

## Fall 2010

### STATE OVERVIEW

2010 is an important election year on the state level. Voters in 37 states will reelect their governors or select new ones. Fourteen governors are running for reelection, while 23 will conclude their tenures in office. Governor Jim Gibbons of **Nevada** lost his primary bid for reelection, and voters there will select his replacement in the November 2 general election.

At present, there are 26 Democratic governors, 23 Republican governors and one independent (**Florida** Governor Charlie Crist who is running for the US Senate, and changed his party affiliation as part of that campaign).

The majority of state legislative seats will appear on ballots across the country in 2010 as well – with legislative elections being held in every state except **Louisiana, Mississippi, New Jersey** and **Virginia**.

Not only is there a large number state legislators being elected, but the enactment of term limit restrictions in the early 1990s in 14 states will have a cascading effect. Top legislative leaders, including house speakers, senate presidents and key committee chairs, will be vacating their seats due to term limits in some states. Additionally, the outcome of these legislative elections will determine who, in large part, will control decisions regarding Congressional redistricting following the reapportionment of US House of Representatives seats by the 2010 Census.

Currently In state legislatures, Democrats control both legislative chambers in 27 states; Republicans control both chambers in 14 states. The remaining states are under split party control, with the **Nebraska** legislature being nonpartisan and unicameral.

The ongoing economic recession is severely limiting the ability of state governments to provide services, and in some instances, to meet basic fiscal obligations. As detailed later in this report, states are facing unprecedented budgetary constraints that will continue in the near term, even as signs of recovery begin to be seen in the broader national economy. These factors come at a time when states are tasked with

implementation of the initial phases of the *Affordable Care Act* (ACA) passed in March 2010.

Preparations to rise to this unprecedented challenge are already underway, though lingering questions remain in state capitals over their ability to take on a surge of enrollees in public insurance plans, and the unforeseen costs of state level implementation. At the same time, states will also enjoy a fiscal benefit that will be as equally difficult to forecast, as more of their residents receive access to health care, ultimately resulting in a healthier population.

The ACA represents a monumental victory for child health and achieves a great number of the Academy's long standing goals of improved access to care, age appropriate benefits, and expansive coverage. AAP chapters will play a critical role in the implementation of health reform as states begin to reshape their public insurance plans, set the groundwork for the development of health insurance exchanges, and oversee new regulation of private insurance.

Much of the decision making on other critical domestic issues will continue to be made on the state level as well. It is under these political and economic conditions that AAP chapters will continue to advocate for the health and well being of children in 2010.

### ACCESS TO CARE/CHILD HEALTH FINANCE

#### State Budgets

States are in the midst of an historic fiscal crisis. According to the Center on Budget and Policy Priorities (CBPP), states closed a total of \$110 billion in budget gaps for FY 2009 and \$196 billion in budget shortfalls for FY 2010. FY 2011 saw states closing \$121, and may face gaps of an estimated \$120 billion in FY 2012. Such a 4-year fiscal downturn would mean states will have closed \$547 billion in aggregate shortfalls over that time frame. To put this crisis in context, states cut \$240 billion during the last state fiscal downturn between FY 2002-2005.

This staggering number also speaks to how large these shortfalls are as a percentage of total state budgets. FY

2010 gaps range from a low of 3.7% in **Kansas** and **Tennessee** to an enormous 52.3% in **Illinois**. All but 4 states (**Alaska, Arkansas, Montana** and **North Dakota**) faced budget gaps for FY 2010.

According to the Nelson A. Rockefeller Institute of Government, which monitors trends in state revenue, state tax collections for the 2nd quarter of 2010 showed a net increase for the 2<sup>nd</sup> consecutive quarter however, with state revenues increasing by 2.2% compared to the same quarter a year prior. Of the 47 reporting states, 30 reported gains in overall tax collections, while 17 still experienced declines. This new data is very welcome; however tax collections remain considerably below prerecession levels.

Of note, on August 11, 2010, President Obama signed HR 1586, which provides an additional \$26 billion to states in the form of extended Federal Medical Assistance Percentage (FMAP) payments and educational assistance to states.

#### **State Responses to Federal Health Care Reform**

Even prior to the enactment of the ACA, state lawmakers began introducing legislation to prevent state implementation of federal health care reform plans. Often based on the American Legislative Exchange Council (ALEC) model "Freedom of Choice in Health Care Act," these state bills seek to (1) protect state citizens from mandated health insurance; (2) prohibit tax payments for a lack of health insurance; and (3) ensure that citizens can continue to participate in the private health care marketplace.

Such legislation has been introduced this year in 40 states (**Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Virginia, Washington, West Virginia, Wisconsin, and Wyoming**). Many of these bills seek to change the state's constitution, which would require legislative action with supermajority passage.

Of these states, **Georgia, Idaho, Utah, and Virginia** have enacted their bills this year. **Arizona** also enacted a bill in June 2009 that requires a ballot initiative on the November

2010 ballot on this issue. Meanwhile **Missouri** enacted legislation that required a ballot measure to require a state constitutional amendment which would prohibit compelling a person to participate in any health care system. This ballot measure was voted upon in August 2010, and was approved. Meanwhile, the attorneys general in 19 states have joined a suit initiated by **Florida** Attorney General Bill McCollum (**Alabama, Alaska, Arizona, Colorado, Georgia, Idaho, Indiana, Louisiana, Michigan, Mississippi, Nebraska, Nevada, North Dakota, Pennsylvania, South Carolina, South Dakota, Texas, Utah, and Washington**) against the US Department of Health and Human Services over the new federal health care reform law. The National Federation of Independent Business (NFIB) has also joined this suit. **Virginia** Attorney General Kenneth Cuccinelli has filed a separate suit against HHS Secretary Kathleen Sebelius over the law.

The lawsuits allege that the individual mandate required by the new federal law and the tax penalty for not obtaining insurance are unconstitutional, and that the required expansion of Medicaid oversteps Congressional authority. The **Virginia** lawsuit additionally claims that the new law violates that state's recently enacted Virginia Health Care Freedom Act, which protects state citizens from being required to have health insurance. On August 2, 2010, a US District judge refused to dismiss the Virginia lawsuit, allowing it to proceed.

The multistate lawsuit was filed March 23, 2010 by the Florida Attorney General. The case is *State of Florida v. U.S. Department of Health and Human Services*, 10-cv-00091, U.S. District Court, Northern District of Florida (Pensacola).

#### **State Implementation of the Affordable Care Act**

States will be undertaking considerable action in implementing various components of the ACA. Some state activities will require legislative and/or regulatory efforts, while others will not. In addition, several components of the ACA include pilot projects or federal grant funds to supplement state activities, which will have implications for states and state programs.

To assist AAP chapters with understanding those components of the ACA that will require state action or have implications for states, the Division of State Government Affairs is releasing a StateHealth document, entitled *State Implementation of the Patient Protection and Affordable Care*

Act. This StateHealth document, which includes a chart of key ACA provisions, provides AAP chapters with an easy-to-use resource that will help with their state advocacy work on ACA implementation.

In 2010, states began introducing legislation to address various components of the *Affordable Care Act*. These bills varied widely in scope, from establishing state commissions to oversee implementation of the ACA, to addressing specific components of the ACA, such as the establishment of state health insurance exchanges. Most of these bills were not enacted. In addition, governors in a number of states have issued executive orders related to the ACA, most often to establish a state board or committee to guide the implementation process. States are expected to introduce much more legislation on the ACA in the 2011 legislative session.

