



# 2007 STATE LEGISLATIVE ACTIVITY

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The State Affairs area of the College's Division of Advocacy and Health Policy is responsible for identifying and tracking legislation at the state level. From January to August 2007, more than 150,000 bills had been introduced in state legislatures across the country. States provide a good barometer for the federal government as they are an ideal "laboratory" for implementing innovative reforms.

Because there are so many bills introduced in state legislatures, it is important to focus the College's state affairs resources. In order to do this, the Health Policy Steering Committee has directed State Affairs to focus on the following five broad categories:

- Medical liability reform
- Provider taxes
- Scope of practice
- Trauma system funding and development
- Regulation of anesthesia in office-based surgery

However, there are issues beyond these categories that are brought to the attention of State Affairs by individual surgeons or College chapters. In those cases, staff may provide advice and resources on the best way to address the state legislation or regulation under consideration.

To date in 2007, State Affairs monitored more than 250 bills

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in 45 states through use of an online legislative and regulatory search service. Following is a representative sample of the types of bills that were monitored.

### ***Medical liability reform***

The number of bills dealing with comprehensive liability reforms in the style of the Medical Injury Compensation Reform Act, including caps on noneconomic damages, has dropped off in recent years. This outcome can be attributed to the fact that more than 30 states now have some type of cap on noneconomic damages and many others have enacted other significant reforms. In those few states left without reforms, the political climates are not favorable to this type of legislation, or constitutional barriers exist. Still, medical liability reforms made up more than one-quarter of the bills tracked by the College. At press time, there were pending medical liability reform proposals in the following states: California, Colorado, Connecticut, Illinois, Indiana, Minnesota, Michigan, Oregon, Pennsylvania, Washington, and Wisconsin. At this time, most significant liability battles are taking place in the courts.

In February, Louisiana's Supreme Court overturned two lower court rulings that struck down the state cap on noneconomic damages. In its ruling, the Court noted that the constitutional challenges (first raised in the appeals process) should have been heard in trial court instead of in the appeals process.

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This issue originally got started in late September 2006, when the Louisiana Court of Appeals struck down the state's 20-year cap on noneconomic damages. The Appeals Court ruled that because the cap was originally enacted in 1975, and considering the devaluation of the dollar, the \$500,000 cap is worth much less today than it was originally intended and no longer constituted an "adequate remedy" under Louisiana law. To read the court's full opinion, visit <http://www.la3circuit.org/opinions/2006/09/092706/04-1069opi.pdf>.

Tennessee is one of the few states still campaigning for serious liability reforms. A coalition was organized by the Tennessee Medical Association and currently has more than 50 partners, including the Tennessee Chapter of the American College of Surgeons. For more information, go to Medical Liability Reform Now or Pay Later? at <http://www.mlrnw.org>.

In February 2007, comprehensive liability reforms were introduced in H.B. 1993/S.B. 2001. The bill originally included reforms such as a \$250,000 stacked cap on noneconomic damages (maximum \$500,000: \$250,000 for physicians and \$250,000 for facilities per incident), a sliding scale for attorneys' fees, affidavit of merit requirements, and periodic payment for damages exceeding \$75,000.

The Senate bill was amended to address only the issue of lawsuits without merit and was passed unanimously by the State Senate; the House bill, however, was ultimately amended further to weaken the Senate provisions and overturn the existing locality rule. The Tennessee Medical Association and its coalition partners, including the ACS Tennessee Chapter, ultimately opposed the amended bill, which was defeated in the House.

In Colorado, the governor signed S.B. 129, a bill that would adjust for inflation the cap on noneconomic damages on January 1, 2008. The bill also included language that this provision will be reviewed in two years.

Kentucky's H.B. 505, which died in committee, would have created a ballot initiative to authorize the General Assembly to enact liability reforms such as pretrial screening panels, statute of limitations, collateral source reform, expert witness qualifications, certificate of merit, and confidentiality of peer review. As it is a long-term initiative, it will likely be reintroduced in 2008.

