State legislative wrap-up: August 2017

This year, states faced a flurry of legislation concerning the ever-present discussions surrounding the nation’s opioid epidemic; telemedicine; physician-insurer relations; physician-led, team-based care; new public health issues; and more. Out-of-network coverage was again a prominent issue across the country, while state transitions to Medicaid managed care have raised numerous issues. Additionally, ongoing debates over administrative hassles and insurer efforts to control utilization affected many states. Finally, the proposed mega-mergers of Aetna-Humana and Anthem-Cigna dominated national and local news, as state and federal regulators wrestled with whether or not to approve these mergers.

In the midst of these legislative, regulatory and private sector issues, medical societies continued to show their value and won more often than can be counted in a single document. In part, this was due to working with state legislatures on solutions, developing coalitions and seeking the best resources from around the country. The American Medical Association (AMA) Advocacy Resource Center has been pleased to contribute to the success of many state and national medical specialty society efforts, and we welcome the opportunity to share our expertise, reach out to our colleagues and enlist colleagues within the AMA on your behalf. This report provides an overview of many 2017 developments to date.

Please refer to the Advocacy Resource Center website for comprehensive resources relating to the Advocacy Resource Center’s state advocacy campaigns, detailed state legislative tracking information and for a list of Advocacy Resource Center attorneys and areas of expertise.

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Health insurer mergers

Overview
On July 3, 2015, Aetna announced an agreement to purchase Humana for $37 billion. On July 24, 2015, Anthem, a Blue Cross Blue Shield insurer, agreed to acquire all outstanding shares of Cigna for an estimated $54.2 billion. Aetna and Anthem pitched from the beginning that the mergers were necessary to, among other things: gain efficiencies; enhance network access; provide new tools and programs that simplify healthcare and improve consumer engagement; and, provide better coordinated, higher-touch, holistic care tied to a person’s specific health and life situation.

2017 Significant activity
The AMA and state medical associations from across the country achieved monumental victories when, on January 23, the District Court for the District of Columbia blocked the merger of Aetna-Humana, and on February 21, the same court blocked the Anthem-Cigna merger. Aetna and Humana abandoned their merger shortly after the January 23 ruling. However, Anthem appealed the lower court’s decision to the U.S. Court of Appeals for the District of Columbia. Throughout the appeal, the AMA and its coalition of 17 state medical associations continued to vigorously oppose the Anthem-Cigna merger. The following is an abbreviated that showcases the level of coordination and collaboration within medicine that resulted in the demise of the Anthem-Cigna merger (here is a more detailed timeline of events):

- **July –September 2015:** Mergers announced; AMA announced its opposition; AMA released its 2015 edition of the “Competition in health insurance: A comprehensive study of U.S. markets”; AMA trustees testified at House Judiciary hearings; and AMA testimony shared with US Department of Justice (DOJ), as well as state attorneys general.
- **October – December 2015:** AMA met with DOJ; AMA publically urged DOJ to block the mergers; AMA convened and held numerous conference calls with a 17 state coalition to fight the mergers; AMA convened call with National Association of Attorneys General (NAAG) and urged AGs to use their authority to block the mergers; and AMA, Florida Medical Association and Florida Osteopathic Medical Association send comprehensive letter to the Florida Office of Insurance Regulation urging it to block the Aetna-Humana mergers.
- **January-April 2016:** Coalition calls continued; AMA created and disseminated a comprehensive monopsony survey and shared summary of results with DOJ and NAAG; AMA collaborated in Florida and filed letter with AG Bondi asking her to reject Aetna-Humana; AMA and California Medical Association testified before the CA Department of Insurance (DOI) opposing Anthem-Cigna and filed a joint statement; and AMA filed statement to Indiana DOI opposing Anthem-Cigna and closely worked with Indiana State Medical Association in preparation for hearings.
- **May-July 2016:** Coalition calls continued; AMA worked with the Medical Society of Virginia in preparation for Virginia’s Bureau of Insurances’ hearing on Anthem-Cigna; AMA filed supplemental report with CA DOI authored by nationally recognized expert; report shared with DOJ and NAAG; AMA filed letter with Missouri Department of Insurance on Aetna-Humana; MO DOI issued order preventing merger; CA DOI urged DOJ to block both mergers; AMA collaborated again in FL and met with the office of the FL AG. AMA secured key documents –signed by nation’s experts – challenging insurer assertions; and DOJ and a number of state AG’s announced they are suing to block both mergers.
- **August-December 2016:** Coalition calls continued; AMA released the 2016 edition of its Competition study; and AMA developed several pieces of model state legislation calling on closer scrutiny of proposed mergers by state regulators, asking for protections against retaliation for physicians and seeking to require the election of insurance commissioners (vs. appointment).
January 2017 – present: Coalition calls continued; District Court for the District of Columbia blocked both mergers; Aetna-Humana merger was abandoned; AMA sent letter to DOJ urging it to steadfastly oppose Anthem-Cigna; AMA filed an amicus brief with the US Court of Appeals in Washington DC related to Anthem-Cigna; at AMA’s suggestion the nation’s experts on antitrust and competition also submitted their own amicus brief supporting our contention; the federal appeals court affirmed trial court’s decision to block Anthem-Cigna; and Anthem abandoned its effort to merge with Cigna.