### **Medicaid /CHIP Administration and Financing**

Between June 2008 and June 2009, Medicaid enrollment grew by 7.5%, or 3.3 million people. This is the first time since the mid-1990s that Medicaid enrollment has grown in every state. A total of 13 states experienced double digit enrollment growth over the past year, and of the 3.3 million new enrollees, 2 million (or 60%) are children.

As of 2008, Medicaid and CHIP provide health insurance coverage to 23.8 million children, or just over 30% of all US children through age 18. There were 8 million uninsured children in the US in 2008, 72.4% of which were eligible for Medicaid or CHIP, but unenrolled.

The *Affordable Care Act* includes maintenance of effort (MOE) requirement for state Medicaid and CHIP programs related to eligibility and enrollment procedures. This prevented states from cutting children from state Medicaid and CHIP this year, most notably in **Arizona**, which had moved to cut its entire CHIP program, but was forced to reinstate it or lose all federal Medicaid funding.

The Division of State Government Affairs continues to provide technical assistance to AAP chapters facing state cuts, including an updated State Strategy resource on preserving Medicaid and CHIP programs during difficult state fiscal conditions. The Division also provided information to AAP chapters on the *American Recovery and Reinvestment Act* (ARRA) and the *Children's Health Insurance Program*

*Reauthorization Act of 2009* (CHIPRA) related incentives for states to increase enrollment in Medicaid and to implement enrollment and retention strategies that will lead to increased federal financing of these programs.

### **CHIPRA, ARRA, and ACA Guidance and Grant Opportunities**

Since the passage of CHIPRA, ARRA, and the *Affordable Care Act*, the Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) have been very active issuing guidance documents and announcements of grant opportunities related to Medicaid, CHIP, health information technology (HIT), ARRA, CHIPRA, and the ACA.

CMS has issued guidance related to CHIPRA, coverage of pregnant women, managed care, newborn deemed eligibility, 2009 H1N1 influenza vaccine, dental care, managed care quality, mental health and substance use disorder parity, enrollment performance bonus payments, CHIP premium grace periods, premium assistance, Express Lane Eligibility, transitional medical assistance, ARRA provisions, ARRA Medicaid prompt payment requirements, the increased FMAP under ARRA, HIT incentive payment state planning funding, coverage of new enrollees in Medicaid, Medicaid financing and political subdivisions, third party liability (TPL), the Money Follows the Person program, the Preexisting Condition Insurance Plan, and the National Correct Coding Initiative, among others. In addition, CMS has issued several opportunity notifications for states and other entities to apply for ARRA, CHIPRA, and ACA grant funding. This funding includes CHIPRA outreach and enrollment grants, CHIPRA quality demonstration grants, Centers for Disease Control and Prevention (CDC) chronic disease grants, state Medicaid HIT incentive payment planning, state health information exchange (HIE) cooperative agreements, HIT Regional Extension Center cooperative agreements, state health insurance exchange (HIE) planning funding, state consumer assistance program funding, the Maternal, Infant, and Child Home Visiting Program, 2010 Public and Prevention Fund monies, among others. The Division of State Government Affairs continues to notify AAP chapters and update its Member Center pages of these opportunities.

In December 2009, CMS awarded the first \$72 million in CHIPRA performance bonus payments for states that have met enrollment performance goals outlined in the legislation. These states include **Alabama, Alaska, Illinois, Louisiana,**

**Michigan, New Jersey, New Mexico, Oregon, and Washington.** Simultaneously, CMS issued guidance in the form of a State Health Official letter, outlining how states will qualify for similar performance bonus payments moving forward.

On February 22, 2010, HHS awarded 10 states and 8 additional partner states a CHIPRA Quality Demonstration Grant. These grants were awarded to **Maine and Vermont; Oregon, Alaska, and West Virginia; Pennsylvania; North Carolina; Florida** and **Illinois; Massachusetts; Colorado** and **New Mexico; Utah and Idaho; South Carolina; and Maryland, Georgia, and Wyoming.** A total of \$100 million will be awarded over 5 years to test various components of children's health care quality, as spelled out in CHIPRA.

On June 10, 2010, the Health Resources and Services Administration (HRSA) and the Administration on Children and Families released the first funding opportunity announcement for the Maternal, Infant, and Early Childhood Home Visiting Program. FY 2010 funding will be \$90 million in total, to be awarded to states and eligible territories. Total funding, which runs through FY 2014, is intended to ensure effective coordination and delivery of health, development, early learning, child abuse and neglect prevention, and family support services to children and families through home visiting programs.

On June 16, 2010, HHS announced the first \$500 million awarded in the Prevention and Public Health Fund, created by the ACA. Half of these funds – \$250 million – will be used to boost the supply of primary care providers in the US. The other \$250 million will invest in prevention and public health services.

On July 22, 2010, the HHS Office of Consumer Information and Insurance Oversight (OCIO) announced the availability of \$29 million in funds to support or establish state offices of insurance consumer assistance or ombudsman programs. These offices will assist consumers with enrollment in insurance plans, complaints, and appeals, among other activities.

On July 29, 2010, HHS announced \$51 million in first round planning grants to states to begin the process of researching and planning for state health insurance exchanges, in accord with the ACA. These grants can be used by states for a

number of initial planning activities related to state plans for health insurance exchanges.

Also included in ARRA is \$19.2 billion devoted to expand the use of information technology (IT) in health care. A significant part of this spending is devoted to incentivize the adoption and meaningful use of health IT by physicians. To receive incentive payments, which will be funneled to Medicaid providers through the Medicaid system, pediatricians will need to meet a 20% Medicaid patient requirement.

On December 30, 2009, CMS issued a proposed rule to define the term "meaningful use" for purposes of ARRA funding of certified electronic health record (EHR) incentive payments. In addition, CMS issued a proposed rule outlining the EHR Medicare and Medicaid incentive payment program. On Tuesday, July 13, 2010, the Department of Health and Human Services released its Final Rule on Meaningful Use of Electronic Health Records (EHR).

#### ***State Children's Health Insurance Program (CHIP) Eligibility***

In 2010, legislation to expand income eligibility for CHIP has been introduced in **Alaska, Rhode Island** and **Virginia.**

The most dramatic reduction in CHIP this year took place in **Arizona**, which moved to eliminate its CHIP program in March. This action would have removed 47,000 children from the program on July 1, 2010, if not but for the maintenance of effort requirement for state Medicaid and CHIP programs found in the *Affordable Care Act*. The state therefore was forced to reinstate CHIP coverage or lose all federal Medicaid funding. Of note, **Arizona** was allowed to continue its enrollment freeze, which it had in place prior to the enactment of the ACA and its MOE requirement.

**California** also proposed a significant reduction to CHIP eligibility this year and **Virginia** proposed an enrollment freeze for CHIP as well as a reduction in eligibility this year. Neither of these proposals has been enacted. **Tennessee** also lifted its previously implemented enrollment freeze earlier this year.

#### ***Medicaid Physician Payment***

In 2010, cuts to Medicaid payment have occurred in **Arizona** (a 5% cut), **Kansas** (a 10% reduction), **Louisiana** (a 4.7% reduction), **Michigan** (an 8% reduction), **Minnesota** (a 7% cut, except for primary care), **Mississippi** (an 8% reduction), **Texas**

(a 1% reduction), and **Virginia** (a 3% reduction). **Oklahoma** saw its announced Medicaid pay cut of 6.75% reduced to 3.25%, which began April 1, 2010. Meanwhile, a cut to Medicaid payment in **North Carolina** (a 3% reduction) has been proposed.

