## STATE GOVERNMENT AFFAIRS

State Legislation Report 2 0 1 3

American Academy of Pediatrics

Dedicated to the health of all children



#### 2013 State Legislation Report

The Academy's advocacy work is a partnership between chapters, committees, councils, sections, and the national organization. The 2013 State Legislation Report outlines 17 key issues relating to children's health and well-being. The State Advocacy FOCUS resource provides an overview of each issue, explains the Academy's position, the advocacy efforts by the Academy and its state chapters, and the progress to date in states. Maps in each State Advocacy FOCUS provide state-by-state information as well as a national perspective, and links to StateTrack profiles provide the current status of state legislative actions on each issue. If you would like more information about a particular state law, including full statutory text, please contact the Division of State Government Affairs.

State Advocacy Blueprint highlights some of the important state child health policy issues that align with Academy initiatives in 2014. We hope that this report is a useful resource for AAP chapters, leaders, members, and others in your continuing efforts on behalf of children's health care and the profession of pediatrics. Thank you for your committed advocacy on behalf of America's children.

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American Academy of Pediatrics



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## American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

141 Northwest Point Boulevard Elk Grove Village, Illinois 60007 800.433.9016, ext 7799 stgov@aap.org

The American Academy of Pediatrics is an organization of 60,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists committed to the attainment of optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults.

Technical assistance with state legislative and regulatory activities is provided by the staff in the Division of State Government Affairs at the AAP headquarters office in Elk Grove Village, Illinois. The division staff provide consultation and strategic guidance to AAP chapters and members who are engaging in advocacy efforts on behalf of child health and pediatric practice. Division staff monitor legislation related to pediatrics in every state and alert chapters to important developments in this area. The division keeps chapter leaders, executive directors, and lobbyists in-tune with the latest state advocacy issues and news about state governments through its e-updates and Web site at <a href="https://www.aap.org/en-us/advocacy-and-policy/state-advocacy">www.aap.org/en-us/advocacy-and-policy/state-advocacy</a>.

The division develops state advocacy resources for use by AAP chapters. Consultation is available to assist chapters with development of testimony and talking points for legislative and public hearings.

To facilitate networking among national and chapter leaders and staff involved in state advocacy, the division, together with the Committee on State Government Affairs (COSGA), provides state legislative advocacy training and educational programs at the AAP Annual Leadership Forum, the AAP National Conference and Exhibition, and other Academy meetings. The division and COSGA also collaborate with the Committee on Federal Government Affairs (COFGA) and the AAP Department of Federal Affairs on the Legislative Conference held in Washington, DC.

The division manages the State Government Affairs area of the AAP Web site which provides a wealth of resources for members and chapters engaging in state advocacy work. Please visit us on the AAP Web site at <a href="https://www.aap.org">www.aap.org</a>.

#### **Division of State Government Affairs Staff**

Committee on State Government Affairs

Jim Pawelski

Director

Anne Edwards, MD, FAAP

Chairperson; Minneapolis, MN

Ian Van Dinther

Senior State Government Affairs Analyst

Nancy Graff, MD, FAAP

Member; La Jolla, CA

Dan Walter

Senior Policy and Government Affairs Analyst

Barry Lawson, MD, FAAP

Member; Bellevue, WA

Katie Crumley

State Government Affairs Analyst

Michael McManus, MD, FAAP

Member; Boston, MA

Wendy Chill

State Government Affairs Analyst

Victor Perez, MD, FAAP

Member; Anaheim, CA

Jeff Hudson

State Government Affairs Specialist

J. Gary Wheeler, MD, FAAP

Member; Little Rock, AR

Hollis Russinof

Program Analyst

Marsha Raulerson, MD, FAAP COFGA Liaison; Brewton, AL

Molly Droge, MD, FAAP

Access Subcommittee Liaison;

Kansas City, MO

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State laws are amended on a frequent basis. The charts and summaries contained in the American Academy of Pediatrics 2013 State Legislation Report are not to be considered legal advice or a restatement of the law. Readers of the 2013 State Legislation Report are strongly encouraged to consult a local attorney regarding the applicability of these laws to specific situations.





#### State Government Affairs Web Resources

MyAAP State Government Affairs Pages: The Division of State Government Affairs maintains a comprehensive resource of online state advocacy materials in the State Government area of the MyAAP Web site for use by AAP members and chapter staff. Find advocacy tools like StateTrack, eupdates, the AAP Advocacy Guide and more at <a href="https://www.aap.org/stgovaffairs">www.aap.org/stgovaffairs</a>.



#### State Advocacy Public Page:

The Division of State Government Affairs also offers advocacy resources and information about the Academy's state government affairs activities to the public on the AAP Web site. Log on to <a href="https://www.aap.org/en-us/advocacy-and-policy/state-advocacy">www.aap.org/en-us/advocacy-and-policy/state-advocacy</a> to learn more.







#### State Government Affairs E-updates

Stay informed about the latest happenings in state government affairs and advocacy through our e-updates: State View, State Health, and Advocacy FLASH e-updates from the AAP Division of State Government Affairs keep chapter leaders, executive directors, lobbyists, and other pediatric advocates in-tune with the latest state advocacy issues and state government news and links to valuable resources from the AAP and sources. Past editions are archived on the State Government Affairs area of the AAP.org Web site.



State *View* examines a wide range of issues and current Academy advocacy initiatives, and provides state government news and analysis from across the states. In 2014, all of the information that *StateView* readers have received in the past will be available directly from the main pages of AAP.org, with weekly digests sent to subscribers, making it easier for you to stay informed and engaged.



State *Health* offers extensive analysis and resources for AAP chapters on implementation of the Affordable Care Act and other federal health reform initiatives impacting states.



Advocacy FLASH alerts chapter advocates to urgent public policy developments and provides the information needed to take action.

For more information on these or other state advocacy resources, contact the Division of State Government Affairs at 800.433.9016, ext 7799 or at <a href="mailto:stgov@aap.org">stgov@aap.org</a>.





#### PAVE: Pediatricians Against Violence Everywhere

The AAP Section on Medical Students, Residents, and Fellowship Trainees (SOMSRFT) 2013-2014 Advocacy Campaign: PAVE the Way to Firearm Injury Prevention (Pediatricians Against Violence Everywhere).



Gun violence is a public health issue that profoundly affects children. Every child has the right to live in a safe home, play in the safety of others' homes, and live without fear of firearms.

Pediatricians see the devastating effects of firearms firsthand in the form of suicides and homicides, and by treating those who have been exposed to gun violence at school, in the community, or at home. According to the CDC, firearm injury is in the top 3 causes of death among youth, causing twice as many deaths as cancer, 5 times as many as heart disease, and 15 times as many as infections. Pediatricians routinely advocate and educate parents regarding the importance of car seats, bike helmets, seat belts, child abuse, and drowning prevention, and should also counsel about firearm injury prevention.

PAVE aims to highlight that approximately 7 young people die each day from gun violence, according to the Centers for Disease Control and Prevention (CDC). To raise awareness of this sobering statistic, we encourage our members to organize an event, send an email, engage on social media, or have an advocacy day on the 7th day of every month through October 2014.