For more information on AMA health insurance merger advocacy, please visit [www.ama-assn.org/advocacy-resource-center](http://www.ama-assn.org/advocacy-resource-center) or contact Wes Cleveland, JD, Senior Attorney, at wes.cleveland@ama-assn.org or (312) 464-4503, or Henry Allen, JD, Senior Attorney, at henry.allen@ama-assn.org or (312) 464-4271.

**Medicaid**

**Overview**

Changes to Medicaid are underway in nearly every state. Many are looking to curb Medicaid spending and align Medicaid with the private market with, for example, arrangements to provide premium assistance to beneficiaries, provide beneficiaries with health savings accounts, or disenroll and “lockout” individuals who do not make required premium payments. Several other states continue to transition Medicaid from its traditional fee-for-service delivery system into new delivery models like collaborative and regional care organizations. In others, Medicaid managed care is expanding its reach to new populations and geographical areas.

**2017 Significant activity**

**Waivers**

Wisconsin and Maine developed comprehensive Medicaid waivers that, among other things, would restructure Medicaid eligibility for beneficiaries. Wisconsin’s Section 1115 Demonstration waiver would require, as a condition of enrollment, certain enrollees submit to drug testing. Those who test positive for drug use would be required to participate in a treatment program. Wisconsin also seeks to limit enrollment to 48 cumulative months for enrollees not working or participating in a training program. Maine’s waiver proposal would also require employment as a condition of eligibility, as well as higher cost-sharing and premiums and financial penalty for non-emergency use of the emergency department.

**Expansion**

As was expected, no new states opted into Medicaid expansion this year while Congress debated the future of the program. However, Arkansas reauthorized its expansion program, which is an extension of the Medicaid expansion program adopted in 2014 and, most notably, used Medicaid funds to enroll beneficiaries into Marketplace plans. The program has undergone several iterations and this year the Arkansas legislature instructed the state to seek a work requirement for most non-disabled adults as a condition of eligibility and to cap eligibility to 100 percent FPL. Similarly, Arizona and Indiana are seeking extensions of their Medicaid expansion waiver programs with the inclusion of work requirements. Ohio’s legislature sought to freeze Medicaid expansion, though the measure was ultimately vetoed by the Governor.

**Delivery system changes**

States continue to develop and test new, innovative delivery systems in the Medicaid program. Thirteen states (AL, AZ, CA, KS, MA, NH, NJ, NM, NY, OR, RI, TX and WA) now have approved Delivery System
Reform Incentive Payment (DSRIP) programs and DSRIP applications are pending approval in North Carolina and Virginia. In Nevada, the legislature passed legislation that would have permitted state residents to buy into the Medicaid program using federal premium subsidies. However, the governor vetoed the legislation citing concerns about implementation. Idaho enacted legislation directing the Medicaid agency to pursue value-based payment opportunities, including full risk, provider-based managed care. North Carolina began planning its overhaul of Medicaid into managed care.

**Payment rates**

Several states saw Medicaid reimbursement rates cut in 2017 to compensate for budget woes, but not all payment-related news was bad. California approved a state budget that included a raise in Medi-Cal rates for physicians through the use of tobacco tax funds and Georgia allocated $17M for primary care payment rates.