A number of other states considered Medicaid payment cuts as state budgets were debated and because states are barred from reducing Medicaid eligibility for children as part of the *Affordable Care Act's* MOE requirement. Many states were waiting for the extension of the ARRA-enacted FMAP increase, which did occur with the passage of HR 1586 on August 11, 2010. This will extend the FMAP increase by 6 months, but not by the same amount. The FMAP will be 3.1% above what it otherwise would be during the 1<sup>st</sup> quarter of 2011, and 1.2% higher than otherwise for the 2<sup>nd</sup> quarter of 2011. As this amount is lower than the ARRA FMAP increase, this may impact state Medicaid payment during the new calendar year.

#### **Medicaid Lawsuits – AAP Chapter Activity**

The AAP **Florida** Chapter/Florida Pediatric Society's lawsuit against their state Medicaid program is in full swing. On August 4, 2009, the court held a preliminary hearing to make a determination on class action status and enforceability, among other issues. The case went to trial on December 7, 2009. Members of the chapter continue to testify in the case, noting their ongoing problems with the state's Medicaid program. The proceedings continued into 2010 as the court can only devote a portion of its time to the case. As of August 2010, chapter members were continuing to offer testimony in the case.

#### **Expanded State Insurance Coverage for Children**

Following the passage of the *All Kids* plan in **Illinois** in 2006 and the approval of subsequent and similar programs in **Pennsylvania, Washington, and Wisconsin**, a number of states have looked at expanding public coverage specifically to children. These proposals differ in detail, but many mirror the **Illinois** model of creating a CHIP buy-in program for children at incomes above current CHIP eligibility levels. Some proposals first expand CHIP coverage to a higher level before creating the buy-in.

Legislation in 2010 to provide a state buy-in option for children was introduced in **California** and **Rhode Island**. Meanwhile, legislation to delay implementation of

**Washington's** buy-in program introduced in that state. None of these bills were enacted.

#### **Universal/Comprehensive State Coverage**

In 2010, state legislation to expand health insurance to all or a significant portion of uninsured residents was introduced or carried over from the 2009 session in **California, Hawaii, Iowa, Maryland, Minnesota, Missouri, Nebraska, New Jersey, Rhode Island, South Carolina, Vermont, and Washington**.

Of note, universal health care legislation was enacted in **Vermont** in 2010. This legislation requires a joint legislative commission to study various plans for providing universal coverage in the state, and to devise 3 options for such a plan, which will be presented to the state in 2011.

National attention remains on **Massachusetts**, which enacted its landmark universal health insurance plan in 2006. In August 2008, the state released a report showing that as of March 2008, more than 439,000 new residents had enrolled in either public or private coverage because of the program, with almost half of these enrolling in some form of private coverage. The state report also found that the number of hospitals and community health center visits by uninsured residents declined by 37% between July and September 2007, compared with the same period the previous year. As a result, the state reduced charity care expenses by \$68 million during that period. The state's uninsurance rate is less than 3%, the lowest in the nation. However, the **Massachusetts** plan has required additional funding at several points along its implementation process, above previous estimates. In August 2009, a Commonwealth Fund report showed that the average family premium offered by employers in **Massachusetts** is currently the highest in the nation, at an average \$13,788/family/year in 2008.

In July 2009, the **Massachusetts** Special Commission on the Health Care Payment System released its recommendations as to reforming the payment system in that state. The report urges **Massachusetts** to abandon fee-for-service payment and adopt a coordinated care strategy based around fixed annual payments. The issue of payment reform was expected to be taken up this year in **Massachusetts**, but was shelved due to a lack of consensus on how to move forward.

In January 2010, the state attorney general released a report that stated **Massachusetts** insurance companies pay some hospitals and doctors twice as much as others for essentially the same patient care. The report points to the market clout of the best-paid providers as a main driver of the state's spiraling health care costs.

In March 2010, the **Massachusetts** Division of Health Care Finance and Policy held several public meetings on health costs and trends in the state. Findings include that:

- The Commonwealth's health care system is a key employer and driver of economic growth for the region.
- Characteristics of the **Massachusetts** health care marketplace may be contributing to the high levels of cost growth.
- Most (88%) of a health insurance premium goes toward spending on health care services as opposed to administrative and other nonmedical services.
- Average monthly health insurance premiums increased 12% from 2006 to 2008. If employers and individuals had purchased comparable benefits each year, the growth in premiums would have been larger.
- Premium trends, benefit levels, and trends in health care spending vary across different sized employer groups.
- Health care spending in the Commonwealth increased 7.5% per year from 2006 through 2008, a growth rate that is higher than the nation.

Meanwhile, a dispute over health insurance rates continues to play out in court in the state. The state has rejected 235 of 274 proposed rate increases by insurance plans in the state this year, calling them "excessive and unreasonable." The state used an emergency regulation to disapprove of these increases, which prompted a lawsuit by health insurers in the state. The governor has introduced a proposal, not yet enacted, to limit premium hikes to 150% of the prior year's increase in medical inflation.

On April 12, 2010, the superior court judge in the case denied the insurers' sought injunction, which would have temporarily turned back the state's denials and allowed the insurers to implement such increased rates while the court hears the case. The insurers are now appealing this decision. As such, the state is now requiring the insurers to submit

"recalculated rates" or face a potential penalty of \$5,000/day for each day the insurer fails to remedy the lack of updated rates.

### **Medical Home**

State lawmakers continue to express significant interest in the medical home and its many benefits. Through ongoing work of the Academy, the Patient-Centered Primary Care Collaborative (PCPCC), the National Academy for State Health Policy (NASHP) and countless other organizations, states have begun to look to the medical home to improve patient care and potentially reduce costs. Many state efforts and pilot projects are building upon the Joint Principles on Medical Home statement, agreed to by the Academy, the American Academy of Family Physicians (AAFP) the American College of Physicians (ACP), and the American Osteopathic Association (AOA).

While legislation is not required to create medical homes, legislators and other state policy makers can implement policies and programs to support various aspects of the medical home. Some states, however, have introduced legislation to explicitly require medical homes in state programs. In previous years, such legislation has been enacted in 14 states (**California, Colorado, Florida, Idaho, Iowa, Louisiana, Maine, Nebraska, New Hampshire, New Mexico, New York, Oklahoma, Washington, and West Virginia**).

In 2010, substantive legislation on the subject of medical home has been introduced in **California, Florida, Hawaii, Maryland, Mississippi, New Jersey, New Mexico, New York, Ohio, Rhode Island, Utah, Vermont, and Washington**. Such legislation was enacted this year in **Maryland, Mississippi, New Jersey, and Utah**.

### **Retail-Based Clinics (RBCs)**

States have examined regulation of retail-based health clinics with the growth of these entities. Legislative activity on this issue has been limited this year. In 2010, legislation to regulate retail-based clinics has been introduced in **Colorado** and **Washington**. Neither bill was enacted.

Of note, in February 2008, **Massachusetts** published final regulations to regulate RBCs. Modifications were made to these final "limited service clinic" regulations, following advocacy on the part of the AAP **Massachusetts** Chapter and

others in the medical community to tighten restrictions on care provided at RBCs. These regulations, in part, disallow RBCs from providing services to children younger than 2 years of age; limit childhood vaccinations provided at RBCs to influenza; require use of clinical practice guidelines for each of its limited service categories; and require retail clinics to maintain policies on referrals.

