

# IN THE DRIVER'S SEAT: *STATE LEGISLATURES SPEED THROUGH 2004*

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**W**ith 2004 coming to a close, it is time to reflect on the actions of the 50 state legislatures. Most of them began their legislative sessions in January or February and adjourned by the end of June. (See table on page 14 for a list of states that either did not meet this year or had full-year sessions.) During that compressed time period, proposed legislation was guided through the twists and turns of the legislative process, not unlike the Monte Carlo Grand Prix (though perhaps not as glamorous or exciting).

Proving once again that they are in the driver's seat when it comes to managing issues directly affecting their citizens, state legislatures considered tens of thousands of bills relating to various aspects of the daily lives of surgeons and their patients. Regulation of professions, insurance, banking, public health and welfare, education, Medicaid, and, yes, medical liability reform are just some of the many issues in the purview of state legislatures.

Although surgeons may not always be behind the wheel of the legislative process, they can offer strategies to win the race toward improved patient care. The State Affairs staff of the College works with chapters and surgeons on various aspects of grassroots advocacy to help them respond to proposed legislation. Because so many health care bills are considered each year, the State Affairs staff focuses on the ones that are the most important to surgeons as recommended by the Health Policy Steering Committee. For 2004, the three priority issues were medical liability reform, trauma system funding and development, and scope of practice expansion.

To assist the chapters, State Affairs staff attended numerous chapter meetings in 2004 to talk about how surgeons can become active in grassroots advocacy, provide updates on College efforts at the federal and state levels, and serve as “advocacy consultants.”

Through our Surgery State Legislative Action Center (SSLAC), a Web-based advocacy tool (<http://www.facs.org/sslac/index.html>), surgeons sent more than 3,000 letters and faxes to their state legislators advocating on behalf of medical liability reform, trauma system funding, and scope of practice issues. Additionally, we helped to place print advertisements in a number of newspapers to support ballot initiatives related to medical liability reform, and State Affairs staff were in regular contact with national surgical specialty societies that collaborated on these issues.

### **Medical liability reform**

Not unexpectedly, medical liability reform remains the number one issue at the state level for surgeons. During 2004, at least 23 state legislatures considered a multitude of bills to address this critical issue. Those states passing reforms were: Arizona (expert witness standards); Mississippi (set a \$500,000 cap on noneconomic damages, abolished joint and several liability); North Carolina (“I’m Sorry” provision); Oklahoma (\$300,000 cap on noneconomic damages); and Ohio (“I’m Sorry” provision, expert witness standards). The governors of two states—Iowa and Missouri—vetoed reform bills containing caps on noneconomic damages.

A few states that were unable to enact medical liability reforms during their legislative sessions

## STATES LEGISLATURES WITH NO SESSION IN 2004

Arkansas	North Dakota
Montana	Oregon
Nevada	Texas

## STATE LEGISLATURES MEETING ALL YEAR

Illinois	Ohio
Massachusetts	Pennsylvania
Michigan	Wisconsin
New Jersey	District of Columbia
New York	Council

did succeed in placing the issue on their general election ballots. Florida, Nevada, Oregon, and Wyoming voters were given the chance to decide on this issue. In addition, Washington State physicians were gathering signatures to force the state’s legislature to adopt a comprehensive reform initiative during next year’s session. If the legislature fails to do so, the initiative will go to the voters in 2006. (See page 6 of this issue for updated information on these ballot initiatives.)

Toward the end of this year, Maryland surgeons learned that their medical liability insurance premiums were going to increase by at least 35 percent, with some experiencing increases of 60 percent or more. Alarmed by these double-digit increases, they joined with other members of the physician community to pressure the General Assembly into holding a special session to enact reforms. Gov. Robert Ehrlich (R) offered strong support for a special session, but legislative leaders were less amenable. The 2005 session will no doubt result in considerable grassroots advocacy activity among Maryland surgeons as they strive to enact much-needed relief.

One interesting development took place in Illinois. Due to the repeated failure of the General Assembly to pass meaningful medical liability reform, two downstate municipalities adopted ordinances incorporating reforms patterned on California’s Medical Injury Compensation Reform

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## MEDICAL STAFF SELF-GOVERNANCE ACT

Incorporates six key principles of medical staff self-governance essential for the professional teamwork of the medical staff:

- Create and amend medical staff bylaws.
- Establish and enforce criteria for medical staff membership and privileges.
- Establish and enforce quality of care and utilization review standards, and oversee other medical staff activities, such as medical records review and meetings of the medical staff and its committees.
- Select and remove medical staff officers.
- Collect and spend medical staff dues.
- Hire independent legal counsel at the expense of the medical staff.

Act. Although the courts ultimately must decide whether the cities have the authority to do this under Illinois' home rule statute, this bold move reinforces the need for the state legislature to act, and provides an alternative approach to medical liability reform worthy of consideration in other states. (For a more detailed description of state medical liability reform efforts, see page 17 of the November 2004 *Bulletin*.)