For more information on this Advocacy Resource Center campaign, please visit [www.ama-assn.org/advocacy-resource-center](http://www.ama-assn.org/advocacy-resource-center) or contact Annalia Michelman, JD, Senior Legislative Attorney, at annalia.michelman@ama-assn.org or (312) 464-4788.

**Medical liability reform**

**Overview**

The AMA and our state and specialty society partners continue to advance medical liability reform (MLR) at the state level. State legislatures in 2017 considered bills that promoted a variety of reforms, including expert witness guidelines, affidavit of merit requirements, collateral source reform and bills that established structures such as pretrial screening panels or health court systems. A handful of states also considered and defeated attempts to raise caps on non-economic damages.

Several state medical associations promoted comprehensive tort reform packages in 2017, hoping to capitalize on a conservative swing in state legislatures. Bills adopted thus far this year include a second attempt at a constitutional amendment to establish a cap on punitive and non-economic damages in Arkansas, passage of legislation to limit liability for wrongful birth; establishment of a medical review panel system in Kentucky; strengthening expert witness standards (Daubert standard) and the collateral source rule in Missouri; and establishment of a collateral source rule, certificate of merit requirements and an emergency volunteer act in West Virginia. Last but not least, Iowa passed a comprehensive, MICRA-based legislative package that includes a $250,000 limit on noneconomic damages in most cases, stronger expert witness standards, a requirement for a certificate of merit in all medical liability lawsuits and an expansion of the state’s previously passed communication and resolution framework.

For more information on medical liability reform or to pursue any of the liability reforms discussed above, please visit [ama-assn.org/go/liability](http://ama-assn.org/go/liability) or contact Kristin Schleiter, JD, Senior Legislative Attorney, at kristin.schleiter@ama-assn.org or (312) 464-4783.

**Reversing the nation’s opioid epidemic**

Similar to 2016, there were more than 1,000 individual pieces of legislation concerning prescription drug misuse, overdose and death in 2017. As in previous years, the increasing death toll and media focus on opioid-related mortality has caused legislators and other policymakers to demand solutions. The most common solutions proposed have been new mandates for physicians to use prescription drug monitoring
programs (PDMPs), restrictions on opioid prescribing, mandates for continuing medical education and increased access to naloxone through standing orders and Good Samaritan protections.

State medical associations have played an increasingly constructive role in shaping those policies, leading to more than 30 states now with a PDMP mandate; at least 19 with opioid prescribing restrictions, and more than 20 with a CME mandate. In addition, almost every state now provides for increased access to naloxone, with most allowing for a standing order prescription.

Earlier this year, the AMA Opioid Task Force released a report quantifying what physicians have done with respect to several different policies. In short:

- Opioid prescriptions declined 16.9 percent between 2012 and 2016;
- PDMP use increased 121 percent between 2014 and 2016 to more than 136 million queries;
- More than 118,000 physicians took CME on opioid prescribing and related areas;
- More than 32,000 naloxone prescriptions were dispensed in the first two months of 2017—a 340 percent increase from 2016; and
- More than 11,000 physicians became certified to provide in-office buprenorphine to treat substance use disorders in the past year.

While these are positive signs, it is clear that there is much more work to do. The nation’s opioid-related death toll continues to rise, and it is increasingly being fueled by heroin and illicit fentanyl. To address this, the AMA Advocacy Resource Center continues to work with dozens of state and national medical specialty societies on this issue in both the state legislative and regulatory arenas. In addition, the Advocacy Resource Center presented national updates and analysis to numerous state and specialty society executive committees, task forces and conference panels.

New partners in support of increasing access to comprehensive treatment—both for pain and for substance use disorders—are being sought in the National Association of Attorneys General, American Association of State and Territorial Health Officials, National City and County Health Officials, Partnership for Drug-Free Kids and other key stakeholders. A new model bill to support partial fills of opioid prescriptions is available for state use and the AMA Opioid Task Force launched a new microsite (www.end-opioid-epidemic.org) to further support state and specialty society efforts to educate their members.