Similar legislation proposed in 2008 in **Illinois** drew the attention of the Federal Trade Commission (FTC), which weighed in on the existing bill, citing anticompetitive concerns with a number of the bill's provisions. Ultimately, the **Illinois** bill failed to pass.

#### ***Purchase of Out-of-State Insurance Plans***

Legislation to allow residents of a state to purchase insurance plans written in other states was introduced in 2010 in at least **California, Colorado, Georgia, Indiana, Maine, Minnesota, New Hampshire, North Carolina, Oklahoma, Pennsylvania, South Carolina, Vermont, Washington, Wisconsin** and **Wyoming**. The only state to allow such cross-border sale of insurance plans is **Rhode Island**, which allows for a regional health insurance compact.

## **ENVIRONMENTAL HEALTH**

### ***Lead***

States continue to propose new measures to toughen state blood lead screening requirements, create new requirements for screening of children for lead upon enrollment in school, or strengthen state efforts to identify children at risk for lead exposure. In 2010, 3 states (**Illinois, New York, and Washington**) introduced legislation to strengthen lead screening standards and requirements, by requiring additional screening of all children for lead upon enrollment in public school, or by creating programs for screening children at risk for elevated blood lead levels. None of this legislation was enacted.

In addition to these legislative actions, some states are struggling with variations between Medicaid EPSDT lead screening requirements and current guidelines from the AAP and the CDC. AAP chapters, with guidance from the AAP Council on Environmental Health, have been working with state Medicaid programs to gain flexibility and clarification of current best practices in blood lead level testing, while ensuring that children are appropriately screened.

### ***Child Product Safety***

In 2009, the 6 major domestic manufacturers of baby bottles announced that they will no longer use bisphenol A (BPA) in their products. This announcement came following increasing pressure from several state attorneys general. State legislatures have continued to introduce legislation addressing BPA and other toxic substances in children's products and other consumer goods that exceed existing state and/or federal requirements, direct state agencies to communicate to the public on these issues, or provide for enhanced enforcement of these measures. Bills addressing BPA in toys or other child products were introduced in 2010 in 12 states (**Illinois, Maryland, Massachusetts, Missouri, New Jersey, New Mexico, New York, Oregon, Pennsylvania, Vermont, Washington, and Wisconsin**). Bills in **Maryland, New York, Vermont, Washington, and Wisconsin** were enacted, which place limits on BPA in children's products. Additionally, **Illinois** enacted legislation in 2010 regulating the sale of children's products that contain cadmium.

## **IMMUNIZATIONS**

### ***Thimerosal***

Recent developments in the US Court of Federal Claims have had a profound effect on the ongoing public discussion and political debate concerning issues of vaccine safety. In February 2009, the court's Special Masters found against petitioners' claims in its Omnibus Autism Proceedings that autism in children has been caused by vaccines; specifically, the MMR vaccine administered in combination with thimerosal containing vaccines. This year, a subsequent ruling addressed a similar claim based upon a causation theory based solely on thimerosal, and as expected, rejected petitioner's claims. An appeal of these decisions to the US Court of Federal Appeals by one of the individual plaintiffs in the test case was rejected as well.

These rulings reinforce what the AAP and other advocates for child health have long asserted; after weighing the large body of evidence examining autism and vaccines, including numerous studies popularized in the lay press that suggested such a link, the Special Masters roundly rejected the test cases. Media coverage following the announcement of these decisions has begun to take a more favorable turn on the side of advocates for routine childhood immunization, with editorial boards from the Los Angeles Times, Wall Street Journal, and many others condemning the proponents of the

autism-and-vaccines theory for prolonging a debate that is now resolved.

State legislatures continued to consider bills in 2010 that would restrict thimerosal containing vaccines, but legislative activity has slowed relative to recent years. Legislation addressing thimerosal has been introduced in 2010 in only 6 states (**Indiana, Kansas, Massachusetts, New Jersey, Washington** and **West Virginia**), and none has been enacted.

Also related to this issue is legislation in **Florida** carried over from 2009 that would have placed new signed informed consent requirements on physicians providing immunizations to children. Following intense advocacy by the Florida Pediatric Society and their coalition partners, this legislation was indefinitely postponed in 2010. This bill appeared earlier in 2009 as a separate provision to a larger bill that addressed thimerosal.

While state legislatures will likely continue to introduce legislation addressing thimerosal and other perceived vaccine safety concerns in the future, AAP chapters have remained vigilant, and have educated state policy makers and the broader public about the safety and value of routine childhood immunization.

In addition to these legislative developments, a ballot initiative signature drive took place in **Oregon** earlier this year. The proposed measure would prohibit the use of thimerosal-containing vaccines, and place a host of other restrictions on the administration of recommended childhood vaccines. Despite initial momentum, this petition drive failed, and the measure will not appear on the 2010 ballot.

#### ***Exemption to School Immunization Requirements***

A secondary component of opposition to routine childhood immunization is the effort to broaden the circumstances under which parents can exempt children from school immunization requirements. As with legislation restricting thimerosal, activity on this issue has slowed as well. Seven (7) states (**Mississippi, New Hampshire, New Jersey, New York, Virginia, Washington, and West Virginia**) introduced exemption legislation in 2010; none was enacted. No state has expanded school immunization exemptions since 2003.

Outbreaks of vaccine preventable disease have also changed the tenor of the debate in state legislatures on these issues.

In response to the 3,800 cases of pertussis reported in 2010 (including the deaths of 8 infants) throughout **California**, the legislature quickly enacted a bill requiring all incoming 7<sup>th</sup> graders to show proof of having received a pertussis booster. As of this writing, the legislation awaits the governor's signature.

#### ***Vaccine Supply/Funding***

A number of states have introduced legislation in 2010 to address vaccine supply and funding. **California** introduced legislation this year to require that provider payment for childhood and adolescent immunizations is not less than the acquisition and administration costs of providing them, and would prohibit copays or deductibles for childhood and adolescent immunizations. This bill is similar to the legislation again introduced in **New Jersey** this year to require insurance plan payment for vaccine administration to be set at a specific level, as required by the state.

Legislation to require insurance coverage of the Human Papillomavirus (HPV) has been introduced in 2010 in **New Jersey, New York, and Pennsylvania**. A bill to eliminate the insurance mandate for HPV has been introduced in **Virginia**.

In addition to these legislative actions, many AAP chapters are engaged at the administrative and regulatory level to maintain adequate funding for state immunization programs. The growing cost of vaccines continues to challenge state immunization programs, and many chapters have voiced concerns over the ability of states to maintain existing coverage. In 2010, positive ground has been gained in **Maine, Idaho, and Washington**, where new funding has been provided to forestall cuts to state universal purchase programs. However, budget cuts in **North Carolina** led to its universal vaccine purchase program to be discontinued, with state purchased vaccines now being provided only to children eligible for the Vaccines for Children (VFC) program. Ongoing budget cuts may negatively impact public immunization programs in other states, and in the face of continued budgetary threats, state vaccine programs may consider moving to more restrictive options.

## **INJURY PREVENTION**

### ***Child Passenger Restraint Systems***

So far in 2010, 14 states (**Arizona, Florida, Illinois, Iowa, Kentucky, Mississippi, Nebraska, New Jersey, New York, Rhode Island, Louisiana, South Carolina, Utah**, and

**Washington**) have introduced legislation addressing child passenger restraint systems. **Illinois** passed a bill that would allow first time *Child Passenger Protection Act* offenders leniency if they provide proof of child passenger safety restraint system and attendance at a child restraint installation class prior to their court date. **Louisiana** increased the penalty for a first or second violation of its child passenger safety law, to include license suspension if proof of a child restraint system is not provided to the court within 90 days of the violation.