### **Provider taxes**

Provider taxes were in the news quite a bit during the 2007 legislative season. With many states looking for unique ways to fund their health care reform proposals, provider and cosmetic surgery taxes were seen as an easy revenue source. Although many agree on the problem, funding the solution is not as easy.

The proposal by Gov. Arnold Schwarzenegger (R) for such taxes in California made big news, although it was never formally introduced into the legislature. However, the threat was much more real in Connecticut with the introduction of H.B. 6652, An Act Establishing the Connecticut Healthy Steps Program, which included a number of taxes on physician and surgical services. One particularly onerous tax, the health care service tax, would have assessed a 3 percent tax on revenue derived from delivering health care services in the state and applied to all providers of medical services, including physicians, hospitals, nursing homes, and other facilities.

The ACS Connecticut Chapter, the Connecticut State Medical Society, and other major physician organizations joined together to testify against this tax and other provisions of H.B. 6652. This tax, as well as a 6 percent sales tax on cosmetic surgery services and a cap that prevents physicians from charging more than 200 percent of the Medicare fee for any service, was ultimately removed.

As press time, H.B. 6652 had not passed, although the Connecticut legislature was in special session to discuss access to health care and the state's budget.

Cosmetic surgery taxes have not fared well in state legislatures, even though they are seen as quick ways to raise some revenue. In fact, the only tax on cosmetic surgery in the country was passed in New Jersey in 2004, and though original projections had the tax bringing in \$24 million in the first year, only \$7.8 million was actually collected.

In March 2006, New Jersey State Assemblyman Joseph Cryan (D), the same legislator who sponsored the tax in 2004, introduced a bill to repeal the tax, calling it "an untested revenue stream that ultimately hasn't delivered."<sup>1</sup> In December 2006, the repeal passed the Assembly 79-0-1 and the Senate 39-0. However, the bill to

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repeal was vetoed in January 2007 by Gov. John D. Corzine (D).

In his veto message, Governor Corzine wrote, “The revenues generated by the cosmetic medical procedure tax, while somewhat less than the original revenue forecast in 2004, are nevertheless recurring and dependable.... In this context, I cannot support repealing this tax, midway through the fiscal year, without establishing an alternative revenue stream to support charity care.”<sup>22</sup>

### **Scope of practice**

Only approximately 13 percent of the bills tracked by State Affairs in 2007 dealt with non-physician scope of practice issues.

New York saw several significant scope battles in 2007. A coalition was formed to help defeat A.B. 7044, which would have expanded the scope of single degree oral surgeons (DDS only) to include elective cosmetic procedures. Under this proposal, dentists would have been allowed to perform cosmetic or reconstructive surgery unrelated to dental care in any health care environment, including office-based practices. Thanks to the work of the coalition (including the New York Chapter of the ACS), this bill died upon its introduction.

Another bill in New York, A.B. 3168/S.B. 1443, would have expanded the scope of podiatry to include conditions of the ankle and all soft tissue structures below the knee anatomically affecting the foot and ankle. This bill died in committee, once again thanks, in part, to the hard work of the New York Chapter.

The outcome was not as successful in Louisiana. Upon signature of the governor in June 2007, podiatry’s scope was expanded to include “...treatment of the ankle, muscles, or the tendons of the lower leg governing the functions of the foot and ankle....”<sup>23</sup>

As further support for addressing scope of practice issues, the College formally joined the Steering Committee of the American Medical Association (AMA) Scope of Practice Partnership. This group is a cooperative advocacy effort between the AMA, state medical associations, and national medical specialty societies and is involved in a wide range of activities, including a combination of legislative, regulatory, and judicial advocacy, as well as programs of information, research, and education.