The campaign has developed resources for use at the clinic, community, chapter/state, and federal levels to address 3 main areas of advocacy with the goal of keeping kids and teens safe:

- Support common sense firearm legislation that protects kids
- · Provide education and research about firearms
- Expand mental health screening and access to treatment

Learn more on our Web pages at <a href="www2.aap.org/sections/ypn/r/advocacy/PAVE.html">www2.aap.org/sections/ypn/r/advocacy/PAVE.html</a>.





### 2014 State Government Information

	Legislative Session		Partisan	Partisan Composition of House			Composition of	of Senate		
State	Convenes	Adjourns	Governor	Democratic	Republican	Other / Vacancy	Democratic	Republican	Other / Vacancy	
Alabama	1/14/2012	5/19/2014	Robert Brantley (R)	37	63	4	11	23	1	
Alaska	1/21/2014	4/20/2014	Sean Parnell (R)	14	26	0	7	13	0	
Arizona	1/13/2014	5/30/2014	Jan Brewer (R)	24	36	0	13	17	0	
Arkansas	2/10/2014	3/21/2014	Mike Beebe (D)	48	51	1	13	21	1	
California	1/6/2014	8/31/2014	Edmund G. Brown (D)	53	25	2	27	13	0	
Colorado	1/8/2014	5/7/2014	John Hickenlooper (D)	37	28	0	18	17	0	
Connecticut	2/5/2014	5/7/2014	Dan Malloy (D)	99	52	0	22	14	0	
Delaware	1/14/2014	6/30/2014	Jack Markell (D)	27	14	0	13	8	0	
Florida	3/4/2014	5/2/2014	Rick Scott (R)	45	75	0	14	26	0	
Georgia	1/13/2014	4/11/2014	Nathan Deal (R)	59	117	4	18	37	1	
Hawaii	1/15/2014	5/1/2014	Neal Abercrombie (D)	44	7	0	24	1	0	
Idaho	1/13/2014	4/12/2014	C.L. "Butch" Otter (R)	13	57	0	7	28	0	
Illinois	1/8/2014	1/13/2015	Pat Quinn (D)	71	47	0	40	19	0	
Indiana	11/19/2013	3/14/2014	Mike Pence (R)	31	69	0	13	37	0	
Iowa	1/13/2014	4/22/2014	Terry E. Branstad (R)	46	53	1	26	23	1	
Kansas	1/13/2014	5/28/2014	Sam Brownback (R)	33	92	0	8	32	0	
Kentucky	1/7/2014	4/19/2014	Steven L. Beshear (D)	54	45	1	14	22	2	
Louisiana	3/10/2014	6/2/2014	Bobby Jindal (R)	44	59	2	15	24	0	
Maine	1/8/2014	4/16/2014	Paul LePage (R)	89	58	4	19	15	1	
Maryland	1/8/2014	4/7/2014	Martin O'Malley (D)	98	43	0	35	12	0	
Massachusetts	1/1/2014	1/6/2015	Deval Patrick (D)	130	29	1	36	3	1	
Michigan	1/8/2014	12/31/2014	Rick Snyder (R)	50	59	1	12	26	0	
Minnesota	2/25/2014	5/19/2014	Mark Dayton (D)	73	61	0	39	28	0	
Mississippi	1/7/2014	4/6/2014	Phil Bryant (R)	57	63	2	20	32	0	
Missouri	1/8/2014	5/30/2014	Jeremiah W. (Jay) Nixon (D)	53	109	1	10	24	0	
Montana	No regular 20		Steve Bullock (D)	39	61	0	21	29	0	
Nebraska	1/8/2014	4/22/2014	Dave Heineman (R)	Nebraska has 49 nonpartisan legislative seats in a 1-chamber legislature.						
Nevada	No regular 20		Brian Sandoval (R)	27	15	0	11	10	0	
New Hampshire	1/8/2014	7/1/2014	Maggie Hassan (D)	218	179	3	11	13	0	
New Jersey	1/14/2014	1/12/2015	Christopher Christie (R)	46	34	0	24	16	0	
New Mexico	1/21/2014	2/20/2014	Susan Martinez (R)	38	32	0	25	17	0	
New York	1/8/2014	1/7/2015	Andrew Cuomo (D)	105	42	3	31	27	5	
North Carolina	5/12/2014	7/21/2014	Pat McCrory (R)	43	77	0	17	33	0	
North Dakota	No regular 20		Jack Dalrymple (R)	23	71	0	13	33	1	

#### 2014 State Government Information

Legislative Session				Partisan Composition of House			Partisan Composition of Senate		
State	Convenes	Adjourns	Governor	Democratic	Republican	Other / Vacancy	Democratic	Republican	Other / Vacancy
Ohio	1/7/2014	12/31/2014	John Kasich (R)	39	60	0	10	23	0
Oklahoma	2/4/2014	5/30/2014	Mary Fallin (R)	29	72	0	12	36	0
Oregon	2/3/2014	3/9/2014	John A. Kitzhaber, MD (D)	34	26	0	16	14	0
Pennsylvania	1/7/2014	11/30/2014	Tom Corbett (R)	92	110	. 1	23	27	0
Rhode Island	1/7/2014	6/23/2014	Lincoln Chafee (D)	69	6	0	32	5	1
South Carolina	1/14/2014	6/5/2014	Nikki R. Haley (R)	45	78	1	18	28	0
South Dakota	1/14/2014	3/31/2014	Dennis Daugaard (R)	17	53	0	7	27	1
Tennessee	1/14/2014	4/17/2014	Bill Haslam (R)	28	70	1	7	26	0
Texas	No regular 2014 session		Rick Perry (R)	55	95	0	12	19	0
Utah	1/27/2014	3/13/2014	Gary R. Herbert (R)	14	61	0	5	24	0
Vermont	1/7/2014	5/2/2014	Peter Shumlin (D)	95	45	10	19	4	7
Virginia	1/8/2014	3/9/2014	Terry McAuliffe (D)*	33	67	0	20	20	0
Washington	1/13/2014	4/4/2014	Jay Inslee (D)	55	43	0	26	23	0
West Virginia	2/12/2014	4/12/2014	Earl Ray Tomblin (D)	54	46	0	24	10	0
Wisconsin	1/14/2014	5/21/2014	Scott Walker (R)	39	57	3	15	18	0
Wyoming	2/10/2014	3/7/2014	Matthew Mead (R)	8	52	0	4	26	0

Key: (D) – Member of the Democratic Party; (R) – Member of the Republican Party; (I) – Independent; Other/Vacancy – Other Party Member or Vacant Seat.; \* Term starts in 2014 Based on information available in November 2013; session dates subject to change. For the most up-to-date information, contact the AAP Division of State Government Affairs. Source: National Conference of State Legislatures; National Governors Association





#### 2014 State Advocacy Blueprint

#### Introduction

If you're a pediatrician, you're an advocate. Children, their families, and the pediatricians who care for them face many challenges today, but they also recognize endless opportunities for change. To seize these opportunities, the AAP, its state chapters, and members engage in a wide spectrum of advocacy activities at the clinical, community, state, and federal levels. The AAP undertakes initiatives to support the work of its members and chapters in their quest to improve the lives of children, their families, and to improve the profession of pediatrics. Here's a blueprint to help you build success in your state in the coming year.