AMA support, including background, analysis and technical support, has been a part of the effort to enact new laws, amend negative provisions (and defeat others) relating to prescription drug monitoring programs, continuing medical education, treatment and naloxone/Good Samaritan protections in at least 19 states (AZ, AL, CO, IA, MA, MD, MS, NE, NV, OH, OK, FL, GA, PA, RI, SD and TN, TX and UT).

One key question that the AMA continues to ask focuses on the outcomes/evaluation of the plethora of new laws being enacted. The AMA is urging many groups to undertake this important work, including the stakeholders noted above as well as the National Governors Association, the National Safety Council, the Federation of State Medical Boards, National Association of Boards of Pharmacy, National Association of State Controlled Substance Authorities, National Alliance for Model State Drug Laws, National Association of Counties, National League of Cities, the Partnership for Drug Free Kids and others.

For more information about the Task Force and any other areas mentioned above, please contact Daniel Blaney-Koen, JD, Senior Legislative Attorney, at daniel.blaney-koen@ama-assn.org or (312) 464-4954.
Private payer reform

Overview

The way in which patients and physicians experience the private health care system can be frustrating to say the least. The Advocacy Resource Center continues to work with state and national medical specialty societies to enact state legislation that helps support physicians and patients in all aspects of their relationships with health insurers and other third party payers. Several states had success this year enacting important reforms. Others continued the fundamental process of laying the groundwork and educating lawmakers about the importance of simplifying, streamlining and increasing the transparency of physician-payer interactions for the benefit of all stakeholders.

In addition to supporting state legislative efforts, the AMA also continued its work with the National Association of Insurance Commissioners (NAIC), National Conference of Insurance Legislators (NCOIL) and other national groups to promote changes to the way private health insurers interact with patients and their physicians. Advocacy Resource Center staff regularly participates in NAIC and NCOIL meetings and are involved, this year, in NAIC workgroups addressing pharmacy benefit managers.

2017 Significant activity

Balance billing

State and specialty societies continue to work through legislative proposals addressing anticipated out-of-network bills or “surprise” bills. In fact, more than half of all states had at least one proposal this year, but only a handful ended up being enacted. Of those enacted, four state laws (AZ, IN, NH and LA) were largely disclosure and/or study committee bills. Texas expanded their current mediation process, while Oregon and Maine passed broader bans on out-of-network billing. A problematic bill passed both Houses in Nevada, but was ultimately vetoed by Governor Brian Sandoval.

As opposed to last year, many medical societies attempted to address the issue proactively (e.g. Georgia), offering legislators proposals that frequently included a ban on “surprise” billing in exchange for a fair payment from insurers for the out-of-network care. The fair payment has been identified most commonly as a percentage of charge data from an independent database (i.e. FAIR Health). Much credit should be given to the American College of Emergency Physicians and American Society of Anesthesiologists who engaged with the other hospital-based specialties to draft principles that support such a legislative proposal. A version of these joint principles was also adopted as AMA policy in June.

Unfortunately, trepidation by lawmakers to adopt a “FAIR Health” standard, and a continued interest in a Medicare or insurer-determine standard, shows medicine has much to do in the way of education and messaging before the next legislative session.

Network adequacy

Ensuring that provider networks offer access timely, quality care continues to be a concern in many states, as narrow networks become the norm and changes to networks take place throughout the year. This year, Illinois was able to get a comprehensive network adequacy bill enacted – no small feat especially given their political environment. And Maryland, which enacted strong legislation last year based on the NAIC’s model bill, is now going through the regulatory process to implement the changes. Draft regulations released earlier this year suggest Maryland may end up with some of the strongest provider network requirements in the country.
Prior authorization and step therapy

There continues to be every indication that utilization review requirements are increasing and expanding. Physician are troubled and frustrated by the overstepping by insurers into the clinical decision making process and with the time, money and energy spent on ensuring their patients can access covered drugs and services.

In January 2017, an AMA convened coalition of 17 groups including several state and specialty medical societies, the pharmacists, hospitals and Arthritis Foundation released a set of utilization management reform principles meant to spur change among stakeholders. Along with a simultaneously released survey on the impact of prior authorization on physician practices, the principles caught the attention of many payers and other industry stakeholders, as well as policymakers, and arguably generated new focus on these problematic requirements. Outreach to lawmakers, payers, benefit managers, accrediting organization and others continue and over 100 additional organizations have signed on as supporters of the principles this year.

