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Today I attended a funeral for Jake,* a two-year-old boy who passed away unexpectedly in his sleep on Sunday morning. I canceled my day in clinic, rescheduled my patients, and spent the day with this little boy's family, not only mourning the loss but celebrating the life of their child who had brought so much sunshine and joy into their lives. My heart aches with the parents, understanding the tremendous sense of loss, the birthday parties that won't happen, the Little League baseball or soccer games they won't attend, or graduation they won't see.

My wife and I have known this child's father for over 17 years. He was one of our son's friends and spent many hours at our house playing games and watching movies, going through our pantry and refrigerator looking for snacks and chocolate milk to which he was always welcome. We went to his wedding reception and later to a baby shower for their daughter, Jake's older sister. About nine weeks ago we were excited to hear that they had just welcomed a new baby into their family.

Jake's father shadowed me as a pre-med student, and I was happy to write a letter of recommendation for him to get into medical school. He was nearing the completion of his first year when this tragedy struck.

This whole experience made me reflect on why I chose to be a physician. Why I chose to study hard in college, chose to delay securing employment while my friends were starting into their careers and buying houses, chose to incur massive student loan debt then continue to defer that debt through residency while working 80 to 100-hour weeks earning what a hospital housekeeper makes now.

I chose this profession because I wanted to gain the knowledge and the skills to be a force for good in someone's life, relieve pain and suffering, extend life, and promote wellness. We all have various reasons why we chose to be physicians, and most of us are likely similar in our reasoning.

It is exhilarating to realize that in certain situations, after running a code for example, if I (or another physician) wasn't there at that time, a person would have died. Or less dramatically, it is incredibly rewarding to see a child get back to playing and being happy after an injury or serious illness kept them from those activities. These are but two of the truly great experiences in medicine. Experiences such as these are varied and almost innumerable for all physicians.

As physicians, we are there to help when our patients get sick, sustain injuries or develop chronic diseases. We suture lacerations, reduce and stabilize fractures, perform procedures, prescribe meds and recommend lifestyle changes to better our patients' lives through improved health. We also show compassion and respect, giving our patients dignity and hope deserved by all people, regardless of economic or social status.

However, despite our best efforts, sometimes our patients pass away sooner than they should. In those instances, we mourn with the family, and often carry the added burden of responsibility because it is our job, our professional duty to not let that happen. My heart aches not only for Jake's family but for the Pediatrician who on Saturday night told them to bring Jake in on Monday morning. After hearing the parents recount the story of Jake's just finishing an antibiotic for an ear infection, how he was acting and the events of the previous week, as a pediatrician, I don't know that I would have done anything differently.

Jake's small family moved across the country so that his dad could attend medical school. Like them, many of us left our homes and family members and moved away to follow our passion and pursue an education in medicine at great personal and financial expense. We do this out of a love for medicine and a desire to serve. (If someone is doing it for the money, most likely they'll be pretty disappointed!)

It's easy to get caught up in the many frustrations we face almost daily including dealing with EHRs and administrators, increasing governmental regulations and bureaucrats telling us how to do our jobs, long hours and scheduling issues – all of which are just the tip of the iceberg. But when I see a young woman at a social event whom I know almost died from meningitis at 4 months old, or when I see a young man playing baseball whom I know had a brain tumor resected, I remember why I chose to be a physician. And I love it!

*Not his real name
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This was the second legislative session during the Covid-19 pandemic, but there were few indications at the Capitol that there was still a pandemic going on. Live remote access to committee hearings over Zoom continued. And there still were no green slips and blue slips we used to write on and send to Representatives and Senators on the floor of their chambers to communicate with them and let them know we wanted to meet with them. And just the same as last year, texts and emails were the main way to contact legislators and their interns. On the other hand, most meetings were held in person, occasionally with some people joining remotely. And it was as helpful as ever to be able to talk directly with legislators and stakeholders about issues and bills.

The members of the 2022 legislature were mostly the same as last year. UMA physicians and Representatives Stewart Barlow, MD (a UMA past president, ENT, Fruit Heights), Ray Ward, MD (family practice, Bountiful), Suzanne Harrison, MD, (anesthesiologist, Draper), and Rosemary Lesser, MD (retired Ob-Gyn, Ogden) continued their service in the House. UMA physician and Senator Michael Kennedy, MD, JD, (family practice, Alpine/Lindon) continued as the sole physician legislator in the Senate. Several physician spouses continued serving in the legislature as well: Rep. Gay Lynn Bennion (James Bennion, MD, occupational medicine, SLC VAMC), Rep. Doug Owens (Cynthia Owens, MD, peds, SLC), Rep. Jennifer Dailey-Provost (Scott Provost, MD, anesthesia, SLC), and Sen. Keith Grover (Julie Grover, MD, Ob/Gyn, Provo). Many other legislators are family members or friends of medicine.

By the end of the session, the Legislature passed 513 bills, just a few more than last year. And this year, again included many bills significant to medicine. This session and last session seemed to have more than the usual number of bills UMA had to fight against. To help us in the fight, UMA emailed Calls to Action to enlist your voice and your expertise to help legislators understand some of these very difficult bills. Legislators receive thousands of emails from many constituents and groups asking them to vote a certain way on bills. Many of these emails are on issues of importance to physicians and patients but are from the
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other side of the issue. This is especially true when mid-level or alternate providers want to expand their scope of practice. Many Utah legislators want to de-regulate businesses and like the sound of allowing healthcare providers to “practice at the top of their license.” But they often don’t realize that this usually means doing something the provider has very little, if any training in – much less than an MD or DO. Your UMA legislative team strives to inform and influence the legislators, but your voice to your representatives (let them know you are their constituent and include your home address) is often critical to their views on these issues.

Legislative hearings and votes frequently happen with very little advance notice; a vote may be scheduled for the next day. Bills may pop up one day and be in committee within 24 hours. As a result, it’s very important for physicians to respond promptly to these calls. When physicians respond to a Call to Action, legislators know that physicians are concerned and watching the actions of their own representatives. As a constituent you can have a very powerful influence.

Your messages can mean even more to legislators if you get to know them and support them in their elections. You can develop a good relationship with them over time and they will listen to you when these important issues come up. Get involved in the political process by serving as a county or state party delegate, serving as an officer in your precinct or in your political party, contributing money, sponsoring fundraising events at your home, or talking with delegates, friends, and neighbors about supporting these candidates. When you support them and get to know them, they will listen more to what you have to say and support you in your asks.

All but three of the legislators mentioned above are running for reelection this year: Sens. Kennedy and Grover are not up for reelection until 2024 and Suzanne Harrison has filed to run for Salt Lake County Council instead. She was redistricted out of her district. Any of them would appreciate your support. Rosemary Lesser will be facing a particularly tough election battle.

We greatly appreciate all of you who do run for office, contribute money to UMPAC, and participate in the political process. Supporting good candidates requires money. Contributing to UMPAC helps us help those candidates who are friendly to the House of Medicine.

The bills that were particularly important to physicians and patients are discussed below.

UMA BILL: UTAH MEDICAL CANDOR ACT

HB 344 Utah Medical Candor Act (Rep. Merrill Nelson and Sen. Michael Kennedy, MD); and
HJR 13 Joint Resolution Amending Court Rules of Procedure and Evidence to Address the Medical Candor Process (Rep. Merrill Nelson and Sen. Michael Kennedy, MD)

This bill and resolution create a voluntary, confidential, non-discoverable, early resolution process for adverse medical events called the Utah Medical Candor process. This legislation creates a voluntary, protected process that a healthcare provider can initiate and invite a patient to participate in. If the patient agrees, the healthcare provider can create and share information about the adverse event to help the patient understand what happened, why, and what will be done to prevent future problems. The healthcare provider working with their malpractice insurer can also offer compensation to the patient if appropriate. The discussions and offer will be legally protected from being used against the healthcare provider in case

UMA President Noel Nye, DO, (right) made all feel welcome at Doctors’ Day at the Legislature
the event doesn’t get fully resolved and the patient later goes to court. With support and advice from Intermountain Healthcare and COPIC, UMA wrote, ran, and negotiated this legislation after reaching an agreement with the plaintiff attorneys (Utah Association for Justice), and this UMA bill PASSED. See separate article on page 20 with the details of the new process.