#### Affordable Care Act (ACA)

State implementation of the ACA is underway, with much of the current media focus on marketplace enrollment for uninsured adults. But there's an untold story with the ACA—it's already working for kids. Not only have children been receiving preventive care as a covered benefit without cost sharing since September 2010, they have enjoyed many other consumer protections that will now be extended to adults as well. Moreover, marketplaces are finding new CHIP and Medicaid eligible children, and connecting them to coverage.

While the federal marketplace Web site had considerable technical problems at launch, the state-based marketplaces are leading the way, and have enrolled a majority of the newly insured. Continued improvements will be necessary to ensure that young adults and families are covered as the law reaches its 2014 "go live" dates and AAP chapters are going to be the eyes and ears of how the law is working for children, families, and pediatricians.

To that end, the AAP asks for your input throughout the year on ACA implementation; our advocacy with payers, state and federal agencies and regulators, and other medical specialties depends on it. Let us know how it's going at <a href="mailto:ACAfeedback@aap.org">ACAfeedback@aap.org</a>.

#### **Cost Containment**

Just as states were innovators in the decade leading up to the ACA, states are again signaling what's next for health reform. As the ACA roll-out continues, states still have huge portions of their budgets dedicated to health care and are under increasing pressure from the private sector to help them control costs. Pediatricians can be good stewards of scarce health care resources in their own clinical practices and professional settings. As market forces press towards consolidation and the development of accountable care organizations (ACOs) and other new health care financing models pediatricians voices must be heard—for patients and the profession. Pediatricians can advocate for health policy that promotes savings as well as the benefits of extending access to care and appropriate benefits for children.

A 2011 AAP white paper on ACOs can be found at: <a href="http://aapnews.aappublications.org/content/32/1/1.6.full.pdf">http://aapnews.aappublications.org/content/32/1/1.6.full.pdf</a>

#### Early Brain and Child Development

Recent scientific advances are driving a paradigm shift in the understanding of how child development impacts human health and disease across the lifespan. Early social and environmental experiences and genetic predispositions influence the development of adaptive behaviors, learning capacities, lifelong physical and mental health, and future economic

productivity. Pediatricians know that child development is the foundation for community and economic development. AAP chapters can work with state policymakers to support creating the right conditions in early childhood—which is more effective and far less costly than addressing a multitude of problems later on in life.

The return on public investment in early childhood is beginning to be better understood and valued by lawmakers—over 500 state legislators signed a letter to the Congressional Budget Conference Committee, urging them to support federal investment in early learning. See the letter at: <a href="https://www.ffyf.org/blog/state-legislators-early-learning-letter-congress">www.ffyf.org/blog/state-legislators-early-learning-letter-congress</a>.

Videos of educational sessions on early brain and child development for the 2013 Pediatrics in the 21<sup>st</sup> Century program at the AAP National Conference are available at the link below: <a href="http://pedialink.aap.org/visitor/cme/about\_aap\_cme/PEDS-21-2013-Agenda-and-Learning-Objectives">http://pedialink.aap.org/visitor/cme/about\_aap\_cme/PEDS-21-2013-Agenda-and-Learning-Objectives</a>

#### **Immigration**

Children of immigrants are the fastest growing population of children in the US and have contributed to the entire growth in the nation's child population over the past decade. Immigrant families are racially and ethnically diverse, and immigrate for variety of reasons that may include seeking economic opportunity, reuniting with family, fleeing war or violence.

Pediatricians can play a special role in supporting the health and well-being of immigrant children in the United States. By recognizing the unique challenges and strengths that many immigrants experience; pediatricians can identify effective practice strategies and relevant resources that support health within the community. AAP chapters enhance this role by educating state policymakers about the challenges being faced by immigrant families and their children, by weighing in on related policy proposals, and by serving as a resource for chapter members who have families in need of assistance.

To link immigrant families in your state to legal services, please see the resources in the new AAP Immigrant Child Health Toolkit, available at the following link: www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Council-on-Community-

Pediatrics/Pages/State-Legal-Resources.aspx

#### **Medicaid Payment**

Pediatricians remain committed to caring for children in the Medicaid program. However, Medicaid payment historically has been too low in many states, which has created unnecessary barriers to access to care for Medicaid enrolled children.

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The ACA sought to begin to address this issue by raising Medicaid payment for primary care services to Medicare levels for 2013-2014. Rollout of this provision of the ACA was delayed in early 2013, but most states began implementing this increase in payment in at least Medicaid fee-for-service care by late summer. Notably, Medicaid managed care organizations have been slow to implement this payment increase. AAP chapters and the Academy will continue to bring this and other issues with implementation of the Medicaid payment increase to the attention of the Centers for Medicare and Medicaid Services (CMS), state Medicaid programs, and Medicaid managed care organizations. The Academy will also be seeking an extension of the payment increase beyond 2014.

More information on the ACA 2013-2014 Medicaid payment increase, including state-by-state self-attestation forms and other information can be found at: <a href="https://www.aap.org/MedicaidPaymentIncrease">www.aap.org/MedicaidPaymentIncrease</a>.

#### Medical Home and the Pediatric Health Care Team

The AAP believes that optimal pediatric care is best rendered by using a team-based approach led by a pediatrician in a medical home. The pediatrician—including pediatric generalists, pediatric medical subspecialists, pediatric surgical specialists, and internal medicine/pediatric physicians—is uniquely qualified to manage, coordinate, and supervise the entire spectrum of pediatric care, from diagnosis through all stages of treatment, in all practice settings. As the clinician most extensively educated in pediatric health care, the pediatrician has the depth and breadth of knowledge, skills, and experience to assume this role and should be held to the highest standards. The medical care of infants, children, and adolescents should be accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.

#### Poverty

There are more than 72 million children younger than 18 years old in the US—45% (32.4 million) live in low-income families; 22% (16.1 million) live in poor families. Poverty can have a profound effect on the health, development, and well-being of children and their families. Pediatricians see these effects firsthand.

AAP chapters can play a role in amplifying the voice of poor children and their families in the state advocacy arena. Weighing in on issues related to income and food security, safety net programs, early education and intervention, access to insurance and a medical home, the needs of special populations such as immigrants or homeless youth, as well as monitoring the state and local budgets can make a difference.

Fighting childhood poverty is a multifaceted effort, one that meets the needs of children in poverty today, and prevents child poverty in the future. The AAP Poverty and Child Health Leadership Work Group has been charged by the AAP Board of Directors to work towards a plan of action to address childhood poverty and to reduce its attendant health effects on children. More information on the Work Group is available at following link: <a href="www.aap.org/en-us/about-the-aap/aap-press-room/pages/US-Must-Not-Neglect-Millions-of-Children-Still-Living-in-Poverty-Says-American-Academy-of-Pediatrics.aspx">www.aap.org/en-us/about-the-aap/aap-press-room/pages/US-Must-Not-Neglect-Millions-of-Children-Still-Living-in-Poverty-Says-American-Academy-of-Pediatrics.aspx</a>.