Not surprisingly, step-therapy legislation was a priority for many states this year, and the enactment of several bills shows the power behind coalition work at the state level. Nearly 20 step-therapy-related bills were introduced this year, with legislation being enacted in several states (CO, IA, MD, TX and WV). Very generally, most bills introduced would require an exception processes for patients who are stable on their current medication, have tried and failed the indicated medication before or for whom the medication would be contraindicated.

Meanwhile, Indiana was able to enact legislation requiring plans to respond using electronic prior authorization (ePA) when the prescriber submits a prior authorization using the standard ePA transactions. Arkansas enacted several improvements to its prior authorization law, as well.

Pharmacy benefit managers

As many states continue to consider legislation addressing the functions and regulation of pharmacy benefit managers (PBMs), the AMA also continues to participate in the NAIC’s workgroup to revise its PBM model bill. Advocacy Resource Center staff participates in regular calls with the NAIC and other stakeholders to debate provisions of the model. The AMA’s priorities include increased transparency in the utilization management processes that the PBM established, as well as increased transparency in the role of PBMs in the decisions making process, including appeals. Moreover, the AMA joined other stakeholders in pushing for state regulation of PBMs similar to the way states regulate insurers.

For more information on the Advocacy Resource Center’s private payer reform campaign, please visit ama-assn.org/go/arc or contact Emily Carroll, JD, Senior Legislative Attorney, at emily.carroll@ama-assn.org or (312) 464-4967.

Public health

Overview

2017 was another active year for public health legislation. Many states continued long-running efforts to chip away at the patient-physician relationship with laws that prescribe or proscribe the content of information exchanged between physicians and their patients, regardless of medical necessity and patient needs. The AMA strongly opposes this type of legislation and believes government interference in the clinical examination room is intrusive and dangerous to patient health.
2017 Significant activity

Women's health
Forty-one abortion restrictions were enacted in 2017. Among those, three states (KS, SD and UT) passed laws dictating the content of information communicated between providers and patients seeking abortions. Three states (IA, KY and WY) enacted legislation requiring providers to administer an ultrasound even when not medically necessary. Iowa passed legislation requiring a 72-hour delay before an abortion may be performed. Texas and West Virginia banned providers from prescribing medication abortion using telemedicine. Two states (IA and KY) banned abortion after 20 weeks and Arkansas banned the use of dilation and evacuation abortion, which is the standard method for abortions after 12 weeks of pregnancy, and abortion for the purpose of sex selection. Wyoming prohibited the donation of tissue from an abortion, as well as research using such tissue, by prohibiting the sale, transfer and distribution of tissue.

On the other end of the spectrum, Delaware approved a measure that would repeal several abortion restrictions and update the state’s abortion laws to reflect the precedent established in Roe v. Wade.

Additionally, with bills enacted in four states (CO, KY, IA and NE) this year, 32 states now require mandatory breast density notification.

Firearms
In February, the United States Court of Appeals for the Eleventh Circuit, sitting en banc (with all the judges), held that three provisions of the Florida Firearm Owners Privacy Act, which prohibited physicians from asking patients about gun ownership, violated the First Amendment. As a result of this decision, Florida physicians retain the ability to communicate freely with their patients regarding safe storage of firearms. More importantly, the decision holds that any law which restricts communications between physicians and patients must withstand First Amendment scrutiny.

In state legislatures, four states (IA, IN, OK and TX) defeated legislation that would have hindered physicians’ ability to counsel patients about gun safety. Four additional states (ND, NJ, TN and UT) enacted legislation to make it more difficult for domestic abusers to obtain a firearm. In November, voters approved three state ballot initiatives – all supported by state medical societies – that aim to prevent gun violence: California’s Prop 63 prohibited the possession of large-capacity ammunition magazines and requires background checks purchase ammunition; Nevada required firearm transfers to go through a licensed gun dealer; and Washington authorized courts to issue extreme risk protection orders to remove an individual from access to firearms. The Washington legislature also passed legislation this year that requires law enforcement to be notified when individuals prohibited from possessing guns attempt to buy them.