UMA BILL: PRESCRIBER DISPENSING

Resolution A3 passed by the UMA House of Delegates last fall directed UMA to “advocate for legislation and regulations allowing physicians to dispense and bill for routine medications in their practice setting.” Consequently, Representative Ray Ward asked UMA if we wanted him to run this bill and we said yes. This bill allows physicians to dispense certain prepackaged legend drugs to their patients they prescribe the drugs to. Other prescribers are included as well. The prescribers’ current licenses will enable them to dispense if the office or clinic where they practice gets licensed by DOPL as a licensed dispensing practice. The practice will designate a dispensing practitioner to be responsible for compliance with the rules, which will be similar to the requirements for pharmacies dispensing the same drugs. The providers themselves do not have to be licensed as a dispensing practitioner. UMA negotiated with stakeholders (mainly pharmacist and pharmacy representatives) that had concerns about the bill. This UMA bill PASSED. See separate article on page 18 about how physicians will be able to dispense under this new law.

SCOPe OF PRACTICE BILLS BY Alternate PROVIDERS

Naturopaths currently prescribe from a formulary list developed by a formulary committee. Their main objective in this bill was to get rid of the formulary. However, they began by seeking overly broad prescriptive authority. UMA negotiated with the sponsor of the bill and naturopaths before they even introduced their bill and got the bill narrowed down before agreeing to not oppose it. The final version of the bill allows naturopaths to prescribe non-controlled drugs that are not on a list of nine excluded categories. These are drugs that they already could prescribe. And they will continue to be able to prescribe testosterone, as they can under current law. This is the only controlled substance they can prescribe. If the FDA develops new drug categories in the future, DOPL will consult with the physicians licensing board and the naturopath board before deciding whether to allow naturopaths to prescribe in those categories. After significant opposition and narrowing of the bill by UMA, UMA withdrew opposition and was neutral on the bill that PASSED.

UMA joined the Utah Ophthalmology Society (UOS) in strongly opposing this proposal for a major expansion of optometrists’ scope of practice. As introduced, the bill would have allowed optometrists to perform any surgery on the eye, including laser surgery, with a few listed exceptions (e.g., retina laser, LASIK, and cataracts). After lengthy discussions, the optometrists changed the bill to list the laser surgeries they most wanted to do, while continuing to remove the current statutory restriction on non-laser surgery. Although the bill would have required some training for optometrists performing laser surgery, UMA and UOS continued in
strong opposition. It was passed by the House, but the sponsor asked the Senate committee not to hear the bill because he knew it would be voted down. So, it was never heard by the Senate and the bill opposed by UOS and UMA FAILED. However, the optometrists seem to be intent on being able to do surgery and, as in other states, are most likely to continue to pursue legislation. The new optometrist school in Provo is also pushing very hard for these procedures for optometrist. If they can pass something like this, they can teach in their school and claim to be a school that offers more than others and a state that offers expansion services to optometrist. This bill is all about money to both the school and the optometrist.

SB 84 Chiropractic Practice Amendments (Sen. Michael McKell and Rep. Karen Peterson)
Current law allowed chiropractors to use x-ray imaging for diagnostic purposes only. They claimed that they already order advanced imaging such as MRIs, Ultrasounds and CTs. They introduced a bill that would have let them “use advanced imaging.” UMA was not happy with that language and after checking into what they could already do, we changed the language to say they could order MRIs, Ultrasounds and CT scans for diagnostic purposes (related to their work). This language means they CANNOT do these procedures themselves or interpret them. With these changes UMA withdrew its opposition, was neutral on the bill, and it PASSED.

Unlike any other interstate compact that Utah has entered into (8-10 of them), the APRN interstate licensure compact would have overridden state law regarding prescribing authority, supervision, and collaboration. This would have changed Utah scope and collaboration laws for APRNs, which includes nurse practitioners, psychiatric nurses, certified registered nurse anesthetists, and certified nurse midwives. After talking with the sponsor and explaining the unprecedented nature of this compact, the sponsor agreed that it should not change state law. After extensive discussions with DOPL, UMA got the sponsor to include language stating, “Notwithstanding any provision in [the compact], [the compact] does not supersede state law related to an individual’s scope of practice under this title.” And the director of DOPL has stated that this means that the compact does not change state law regarding scope of practice, including supervision, prescriptive authority, and other elements. With this and other changes, UMA changed its position from opposition to neutral, and the bill PASSED.

UMA PRIORITY BILLS

UMA worked with the sponsor to pass this bill providing money to expand existing medical residency programs and to begin new ones, including a new forensic psychiatric fellowship in the state to specifically help out the jails with psychiatric needs. The Medical Education Council will receive $5 million in fiscal year 2023 and $2 million ongoing to provide grants to expand and create these residencies. This bill includes language, approved by the UMA, that requires residency programs under these grants to “agree to implement selection processes for a residency position that treat applicants from D.O. programs and applicants from M.D. programs equally.” This bill also includes language which clarifies that existing residency programs funded by state grants are also to treat MDs and DOs equally. PASSED

Continued on page 12...
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SB 185 Children’s Health Coverage Amendments (Sen. Luz Escamilla and Rep. Mike Schultz)
As directed in UMA HOD 2021 Resolution A1, Expanding Health Insurance Coverage for Utah Children, UMA supported the sponsor of this bill to expand eligibility for the Medicaid and Children’s Health Insurance Program to include all Utah children, regardless of legal status. This would have cost the state $9 million in ongoing funding, which the Legislature was not willing to do this year. These types of bills are very controversial because of the immigration status. If the bill did not cover illegal aliens, it most likely would have passed. It passed the Senate but was never considered by the House. UMA will continue to advocate for coverage for all children and will work with Legislators to accomplish this. FAILED

UMA SUPPORTED BILLS

SB 121 Anesthesiologist Assistant Licensing Act (Sen. Michael McKell and Rep. Mike Schultz)
Physician assistants (PAs) are not trained in providing anesthesia care, so anesthesiologists assistant (AA) training was set up years ago. They are similar to PAs but specifically trained in anesthesia care. They have not been licensed in Utah so they could not work here yet. Anesthesiologists proposed this bill to license AAs in Utah. About 16 other states license AAs. AAs practice under the supervision of an anesthesiologist. This bill has been proposed a number of times but was always opposed by CRNAs and their supporters. With the support of UMA, the Utah Society of Anesthesiologists decided to run the bill again this year. With much hard work and some compromises, it PASSED.

SB 136 Air Quality Policy Amendments (Sen. Luz Escamilla and Rep. Stephen Handy); and
HB 443 Utah Inland Port Authority Amendments (Rep. Mike Schultz and Sen. Jerry Stevenson)
UMA HOD 2021 Resolution B2, Negative Health Impacts of the Utah Inland Port, directed UMA to advocate for a human health risk assessment as a part of the Inland Port project. UMA worked on and supported these two bills to advocate for the human health risk assessment.

SB 136 directs the Department of Environmental Quality to study and make recommendations on a program to reduce diesel emissions, including potential mitigation projects that could be implemented by the Utah Inland Port Authority to reduce emissions in and around the port. This bill was originally supposed to include the inland port environmental human health risk assessment. However, this bill and HB 443 were extensively negotiated by stakeholders (the final substitute was sponsored by Rep. Mike Schultz) and that provision was not accepted. This bill still will help address and reduce pollution by the port, so UMA supported it and it PASSED.

HB 443 made major changes to the structure and function of the Inland Port. The sponsor worked extensively with the Salt Lake City mayor to address concerns about the Inland Port. One of the changes directs the Port to spend 40% of the tax revenue it receives to mitigate the environmental impacts of the port. An additional 40% is required to be spent on other mitigation projects, such as an environmental impact assessment. When UMA discussed the environmental human health risk assessment with the sponsor, he said that we could push for that to be done under the environmental impact assessment. UMA supported this bill and it PASSED.