### **Trauma**

Helping state committees on trauma (COT) implement grassroots advocacy activities related to trauma-focused legislation is an important part of State Affairs’ responsibilities. Approximately 23 percent of the bills tracked during 2007 were trauma-related and were focused on the following four categories:

- Injury prevention
- Trauma system funding and development
- Repeal of the Uniform Accident Sickness and Policy Provisions (UPPL)
- General trauma issues

In May 2007, Indiana’s governor signed H.B. 1237, a bill that amends the requirement for seat belt usage from occupants of the front seat to all occupants in a motor vehicle equipped with safety restraints. Maine also passed L.D. 24, which made a driver’s failure to wear a seat belt a primary offense.

Tennessee’s trauma community was successful in stopping H.B. 1283, a bill that would have repealed the helmet law for motorcyclists. The bill’s original sponsor was a family physician, Rep. Joey Hensley (R), but he withdrew his sponsorship in May; it was then taken up by Representative Todd (R), but after this change in sponsorship, the bill saw no more activity.

Tennessee also passed legislation that created the Tennessee Trauma Center Funding Law of 2007, which will be funded partially from an increase in the state cigarette tax, providing approximately \$10 million annually. Julie Dunn, MD, FACS, Chair of the Tennessee COT, testified in support of the funding law and worked very hard to see this legislation pass. (See related story, page 18.)

Arkansas’ H.B. 1575 would have created a trauma fund by increasing the fine on driving under the influence by \$50 and increasing fines on certain moving violations by \$25, but this bill died upon adjournment.

Georgia had several funding bills introduced in 2007. However, by early April, only two bills—H.B. 77 and S.B. 125—were still alive. The combined revenue of these bills was estimated to generate less than half of the \$80 to \$85 million recommended by the Joint Comprehensive Trauma Services Study Committee in its final report. Ultimately, neither bill passed. However,

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S.B. 60, which created the Georgia Trauma Care Network Commission and the Georgia Trauma Trust Fund, was signed by the governor in May and went into effect July 1.

One of the duties of the trauma commission will be to distribute the money from the trust fund. The distribution formula will be determined and reviewed by the commission with special emphasis on the following:

- Uncompensated physician trauma care services provided in designated trauma centers
- Uncompensated trauma care services provided by emergency medical service to patients transported to designated trauma centers
- Uncompensated trauma care services of designated trauma centers
- Trauma care readiness costs for designated or certified trauma care service providers
- Trauma care service start-up costs for providers seeking a trauma care designation or certification.<sup>4</sup>

In May 2006, after Arizona's Gov. Janet Napolitano (D) vetoed H.B. 2315, which would have raised the burden of proof from "a preponderance of evidence" to "clear and convincing evidence" in order to win a lawsuit against emergency-room personnel, she appointed a task force to consider this issue. In 2007, the task force recommended passage of S.B. 2315. However, political maneuvering caused this bill to fail passage in the House on third reading by a very slim margin.

In 2007, half a dozen states introduced legislation to repeal the UPPL—the law that allows health insurers to not be required to reimburse patients for costs incurred when an accident is a result of "the insured's being intoxicated or under the influence of any narcotic."<sup>5</sup> Such efforts to repeal were often successful.

Illinois, Indiana, Oregon, and the District of Columbia all passed UPPL repeal in 2007, joining the following states that had already prohibited such denial of coverage: Colorado, Connecticut, Iowa, Maryland, Nevada, North Carolina, Rhode Island, South Dakota, and Washington State. Tennessee passed a joint resolution to direct the state's comptroller to study current drug laws, including repeal of UPPL. In Texas, however, the repeal bill (H.B. 634) was heard in committee in April but was left pending and died upon adjournment. California has passed UPPL repeal for the last several years

only to have it vetoed by the governor. This year, UPPL repeal was included in A.B. 1461, a bill to create "a two-year pilot project to demonstrate the efficacy and cost-effectiveness of a specified early methamphetamine intervention model in identifying and diverting methamphetamine addicts." The bill was moving forward at press time.

The following states have never enacted UPPL: Massachusetts, Michigan, Minnesota, New Mexico, New Hampshire, Oklahoma, Utah, Vermont, and Wisconsin (however, courts have ruled that insurance companies can use alcohol/drug exclusions in states that are silent on alcohol exclusion laws).