### ***Child Passenger Safety – Seatbelts***

States continue to address childhood passenger safety through seatbelt requirements. Eleven (11) states (**Colorado, Hawaii, Iowa, Kansas, Massachusetts, Michigan, Minnesota, Mississippi, Rhode Island, Virginia, and West Virginia**) have introduced legislation this year either requiring the primary enforcement of current seatbelt laws or enacting more stringent seatbelt requirements. In 2010, 3 states (**Colorado, Kansas, and Minnesota**) enacted legislation requiring the primary enforcement of seatbelt laws at all ages in both the front and back seats. **Iowa** enacted a bill that requires that children between the ages of 6 and 18 years be transported in a vehicle other than a school bus is restrained by a safety belt or harness. **Virginia** increased its mandatory seatbelt age requirement from 16 years to 18 years.

### ***Teen Driving***

Graduated driver's licensing (GDL) and the prevention of teen automobile highway deaths continue to be a priority for state legislatures. Bills on this issue take a number of different approaches to improve teen driving skill and licensing requirements, which include: strengthening existing graduated driver's licensing requirements; placing passenger and hours of operation restrictions on new drivers; requiring positive behaviors (no alcohol, drug, or speeding infractions, good school attendance, etc) as a condition of full licensure; and/or setting limits on cell phone use by teen drivers. So far into 2010, 16 states (**Alabama, California, Colorado, Georgia, Iowa, Indiana, Kansas, Maryland, Mississippi, Missouri, New Hampshire, New Jersey, Pennsylvania, Tennessee, Vermont, and Virginia**) have introduced legislation addressing teen driving requirements. In 2010, **Alabama** instituted broad changes in its graduated drivers' licensing system. Learner's permit holders will now be

required to be at least age 15, pass a written test, and be accompanied by a parent/guardian or licensed driver older than 21 years of age. To obtain a provisional driver's license, a teen must be at least age 16 years old and have parent/guardian's legal permission. A provisional driver's license holder is prohibited from using a mobile phone, may only carry 1 nonrelated passenger, and cannot drive between the hours of 12 am - 6 am unless accompanied by a parent/guardian or a licensed driver older than 21. **Colorado** changed its law to allow teens younger than 18 years who have not finished a certified behind the wheel training the ability to apply for a driver's license after receiving the required number of hours of behind the wheel hours with a licensed parent/guardian. **Georgia** enacted legislation to allow teens as young as 14 years of age with permanently disabled parents or guardians to obtain a restricted learner's permit to drive their disabled parent(s).

### ***Mobile Phone Use While Driving***

States continue to address research indicating that drivers who send and receive text messages while driving are 23 times more likely to be involved in a collision than drivers who do not send text messages while driving. Because teen drivers are far more likely to send and receive text messages while driving than adults, these bills, though not specifically directed towards teen drivers, have a greater impact on preventing teen driving accidents.

So far in 2010, 32 states (**Alabama, Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Mississippi, Nebraska, New Jersey, New Mexico, New York, Oklahoma, Pennsylvania, South Carolina, Vermont, Virginia, Washington, Wisconsin, West Virginia, and Wyoming**) have introduced legislation to address handheld mobile device use while driving; of these, 6 states (**Colorado, Georgia, Kentucky, Massachusetts, and Vermont, and Washington**) enacted legislation in 2010 prohibiting drivers younger than 18 years old from using a mobile phone while driving. Three (3) more states (**Delaware, Maryland, and Nebraska**) will prohibit the use of mobile phones by all drivers unless using a hands-free device. Ten (10) states (**Connecticut, Georgia, Iowa, Kansas, Kentucky, Michigan, Vermont, Washington, Wisconsin, and Wyoming**) enacted legislation in 2010 that will prohibit all drivers from sending and receiving text messages while driving. Finally, **Oklahoma** enacted a bill this

year that prohibits “distracted driving” but does not specifically prohibit the use of handheld mobile devices while driving.

### **All-Terrain Vehicles (ATVs)**

State lawmakers have considered bills this year to place limits on youth operation of ATVs by requiring helmet use, limiting use of ATVs based upon age, engine displacement or vehicle size, and/or to require safety certification. To date in 2010, 4 states (**Massachusetts, Minnesota, Mississippi, and Washington**) have introduced legislation addressing the use of ATVs by minors. **Massachusetts** became the first state to prohibit the use of ATVs for children younger than 14 on private and public lands. The landmark bill, supported by the AAP **Massachusetts** Chapter, will also increase fines and strengthen penalties for reckless or negligent use of ATVs.

### **Safety Helmets**

Six (6) states (**California, Georgia, Illinois, Massachusetts, Mississippi, and New Jersey**) have introduced legislation in 2010 to require safety helmet use by children engaged in bicycling, scooter riding, motorcycle riding, or skiing. To date, none of this legislation has been enacted.

### **Firearms and Children**

Firearm regulation remains a very unsettled issue on the state level, with little progress being made toward new gun safety legislation. Little activity on the issue has taken place in recent years other than that addressing the concealed carry of firearms in schools and on college campuses.

On June 26<sup>th</sup>, the US Supreme Court issued a ruling, on *the McDonald v. City of Chicago* case, in which a **Chicago** resident challenged the city’s near 30-year ban on handguns, 1 of the nation’s strictest, that barred city residents from possessing handguns for their own use, including in their homes. The Supreme Court’s 5-4 decision on June 26 effectively voided the 1982 ordinance by extending the court’s the Supreme Court’s 2008 ruling in **District of Columbia v. Heller** ruling to state and local laws.

In the 2008 landmark Heller ruling, the Court struck down the **District of Columbia**’s handgun ban as unconstitutional, but the ruling did not immediately affect other state and local gun laws because of the district’s status as a federal protectorate. In the McDonald case, the Court ruled that the 14th Amendment extends the Second 2nd Amendment

protections of the federal government to states and localities, against laws that infringe on “the right to keep and bear arms.”

The McDonald ruling did not have an immediate effect on state and local gun laws outside the **Chicago** area. However, it sets the stage for Second Amendment legal challenges to local and state gun laws, including laws requiring the safe storage of firearms and trigger locks, and laws aimed at protecting children from firearms. Legal challenges already are pending against several state and city gun laws. **San Francisco** officials are defending a legal challenge by the National Rifle Association over a law that bans handguns in private homes unless the handguns are stored in a locked container or have engaged trigger locks. The lawsuit, which was filed in US District Court in March, may affect other state and local child access protection laws.

In addition to safe storage lawsuits, legal challenges are under way across the country to a variety of state and local laws, including requiring gun owners to be at least 21 years of age; bans on assault weapons and certain types of ammunition; prohibitions on carrying guns in bars, restaurants and churches; and laws prohibiting domestic violence offenders from owning guns. In a ruling issued before the McDonald decision, the **Massachusetts** State Supreme Court concluded that the state has the authority to require that **Massachusetts** residents store guns with trigger locks in private residences. The ruling concluded that the state had the authority to regulate handguns, opening the door to possible legal challenges in light of the McDonald ruling.

## **MEDICAL LIABILITY REFORM**

State legislatures continue to grapple with issues related to medical liability, despite the stalemate between competing interests that legislation on the subject usually generates. With medical liability concerns left largely unaddressed in federal health care reform, policy making on medical liability reform will likely continue to be addressed on a state-by-state basis.