A year ago, Rep. Dailey-Provost ran a bill (HB 102) to require jails to provide prisoners with the option of continuing certain prescribed contraceptives. To get that bill passed, the sponsor agreed to a provision that would automatically repeal the bill in June 2022. This bill repeals that sunset date and adds patch and vaginal ring to the types of prescribed contraceptives covered. UMA supported the bill. PASSED

HB 207 Inmate Treatment Amendments (Rep. Christine Watkins)
This bill would have required jails to allow prisoners to continue a medication assisted treatment plan if the prisoner was an active client prior to arrest. UMA supported this bill, but the House Law Enforcement Committee never considered it. FAILED

This bill directs Medicaid to reimburse a healthcare provider for a Medicaid patient’s participation in the National Diabetes Prevention Program developed by the CDC. UMA supported this bill for its potential to improve the health of the patients involved while reducing cost to the government. PASSED

HB 220 Pregnancy and Postpartum Medicaid Coverage Amendments (Rep. Rosemary Lesser, MD)
This bill would have directed Utah Medicaid to seek authorization to expand eligibility for Medicaid to pregnant
women under 200% of the federal poverty level and continue eligibility for 14 months after the end of pregnancy. Although UMA supported this bill, it had a $14 million fiscal note and was never considered by the House Business and Labor committee. FAILED

HB 384 Anesthesia and Sedation Amendments (Rep. Suzanne Harrison, MD, and Sen. Michael Kennedy, MD)
In 2017, then-Rep. Kennedy passed HB 142 to create a database of adverse events from anesthesia and sedation in an out-patient setting. Following the report issued last summer from the information gathered in that database, this bill provides for additional information to be collected in the database, requires the data to be reported based on the level of sedation, directs the Department of Health and Human Services to request information for the database, and establishes additional safety parameters when a patient undergoes anesthesia or sedation outside of a hospital, including having a person with ACLS or PALS training to be present. The bill also provides whistleblower protections for employees who notify DOPL of violations of the law. UMA worked with the sponsor of the bill in drafting the language and supported the bill. PASSED

MEDICAL CANNABIS BILLS

SB 190 Medical Cannabis Act Amendments (Sen. Evan Vickers and Rep. Joel Ferry)
Every year since the enactment of the state’s medical cannabis program in 2018 it has seen multiple amending bills, some refining the program and others seeking to change and expand it. This 100-page bill makes numerous changes, small and large, in the program. One of the most notable changes is adding psychoactive THC analogs in the total THC level. This level determines whether a product is

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regulated under the medical cannabis laws or the hemp laws. The bill requires retailers of hemp or cannabinoid products to include a statement that the product is not cannabis or medical cannabis. Since the number of Utah testing labs has been low, it allows the Department of Agriculture to partner with research universities in the state to provide cannabis testing services. As is true of other medicines, it adds aerosol as an approved dosage form. And it limits liquid suspensions to 30 ml. UMA worked with the sponsor in preparing the wording of the bill and UMA supported it. PASSED

SB 195 Medical Cannabis Access Amendments (Sen. Luz Escamilla and Rep. Raymond Ward, MD)
This is a long medical cannabis bill with provisions promoted by the cannabis user community. UMA opposed the provision adding acute pain as a qualifying condition for a 30-day supply of medical cannabis. Unfortunately, that provision was added by Dr. Ward (the House sponsor) and with him pushing that portion of the bill, UMA had a hard time arguing against it. Dr. Ward argued that cannabis is safer than opioids for acute pain, especially for some patients. UMA pointed out that studies do not bear out the efficacy of cannabis for acute pain. UMA’s opposition to this was overridden by concerns about opioids. UMA was also concerned about the requirement for hospice programs to provide a qualified medical provider to treat its patients. UMA supports access to qualified medical providers but opposes mandating their employment. UMA supported the provisions requiring healthcare providers to review a patient’s history of substance or opioid use disorder before recommending medical cannabis and the provision allowing caregiver facilities to receive a shipment of medical cannabis on behalf of a patient. UMA was also concerned about legislating that residency programs be required to educate on medical cannabis. This should not be dictated by the legislature. UMA and many others were concerned about allowing a student to have medical cannabis on school grounds and the provision was removed. PASSED

SB 46 Medical Cannabis Patient Protection Amendments (Sen. Daniel Thatcher and Rep. Joel Ferry)
This bill arose from the cases of municipal safety employees who were restricted in or released from their employment because they had medical cannabis cards – not based on using the drug. After some discussion with UMA and suggested language by UMA, the municipalities recognized that an employee’s status as a medical cannabis card holder should be treated in the same way an employee’s controlled-substance prescription is treated. This bill clarifies those provisions of the law. UMA did not take a position on the final bill. PASSED

OTHER BILLS UMA OPPOSED, THEN WORKED TO CHANGE OR DEFEAT

HB 60 Vaccine Passport Amendments (Rep. Walt Brooks and Sen. Michael Kennedy, MD)
Through its various iterations, this bill would have prohibited places of public accommodation, governmental entities, and employers from taking action based on an individual’s immunity status. UMA was very concerned about the public health implications and prohibiting individual businesses from making the decision on vaccines in their business and opposed the bill along with the business community. After much controversy, six substitutes, and passing in the House, this bill died in the Senate. Unfortunately, some of what the bill would have done was taken over by HB 63 (see the next bill). FAILED

This bill also went through several
iterations and changes. Basically, the bill provides an exemption from vaccine requirements for those who get a letter from their physician or other primary care provider stating they were previously infected by Covid-19. UMA opposed the bill as originally drafted because it would have exempted employees from employers’ vaccine requirements, even if the employers are healthcare providers. The final version excludes an employer if reassignment of the employee is not practical and the employer “establishes a nexus between the [vaccine] requirement and the employee’s assigned duties and responsibilities; or the employer identifies an external requirement for vaccination that is not imposed by the employer and is related to the employee’s duties and responsibilities.” This will allow healthcare providers’ offices that are subject to CMS requirements to continue to require vaccination. PASSED

H.B. 400 Associate Physician License Amendments (Rep. Stewart Barlow, MD, and Sen. Michael Kennedy, MD) This bill modifies specific supervision requirements and allows the associate physician to practice in all areas and all specialties. Initially, this bill would have enabled a graduate to continue as an Associate Physician indefinitely, but UMA worked with the sponsor and that proposal was withdrawn. PASSED

HB 127 Medical Practice Amendments (Rep. Rex Shipp) Although the sponsor’s stated intent was to prohibit a physician from performing a transgender procedure on a minor, this bill would have made it a criminal offense to perform many routine and medically indicated procedures for minors. UMA opposed this bill and explained our opposition to the sponsor and also some of the unintended consequences it would have. The bill was blocked in rules committee and never came out, so it FAILED.

HB 116 Medical Billing Amendments (Rep. Mike Winder and Sen. Luz Escamilla) A constituent of the sponsor complained that they had received a medical bill more than a year after the care had been provided, so he ran this bill. Although UMA pointed out that there are already prompt pay and billing laws, the sponsor insisted on moving forward with a bill, so UMA worked with him to try to avoid unintended consequences. In the end, although the bill was much improved from where it began, it still stirred up opposition from all interested parties including the Chair of the Senate Committee (Senator Mike Kennedy, MD). The bill was held in committee, so it eventually FAILED.

HB 109 Death Certificate Amendments (Rep. Stephen Handy) Before introducing this bill, the sponsor approached UMA about running a bill to have healthcare providers who declare a death indicate whether air pollution was a contributing factor. UMA explained that we wouldn’t be ok to require providers to make this declaration, but would be ok with the bill if it were simply an option, which is already the case. The bill never made it out of the Rules committee, so it FAILED.