#### Conclusion

AAP chapters will face a multitude of advocacy issues in 2014, and the 2014 State Advocacy Blueprint is not all-inclusive. The AAP Committee on State Government Affairs (COSGA) and Division of State Government Affairs developed this resource as tool to assist chapters by identifying state policy trends that align with AAP concerns and to recognize opportunities for success. COSGA and the Division are ready to assist chapters with any of the numerous issues they will take on in their states in 2014.







### Health Insurance Marketplaces

OVERVIEW

The Patient Protection and Affordable Care Act (ACA) creates health insurance marketplaces (also called exchanges) where individuals and small businesses can purchase health insurance. The ACA gave states the option of creating their own marketplaces or allowing the federal government to run their marketplaces, providing considerable federal planning and development funds as part of the process. Individuals seeking marketplace insurance coverage are to be screened for Medicaid and Children's Health Insurance Program (CHIP) eligibility and enrolled as appropriate. Those not Medicaid or CHIP eligible and without access to affordable employer-based health insurance can enroll in health insurance through the marketplace. Those in families with incomes below 400% of the federal poverty level (FPL) will receive advanced premium tax credits to help purchase insurance, and those with incomes below 250% FPL will receive cost sharing reductions. Small businesses may purchase insurance for employees through Small Business Health Insurance Options Program (SHOP) marketplaces. All marketplace plans must be qualified health plans (QHPs) and meet minimum federal requirements, including the provision of essential health benefits (EHB). Plans are sold in 4 tiers-platinum, gold, silver, and bronze-each meeting an actuarial value standard and following established limits on cost sharing and other requirements.

- The AAP advocates for universal and insured financial access to quality health care for all newborns, infants, children, adolescents, young adults, and pregnant women.
- The AAP supports a "no wrong door" approach to insurance obtained through a marketplace, so children and families are immediately enrolled in the insurance programs or plans for which they are found eligible.
- Benefits provided in plans sold through marketplaces should provide all services children need, including, at minimum, those services outlined in the AAP Policy Statement, Scope of Health Care Benefits for Children From Birth Through Age 26. Essential health benefits (EHB) packages may need to be supplemented to ensure children receive all eligible services, particularly in the areas of habilitative care, mental and behavioral health, and vision and oral health care.
- Families are encouraged to thoroughly consider the needs of children and purchase health insurance plans that meet those needs.
- All insurance plans and marketplace policies should encourage the maintenance of the medical home, where the pediatrician, other physicians, and the pediatric care team works in partnership with a child and a child's family to assure that all of the medical and nonmedical needs of the patient are met.

- In 2012, there were 5.3 million (7.2%) uninsured children in the United States; a decline of 2.1% since 2008. Medicaid and CHIP have continued to provide a critical health insurance safety net for children during a slow nationwide economic recovery.
- Health insurance marketplaces opened October 1, 2013 and will provide coverage options for those without access to affordable employer based coverage. Families have until March 31, 2014 to obtain coverage without paying the 2014 tax penalty.
- Small businesses with fewer than 50 employees are eligible to purchase health insurance for employees via the SHOP marketplace, which may be combined with the individual marketplace at the state level. Small employers with fewer than 25 employees may be eligible for tax credits for insurance purchased through a marketplace.
- Early enrollment figures (November 21, 2013) indicate that at least 200,000 individuals have enrolled in private coverage through marketplaces, and as many as 400,000 have enrolled in Medicaid since the October 1, 2013 open enrollment period began.

 16 states and DCdeclared a state based marketplace (SBM) for 2014

 27 states-declared a federally facilitated marketplace (FFM) for 2014

7 states-declared a partnership marketplace (PM) for 2014

(PM) for 2014

Notes: Utah will have an FFM for individuals and a state based SHOP marketplace in 2014.

\* = State has declared a state based marketplace but will not have infrastructure ready in time for 2014, therefore will be running a partnership marketplace for 2014.

- AAP ACA Marketplace Resources www.aap.org/ACAMarketplace
- <u>Healthcare.gov</u>-www.healthcare.gov
- Making Health Insurance Exchanges Work for Kids (First Focus Report) –
   www.firstfocus.net/library/fact-sheets/making-health-insurance-exchanges-work-for-kids
- Kaiser State Health Insurance Marketplace Profiles http://kff.org/state-health-marketplace-profiles
- <u>Families USA Marketplace Publications</u> www.familiesusa.org/health-reform-central/publications.html#Exchanges



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### **Medicaid Expansion**

OVERVIEW

As enacted, the Patient Protection and Affordable Care Act (ACA) required states to expand Medicaid to a newly eligible adult population-those who are younger than 65 years old, not pregnant, not eligible for Medicare, and who have family incomes up to 133% of the federal poverty level (FPL, 138% with 5% income disregard). However, the 2012 US Supreme Court decision on the constitutionality of the ACA made this expansion optional for states. The federal government will finance the Medicaid expansion at 100% for the first 3 years (2014-2016) and begin to taper each year after through 2020, when federal financing will be fixed at 90%.

Because this is a state option, some are expanding, others are not. Still others have proposed a "private option" using federal Medicaid funds to subsidize the state's expansion population's insurance premiums on plans purchased through an insurance marketplace.

There is no deadline for states to decide to expand Medicaid to this newly eligible population.

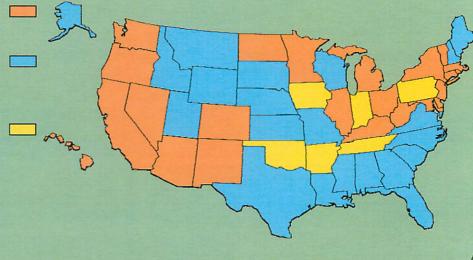
- The Academy supports state chapter advocacy for ACA Medicaid expansions to the newly eligible adult population.
- The AAP has concerns about some "private option" proposals that include the elimination of EPSDT coverage for 19-20 years olds and cost sharing for individuals earning more than 100% FPL.
- The Academy supports outreach efforts to former foster care children who have graduated from the foster care program and are eligible for Medicaid to age 26.
- States should replicate effective strategies-similar to those that have been effective in the Children's Health Insurance Program (CHIP)-for enrolling children in Medicaid.

## FACTS

- In states that may not expand Medicaid by 2014, as many as 6.4 million individuals would remain uninsured.
- Families with low incomes and uninsured parents are 3 times more likely to include eligible but uninsured children when compared to families with parents covered by private insurance or Medicaid.
- Children whose parents have health insurance coverage are less likely to have breaks in their own coverage and more likely to remain insured.
- Individuals with incomes below 100% FPL are not eligible for premium tax subsidies for plans purchased in a marketplace. This population will likely remain uninsured in nonexpansion states.