### **Trauma**

Legislation dealing with trauma-related issues surfaced in a number of states. In Indiana, the state Committee on Trauma (COT) successfully won passage of a requirement that automobile passengers under eight years old be seated in a child restraint system. Meanwhile, Oklahoma's COT convinced legislators to increase funding for the state's trauma system, including reimbursement for uncompensated care. In addition, a measure was added to the general election ballot in that state to raise the tobacco tax on cigarettes by 80 cents a pack, with some of the additional revenue allocated to the trauma system. Finally, California voters were to vote on Proposition 67, the Emergency Medical Care Initiative. This ballot

measure would add a 3 percent surcharge for telephone usage. Funds collected would be used to provide emergency personnel training and equipment, reimbursement for uncompensated emergency physician care, uncompensated community clinic care, emergency telephone system improvements, and hospital emergency services.

### **Scope of practice**

Supporting patient safety and quality of care in state legislatures can be a difficult proposition when battling well-funded and organized allied health professionals who are trying to expand their scopes of practice. Hence, the College joined with other surgical specialty societies in responding to single-degree (DDS) oral surgeons seeking to perform elective cosmetic surgical procedures of the head and neck, and optometrists aggressively seeking to perform eye surgery.

In California, dentists succeeded in gaining passage of legislation to expand their scope, only to see it vetoed by Gov. Arnold Schwarzenegger (R) at the urging of the Coalition for Safe Plastic Surgery (<http://www.safeplasticsurgery.org>). In his veto message, the governor noted his desire to "fully ensure the safety of California's consumers," and called on the Department of Consumer Affairs to conduct an occupational analysis of oral and maxillofacial surgeons to determine whether they should be permitted an expansion of their scope of practice.

While optometric expansion bills were defeated in nine states, Oklahoma's legislature passed a bill permitting optometrists to use scalpels to perform cataract surgery, plastic surgery, facial reconstruction, and eyeball removal. The American Academy of Ophthalmology's "Surgery by Surgeons" campaign, with support by the College and the American Medical Association, is educating Oklahoma citizens on the dangers of this scope expansion through a series of radio and newspaper ads and is working with state officials to develop regulations for implementing the legislation.

### **Other issues**

*Medical staffs.* Conflicts between medical staffs and hospitals occur all too commonly, and physicians in California succeeded in passing the Medical Staff Self-Governance Act to address some significant problems in that state. The law clearly

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established the independent status of the medical staff and set forth medical staffs' basic rights and responsibilities. (See boxed item on page 15 for details.)

*Surgical taxes.* New Jersey surgeons and other physicians strenuously opposed two bills that implemented new taxes on surgical procedures. The first imposed a 6 percent tax on gross receipts generated from cosmetic surgical procedures considered medically unnecessary. The second assessed a 3.5 percent tax on the gross receipts of ambulatory surgical centers *not* owned by hospitals and was intended to raise funds for uncompensated hospital care. The New Jersey Chapter of the College, the Medical Society of New Jersey, and other surgical organizations have joined together to repeal these taxes.

### **Advocacy for 2005**

Every state legislature will meet in regular session in 2005, providing ample opportunities for surgeons to participate in grassroots advocacy. While no crystal ball is available to predict what issues will have the political momentum for passage, it is a pretty safe bet that the following topics will be on the minds and agendas of legislators:

1. *Medical liability reform.* Crisis states will remain in that circumstance until their respective state legislatures take action to enact meaningful reforms, including caps on noneconomic damages. Expect municipalities and other local government entities, such as counties, to consider dealing with this issue on their own.

2. *Hospital/physician conflicts.* States experiencing construction of specialty hospitals with physicians as owners will see an increase in legislation supported by hospital associations to greatly restrict these facilities, including attempts to go after ambulatory surgery centers and other outpatient facilities not owned by hospitals.

3. *Scope of practice.* The usual allied health professionals will continue efforts to expand their practice into areas legitimately reserved for trained physicians.

4. *State budget shortfalls.* As legislators work to pare costs and increase revenues, Medicaid reimbursement rates may be cut, and new taxes may be assessed on health care services to meet budget needs.

Regardless of the issue, surgeons and ACS chapters need to be advocates for their patients and their profession. Regular interaction with legislators through letters sent via the SSLAC, personal telephone calls to elected officials, participation in coalitions with other state specialty and medical societies, visits to the state capital to meet with legislators, and contributions to political action committees are all essential components of successful grassroots advocacy. The State Affairs staff of the College is available to help with all of these activities and are an excellent resource to speak at chapter meetings, set up action alerts and letters on the SSLAC, and so on. As state legislative issues arise, chapters are encouraged to contact Jon Sutton, Manager, State Affairs, at [jsutton@facs.org](mailto:jsutton@facs.org), or by calling him at 312/202-5358. 