In September 2006, the College adopted a formal statement calling for the repeal of UPPL. The Statement on Insurance, Alcohol-Related Injuries, and Trauma Centers, a useful document for educating legislators and policymakers on repealing UPPL, can be found online at [http://www.facs.org/fellows\\_info/statements/st-55.html](http://www.facs.org/fellows_info/statements/st-55.html).

### ***Regulation of office-based surgery***

A few states implemented standards for office-based surgery. New York Gov. Eliot Spitzer (D) signed legislation in July that reflects the standards for in-office procedures set forth in the ACS patient safety principles for office-based surgery. Under this new law, surgeons who perform in-office procedures using moderate sedation, deep sedation, or general anesthesia must have their offices accredited by a nationally recognized agency by July 2009, and adverse events must be reported to the New York Department of Health's Patient Safety Center.

Meanwhile, other state medical boards have advanced patient safety for office-based surgery through the regulatory process. The South Carolina Board of Medical Examiners expanded the state's patient safety guidelines for office-based procedures by adopting formal regulations based on the type of anesthesia used. The new requirements focus on the following issues: accreditation from one of the major accrediting organizations, certification in advanced resuscitative techniques, staffing levels and training requirements, emergency transfer agreements with local hospitals or admitting privileges by the surgeon, and various performance improvement and facility standards. In Tennessee, the Board of Medical Examiners

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finalized similar regulations, and the Arizona Medical Board continued efforts to draft its own set of office-surgery rules.

### **Miscellaneous legislation**

Of the bills that fall in the “miscellaneous” category, the majority pertained to patient safety (which includes hospital-acquired infection reporting requirements and informed consent issues). As mentioned earlier, 2007 also saw a large percentage of bills dealing with insurance coverage of both the uninsured and the underinsured.

### **New state advocacy programs**

State Affairs unveiled several new resources for ACS chapters and members in 2007. An Advocacy Handbook and a resource list of more than 60 useful Web sites is now available online on the Advocacy home page on the Web portal and the College Web site.

Another resource, The Advocacy Forum, was added to the Web portal. This forum is an electronic bulletin board for members to discuss current advocacy issues and ask questions on a variety of issues. Other information, including bill tracking reports and notices of headlines in new issues of *Cross Country*—a monthly newsletter dedicated to state legislative efforts—will also be posted on the board.

### **Ongoing state advocacy**


Identifying and tracking state legislation is just one component of the College’s State Affairs program. In 2007, the College continued to publish ACS *Cross Country*, and participated in several issue-based coalitions. In addition, staff worked with ACS chapters to address issues in their states and helped them use the Surgery State Legislative Action Center (SSLAC), a Web-based advocacy tool (<http://www.facs.org/sslac/index.html>). Co-sponsored by 12 surgical specialty societies, the SSLAC provides surgeons a quick and easy way to send prewritten letters to their state legislators or other elected officials.

The StAR (state advocacy representative) program continues to provide an opportunity for surgeons throughout the country to discuss state legislative concerns. StARs act as liaisons between the College and their state legislatures. Quarterly conference calls are held to discuss

ACS state legislative activities and to provide an opportunity for StARs to share state legislative information regarding their own state with both the College and their colleagues in surrounding states. Because many legislative concepts often cross state borders, the calls can serve as an early warning system for contiguous states.

### **A final reminder**

Now is the time for chapters and other groups to begin preparing for next year. State Affairs staff can assist with planning a Day at the Capitol, address advocacy planning/strategy issues (including development of a Chapter Advocacy and Health Policy Committee), and help develop testimony for presentation at state legislative committee hearings. In addition, staff is willing to participate as speakers for any chapter event or other stakeholder group.

For more information on state legislative issues or to become a StAR, contact Melinda Baker at 312/202-5363 or [mbaker@facs.org](mailto:mbaker@facs.org). 

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