## PROGRESS

- 23 states-enacted Medicaid expansion
- 21 states-did not enact Medicaid expansion
- 6 states-are exploring other options



- AAP StateHealth—AAP Supports Chapter Advocacy for ACA Medicaid Expansions—www.aap.org/enus/my-aap/advocacy/state-government-affairs/Documents/STATEHEALTH\_07\_17\_12.pdf
- AAP StateHealth-New Resources to Support Medicaid Expansion Efforts-www.aap.org/en-us/myaap/advocacy/state-government-affairs/Documents/STATEHEALTH\_7\_29\_13.pdf
- <u>Kaiser Commission on Medicaid and the Uninsured</u> http://kff.org/about-kaiser-commission-on-medicaid-and-the-uninsured/
- Center on Budget and Policy Priorities—Medicaid Expansion Tool Kit for Advocates www.cbpp.org/cms/index.cfm?fa=view&id=3819
- <u>Families USA-Medicaid Expansion Center</u> www.familiesusa.org/issues/medicaid/expansion-center/



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OVERVIEW

### Medicaid Payment Increase

The Patient Protection and Affordable Care Act (ACA) includes a critical provision to increase Medicaid payment for primary care services to Medicare levels in calendar years 2013-2014. This provision, championed by the AAP, raises Medicaid payment for evaluation and management (E/M) and immunization administration services provided by primary care physicians with specialty designations of pediatric medicine, family medicine, and/or general internal medicine during these 2 years. Subspecialists boarded under 1 of the aforementioned specialty member boards—as well history-are also eligible for the Medicaid payment increase.

The increase applies to fee-for-service care as well as care provided in Medicaid managed care organization (MCO) structures. Physicians must self-attest eligibility for the payment increase to their state Medicaid programs in order to receive it, and while retroactive payment at increased levels is available to January 1, 2013, some states have implemented self-attestation deadlines to receive these payments.

Implementation of the ACA Medicaid payment increase was delayed in 2013 and is now being rolled out across the country.

- Medicaid payment is set by each state and has historically been low.
- Low Medicaid payment negatively impacts the ability of pediatricians to participate in the program and impedes access to care for enrollees.
- The AAP has long sought federal enforcement of the Medicaid "equal access" provision and to those that are at least equivalent with Medicare rates.
- The AAP supports full and timely implementation of the ACA Medicaid payment increase to ensure increased access to care for children insured by Medicaid.
- The Academy will advocate for an extension of the ACA Medicaid payment increase past 2014.

- The Medicaid payment increase applies to E/M codes 99201 through 99499 as well as vaccine administration codes 90460, 90461, 90472, 90473, and 90474, or their successor codes. These include codes not recognized for payment by Medicare but assigned Relative Value Units (RVUs).
- Rates paid under the ACA Medicaid payment increase will be set using current year RVUs and the current year Medicare conversion factor (CF) or the 2009 Medicare conversion factor (CF), whichever results in higher payment. The 2009 CF is being used for calendar year 2013.
- States may make site of service and/or geographic adjustments to this increased Medicaid payment. Physicians eligible for the Medicaid payment increase must self-attest eligibility to their state Medicaid programs. States were allowed to establish reasonable deadlines for self-attestation for purposes of retroactive payment to January 1, 2013.

- 41 states administering Medicaid payment increase
- 7 states-not acting on Medicaid payment increase
- 2 states-Medicaid rates already higher than Medicare rates

Additional Information:

<u>AAP Medicaid Payment Increase</u>

<u>Resources-www.aap.org/MedicaidPaymentIncrease</u>

Se November 27, 2013 Source: AAP and AMA Surveys

MORE

- CMS resources www.medicaid.gov/AffordableCareAct/Provisions/Provider-Payments.html
- How Much Will Medicaid Physician Fees for Primary Care Rise in 2013? (Kaiser Commission on Medicaid and the Uninsured)

http://kff.org/medicaid/issue-brief/how-much-will-medicaid-physician-fees-for/

- Primer on Medicaid Payment Increase Final Rule (Kaiser Family Foundation) –
   http://kff.org/health-reform/issue-brief/increasing-medicaid-payments-for-certain-primary-care/
- Medicaid Payment Primary Care Rate Increase Next Steps for States (Center for Health Care Strategies) – www.chcs.org/usr\_doc/Final\_Rule\_Analysis\_112612.pdf

## State Advocacy FOCUS American Academy of Pediatrics





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### **Bullying Prevention**

OVERVIEW

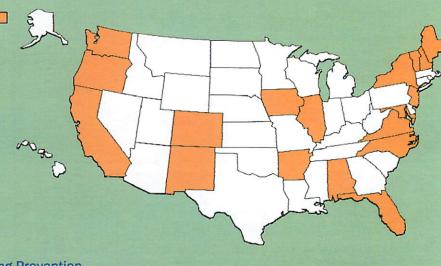
Bullying is unwanted, aggressive behavior among school-aged children that involves a real or perceived power imbalance. The behavior is or can be repeated over time. Bullying includes threats, spreading rumors, physical or verbal attacks, and intentional exclusion or marginalization. Bullying can take place in or outside of school. Cyberbullying takes place via phones or computers, can happen anytime, and can be as harmful as in-person bullying.

In recent years, states have become more aware of the long-term effects of bullying and have started to require that schools address both in-school and out-of-school bullying. State legislators have also recognized that bullying does not necessarily take place between classmates and have introduced legislation that would address bullying that takes place outside of the school administrator's purview.

- The AAP recommends that pediatricians should advocate for bullying awareness by teachers. educational administrators, parents, and children, and supports adoption of evidence based
- Effective state policy clearly defines the role and the authority of the school officials, teachers, and other school employees to address bullying and would require a zero tolerance policy for bullying based on race, ethnicity, gender, sexual orientation, gender identity, disability, religious beliefs, and other personal attributes.
- The policies should apply to students in all schools, both on or off campus, or through the use of technology (ie, cyberbullying).

- More than 160,000 US students stay home from school each day from fear of being bullied.
- Bullying directly affects a student's ability to learn.
- Students who are bullied find it difficult to concentrate, show a decline in grades, and lose self esteem, self-confidence, and self-worth.
- Students who are bullied report more physical symptoms, such as headaches or stomachaches, and mental health issues, such as depression and anxiety, than other students.
- Students can be especially effective in bullying intervention. More than 55% of bullying situations will stop when a peer intervenes. Student education of how to address bullying for peers is critical, as is the support of adults.

18 states –
 comprehensive bullying prevention laws



Additional Information:

2013 State Track Profile: Bullying Prevention

- AAP Policy–Role of the Pediatrician in Preventing Violence– http://pediatrics.aappublications.org/content/124/1/393.full
- Connected Kids-Bullying-It's Not Okay-www2.aap.org/connectedkids/samples/bullying.htm
- It Gets Better Project-www.itgetsbetter.org
- National Association of School Psychologists—Bullying Prevention Resources www.nasponline.org/resources/bullying/index.aspx
- US Department of Education-Stop Bullying Now-www.stopbullying.gov







OVERVIEW

### School Physical Education and Activity

Though rates of childhood obesity have shown small improvements recently, the number of healthy weight children in the US is still far from ideal. Increased awareness of the importance of healthy, active living through First Lady Michelle Obama's "Let's Move" campaign and federal efforts to improve school nutrition programs have made great strides in turning the tide of obesity, but state

Currently, physical education and activity standards vary greatly across the states.

Every state and District of Columbia requires physical education at some grade levels, but no state requires daily physical education for all children in grades K-12. Despite evidence that shows that children benefit not only physically, but mentally, from daily recess, very few states mandate time for physical activity during the school day.