HB 104 Telehealth Amendments (Rep. James Dunnigan) Under the guise of improving telehealth, this bill would have authorized a broad new use of telehealth to enable prescribing a range of legend drugs to individuals who become patients through only asynchronous interaction with the prescriber through a branching questionnaire. This bill would not help physicians, just online companies that provide certain drugs. UMA discussed the bill with the sponsor and voiced strong opposition as did others. The sponsor decided against moving the bill forward this year. FAILED

HB 283 Mental Health Professional Licensing Amendments (Rep. Norman Thurston and Sen. Todd Weiler) UMA opposed this bill though it did not affect physicians. All the other mental health professions also opposed, because it lowered the number of minimum hours of clinical social work training and clinical mental health counselor training from 4,000 to 3,000. But the legislature likes to reduce regulatory requirements, and this is the standard in other states, so it PASSED.

HB 365 Telehealth Amendments (Rep. James Dunnigan) Under the guise of improving telehealth, this bill would have authorized a broad new use of telehealth to enable prescribing a range of legend drugs to individuals who become patients through only asynchronous interaction with the prescriber through a branching questionnaire. This bill would not help physicians, just online companies that provide certain drugs. UMA discussed the bill with the sponsor and voiced strong opposition as did others. The sponsor decided against moving the bill forward this year. FAILED
develop a standard form for releasing health records to a patient, patient’s representative, or other authorized party that is compliant with HIPAA and 42 CFR Part 2 (confidentiality of substance abuse disorder patient records). Healthcare providers and their third-party contractors will be required to accept the form by January 1, 2023. UMA supported this bill to simplify and standardize the form for releasing medical records. PASSED

SB 194 Medical Rationing Amendments (Sen. Lincoln Fillmore and Rep. Brady Brammer)
The current law does not authorize the Department of Health and Human Services to develop crisis standards of care. This bill originally required the Department to inform the Legislature and associations representing hospitals or healthcare professionals, if they would be affected, if the department adopted, required, or recommended rationing criteria for scarce healthcare resources. UMA was concerned about the Legislature’s intervention in this process. The final version of the bill clarified that the bill only applies to resources the federal government has allocated to the state to distribute. PASSED

OTHER UMA SUPPORTED BILLS

This bill expands the Medicaid program for medically complex children on an ongoing basis to include 130 more than those served in 2022 and made some minor modifications to the program. UMA supported this bill. PASSED

This bill directs the Department of Health and Human Services to medically-accurate visual images of what is happening to the unborn child at each step of each type of abortion procedure; (ii) a description of the gestational ages at which each type of abortion procedure is normally used.” It also would have imposed a $50,000 fine per occurrence on a physician who violated the special informed consent requirements for an abortion. UMA opposed this bill. The bill did not get out of rules. FAILED

HB 228 Health Information Sharing Act
This bill would have directed the Department of Public Safety to set up a database for information on individuals diagnosed with mental illness, behavioral disorders, or neurological or developmental disorders. The information would be available only to authorized public safety personnel including dispatchers, but not to the public. Physicians would be required to provide information about the database to eligible patients. Concerned about the many problems with this database and process, UMA opposed the proposed language in the bill and spoke to the sponsor, who said he was starting a conversation but wouldn’t push the bill through this session. FAILED

This bill would have created a grant program to enable a social worker to respond with a peace officer to an incident involving illegal or unsafe conduct where mental health might be a factor. UMA supported the bill as a way to improve interaction of law enforcement with those with mental health issues. A very significant fiscal note was not funded, so the bill FAILED.

OTHER BILLS UMA FOLLOWED OR WORKED ON

HB 316 Medical Assistant Amendments (Rep. Douglas Welton and Sen. Michael Kennedy, MD)
The bill was requested by Intermountain Healthcare to allow medical assistants to be more involved in giving vaccinations. The bill authorizes medical assistants to administer vaccines under the general supervision of a physician instead of indirect supervision which is the supervision level they had before the bill. It does not expand their care under indirect supervision to other areas of medical assistant practice. After discussing the bill with Intermountain and the sponsor, UMA was neutral on it. PASSED

This bill establishes that a member of a medical panel appointed under Workers’ Compensation is considered a state employee for purposes of indemnification under the Utah Governmental Immunity Act, while acting as a member of the panel. This clarifies an important legal protection for physicians serving on Workers’ Compensation medical panels. UMA supported the bill. PASSED

HCR 11 Concurrent Resolution Honoring the Work of Primary Care Providers to the Citizens of Utah (Rep. Jennifer Dailey-Provost and Sen. Michael Kennedy, MD)
UMA supported this resolution which acknowledges and expresses gratitude for the ongoing work of primary care providers to maintain the health of Utah citizens. PASSED

SB 228 Health Information Sharing Act
This bill would have directed the Department of Public Safety to set up a database for information on individuals diagnosed with mental illness, behavioral disorders, or neurological or developmental disorders. The information would be available only to authorized public safety personnel including dispatchers, but not to the public. Physicians would be required to provide information about the database to eligible patients. Concerned about the many problems with this database and process, UMA opposed the proposed language in the bill and spoke to the sponsor, who said he was starting a conversation but wouldn’t push the bill through this session. FAILED
CONCLUSION

Thank you to UMA leaders, staff, and involved members for all you do to support UMA’s legislative efforts. With your help UMA had a very good legislative session and was able to accomplish much for Utah’s physicians and patients this year.

We were grateful to be able to hold our Doctor’s Day at the legislature again this year. Many physicians and spouses traveled from around the state to attend the event. They visited the Capitol, learned about the legislative process, and discussed with their legislators important issues for physicians and patients. We greatly appreciate those who took the time to be involved.

Thanks also to the members of the UMA Legislative Committee and Board of Directors for their dedication in reviewing the bills and developing UMA positions. In addition to the bills discussed and explained above, the UMA legislative committee also discussed and took a position or no position on many other bills; in total, almost 200 bills were reviewed this year. UMA members will be able to login to the UMA website and review a more complete list of bills under “Advocacy” once the list is prepared.

We particularly give a special thanks to Jim Antinori, MD, who continues to chair the Legislative Committee, review every bill presented to the legislative committee and thoughtfully present and run the meeting as he has for many years. We would not be nearly as successful without his leadership of the legislative committee.

We encourage all physicians and their spouses to get involved with UMA in the legislative process. We appreciate your continued support.

Note: Unless another effective date is stated in the bill or it is vetoed by the Governor, the legislative changes adopted in the 2022 general session go into effect May 4, 2022.
Starting May 4, 2022, physicians (and nurse practitioners and physician assistants) can dispense certain non-controlled medications and devices from their office under certain circumstances and within certain parameters.

H.B. 301 – Medication Dispenser Amendments passed in the just concluded 2022 Utah legislative session. This bill, which became law when the Governor signed it on March 24, 2022, allows physicians to dispense if they practice at a licensed dispensing practice (which can be their clinic or office as long as it is licensed to dispense), if they are prescribing and dispensing that prescription for their own patient for an acute condition for which they saw the patient the same day as they are dispensing to the patient. Here are the details of the new law.

WHO CAN DISPENSE AND UNDER WHAT CIRCUMSTANCES?
A licensed DO or MD who practices at a licensed dispensing practice. Also, APRNs and PAs.

WHAT IS A DISPENSING PRACTICE?
A dispensing practice is a health care practice that has submitted a written application to DOPL, has paid a fee determined by DOPL, and has designated at least one dispensing practitioner who is responsible for all activities of the licensed dispensing practice related to the dispensing of drugs.

The responsible dispensing practitioner shall:
1. Be currently professionally licensed to prescribe and administer drugs;
2. Practice at the licensed dispensing practice;
3. Accept responsibility for the legal compliance of the practice’s dispensing operation; and
4. Be personally in charge of the practice’s dispensing operation.

The dispensing practice shall:
1. Maintain a license for each location of the licensed dispensing practice;
2. Renew its license for dispensing every two years;
3. Report in writing to DOPL no less than 10 days before: a) a permanent closure of the licensed dispensing practice; b) a change of the name or ownership of the dispensing practice; c) a change of location of the licensed dispensing practice; and d) any other matter that DOPL requires to be reported;
4. Report in writing to DOPL if they have a theft of a drug or any disaster, accident or emergency that may affect the purity of labeling of a drug, medication, device, or other material used in the diagnosis or treatment for injury, illness, or disease immediately upon the occurrence;
5. Keep a copy of reporting documentation for two years; and
6. Follow rules established by DOPL regarding security, labeling, storage, supervision, inventory control, and patient counseling, and anything else DOPL establishes through rule.