2010 has seen a number of bills on the issue introduced, though most have not advanced in state legislatures. Most medical liability state legislation addresses more than 1 component of the issue, and as in years past, the vast

majority of such legislation introduced in 2010 will not reach enactment.

Of most immediate concern for advocates of medical liability reform are recent decisions from state supreme courts. The **Arizona** Supreme Court ruled in 2009 to uphold a 2005 law allowing the state legislature to limit expert witness testimony in medical malpractice lawsuits. Under current law, expert witnesses must be licensed as a health care provider, a specialist in the same area as the defendant, and actively practicing or teaching in the same field. In **California**, a 2009 challenge to damage caps established by MICRA was not heard by the state supreme court, leaving the long-standing cap intact. The **Missouri** Supreme Court ruled earlier this year that its caps on noneconomic damages cannot be applied retroactively. 2005 legislation lowered caps on noneconomic damages to \$350,000 (which were capped at \$579,000 prior to the enactment of the law). A lower court decision ruled in favor of applying the higher capped amount on the basis that the plaintiff was injured prior to its enactment, but that ruling was overturned in state supreme court.

However, a lower court decision challenging the damage cap in **Georgia** was upheld in March 2010 by the state supreme court, striking the state's 2005 law capping noneconomic damages at \$350,000. Similarly, the **Illinois** law limiting compensation for noneconomic damages at \$500,000 was struck down in February 2010. The supreme courts of **Kansas, Maryland** and **West Virginia** are all currently considering challenges to the constitutionality of their existing caps as well.

## MENTAL HEALTH

States are addressing pediatric mental health care in a variety of ways, including introducing legislation to provide insurance parity, mandating coverage of services for children with autism, and strengthening existing parity requirements between mental health and physical health insurance benefits.

### **Insurance Parity Mandates**

Legislatures continue to address the coverage of mental health services by private insurers. In 2010, 11 states (**Alaska, Arizona, Florida, Hawaii, Iowa, Kansas, Massachusetts, New Jersey, North Dakota, Ohio, and South Carolina**) have introduced legislation to increase the coverage of mental health benefits. In 2010, **New Hampshire** enacted

legislation to form a committee to study comprehensive mental health and substance abuse insurance parity.

In October 2008, Congress passed the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008*. The new law, which went into effect January 1, 2010, requires equity between mental health and substance abuse benefits and medical and surgical benefits in employer-sponsored group health insurance plans larger than 50 employees. The law also requires equity in all financial requirements, including deductibles, copayments, coinsurance, out-of-pocket expenses, and in all treatment limitations, including frequency of treatment, number of visits, days of coverage, or other similar limits. The federal legislation does not override state laws that require additional coverage, and subjects the definition of mental health conditions to state law.

States are also moving to address coverage of treatment for autism spectrum disorders (ASD), including habilitative care and early diagnosis and treatment of autism. Many state legislators now are looking to require insurance plans written in the state to provide coverage for ASD treatment, most often seeking to explicitly cover applied behavioral analysis (ABA) and other treatments. In 2009, legislation to require autism insurance coverage was enacted in **Colorado, Montana, Nevada, New Jersey, New Mexico, Texas, and Wisconsin**, bringing the total to 15 states that have autism insurance mandate laws. Also of note in 2009, **Illinois** enacted broad legislation to require private group and individual insurers to cover habilitative services for children with a congenital, genetic, or early acquired disorder, including ASD. This legislation was supported by the AAP **Illinois** Chapter, and similar legislation was previously enacted in **Maryland**.

In 2010, 20 states (**Alaska, Delaware, Georgia, Iowa, Kansas, Kentucky, Maine, Maryland, Michigan, Minnesota, Missouri, New Hampshire, New York, Ohio, Rhode Island, Tennessee, Virginia, Vermont, and Washington**) and the **District of Columbia** introduced legislation to require insurance plan coverage of treatment of autism. Of these, the **Iowa, Kansas, Kentucky, Maine, Missouri, New Hampshire** and **Vermont** bills were enacted. In addition, **Oklahoma** a bill to require health insurance policies to provide the same coverage and benefits to children who have been diagnosed with autism as those who have not, and **Massachusetts**

enacted legislation clarifying the services provided under its existing mandate.

## **NUTRITION**

### ***Trans Fat Bans and Menu Labeling***

Following in the lead of **New York City** and **California**, which have banned the use of trans fats in restaurant foods, so far in 2010 7 states (**Delaware, Hawaii, Illinois, Maryland, Massachusetts, New York, and South Carolina**) have introduced legislation that would prohibit the use of trans fats in the preparation of food in restaurants. To date, none of these bills have been enacted.

Among the provisions of the *Affordable Care Act* is a mandate that all chain restaurants with 20 or more locations display calories on menus, menu boards, and drive-through displays, as well as on vending machines. Temporary specials appearing on the menu for less than 60 days, condiments and test market foods are exempt. The Food and Drug Administration (FDA) will establish the specific regulations. The provision goes into effect in 2011 and will preempt all existing state and local menu-labeling requirements.

Prior to the enactment of federal health reform, 17 states (**Delaware, Florida, Hawaii, Illinois, Kansas, Kentucky, Maryland, Missouri, New York, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Wisconsin, and West Virginia**) introduced menu labeling legislation.

### ***Sugar-Sweetened Beverage Taxes***

In 2010, 17 states (**Arizona, California, Colorado, Connecticut, Hawaii, Illinois, Kansas, Michigan, Mississippi, New Hampshire, New Mexico, New York, Rhode Island, Tennessee, Virginia, Vermont, and Washington**) and the **District of Columbia** introduced legislation to tax or increase current taxes on sugar-sweetened beverages including carbonated soft drinks. Of these states, **Colorado** passed a bill that removed soft drinks and candy from the state's sales tax exemption on food.

### ***Physical Education and BMI Screening Requirements***

Building off of the success that **Arkansas** has had in slowing obesity rates after the state enacted comprehensive, school-based obesity prevention legislation in 2003, states are continuing to look to school-based interventions as a first step in combating childhood obesity rates.

Eighteen (18) states (**Alabama, Arizona, California, Florida, Hawaii, Illinois, Kentucky, Louisiana, Maryland, Minnesota, Missouri, New Jersey, New York, Oklahoma, Tennessee, Utah, Virginia, and Washington**) and the **District of Columbia** have introduced legislation in 2010 to require schools to increase time within the school day devoted to physical activity or strengthen physical education standards. **Minnesota** enacted legislation that will require that state schools adopt the National Association for Sport and Physical Education standards for grades K-12, promote quality recess, and post school wellness policies on school Web sites. **Oklahoma** passed a bill that requires schools to provide at minimum 60 minutes of physical education a week, not including recess, to students in grades K -6. The legislation also strongly encourages physical education in grades 7-12, including 20 minutes a day for recess.

States are also considering mandating body mass index (BMI) screening in schools to provide the state child obesity data and to provide parents with information about their child's BMI relative to their peers. So far this year, 4 states (**Mississippi, New Hampshire, New York, North Carolina, and Ohio**) introduced legislation mandating BMI screening in schools. A bill enacted in **Ohio** will now require periodic body mass index (BMI) measurements in schools.

### ***School Nutrition Requirements***

States policymakers are examining the food provided to children in school lunch/breakfast programs and from other sources such as vending machines. This year 28 states (**Alaska, California, Colorado, Delaware, Florida, Hawaii, Illinois, Iowa, Kansas, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, New Jersey, New Mexico, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Utah, Vermont, Virginia, and Washington**) and the **District of Columbia** have introduced legislation addressing school nutrition requirements. So far in 2010:

- **California** and **Iowa** enacted legislation that requires the availability of free, clean drinking fountains in all schools.
- **Colorado** enacted legislation that will provide grants to state schools to improve school nutrition. **Colorado** also enacted a bill that will create a farm-to-school program that will provide locally grown fruits and vegetable to state schools.