- All children should receive at least 1 hour of physical activity a day.
- Physical activity should be promoted at home, in the community, and at school, but school is perhaps the most encompassing way for all children to benefit.
- Recess can serve as a counterbalance to sedentary time and contribute to the recommended 60 minutes of moderate to vigorous activity per day, a standard strongly supported by AAP policy as a means to lessen risk of overweight.
- Schools should also provide 1 hour of quality physical education daily to all students in grades K-12. It should emphasize enjoyable participation in physical activity that helps students
- Physical education classes should allow participation by all children regardless of ability, illness, and/or injury, including those with obesity and those who are disinterested in traditional competitive team sports.

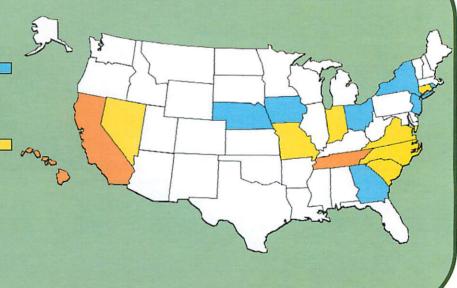
- Childhood obesity has more than doubled in children and tripled in adolescents in the past 30 years.
- The percentage of children aged 6-11 years in the US who were obese increased from 7% in 1980 to nearly 18% in 2010. Similarly, the percentage of adolescents aged 12-19 years who were obese increased from 5% to 18% over the same period.
- In 2010, more than 1/3rd of children and adolescents were overweight or obese.
- Children and adolescents who are obese are likely to be obese as and are therefore more at
  risk for adult health problems such as heart disease, type 2 diabetes, stroke, several types of
  cancer, and osteoarthritis.
- Healthy lifestyle habits, including healthy eating and physical activity, can lower the risk of becoming obese and developing related diseases.

3 states-laws
requiring daily physical
education for grades K-12
and recess for grades K-6

 7 states-laws requiring only daily physical education for grades K-12

 7 states-require only daily recess for grades K-6

Additional Information:
2013 StateTrack Profile:
Physical Education in School
2013 StateTrack Profile:
Physical Activity in Schools



- AAP Policy-Active Healthy Living: Prevention of Childhood Obesity Through Increased Physical Activity-
- http://aappolicy.aappublications.org/cgi/content/full/pediatrics;117/5/1834
- AAP Policy-The Crucial Role of Recess
  - http://pediatrics.aappublications.org/content/131/1/183.full
- AAP Policy-Prevention of Pediatric Overweight and Obesityhttp://aappolicy.aappublications.org/cgi/content/full/pediatrics;112/2/424
- AAP Obesity Policy Opportunities Tool—www.aap.org/obesity/matrix\_1.html
- Centers of Disease Control and Prevention-Childhood Obesity-www.cdc.gov/obesity/childhood





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OVERVIEW

### Child Passenger Safety

Motor vehicle crashes are the leading killer of children older than 1 year, yet state legislative efforts to improve child passenger safety standards have remained largely stalled in recent years. Missing from many state child passenger laws are requirements for safety seat to be rear-facing seats until age 2 years and rear seat requirements for older children.

While great progress has been made on the state level to keep children safe, more work remains for advocates of child safety and injury prevention.

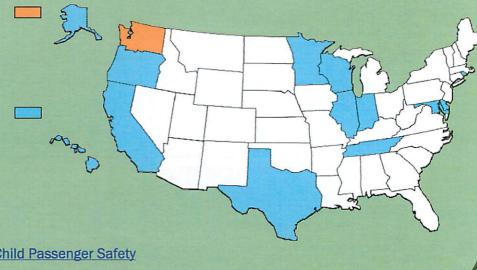
- Infants and toddlers should ride facing the rear of the vehicle until they are at least 2 years old. States may choose to adopt age 1 requirements immediately, and phase in a requirement to ride rear-facing until age 2 within 2-4 years, with interim provisions for educating parents about the benefits of their child riding rear-facing as long as possible.
- Young children should ride in car safety seats with a harness until at least age 4 years, with guidance educating parents and caregivers about the benefits of riding in a seat with a 5-point harness up to the highest weight or height allowed by the manufacturer.
- School-aged children should ride in belt positioning booster seats until at least age 8 years or until the seat belt fits correctly, as described by the AAP and NHTSA.
- Children should ride in the rear seat until age 13 years.
- Seat belt laws should apply to all vehicle occupants and should be subject to primary

- More than 1,200 children in the US, ages 14 years and younger, died as occupants in motor vehicle crashes, and approximately 171,000 were injured, in 2010.
- More than 618,000 children ages 0-12 years rode in vehicles during a 1 year period without
  the use of a child safety seat, booster seat, or seat belt at least some of the time, according to
  the Centers for Disease Control and Prevention (CDC).
- Child safety seats reduce the risk of death in passenger cars by 71% for infants, and by 54% for toddlers ages 1 to 4 years.
- Booster seats reduce the risk for serious injury by 45% for children ages 4 to 8 years.
- There is strong evidence that child safety seat laws are effective in increasing child safety seat use.

- 1 state-law includes 4 of 5 AAP recommended child passenger safety provisions
- 13 states-laws include 3 of 5 AAP recommended child passenger safety provisions

Additional Information:

2013 StateTrack Profile: Child Passenger Safety



- AAP Policy-Child Passenger Safetyhttp://pediatrics.aappublications.org/content/early/2011/03/21/peds.2011-0213.full.pdf+html
- AAP Technical Report-Child Passenger Safetyhttp://pediatrics.aappublications.org/content/127/4/e1050.full
- HealthyChildren.org Car Seat Guide for Families www.healthychildren.org/English/safety-prevention/on-the-go/pages/Car-Safety-Seats-Information-for-Families.aspx



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### **Teen Driving**

OVERVIEW

Teen drivers have a higher rate of crashes than drivers of any other age group as drivers lack the experience and ability to perform many of the complex tasks associated with driving. Teens, particularly males, are more likely succumb to peer pressure, overestimate their abilities, and have

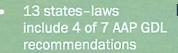
The chance of a teen driver being involved in a car crash is directly proportional to the number of teenage passengers being transported. Alcohol and drug use increases risks. Teenage drivers drive after using drugs and alcohol less often than older drivers, but experience twice as many alcohol

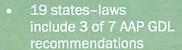
Seatbelt use matters. Teenage drivers wear restraints far less often than other drivers. More than half of the teenagers killed in automobile crashes in 2004 were not wearing seatbelts. Teens are also far more likely to text and drive and to become more easily distracted than other drivers.

- A learners permit period that starts at age 16 and lasts no less than 6 months
- 50 hours of adult-supervised, on the road driving during the permit stage with 10 hours at
- Nighttime driving restriction that lasts from 12:00 am-5:00 am until age 18.
- Passenger restrictions including no teenage passengers the first 6 months of provisional licensure, and then no more than 1 teenage passenger until age 18.
- Prompt imposition of fines, remedial driver's classes, or license suspension for passenger or
- No mobile phone use, including the use of hands-free devices.