DOPL will establish rules for conducting audits and inspections of licensed dispensing practices.

WHAT CAN BE DISPENSED BY A DISPENSING PRACTITIONER?
A drug pre-packaged by the drug manufacturer, a pharmaceutical wholesaler or distributor, or a licensed pharmacy in a fixed quantity. The drug must be for the dispensing practitioner’s patient, for a condition that is not expected to last longer than 30 days, and
for which the patient has been evaluated on the same day on which the drug is dispensed. The dispensing practitioner may NOT dispense a controlled substance, gabapentin (which is reported to the controlled substance database in Utah), a drug or class of drugs prohibited by DOPL, or a supply of a drug that exceeds 30 days.

That is not to say that a dispensing practitioner cannot prescribe and dispense the same medicine if they later see the patient again.

**WHAT MUST BE DISCLOSED TO THE PATIENT WHEN DISPENSING**
The dispensing practitioner must disclose:

1. Verbally and in writing that the patient is not required to fill the prescription through the dispensing practitioner and that the patient has the right to have the prescription filled through a pharmacy; and

2. If the patient will be responsible to pay cash for the drug, disclose that the patient will be required to pay cash for the drug and the amount that the patient will be charged by the practice for the drug.

A dispensing practitioner may NOT make a claim against workers’ compensation or automobile insurance for the drug dispensed unless the dispensing practitioner is contracted with a pharmacy network established by the claim payor.

**WHAT IS NOT REQUIRED UNDER THIS LAW OR WHAT THIS LAW DOES NOT CHANGE**
A physician is NOT required to dispense.

This law does not apply to:

1. A prescriber dispensing under the Dispensing Medical Practitioner law;

2. A physician dispensing a drug sample as allowed by current law (Utah Code 58-1-501.3 or 58-17b-610);

3. A physician dispensing a prescription drug or device that is needed for a patient’s immediate need in an emergency department in accordance with Utah Code 58-17b-610.5; or

4. A physician who dispenses a drug in an emergency (as defined by the division in rule).

The new law does NOT address insurance payment for dispensing other than as stated above.
In Utah there is a new opportunity for healthcare providers to resolve adverse events with patients in a way that invites open communication, preserves the provider-patient relationship, and contributes to patient safety improvement. It’s a legally protected, early-resolution process called medical candor. It is a voluntary process for the healthcare provider and the patient.

In its 2022 session just concluded, the Utah Legislature passed HB 344, Utah Medical Candor Act, and HJR 13, Joint Resolution Amending Court Rules of Procedure and Evidence to Address the Medical Candor Process. Sponsored by Rep. Merrill Nelson and Sen. Michael Kennedy, MD, HB 344 sets up the framework and HJR 13 sets up the legal protections for the medical candor process in Utah. Similar laws have been adopted in Colorado, Iowa, Massachusetts, and Oregon.

Any injury or suspected injury associated with healthcare is eligible for the medical candor process. When a physician or other healthcare provider or facility recognizes that an adverse event has occurred, the provider or facility should discuss the matter with their professional liability carrier. The insurer should be involved in the candor process with the provider. The provider then investigates the adverse event to determine if the provider wants to invite the patient to participate in an open discussion about what happened, why, and what can be done to prevent similar issues in the future. These are things a patient often wants to understand but they are rarely and poorly communicated, if at all, in the current legal process. Often these are also things that the provider would like to share with the patient but is warned against doing so (outside the candor process). If the provider decides to proceed, the provider sends the patient a written notice which must include details (spelled out in the law) about the patient’s rights, including the opportunity to hire an attorney to help the patient in the process, and the patient’s responsibilities under the candor law.

If other healthcare providers were involved in the adverse event, they need to be notified of the investigation in a timely manner and invited to participate in the process, but they can choose to participate or not. Similarly, a patient can invite others to be involved on the patient’s behalf, whether that’s an attorney, relative, or friend. All who participate, including the patient, must agree to keep confidential the information that is disclosed in the candor process, unless it is information, like the medical record, that was not prepared for or during the candor process or subject to another protection.

There are special considerations for a healthcare provider involved in the adverse event that does not choose to participate in the candor process. The providers that participate may give the patient information about the care provided by the non-participating provider only from the medical record. The participating providers may not characterize, describe, or evaluate healthcare provided or not provided by a non-participating provider, nor attribute fault or responsibility to them. This will need to be explained so the patient understands what can be said and not said.

The provider and the liability insurer can also determine whether to offer compensation to the patient. If an offer is made, it needs to be provided in writing to the patient and it needs to advise the patient of the patient’s right to seek legal counsel at the patient’s expense. If the patient agrees to the offer, the patient will likely sign documents that release the provider from liability. This would prevent the patient from being able later
to bring a lawsuit. The patient, of course, can choose not to accept the offer.

As long as the patient (or patient’s attorney) does not present a written claim to the provider, the patient can be compensated without the compensation having to be reported to the National Practitioner Data Bank. If a written claim is made, the provider may still proceed with the candor process (assuming the patient is willing) but any compensation will have to be reported.

One of the key elements of the new law is the legal protection of the information “created for or during” the candor process. Without this protection, it is accurate to say “anything you say can and will be used against you in a court of law”; not only what you say to the patient, but any discussions you have with other people involved with the patient’s care, unless it is part of peer review or care review analysis or under another privilege. To facilitate candid discussion, the law now *protects any information, communication or material created for the medical candor process or created during the process. The communications and offers of compensation do not constitute an admission of liability. It is all protected from being legally discovered (such as in a document request or legal deposition) or admitted as evidence in court proceedings if the patient is not satisfied through the candor process and later sues the provider.

In other states where this has been implemented, the great majority of incidents that might otherwise have gone to court are resolved earlier and more amicably through the candor process. We hope this new process will similarly benefit the physicians and their patients in Utah as well.

*The medical candor law goes into effect May 4, 2022.
Delta-8 tetrahydrocannabinol, also known as delta-8 THC, is a psychoactive substance found in the Cannabis sativa plant, of which marijuana and hemp are two varieties. Delta-8 THC is one of over 100 cannabinoids produced naturally by the cannabis plant but is not found in significant amounts in the cannabis plant. As a result, concentrated amounts of delta-8 THC are typically manufactured from hemp-derived cannabidiol (CBD).

It is important for consumers to be aware that delta-8 THC products have not been evaluated or approved by the FDA for safe use in any context. They may be marketed in ways that put the public health at risk and should especially be kept out of reach of children and pets.

Here are 5 things you should know about delta-8 THC to keep you and those you care for safe from products that may pose serious health risks:

1. Delta-8 THC products have not been evaluated or approved by the FDA for safe use and may be marketed in ways that put the public health at risk.

The FDA is aware of the growing concerns surrounding delta-8 THC products currently being sold online and in stores. These products have not been evaluated or approved by the FDA for safe use in any context. Some concerns include variability in product formulations and product labeling, other cannabinoid and terpene content, and variable delta-8 THC concentrations. Additionally, some of these products may be labeled simply as “hemp products,” which may mislead consumers who associate "hemp" with "non-psychoactive." Furthermore, the FDA is concerned by the proliferation of products that contain delta-8 THC and are marketed for therapeutic or medical uses, although they have not been approved by the FDA. Selling unapproved products with unsubstantiated therapeutic claims is not only a violation of federal law, but also can put consumers at risk, as these products have not been proven to be safe or effective. This deceptive marketing of unproven treatments raises significant public health concerns because patients and other consumers may use them instead of approved therapies to treat serious and even fatal diseases.