Tobacco
This year, New Jersey became the third state to raise the age to purchase tobacco products to 21. California and Hawaii passed such laws in prior years. Legislation was introduced in 21 states (AR, AZ, CT, FL, IA, ID, IL, IN, MA, MD, MS, NE, NJ, NM, NY, OR, TN, TX, VT, WA and WV) to raise the minimum age to purchase tobacco products.

Public safety
Six states (AL, AZ, FL, LA, UT and WA) passed legislation allowing schoolchildren to possess and use sunscreen without a prescription in schools and camps. Texas became the 47th state with a state-wide texting while driving ban. Only three states (AZ, MO and MT) still permit texting while driving.
LGBTQ and transgendered patients

In 2017, four states (CT, NM, NV and NY) banned conversion therapy for minors. However, two states (AL and TX) passed laws allowing social service agencies to refuse to provide services that conflict with the sincerely held religious beliefs of the agency. These laws are understood to permit discrimination against LGBTQ individuals. Sixteen states (AL, AR, IL, KS, KY, MN, MO, MT, NY, SC, SD, TN, TX, VA, WA and WY) considered so-called bathroom bills, which restrict access to restrooms and locker rooms on the basis of sex or gender assigned at birth. None, however, were enacted into law this year.

For more information on this Advocacy Resource Center campaign, please visit ama-assn.org/go/arc or contact Annalia Michelman, JD, Senior Legislative Attorney, at annalia.michelman@ama-assn.org or (312) 464-4788.

Team-based care/Scope of practice

Overview

State legislatures in 2017 considered over 750 bills seeking to eliminate team-based care models of health care delivery and/or expand the scope of practice of non-physician health care professionals. State medical associations had resounding success in defeating two categories of scope bills, both related to prescriptive authority: psychologist prescribing and naturopaths’ quest for authority to prescribe controlled substances. Though tough fights in all cases, most bills that threatened passage have been defeated with the support of the Advocacy Resource Center and – as is often the case with scope bills – a coordinated state and specialty effort.

2017 Significant activity

Advanced practice registered nurses

This year over 175 bills were filed to expand the scope of practice of advance practice registered nurses (APRNs). Many of these bills chip around the edges of state laws, notably laws regarding certification of a disability or cause of death, authorization of involuntary commitment, and so on. Fighting these types of bills – which often simply add “and nurse practitioners” throughout state laws – continue to be a source of frustration for state medical associations. Still other bills seek APRN practice independent of physician supervision, collaboration or oversight.

Medicine has been largely successful this year in preventing APRN independent practice laws from passing. To date, bills have been defeated in seven states (AR, FL, KY, IN, MS, TN and VA). A bill expanding nurse anesthetists’ prescriptive authority in Arizona passed with an amendment advocated for by the state medical association, exempting a physician or surgeon from liability for any act or omission of a nurse anesthetist who orders or administers anesthetics. This amendment was intended to address the nurse anesthetists’ talking point claiming that surgeons are hesitant to supervise nurse anesthetists due to fear of liability. In addition, New Mexico’s legislature failed to pass a bill that would have required health facilities to grant admitting and discharge privileges to nurse practitioners and nurse midwives.

Still, some state medical associations continue to feel pressure from legislators to compromise with APRNs on independent practice. 2018 may bring several such compromises from several states, potentially turning on a “transition to independence,” allowing independent practice after a defined number of hours or years of clinical practice.
The Advocacy Resource Center continues to work with state and specialty medical societies to address APRN issues and physician-led, team-based care.

APRN Multistate Licensure Compact

The National Conference of State Boards of Nursing (NCSBN) recently launched a revised APRN Multistate Licensure Compact (APRN Compact). The APRN Compact differs from the Federation of State Medical Boards Compact (FSMB Compact) in two key ways:

- The APRN Compact grants a multistate license – a licensed APRN will have to apply for a single multistate license that will allow the APRN to practice in any APRN Compact state. In comparison, the FSMB Compact creates a pathway by which physicians can obtain multiple single-state licenses.

- The APRN Compact authorizes any APRN practicing in an APRN Compact state under an APRN Compact license to practice independently. As such, the APRN Compact undermines state law in a way that the FSMB Compact does not. APRNs practicing in APRN Compact states with a regular license (not a multistate license) will still be required to follow state law on collaborative practice. In addition, all APRNs, whether practicing under a regular or multistate license, will have to follow the applicable state’s rules for collaboration/supervision while prescribing controlled substances.

