the demand on Emergency Room personnel to deal with abortion complications has increased 500%, increasing medical scarcity and threatening the conscience rights of medical providers. Maryland emergency rooms already have the longest wait times in the nation.

## **Abuse of Abortion Drugs**

The state also is neglecting the fact that as much as 65% of abortions are not by choice, but by coercion. Because of the deregulation of abortion drugs, we are seeing many examples across the nation of individuals being prosecuted for coercing women into ingesting abortion drugs without their knowledge or consent, most often resulting in miscarriage. Potential for misuse and coercion is high when there is no way to verify who is consuming the medication and whether they are doing so willingly. Sex traffickers, incestuous abusers and coercive partners all take advantage of easily available chemical abortion drugs. (See Article:

<https://www.independent.co.uk/news/world/americas/massachusetts-abortion-pill-boyfriend-charged-robert-kawada-b2553243.html> )

## **The Public Opposes Funding for Abortions**

A [2026 Marist poll](#) showed that 54% of Americans, both “pro-life” and “pro-choice” oppose the use of tax dollars to pay for a woman’s abortion. Maryland taxpayers believe that the state only uses public funds for abortions that are deemed “medically necessary” in order to save the life or health of the mother. Taxpayers do not support the use of public funds for elective abortions, which make up the vast majority of abortions committed in Maryland.

Without amendment, this bill could allow additional public funds to be used as corporate welfare for the abortion industry and abortion drug manufacturers, further subsidizing these for-profit businesses and their non-profit partners. This is in direct conflict with the will of 88% of people who prefer funding for programs that protect the lives of both mothers and children.

## **Subsidizing Corporate Abortion**

Abortion is big business in Maryland. Maryland taxpayers subsidize the abortion industry in Maryland through direct Maryland Medicaid reimbursements to abortion providers, through various state grants and contracts, and through pass-through funding in various state programs. Health insurance carriers are required to provide reproductive health coverage to participate with the Maryland Health Choice program. Public departments and programs subsidizing abortion and abortion providers include the Maryland State Department of Education, Maryland Department of Health, Abortion Care and Reproductive Clinical Health Program, Maryland Family Planning Program, Maternal and Child Health Bureau, the Children’s Cabinet, Maryland Council on School Based Health Centers, Maryland Assembly for the Advancement of School Based Health, Community Health Resource Commission, Maryland Children’s Health Program (MCHP) and Maryland Stem Cell Research Fund.

**Public Funding through Maryland Medicaid** – A companion bill introduced this session, HB529/SB244, *Code Revision – Health-Maryland Medical Assistance Program*, already seeks to reimburse pharmacists for prescribing abortion drugs. The *Maryland Medical Assistance Program* and the *Maryland Children’s Health Program* (MCHP) are the two primary programs used for publicly funded reimbursements to abortion providers in Maryland.

According to the Maryland Department of Legislative Services in their *Analysis of the FY2025 Maryland Executive Budget*, Maryland taxpayers, through the Maryland Medical Assistance Program, are being

forced to pay for *elective* abortions. In 2023, taxpayers spent at least \$7.9 million for 12,727 abortions, with **less than 11 of those abortions due to rape, incest or to save the life of the mother.**

Medical Assistance Expenditures on Abortion Language attached to the Medicaid budget since 1979 authorized the use of State funds to pay for abortions under specific circumstances. Specifically, a physician or surgeon was required to certify that, based on his or her professional opinion, the procedure is medically necessary. Similar language was attached to the appropriation for **MCHP** since its advent in fiscal 1999. However, this language was repealed in 2022.

### **Funding restrictions are constitutional**

The Supreme Court of the United States, in *Dobbs v. Jackson Women’s Health* (2022), overturned *Roe v. Wade* (1973) and held that there is no right to abortion found in the Constitution of the United States. As early as 1980 the Supreme Court affirmed in *Harris v. McRae*, that *Roe* had created a limitation on government, not a government funding entitlement. The Court ruled that the government may distinguish between abortion and other procedures in funding decisions -- noting that “*no other procedure involves the purposeful termination of a potential life*”, and held that there is “*no limitation on the authority of a State to make a value judgment favoring childbirth over abortion, and to implement that judgment by the allocation of public funds.*”

**The Maryland General Assembly must put patient safety before abortion politics and profits. For these reasons, we respectfully urge you to issue an unfavorable report on this bill in order to protect women’s health against substandard medical care, dangerous abortion drugs and abortion coercion through forced ingestion. Pharmacists ARE NOT physicians and pregnancy IS NOT a minor condition.**

**We appeal to you to prioritize the state’s interest in human life, healthy pregnancy outcomes and to restore to all people, born and preborn, our natural and Constitutional rights to life, liberty, freedom of speech and religion.**

# **SB 506\_HB 1150\_ Health Occupations - Pharmacists**

Uploaded by: Trudy Tibbals

Position: UNF

**SB 506/HB 1150**: Health Occupations - Pharmacists - Minor Conditions and HIV Prevention and Treatment: Please vote **TO OPPOSE** this bill.

Dear Finance and Health Committees:

I am writing to respectfully **oppose SB 506 /HB 1150**, concerning *Health Occupations – Pharmacists – Minor Conditions and HIV Prevention and Treatment*.

While pharmacists play a valuable and respected role in our healthcare system, this bill would require them to take on responsibilities that are traditionally—and appropriately—within the scope of a licensed physician. **Pharmacists do not receive the same level of diagnostic training, clinical residency experience, or comprehensive medical education as physicians**, yet this legislation expands their authority in ways that effectively place them in a diagnostic and treatment role.

Physicians complete years of medical school, clinical rotations, and supervised residency training specifically focused on diagnosing complex conditions, recognizing contraindications, managing complications, and coordinating long-term patient care. **Pharmacists**, though highly trained in medication management, **are not trained to conduct full medical evaluations or manage broader underlying health conditions** that may present with similar symptoms.

Allowing pharmacists to independently assess and treat so-called “minor conditions” or manage aspects of HIV prevention and treatment risks **fragmenting patient care**, missing underlying diagnoses, and **weakening continuity between patients and their primary care providers**. **Healthcare decisions should be based on a complete medical history and physical evaluation, not limited interactions in a retail setting.**

**This bill may also blur professional boundaries and create liability and oversight concerns**, placing pharmacists in difficult clinical situations for which their training was not designed. Expanding scope of practice in this manner should not substitute for increasing access to physicians or strengthening primary care infrastructure.

Maryland should prioritize **safe, coordinated, physician-led care**, ensuring that patients receive comprehensive evaluation and continuity of treatment—not a piecemeal expansion of duties that alters long-established standards of medical practice.

For these reasons, I respectfully urge you to **oppose SB 506 /HB 1150**.

Thank you for your time and thoughtful consideration.

Respectfully,  
Trudy Tibbals