2. The FDA has received adverse event reports involving delta-8 THC-containing products.

From December 2020 through July 2021, the FDA received adverse event reports from both consumers and law enforcement describing 22 patients who consumed delta-8 THC products; of these, 14 presented to a hospital or emergency room for treatment following the ingestion. Of the 22 patients, 19 experienced adverse events after ingesting delta-8 THC-containing food products (e.g., brownies, gummies). Adverse events included vomiting, hallucinations, trouble standing, and loss of consciousness.

National poison control centers received 661 exposure cases of delta-8 THC products between January 2018 and July 31, 2021, 660 of which occurred between January 1, 2021, and July 31, 2021. Of the 661 exposure cases:

- 41% involved unintentional exposure to delta-8 THC and 77% of these unintentional exposures affected pediatric patients less than 18 years of age.
- 39% involved pediatric patients less than 18 years of age.
- 18% required hospitalizations, including children who required intensive care unit (ICU) admission following exposure to these products.

3. Delta-8 THC has psychoactive and intoxicating effects.

Delta-8 THC has psychoactive and intoxicating effects, similar to delta-9 THC (i.e., the component responsible for the “high” people may experience from using cannabis). The FDA is aware of media reports of delta-8 THC products getting consumers “high.” The FDA is also concerned that delta-8 THC products
likely expose consumers to much higher levels of the substance than are naturally occurring in hemp cannabis raw extracts. Thus, historical use of cannabis cannot be relied upon in establishing a level of safety for these products in humans.

4. Delta-8 THC products often involve use of potentially harmful chemicals to create the concentrations of delta-8 THC claimed in the marketplace.

The natural amount of delta-8 THC in hemp is very low, and additional chemicals are needed to convert other cannabinoids in hemp, like CBD, into delta-8 THC (i.e., synthetic conversion). Concerns with this process include:

- Some manufacturers may use potentially unsafe household chemicals to make delta-8 THC through this chemical synthesis process. Additional chemicals may be used to change the color of the final product. The final delta-8 THC product may have potentially harmful by-products (contaminants) due to the chemicals used in the process, and there is uncertainty with respect to other potential contaminants that may be present or produced depending on the composition of the starting raw material. If consumed or inhaled, these chemicals, including some used to make (synthesize) delta-8 THC and the by-products created during synthesis, can be harmful.

- Manufacturing of delta-8 THC products may occur in uncontrolled or unsanitary settings, which may lead to the presence of unsafe contaminants or other potentially harmful substances.

5. Delta-8 THC products should be kept out of the reach of children and pets.

Manufacturers are packaging and labeling these products in ways that may appeal to children (gummies, chocolates, cookies, candies, etc.). These products may be purchased online, as well as at a variety of retailers, including convenience stores and gas stations, where there may not be age limits on who can purchase these products. As discussed above, there have been numerous poison control center alerts involving pediatric patients who were exposed to delta-8 THC-containing products. Additionally, animal poison control centers have indicated a sharp overall increase in accidental exposure of pets to these products. Keep these products out of reach of children and pets.

Why is the FDA notifying the public about delta-8 THC?

A combination of factors has led the FDA to provide consumers with this information. These factors include:

- An uptick in adverse event reports to the FDA and the nation’s poison control centers.

- Marketing, including online marketing of products, that is appealing to children.

- Concerns regarding contamination due to methods of manufacturing that may in some cases be used to produce marketed delta-8 THC products.

The FDA is actively working with federal and state partners to further address the concerns related to these products and monitoring the market for product complaints, adverse events, and other emerging cannabis-derived products of potential concern. The FDA will warn consumers about public health and safety issues and take action, when necessary, when FDA-regulated products violate the law.
Medical professionals typically like to work hard and play hard. Unfortunately, for two years running a global pandemic has swung the pendulum far toward the work hard side. As the health care crisis abates and COVID-19 shifts toward endemic status, work demands may finally ease and allow for physicians to rekindle a pent-up sense of wanderlust. Travel restrictions are already easing and, at some point over the next 12–18 months, the industry is expected to return to and even exceed pre-pandemic levels.

There is no doubt that the events of recent years have had a big impact on how consumers travel. One travel supplier, CarTrawler, conducted a survey recently of travel trends in 2022 among U.S. and U.K. consumers. Here are several of their key findings:

**TRAVELERS ARE GAINING CONFIDENCE**

Despite health and safety concerns, 77% of travelers still experience positive emotions when travelling, comprising 50% excitement, 38% anticipation and 12% happiness. In fact, those that have taken a trip in the past year are almost 2x more confident to fly (with new regulations and cleaning), than those that have not been travelling during that period.

**CONSUMERS PRIORITIZE FLEXIBILITY AND TRANSPARENCY**

Travelers are demanding options, freedoms and clear communication when booking their travel, and they are demonstrating a willingness to pay for it. 73% of consumers are willing to spend more for travel insurance than they did pre-pandemic.

**SUSTAINABILITY IS TRENDING**

Most travelers are environmentally conscious, but increasingly the younger generation is showing more of a willingness to pay more for sustainable options. Almost three-quarters of consumers will now pay more to rent an environmentally friendly car ($22 more on average in the U.S.), and over half would choose an airline that has pledged carbon neutrality.

**SHIFT IN TRAVEL PREFERENCES**

In the last two years, 85% of travelers have gone on road trips. Now, 35% of travelers say that the distance they are willing to drive instead of flying has increased. 49% of respondents are now more likely to drive their own car, 24% are more likely to rent a car, and 22% are more likely to use an airplane for future travels.

**LOYALTY IS KING**

The vast majority of travelers (86%) are enrolled in loyalty programs, mainly for the savings/free bookings. 45% utilize rewards in airlines, 41% in hotels, 35% in credit cards, and 35% in retail. 21% of U.S. travelers list “earning and using loyalty rewards” as a top priority when booking a trip.

To strike a healthy work-life balance for you and your family, travel is likely to appear on your calendar in the near future. We hope you can get out and have some fun. Please be sure to check out exclusive hotel, car rental and entertainment discounted rates through the UMA Travel Discount program on our member benefits webpage, where members save an average of 10-20% on their bookings.
2021 was a very strong year for stocks. The S&P 500 Index was up almost 30%, nearly setting a record for the number of times a new high was reached throughout the year. Many investors are often conflicted about these record-high stock prices; they are pleased to see their investments gain in value but apprehensive that higher prices may somehow foreshadow a dramatic downturn. Financial journalists periodically stoke investors’ concerns by suggesting the laws of physics apply to financial markets—suggesting that “what goes up must come down.” Fortunately, stocks are not subject to the law of gravity. Instead, stocks can be more aptly described as perpetual claim tickets on companies’ earnings and dividends.

Whether at a new high or a new low, today’s share prices reflect investors’ collective judgment of what tomorrow’s earnings and dividends are likely to be—and those of all the tomorrows to come. And stocks should be priced to deliver a positive expected return for the buyer. Otherwise, investors would find other ways to put their hard-earned money to use. Thousands of business managers go to work every day seeking projects that offer profitable returns on capital while providing goods and services people desire. Although some new ideas and the firms behind them don’t work out, history offers evidence that investors around the world can be rewarded for the capital they provide.

As businesses thrive and their stock prices increase, many may find themselves reluctant to make new purchases. The traditional “buy low, sell high” mantra suggests committing funds to stocks at, or near, all-time highs is a surefire recipe for disappointment. However, if stocks are priced to deliver a positive expected return for investors, reaching record highs regularly is the outcome one would expect.

Using month-end data over the 94-year period ending in 2020, the S&P 500 Index produced a new high in ending wealth in more than 30% of monthly observations. Moreover, purchasing stocks at all-time records has, on average, generated similar returns over subsequent one-, three-, and five-year periods when compared to those of a strategy that purchases stocks following a sharp decline.

All this is not to say that there aren’t concerns about the economy and markets. Inflation and interest rates are on the rise, supply chains are constrained, and the various stimulus packages enacted to combat the pandemic-driven downturn are winding down. These issues pose new challenges to financial markets but may also prove the Wall Street adage that stocks “climb a wall of worry.”