- The **District of Columbia** enacted legislation that will establish nutrition standards for all school meals and food sold within the school and establish a farm-to-school program.
- **Florida** enacted a farm-to-school program that provides fresh fruits and vegetables to schools from local producers.
- **Illinois** passed a bill that requires the state keep a school nutrition and physical activity “best practices” database.
- **Massachusetts** enacted a bill requiring that the Department of Education develop nutritional guidelines for schools and that competitive foods sold within the schools must meet school nutrition standards.
- **Mississippi** enacted legislation to provide financial incentives to schools that implement healthier school lunch programs this year as well.
- **North Carolina** passed a bill that requires the state Child Care Commission to set nutrition standards for licensed child care centers.
- **Ohio** enacted comprehensive childhood obesity prevention legislation in 2010. The bill establishes nutritional standards for foods sold in schools, requires students to have periodic body mass index (BMI) measurements, and requires daily physical activity.
- **Virginia** enacted legislation to require nutritional standards for competitive foods sold in schools.

**Pennsylvania**, and **Tennessee**) have introduced legislation that would require each school district to create an emergency medical plan for students with special health care needs or require that the schools hire or train unlicensed assistive personnel in the administration of emergency medications under the supervision of a school nurse or school principal. This year, **Florida** enacted legislation that prohibits school districts from redistricting students with diabetes or other chronic health conditions that could require medical attention during the school day and allows certain students with chronic conditions the authority to self-administer medication. **Mississippi** passed a bill that requires all students with life-threatening allergies and asthma to have on file an allergy/asthma action plan that includes a physician orders on how to manage and treat the condition. **South Dakota** enacted legislation that will allow students with asthma and anaphylaxis and determined by a physician to be capable, to administer their own emergency medication as needed.

#### ***Performance-Enhancing Drugs***

Drug screening in schools has been a focus of state legislation in recent years. Media coverage of the use of steroids by professional baseball players, in part, has led state lawmakers to reexamine the issue of steroid use by student athletes. So far in 2010, 3 states (**Mississippi, New Jersey, and New York**) have introduced bills mandating testing of student athletes for performance-enhancing drugs. So far none of these bills have been enacted.

#### ***Concussion/Head Injury Return to Play***

The long-term cognitive effects of concussions on athletes has received widespread media attention recently with new research showing that current and former National Football League (NFL) players are 19 times more likely to suffer Alzheimer’s disease and dementia than other men aged 30-49. State legislators have taken the opportunity to address this high profile issue by introducing legislation outlining steps for concussion management in student athletes.

This year, 19 states (**Alabama, California, Colorado, Connecticut, Florida, Idaho, Maryland, Maine, Massachusetts, Missouri, New Jersey, New Mexico, New York, Oklahoma, Pennsylvania, Rhode Island, Texas, Virginia, and Vermont**) introduced legislation requiring that student athletes receive clearance from a health care professional trained in the evaluation and management of

## **SCHOOL HEALTH**

### ***Emergency Resuscitation and CPR***

To date in 2010, 3 states (**Massachusetts, Pennsylvania and Tennessee**) introduced similar bills that would require automatic external defibrillators (AEDs) in schools, playgrounds, or at athletic competitions. **Tennessee** enacted legislation requiring that all schools have an automatic external defibrillator in place and that the first AED received by a school be placed in the school’s gymnasium. In addition to these bills addressing AEDs, 5 states (**California, Massachusetts, New York, Pennsylvania, and Tennessee**) introduced legislation in 2010 that require schools to provide and/or that teachers are trained in CPR.

### ***School Emergency Medication Plans and Administration***

In 2010, 9 states (**Florida, Illinois, Kentucky, Massachusetts, Mississippi, Missouri, New York,**

concussions before returning to play. Of these states, **Connecticut, Idaho, Massachusetts, New Mexico, Oklahoma, Rhode Island,** and **Virginia** all enacted legislation that sets guidelines for dealing with concussions or other head injuries in young athletes. In addition, many state interscholastic sports associations have set their own “return to play” guidelines for head injuries received by student athletes.

In 2009, **Washington** became the first state to enact legislation that requires student athletes removed from a game because of a suspected head injury to receive medical clearance before returning to practice. **Oregon** quickly followed suit with legislation enacted later that year. The bills, which do not specify clearance from a physician but rather any health care provider trained in the management of head injuries, has been led by a 50-state campaign advanced by the American College of Sports Medicine (ACSM) and the Brain Injury Association of America (BIAA). It is important to note that the way that the bills are currently written, nonphysician health care providers – including athletic trainers, chiropractors, or physical therapists – would have the authority to evaluate a student athlete and determine whether head injuries warrant sitting the student athlete out of future practices and games.

### **Diabetes Management in Schools**

The American Diabetes Association (ADA) is currently promoting model legislation that permits training of nonmedical school employees, referred to as “trained diabetes personnel,” to provide emergency assistance to students with diabetes. The model legislation is intended to fill the gap in schools where a school nurse is not present or the school is understaffed (the legislation calls for 3 school employees to receive training). The bill authorizes trained personnel to administer glucagon and insulin, perform finger-stick blood glucose checking, and other diabetes management tasks. The legislation also provides immunity from civil liability for trained personnel.

In 2010, 5 states (**California, Florida, Illinois, Missouri,** and **North Carolina**) have introduced legislation that would require that unlicensed assistive personnel trained as diabetes care aides in schools. These bills remain pending.

## **SCOPE OF PRACTICE**

2009 saw a wide range of legislative activity regarding the scope of practice of nonphysician providers, and 2010 has followed a similar path. With the enactment of federal health reform, state lawmakers have received pressure from organizations representing the interests of nonphysician clinicians who will capitalize on the impending demand for primary care to justify scope expansions.

Hundreds of bills were introduced to expand the scope of practice of a wide array of nonphysician providers, in legislation to permit optometrists, psychologists, chiropractors, naturopaths, and others to obtain new prescriptive authority and perform additional procedures.

### **Nurse Practitioners**

Perhaps of most immediate impact to pediatrics and other primary care specialties are those bills to expand the scope of nursing. In 2010, 28 states (**Alabama, Arizona, California, Florida, Georgia, Hawaii, Iowa, Illinois, Kansas, Kentucky, Maryland, Massachusetts, Minnesota, Missouri, Mississippi, Nebraska, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Virginia, Vermont, Washington, Wisconsin,** and **Wyoming**) introduced legislation addressing scope of nursing practice issues. Measures ranging from general scope expansions to seeking independent prescribing rights, to deeming the state nursing board as the sole authority to interpret the practice of nurse practitioners as well as measures seeking complete independent practice on par with primary care physicians are being considered.

A number of these bills were enacted (or are approaching that point) this year. In **Arizona**, a new law allows “psychiatric and mental health” nurse practitioners to perform independent patient evaluations, serve as admitting officers, and be defined as mental health professionals on par with physicians. Lawmakers in **California** have passed and sent a bill on to the governor that would authorize California State University to award the Doctor of Nursing Practice (DNP) degree. The bill specifically distinguishes the DNP degree from other research-based doctoral nursing degrees at the University of California and requires the program to serve professionals who are working full-time, to train nurses for advanced practice, and to prepare faculty to teach in postsecondary nursing programs.