So far, only three states (ID, ND and WY) have joined the APRN Compact. Given that the APRN Compact undermines state law — and undermines state law to grant independent practice — the Advocacy Resource Center expects to actively oppose this Compact.

Physician assistants

The American Academy of Physician Assistants (AAPA) made progress this year on independent practice, with a resolution passing the AAPA House of Delegates (AAPA HOD) in May that would support physician assistants (PAs) moving from a supervisory to an independent relationship with physicians.

Previously, AAPA adopted model legislation replacing all references to supervision with collaboration; utilizing the term PA instead of “Physician Assistant” throughout; removing the concept that the PA is the agent of the physician; creating a separate and independent PA board; and allowing insurers to reimburse PAs directly.

This spring, however, the AAPA HOD adopted a policy proposal that states that PAs should commit to “Optimal Team Practice,” which emphasizes the PA’s commitment to team based care, but states that the degree of collaboration between PAs and physicians should be determined at the practice level, not by state law. As such, the adopted policy would eliminate provisions in laws and regulations that require a PA to have a specific relationship with a physician in order to practice. State medical associations should be prepared for proposals for either independent or collaborative practice in future legislative sessions.

Other scope issues

In other scope news, states legislatures in 2017 considered the usual range of scope bills — optometrists seeking surgical authority; naturopaths seeking prescriptive authority; and psychologists and pharmacists seeking prescriptive authority.

States continue to grapple with psychologist prescribing bills, which are enjoying renewed interest after passage of compromise legislation in Illinois in 2014 that allowed for extremely limited prescriptive authority after completion of a two-year educational program similar to PA education, and in collaboration with a
physician. Similar legislation in Iowa passed last year at the eleventh hour, with the addition of joint rulemaking authority by the board of medicine and the board of psychologists. This year, legislation passed in Idaho, due to pressure from the legislature to find compromise. A bright spot in psychologist prescribing legislation was in Hawaii, where legislation that threatened to pass in 2016 failed to move this year.

There continues to be limited interest in assistant physician legislation (a/k/a graduate registered physicians, special permit holders or associate physicians). While in 2016, assistant physician legislation was uniformly defeated, in 2017, legislation was signed into law in Utah.

The other major area of activity this year relates to optometrists’ efforts to gain surgical authority. Bills have been filed in dozens of states, with significant advocacy efforts taking place in five states (AL, FL, GA, MD and NC). Georgia’s bill was signed in early May, allowing optometrists to perform injections around and into the surface layer of the eye, upon the condition that they have completed or are enrolled in a 30-hour certification training course. However, in addition to signing the bill, Georgia’s governor issued a corresponding Executive Order stipulating several additional measures intended to protect the public health, including that the training program be sponsored by an appropriately credentialed school and approved by the state board of ophthalmology. A bill similar to Georgia’s is awaiting the Governor Bill Walker’s signature in Alaska. To date, optometry bills also have been defeated in two states (FL and MD).

**Telemedicine**

**Overview**

Following release of AMA model telemedicine legislation, states saw a flurry of activity in the area, with dozens of laws and regulations proposed to address telemedicine licensure, reimbursement, and practice standards. While most attention was given to debates over how to establish a patient-physician relationship via telemedicine – in person, face-to-face or over the phone – states continue to make gains in passage of coverage parity laws, ensuring that physicians will be compensated for treating their patients via telemedicine. Many of these laws were based on the Advocacy Resource Center’s drafted model legislation “The Telemedicine Act” which addresses these and other issues related to telemedicine.

**2017 Significant activity**

State legislatures and regulatory boards tackled a variety of telemedicine issues this year. Medicaid coverage parity was a popular topic, as were laws that outline requirements for licensure; prescribing of controlled substances; the (removal of the) requirement to be in the same state as the patient to practice telemedicine; and of course, how to properly establish a patient-physician relationship. Many of these bills were either based on the AMA model state Telemedicine Act, or were amended significantly to incorporate language from the model bill.

**Coverage parity**

Studies consistently suggest that inadequate or nonexistent private or public payment is the primary obstacle to physician adoption of telemedicine. Addressing this issue, in 2015 states passed the halfway point of coverage parity laws, with now over 31 states having laws that enforce private coverage of medical care provided via telemedicine.