For investors who are sitting on the sidelines believing they may have “missed the boat,” here are five different approaches to get back into the market. Imagine hypothetically that you received $12,000 on the first day of every single year for the last decade. In this scenario, you must invest the money in a U.S. stock portfolio—and you can’t take it out of the market. Would it be best to invest the full sum as soon as you get it (strategy #2)? Or

### Average annualized returns for S&P 500 Index after market highs and declines

<table>
<thead>
<tr>
<th></th>
<th>1 year later</th>
<th>3 years later</th>
<th>5 years later</th>
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<tbody>
<tr>
<td>After new market high</td>
<td>13.9%</td>
<td>10.5%</td>
<td>9.9%</td>
</tr>
<tr>
<td>After 20% market decline</td>
<td>11.6%</td>
<td>9.9%</td>
<td>9.6%</td>
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</table>
to invest a little bit at a time (say, $1,000 per month) (strategy #3)? Or should you attempt to invest it on the day the market hits its low point for the year (strategy #1)?

As the chart shows, perhaps unsurprisingly, investing at the lowest point of each year would have yielded the highest ending wealth—$314,890 following the 10-year period. However, studies have shown that perfectly timing the market is virtually impossible, so what proved to be the next best strategy?

Investing the money in one lump sum at the beginning of each January (strategy #2) provided investors with the next best results with an ending wealth of $311,513, a small price to pay for not being able to time the market perfectly.

Investing once per month (strategy #3) may be the most practical and easiest to implement due to pay schedules. This also allows investors to ride out some of the month-to-month volatility by not putting all their money in the market at once.

In contrast, not being invested (strategy #5), and simply leaving the money in cash, yields by far the worst ending wealth—$125,990—of any investment option. Consider strategy #4 compared to strategy #5 — investing your money on the worst days of the market every year is still more favorable than not investing at all. Any decision you make with your money—even choosing not to invest—is an investment decision. By choosing not to invest, you’re risking today’s money having less value in the future due to inflation. Fear of the market should no longer be an excuse not to invest in the market.

Humans are conditioned to think that, after the rise, must come the fall, tempting us to fiddle with our investments. Reaching a new high doesn’t mean that stocks are overvalued or have reached a ceiling. In fact, the data suggest that such signals only exist in our imagination and that our efforts to improve results are just as likely to be counterproductive. Investors should take comfort in knowing that share prices are not fighting the forces of gravity when they increase and have confidence that record highs only tell us the system is working just as we would expect—nothing more.

And, fortunately, you don’t need to time the market to be a good investor. In fact, it’s time in the market, that counts most, and there is no time like the present to get started. If you would like to discuss an investment strategy based on your own long-term goals and objectives, please contact our UMAFS team at questions@umafs.org or 801-747-0800.

### Hypothetical ending wealth after investing $12,000 per year

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Ending Wealth</th>
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<tbody>
<tr>
<td>Investing at annual market low point</td>
<td>$314,890</td>
</tr>
<tr>
<td>Investing on the first day of the year</td>
<td>$311,513</td>
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<tr>
<td>Investing on the first day of each month</td>
<td>$290,026</td>
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<tr>
<td>Investing at annual market high point</td>
<td>$263,875</td>
</tr>
<tr>
<td>Not investing, staying in cash</td>
<td>$125,990</td>
</tr>
</tbody>
</table>

Period ending December 31st, 2021

Note that one year represents a 12-month period ending December 31st.

Assumes an investment of $12,000 per year into a hypothetical S&P 500 Index portfolio with no withdrawals between Jan 1st, 2012 and Dec 31st, 2021.

Source: Russell Investments.

Cash return based on return of $12,000 invested each year in a hypothetical portfolio of 3-month Treasury bills represented by the FTSE Treasury Bill 3-month Index without any withdrawals between Jan 31st, 2012 and Dec 31st, 2021.

Source: Morningstar.

Indexes are unmanaged and cannot be invested in directly. Returns represent past performance, are not a guarantee of future performance, and are not indicative of any specific investment.

Hypothetical analysis provided for illustrative purposes only.
As a premier medical liability insurance carrier, we are committed to being there when you need us. Our physicians and other staff serve as extended members of your team to help answer questions or navigate difficult situations. And when it’s urgent, you have 24/7 access to a physician via our Risk Management hotline. Plus, our legal and HR experts help you tackle other issues as they arise. That’s Value Beyond Coverage.
CME SPOTLIGHT

UPDATED COURSE for 2022

Title: Controlled Substances: Education for the Prescriber (2022)

When: On-demand Webinar
Where: Online at cme.utahmed.org
Provider: UMA Foundation
CME: 3.5 AMA PRA Category 1 Credits™

This education is specifically designed to comply with Utah State Law, which requires health care providers licensed to prescribe controlled substances to complete DOPL-approved continuing education on Schedule II and III controlled substances that are applicable to opioid narcotics, hypnotic depressants, or psychostimulants.

Following this activity, learners should be able to:

- Know existing laws and rules pertaining to prescribing controlled substances;
- Provide patients the care they need to restore and maintain their health;
- Mitigate the burdens of illness, injury and aging, including appropriate prescriptions for controlled substances when indicated;
- Minimize adverse effects of controlled substance use and reduce risks to the public health.
- Know Utah requirements and limitations in recommending medical cannabis.

CME CALENDAR

April 2022
6–9/9 Health Science Leadership Development Program, In-person at various locations, UUCME (71.75)
15 Integrative Primary Care & Substance Use Disorder Treatment ECHO, Online, UUCME (1.0)
19–22 UCoPE - Utah Certificate of Palliative Care Education, Online, UUCME (26.25)
22 57th WINO Conference, Salt Lake City, UUCME (7.0)
22 Pediatric Trauma Update, Online, IHC (4.25)
29 Integrative Primary Care & Substance Use Disorder Treatment ECHO, Online, UUCME (1.0)

May 2022
9–11 Generations - Clinical Interventions for Behavioral Health Disorders, Online & SLC, ESI (up to 100.0)
13 Integrative Primary Care & Substance Use Disorder Treatment ECHO, Online, UUCME (1.0)
14 UofU School of Medicine Alumni CME Symposium, Salt Lake City or Virtual, UUCME (3.25)
17–20 Conference for the Curious Clinician in Primary & Specialty Care 2022, Ogden, OSMS (28.5)
27 Integrative Primary Care & Substance Use Disorder Treatment ECHO, Online, UUCME (1.0)

June 2022
1–3 Addictions Update: Science, Policy & Treatment, Online & SLC, ESI (39.5)
10 Integrative Primary Care & Substance Use Disorder Treatment ECHO, Online, UUCME (1.0)
24 Integrative Primary Care & Substance Use Disorder Treatment ECHO, Online, UUCME (1.0)
24 Ethics Committee Training Conference, Online, UUCME (4.0)