**Hawaii's** governor signed 2 bills this year that ensure the expanded scope of nurses and nurse practitioners. One bill requires insurers to recognize advance practice registered nurses as primary care providers. The other redefines the practice of nursing, allows the nursing board to determine a nurse's scope of practice, and limits a nurse's liability when tasks are delegated to unlicensed personnel.

A new **Iowa** law allows nurse practitioners and physician assistants to form professional limited liability companies and professional corporations. In neighboring **Illinois** 2 bills were enacted allowing for delegation of prescriptive authority to advanced practice nurses for Schedule III – V controlled substances and allowing advanced practice registered nurses (APRN) to be licensed as a certified registered nurse anesthetist (CRNA) even if the individual does not have the required graduate degree – providing that s/he meets other criteria.

The governor of **Kentucky** signed 2 bills relating to nurse practitioner scope this year. One bill amends the definition of nurse practitioner to include APRNs and qualifies APRNs certified in at least one population focus (family or individual across lifespan, adult or gerontology, neonatology, pediatrics, women's health and gender-related health, psychiatric mental health). The second bill allows the 6 state universities to offer DNP degrees to students. **Maryland** amended its nurse practice statute this year, amending the practice definition of nurse practitioner to mean a nurse practitioner who is authorized to practice independently in a variety of settings and perform a variety of functions including comprehensive physical exam; establish a medical diagnosis for common, chronic, stable, short-term, or acute health problems; order, perform, and interpret lab test, prescribe drugs, perform diagnostic, therapeutic, or corrective measures; refer an individual to a licensed physician or other health care provider; provide emergency care; and admit an individual to a hospital or nursing facility.

### ***Truth In Advertising***

Efforts have continued this year to enact state laws aimed at helping health care consumers navigate through the increasingly complex marketplace by requiring physicians and nonphysician health care providers to clearly state their level of education, training, and licensing in clinical encounters, advertising and marketing materials and other forms of communication.

A new **Arizona** law requires any advertising (radio, television, billboards, electronic media, brochures and pamphlets, mail and telephone solicitations, direct and indirect marketing tools to obtain business from consumers) for health care services to include the health professionals title, license held, and license under which s/he practices. Violations are considered acts of unprofessional conduct. **Illinois** enacted a comprehensive bill requiring advertisements (audio, video, print, business cards, letterhead, Internet, e-mail, and other communication used in the course of business) for health care services to identify the level of license held by the professional and to be free of deceptive or misleading information. In addition, the new law requires health care professionals to wear a nametag and clearly post in their care settings information on their professional licenses – using only titles or licenses used in the licensing act itself. Violators are charged with unprofessional conduct and subject to disciplinary action based on codes governing their professions.

**Oklahoma's** 2009 law requires that any advertisement for health care services that includes the name of a provider must identify the type of license held by the individual, using the applicable degree or terminology for the profession. The law also defines the following as a deceptive act, "describing the profession, skills, training, expertise, education, or licensure of a person in a fashion that causes the public, a potential patient, or current patient to believe that the person is a medical doctor, doctor of osteopathic medicine, doctor of dental surgery, doctor of dental medicine, doctor of optometry, doctor of podiatry, or doctor of chiropractic when that person does not hold such credentials." In addition, the law defines several groups of professional who may use the title "doctor" or "Dr" but also require use of degree/licensing designation – MD (surgeon, medical doctor, or doctor of medicine), DO (surgeon, osteopathic surgeon, osteopath, doctor of osteopathy, or doctor of osteopathic medicine), DDS or DMD (dentist, doctor of dental surgery, or doctor of dental medicine), OD (optometrist or doctor of optometry), DPM (podiatrist, doctor of podiatry, podiatric surgeon, or doctor of podiatric medicine), DC (chiropractor or doctor of chiropractic), PhD, EdD, PsyD (psychologist, therapist, or counselor), PhD, EdD (language pathologist, speech pathologist, or speech and language pathologist), PhD, EdD (audiologist).

## **SUBSTANCE ABUSE**

### ***Marijuana Legalization/Decriminalization***

With state budgets making legislators desperate for additional sources of revenue, in 2010, some states considered an unlikely source for new tax money – legalizing and taxing the sale of marijuana. Four (4) states (**Massachusetts, New Hampshire, Rhode Island, and Washington**) considered bills that would legalize marijuana. **California** will be voting on a referendum in November that would allow local governments to legalize and tax marijuana, bringing in an estimated \$1.8 billion in additional tax revenue. Though state legislatures are unlikely to vote to legalize marijuana this year, a win for California Proposition 19 in the fall could encourage more states to consider the option.

States are also considering reducing the status of a marijuana possession violation from a criminal offense to a civil infraction. In 2010, 5 states (**California, Connecticut, New Hampshire, Rhode Island, and Vermont**) considered legislation to decriminalize marijuana. Nineteen (19) states (**Alabama, Arizona, Delaware, Illinois, Iowa, Kansas, Maryland, Massachusetts, Minnesota, Missouri, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, South Dakota, Tennessee, Virginia, and Wisconsin**) and the **District of Columbia** are also considering legalizing marijuana for medicinal use. In November 2010, 3 states (**Arizona, Oregon, and South Dakota**) will consider medical marijuana on the ballot. Both the **District of Columbia** and **New Jersey** passed laws legalizing medical marijuana in 2010.

### **TOBACCO**

#### ***Smoke-Free Workplace Laws***

Clean Indoor Air legislation continues to sweep across the states. So far in 2010, 9 states (**Alabama, Indiana, Kansas, Mississippi, Missouri, Oklahoma, Pennsylvania, South Carolina, and West Virginia**) have introduced smokefree workplace legislation. **Kansas** became the most recent state to enact a comprehensive ban on smoking. The ban will include restaurants and bars, but exclude casinos.

#### ***Smoking in Vehicles with Children***

States continue to attempt to address children's exposure to secondhand smoke in vehicles. This year, 8 states (**Arizona, Florida, Georgia, Maryland, Massachusetts, Mississippi, Missouri, and Virginia**) have introduced legislation to provide penalties to drivers who subject minors to secondhand smoke in vehicles. These bills were not enacted.

### **UNDERAGE DRINKING**

#### ***Providing Alcohol to Underage Individuals***

States are continuing to look at strengthening punishment of those who provide alcohol to minors to reduce underage drinking. In 2010, 3 states (**Connecticut, Minnesota, and Vermont**) considered legislation that increase penalties for adults convicted of furnishing alcohol to minors. None of these bills became law.

#### ***Underage Drinking Penalties***

This year, lawmakers in 7 states (**Alaska, Hawaii, Mississippi, New Jersey, New York, Oklahoma, and Wyoming**) introduced bills that would increase the penalties for those cited with underage drinking or using false identification to obtain alcohol. Of these states, **Alaska** passed a bill that will increase penalties for those convicted of underage drinking or supplying alcohol to minors, and **Wyoming** enacted legislation that creates an offense for those younger than 21 years of age who attempt to gain admittance to places that serve alcohol.

If you have any questions or need assistance with state advocacy activities, please contact the Division of State Government Affairs at 800/433-9016, ext 7799 or at [stgov@aap.org](mailto:stgov@aap.org).

For more information on state advocacy resources and activities, be sure to visit the State Government Affairs Web page on the Member Center of the AAP Web site at [www.aap.org/moc/stgovaffairs/](http://www.aap.org/moc/stgovaffairs/)

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