- If every state had a graduated driver's license program that met AAP recommendations:
  - 175 fewer teens would die in crashes every year
  - 350,000 fewer teens would be injured
  - Over \$13 billion in crash-related expenditures would be saved
- No state has more than 5 of the 7 provisions recommended by the AAP.
- Fatal crashes involving 16 year old drivers are reduced by 28% and injury crashes by 40% in states with 5 of the 7 AAP recommended GDL provisions.
- Fatal crashes involving 16 year old drivers are reduced by 21% and injury crashes are reduced by 36% in states with 4 out of the 7 AAP recommended GDL provisions.
- States with fewer than 2-3 provisions in their GDL see much smaller reductions in teen fatal and nonfatal injuries than states with at least 4 provisions.

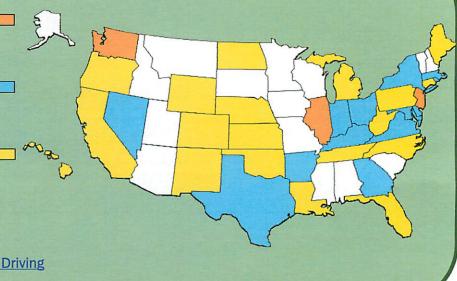
 3 states and DC-laws include 5 of 7 AAP GDL recommendations





Additional Information:

2013 StateTrack Profile: Teen Driving



- The Teen Safe Driving Grant Program Sponsored by The Allstate Foundation www.healthychildren.org/English/our-mission/aap-in-action/Pages/AAP-Chapters-Improving-Teen--Driving-Safety.aspx
- Allstate Foundation Teen Safe Driver Program www.allstatefoundation.org/teen-driving
- Insurance Institute for Highway Safety (IIHS)—www.iihs.org
- Governor's Highway Safety Association (GHSA) www.ghsa.org
- National Safety Council www.nsc.org
- Safe Kids USA-www.safekids.org



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### **Distracted Driving**

OVERVIEW

In 2011, the National Transportation Safety Board (NTSB) recommended that states ban use of all portable electronic devices, including hands-free devices, for all drivers. Comparing the risk of crash while driving distracted to driving under the influence, the NTSB notes that distracted driving is becoming an epidemic.

Mobile phone use while driving has been estimated to increase crash rates by 400%, and hands-free models are not associated with significantly less risk. Teen drivers are more likely to take risks behind the wheel and their inexperience with driving increases the risk of crashing while driving while using a mobile device.

As with seatbelt use, parental modeling plays an important role in the reduction of teen use of mobile devices while driving. State laws that prohibit use of portable electronic devices for all drivers are more effective in reducing rates of distracted driving by teens.

- Evidence shows that distractions may be a greater problem for the inexperienced driver. Distracted novice drivers tend to glance away from the road for longer periods of time, during which they have trouble responding to hazards and staying in their lane.
- The use of mobile phones while driving should be prohibited.

### FACTS

- Nearly 2,700 US 16-19-year-olds were killed, and approximately 282,000 were treated in emergency departments, for motor vehicle crash injuries in 2010.
- Nearly 3,100 people in the US died, and 416,000 were injured, in crashes that involved a
  distracted driver in 2010.
- Nearly 303 million people in the US have mobile phones. At any given moment during the
  daylight hours, more than 800,000 vehicles are being driven by someone using a handheld
  mobile phone.
- Drivers using mobile phones are 4 times as likely to crash, and there is no difference in crash risk between handheld and hands-free phone use.

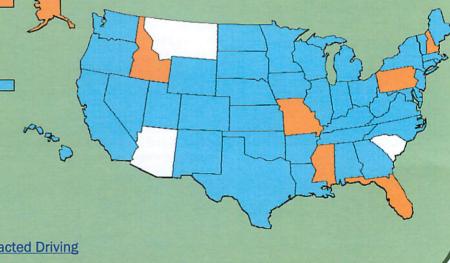
PROGRESS

MORE

 7 states-laws prohibiting minors from texting while driving

 40 states and DClaws prohibiting minors from using mobile phones and texting while driving

Additional Information: 2013 StateTrack Profile: Distracted Driving



AAP Policy-The Teen Driver-http://pediatrics.aappublications.org/content/118/6/2570.full

The Teen Safe Driving Grant Program Sponsored by The Allstate Foundation—
 www.healthychildren.org/English/our-mission/aap-in-action/Pages/AAP-Chapters-Improving-Teen
 -Driving-Safety.aspx

 Centers for Disease Control and Prevention (CDC)—Distracted Driving www.cdc.gov/motorvehiclesafety/distracted\_driving/

 <u>National Safety Council-Distracted Driving-</u> www.nsc.org/safety\_road/Distracted\_Driving/Pages/distracted\_driving.aspx

 National Highway Transportation Safety Administration (NHTSA)—Distracted Driving www.distraction.gov/









### Safe Storage of Firearms

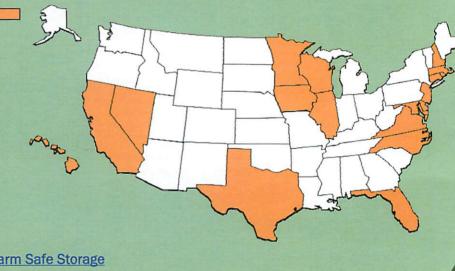
The presence of unlocked guns in homes increases the risk of both unintentional gun injuries and intentional shootings. Safe storage laws require guns to be stored locked and unloaded when any person prohibited from possessing a gun is present in the gun owner's home, including convicted felons, those convicted of domestic violence, and those with certain mental health conditions. Child Access Prevention (CAP) laws impose criminal liability on adults who negligently leave firearms accessible to children or otherwise allow children access to firearms.

Because unintentional injuries continue to be the leading cause of death in children older than 1 year, pediatricians play a key role in injury prevention by providing anticipatory guidance to parents to help minimize the risk of injury in the child's everyday environment. The presence of firearms in the home poses an increased risk to a child, and asking a parent a question about gun ownership can open up an opportunity to educate parents about potential dangers to which their child is child passenger safety seat safety, drowning prevention, parental tobacco use, and developmental

- The AAP is committed to protecting of children from firearm-related injury and violence. The prevent firearm-related injuries in children and adolescents.
- The AAP supports a number of measures to reduce the destructive effects of guns in the lives of children and adolescents, including safe storage and CAP laws.
- To prevent gun-related death and injuries, the AAP recommends that pediatricians provide firearm safety counseling to patients and their families.

- Research in several US urban areas indicates that a gun stored in the home is associated with a 3-fold increase in the risk of homicide and a 5-fold increase in the risk of suicide.
- Laws reducing child access to firearms, which primarily require safe gun storage, are
  associated with lower overall adolescent suicide rates. The presence of a firearm at home
  increases the risk of suicide even among those without a previous psychiatric diagnosis.
- Suicide attempts involving a firearm more often are fatal (91%) compared with those involving drug overdoses (23%). The increased risk of suicide is particularly striking for younger persons where guns are stored loaded and/or unlocked.
- Like counseling on seat belt use or pool safety, counseling parents on firearm ownership and safe storage practices is important and helps mitigate the risk of death and injury to children.
- In controlled studies, individuals who received physician counseling were more likely to report the adoption of 1 or more safe gun-storage practices.