Recurring Activities
Recurring activities are scheduled at St. Mark’s Hospital, IHC Hospitals, Primary Children’s Medical Center, and the University of Utah School of Medicine. Contact the sponsor for specific information. For more information on the above listings, please call the provider at the phone number listed on the following page.
# Utah CME Sponsoring Organizations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Name</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALT</td>
<td>Alternative CME, SLC, 801/200-4321</td>
<td>PRKA Program of Addiction Research, Clinical Care, Knowledge, Advocacy, SLC, 801/585-6667</td>
</tr>
<tr>
<td>ACOG</td>
<td>American College of Obstetrics and Gynecology, UT Chapter, SLC, 801/747-3500</td>
<td>STW Steward Health Care Utah, South Jordan, 801/984-2384</td>
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<tr>
<td>ACP</td>
<td>American College of Physicians, UT Chapter, SLC, 801/582-1565 x2441</td>
<td>TRH Timpanogos Regional Hospital, Orem, 801/714-6505</td>
</tr>
<tr>
<td>ACS</td>
<td>American College of Surgeons – Email <a href="mailto:UtahATLS@gmail.com">UtahATLS@gmail.com</a> for info about ATLS</td>
<td>UAFP Utah Academy of Family Physicians, SLC, 801/587-3285</td>
</tr>
<tr>
<td>AMA</td>
<td>American Medical Association, Chicago 312/464-4761</td>
<td>UHLF Utah Healthy Living Foundation, SLC, 801/993-1800 or 801/712-8831</td>
</tr>
<tr>
<td>AUCH</td>
<td>Association for Utah Community Health, SLC, 801/924-2848</td>
<td>UDS Utah Dermatology Society, SLC, 801/266-8841</td>
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<tr>
<td>CA</td>
<td>Collegium Aesculapium, Orem, 801/802-0449</td>
<td>UMAF Utah Medical Association Foundation, SLC, 801/747-3500</td>
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<td>CM</td>
<td>CoMagine, SLC, 801/892-6645</td>
<td>UMIA Utah Medical Insurance Association, SLC, 801/531-0375</td>
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<td>IHC</td>
<td>Intermountain Healthcare CME, SLC, 800/842-5498</td>
<td>UUCME University of Utah Continuing Medical Education, SLC, 801/581-8664</td>
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<tr>
<td>LVH</td>
<td>Lakeview Hospital, Bountiful, 801/299-2546</td>
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<tr>
<td>OSMS</td>
<td>Ogden Surgical-Medical Society, Ogden, 801/564-5585</td>
<td></td>
</tr>
<tr>
<td>PCH</td>
<td>Primary Children's Hospital, SLC, 800/910-7262</td>
<td>VA VA Center for Learning, SLC, 801/584-2586</td>
</tr>
</tbody>
</table>

## The following websites offer online continuing medical education:

- cme.utahmed.org
- psnet.ahrq.gov/cme
- thedoctorschannel.com/cme
- freecme.com
- pri-med.com/compmoOnlineCME.aspx
- medicine.utah.edu/cme
- cmelist.com
- ama-assn.org/education-center
- baylorcme.org
- medscape.org
- vlh.com
- nejm.org/continuing-medical-education
- reachmd.com/programs
- cms.gov/Outreach-and-EducationLearnEarn-CreditEarn-credit-page.html
- primarycarenetwork.org
- emedevents.com

## The following sites allow you to search databases to locate medical meetings throughout the country

- ama-assn.org
- eMedEvents.com
NEW REQUIRED MINIMUM DISTRIBUTION RULES FOR IRAS AND RETIREMENT PLANS:
REVIEWING YOUR BENEFICIARY DESIGNATIONS AND TRUSTS IS CRITICAL
BY JOHN R. MADSSEN, ESQ. RAY QUINNEY & NEBEKER PC.

The Secure Act made a major change to the rules governing timing of distributions from IRAs and qualified retirement plans (e.g., 401k plans, profit sharing plans and pension plans) to non-spouse death beneficiaries. The law now provides that non-spouse beneficiaries (with limited exceptions) must complete taking distribution from IRAs and qualified retirement plans not later than 10 years after the death of the plan participant/IRA owner. Under the new law, annual minimum distributions are not required, so the non-spouse beneficiary could theoretically not take a distribution until the end of the 10-year period. (Note: the IRS has recently proposed new regulations, which, if finalized, would now generally require that a non-spouse beneficiary take annual minimum distributions during the 10-year payout period. We will all need to keep an eye on the potential finalization of these proposed regulations).

Prior law allowed a non-spouse beneficiary to take annual distributions over the life expectancy of the beneficiary, so the new 10-year rule usually results in a much shorter payment period for a non-spouse beneficiary. A spouse beneficiary can still generally roll over the deceased spouse’s IRA/retirement benefit to the surviving spouse’s IRA, not start required minimum distributions until after the surviving spouse attains age 72, and then take annual required minimum distributions based on a very favorable joint life expectancy IRS Table (the Uniform Lifetime Table). Given the dramatic change in the law applicable to non-spouse beneficiaries, it is important for each person to review and potentially review or update his/her estate planning documents and IRA/retirement plan beneficiary designations in order to make sure those documents and designations take into account the above-referenced change in the law. For example, many estate planning trusts were written to include what is known as “conduit trust” provisions, which require the trustee to pay out to the trust beneficiaries during the same calendar year of receipt any distributions received by the trust during that year from IRAs and retirement plans. Some trusts may also include provisions that require the Trustee to take annual distributions of any required minimum distributions from IRAs/retirement plans. Because the new law doesn’t require annual minimum distributions to non-spouse beneficiaries (but only that the total IRA/retirement plan benefit be distributed by the end of the 10-year period) there is no longer an annual post-death minimum distribution for non-spouse beneficiaries (subject to any change to existing rules under any new final regulations). Accordingly, the language of the trust may need to be revised.

Because of the new 10-year payout rule for IRA/retirement plan benefits payable to a non-spouse beneficiary, you should consider whether you really want to retain “conduit trust” provisions in your trust document. Some clients have determined to remove conduit trust provisions and instead include what are known as “accumulation trust” provisions, where the Trustee is not mandated to annually distribute all IRA/retirement plan distributions to non-spouse beneficiaries, but where the Trustee instead has discretion to decide whether (a) to distribute part or all of such distribution amounts for the needs of the beneficiary during a particular year or (b) to instead have part or all of such distribution amounts stay (accumulate) in the trust for the future needs of the beneficiary. There is no one correct answer to this question. You should review your own circumstances and desires in determining how to have the trust provisions drafted.

As you consider how you wish to designate beneficiaries for your IRA/retirement plan benefits, some additional issues to consider include:

1. Most individuals name his/her spouse as primary beneficiary, as a spouse has the most flexibility to delay payments and then take distributions based on the most favorable IRS distribution table;

2. Name a trust as primary or contingent beneficiary only where that designation is desired after considering all facts and circumstances. If there is no overriding reason to name a trust as beneficiary (such as where minor children are involved), it is generally better to name individuals as primary and contingent beneficiaries;

3. Consider naming a charity(ies) as primary or contingent beneficiary, since no estate tax or income tax applies to charities;

4. Consider whether naming a charitable remainder trust may be a desired alternative (which can result in payments to non-spouse beneficiaries over a period in excess of 10 years);

5. Consider making lifetime qualified charitable distributions directly from IRAs to public charity(ies) after attaining age 70 ½ (which can be treated as part of the required minimum distribution for that year);

6. Consider designating IRA/retirement plan beneficiaries who are in lower income tax brackets (and leave other assets to persons who are in higher income tax brackets);

7. Consider expanding the number of designated beneficiaries, so as to spread IRA and retirement plan distributions over more income tax returns.

In conclusion, much thought should go into how to designate the primary and contingent beneficiaries of your IRA/retirement plan benefits. The designations need to coordinate with the provisions you have included in your last will and testament and trust documents. If a trust is named as primary or contingent beneficiary, care should be taken to make sure the trust provisions coordinate with the beneficiary designations and will accomplish your desired estate planning goals.

In conclusion, much thought should go into how to designate the primary and contingent beneficiaries of your IRA/retirement plan benefits. The designations need to coordinate with the provisions you have included in your last will and testament and trust documents. If a trust is named as primary or contingent beneficiary, care should be taken to make sure the trust provisions coordinate with the beneficiary designations and will accomplish your desired estate planning goals.

John R. Madsen

Mr. Madsen received his accounting and law degrees from Brigham Young University. He is admitted to practice before the courts of the States of Utah and Wyoming, the United States District Court, District of Utah, and the United States Tax Court. He is a fellow of the American College of Trust and Estate Counsel (ACTEC) and has been included in the listing of Utah Legal Elite in the area of Estate Planning. He has also been included in the list of The Best Lawyers in America and in Mountain States Super Lawyers in the areas of Estate Planning and Employee Benefits Law. Mr. Madsen has served as President of the Salt Lake Chapter of the Western Pension and Benefits Conference. He is currently a member of the Salt Lake Estate Planning Council and the Western Pension and Benefits Conference. He is a shareholder and Director at Ray Quinney & Nebeker. His practice concentrates in the areas of estate planning and probate, pension and profit sharing plans, and closely held business planning.

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