States continued to expand coverage of telemedicine in 2017, with bills being signed into law in seven states (AR, CO, IN, MD, ND, NE and UT). Consistent with the AMA model state legislation, the “Telemedicine Reimbursement Act,” most of these laws provide that a health benefit plan shall cover the telemedicine services of a physician on the same basis as the health benefit plan provides coverage for the same services.
Practice issues: Establishment of the patient-physician relationship

States also considered legislation and regulation that provides guidance on establishing the patient-physician relationship. Four states (MN, OR, TX, WA and WY) (WY specifically directing medical board to promulgate rules) modernized state laws by clarifying that a physician can establish a relationship with a patient via telehealth if certain conditions are met, such as a referral from the patient’s treating physician, or certain technical capacity like the ability to connect to the patient via videoconference. At the same time, states including Virginia and West Virginia clarified laws regarding prescriptive authority.

One state’s legislation requires particular attention. After longstanding litigation between Teladoc and the state medical board, Texas in 2017 adopted legislation to authorize medical care to be delivered to a new patient via telemedicine. The new law deletes the previous requirement that physicians have a face-to-face visit with a patient prior to a telemedicine visit (whether face-to-face meant in-person was the primary question at issue in Texas’ litigation). Instead, the law conditions the physician’s use of telemedicine on the physician having relevant clinical information that would be required in accordance with the standard of care – which the new law describes as that same standard that would apply to an in-person setting. Physicians can thus establish a relationship with a new patient via telemedicine so long as the physician has clinically relevant photographic or video images, the patient’s relevant medical records including medical history, lab or pathology histories, or another form of audio-visual technology that allows the practitioner to comply with the standard of care. The physician must provide the patient with guidance on follow-up care and, with the patient’s consent, provide the patient’s primary care physician the medical record within 72 hours with an explanation of treatment, analysis, and diagnosis.

For more information on these and other telemedicine-related legislative activity, including AMA model telemedicine legislation, please visit ama-assn.org/go/arc or contact Kristin Schleiter, JD, Senior Legislative Attorney, at kristin.schleiter@ama-assn.org or (312) 464-4783.

Interstate Medical Licensure Compact

The newly released Interstate Medical Licensure Compact (the Compact) made tremendous gains in 2017, with four more states passing legislation to join the Compact (ME, NE, TN and WA). This brings the total number of states in the Compact to 22 (AL, AZ, CO, ID, IA, IL, KS, ME, MN, MS, MT, NE, NV, NH, PA, SD, TN, UT, WA, WI, WV and WY).

The Compact was officially launched in 2017 and started accepting applications for licensure. Physicians can now apply for expedited multiple state licenses at www.imlcc.org. Currently, eight of the 22 states in the Compact can serve as the primary state of licensure and source of verification. The remaining states are setting the groundwork for the ability to conduct background checks. Legislation to enable or reaffirm this authority is moving quickly.

The Advocacy Resource Center will be working to ensure that the Compact continues to gain steam in 2018, as the Compact’s promise of license portability will best be realized if every state is a member.

For more information on the Compact, please visit ama-assn.org/go/arc or contact Kristin Schleiter, JD, Senior Legislative Attorney, at kristin.schleiter@ama-assn.org or (312) 464-4783.
Truth in advertising

Overview

2017 was a steady year for the AMA's Truth in Advertising (TIA) campaign, which highlights the need for health care providers to clearly and honestly state their level of training, education and licensing. Since the inception of this campaign in 2010, 36 states have introduced and 20 states have enacted legislation based on AMA TIA model state legislation. The AMA is interested in working with any state that wishes to introduce TIA legislation for the first time, or to renew a push for transparency in advertising for medical services.

2017 Significant activity

Three states (HI, OH and MN) considered introduced legislation based on the AMA TIA Campaign in the 2017 legislative session. So far this year, only Minnesota’s legislation has gotten across the finish line.

For more information on the TIA Campaign, please visit ama-assn.org/go/tia or contact Kristin Schleiter, JD, Senior Legislative Attorney, at kristin.schleiter@ama-assn.org or (312) 464-4783.