 18 states-laws requiring safe storage of firearms



Additional Information:

2013 StateTrack Profile: Firearm Safe Storage

- AAP Policy-Firearm-Related Injuries in the Pediatric Population –
   http://pediatrics.aappublications.org/content/early/2012/10/15/peds.2012-2481.full.pdf
- AAP Division of State Government Affairs—State Gun Safety Laws (MyAAP login required) www.aap.org/en-us/my-aap/advocacy/state-government-affairs/Documents/GunSafetyLaws.pdf
- Center to Prevent Youth Gun Violence-Ask Campaign www.cpyv.org/programs/ask/parents/what-is-the-ask-campaign
- <u>Children's Defense Fund (CDF)-Protect Children, Not Guns</u>-www.childrensdefense.org/childresearch-data-publications/data/protect-children-not-guns-2013.html
- Law Center to Prevent Gun Violence-http://smartgunlaws.org
- Moms Demand Action for Gun Sense in America-http://momsdemandaction.org

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### Assault Weapons Bans

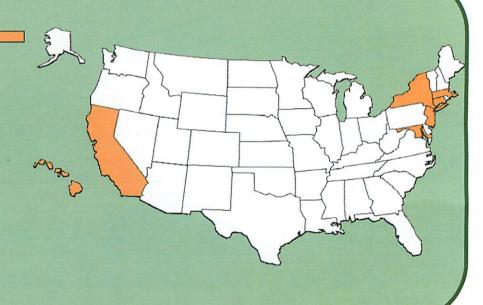
OVERVIEW

Despite AAP advocacy efforts to renew the law, the federal assault weapons ban has languished in Congress since the expiration. Meanwhile, states have enacted their own bans on assault weapons along with high-capacity detachable magazines-typically defined as those which hold used in most of the high profile mass shootings in the US including those at Columbine High School (Colorado), Virginia Tech (Virginia), Tucson (Arizona), Aurora (Colorado), Oak Creek (Wisconsin), and Newtown (Connecticut).

- The AAP is committed to protecting children from firearm-related injury and violence.
- The absence of guns in homes and communities is the most reliable and effective measure to prevent firearm-related injury and violence in children and adolescents.
- Recognizing the deadly consequences of firearms to children, adolescents, and young adults, the AAP supports firearm regulation, including a ban on assault weapons and high capacity magazine sales, as an effective strategy to reduce firearm-related injuries.

- Assault weapons are dangerous, military-style guns that are built to do the most damage and kill or maim the maximum number of people in the shortest amount of time.
- Assault weapons are distinguishable from other semiautomatic firearms based on the combat-style features that allow a shooter to control the weapon while quickly discharging large amounts of ammunition.
- The public supports banning assault weapons.
- A 2013 Johns Hopkins University poll found 69% of respondents support a ban on the sale of military-style assault rifles, and 68.4% support a ban on the sale of large-capacity ammunition feeding devices capable of accepting more than 10 rounds.

 7 states-laws banning assault weapons



Additional Information: 2013 StateTrack Profile: Assault Weapons and High Capacity Magazines

- AAP Policy-Firearm-Related Injuries in the Pediatric Population http://pediatrics.aappublications.org/content/early/2012/10/15/peds.2012-2481.full.pdf
- AAP Division of State Government Affairs—State Gun Safety Laws—
   www.aap.org/en-us/my-aap/advocacy/state-government-affairs/Documents/GunSafetyLaws.pdf
- Brady Campaign to Prevent Gun Violence http://bradycampaign.org/
- Children's Defense Fund (CDF)-Protect Children, Not Gunswww.childrensdefense.org/child-research-data-publications/data/protect-children-not-guns-2013.html
- Law Center to Prevent Gun Violence-http://smartgunlaws.org/
- Moms Demand Action for Gun Sense in America-http://momsdemandaction.org





### Universal Background Checks for Gun Purchases

OVERVIEW

Current federal law requires background checks to be performed for anyone purchasing a firearm at a federally licensed gun dealer-however only 40% of guns sold in the US are sold through a federally licensed dealer.

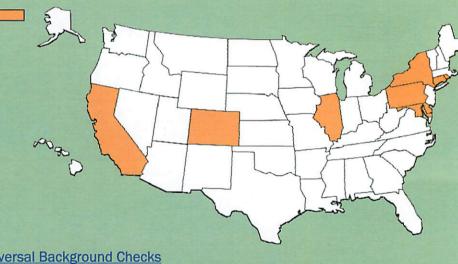
In most states, sales at gun shows, flea markets, and private gun sales are not subject to

States with universal background check laws require that all sales of firearms take place through a licensed dealer who can perform a background check prior to the sale.

- The AAP is committed to protecting children from firearm-related injury and violence.
- The absence of guns in homes and communities is the most reliable and effective measure to prevent firearm-related injuries in children and adolescents.
- The AAP supports a number of specific measures to reduce the destructive effects of guns in the lives of children and adolescents, including the regulation of the manufacture, sale,
- In addition to background checks for purchasers, other measures aimed at regulating access of guns should include mandatory waiting periods, closure of the gun show loophole, and mental health restrictions for gun purchases.

- 30% of guns involved in criminal trafficking are connected to gun shows, where background
  checks aren't required. The trafficking of guns generally involves a highly efficient, organized,
  and profitable business that moves guns from legal manufacture to dealers to criminals and
  young people who can't buy guns legally.
- States that have not closed the gun show loophole are twice as likely to be the sources of crime-use guns recovered in other states when compared to states that have closed the loophole, according to a 2008 report by Mayors Against Illegal Guns.
- With thousands of Websites that offer firearms for sale, the Internet marketplace for guns is
  vast and growing. The number of gun ads listed by private sellers on popular online retail sites
  has expanded almost 7-fold, from 12,000 in December 2011 to 83,000 active ads in August
  2013.
- 88% of those surveyed in the US, including 85% of gun owners, favor universal background checks on sales of all weapons.

 9 states-laws requiring universal background checks for firearms purchases



Additional Information:

2013 StateTrack Profile: Universal Background Checks

- AAP Policy-Firearm-Related Injuries in the Pediatric Population –
   http://pediatrics.aappublications.org/content/early/2012/10/15/peds.2012-2481
- AAP Division of State Government Affairs—State Gun Safety Laws (MyAAP login required) www.aap.org/en-us/my-aap/advocacy/state-government-affairs/Documents/GunSafetyLaws.pdf
- Brady Campaign to Prevent Gun Violence http://bradycampaign.org
- Children's Defense Fund (CDF)—Protect Children, Not Guns www.childrensdefense.org/child-research-data-publications/data/protect-children-not-guns-2013.html
- Law Center to Prevent Gun Violence-http://smartgunlaws.org
- Moms Demand Action for Gun Sense in America http://momsdemandaction.org





### **Newborn Screening for** Critical Congenital Heart Disease

OVERVIEW

Critical congenital heart disease (CCHD) is a group of 7 congenital heart defects that affect newborns and is 1 of the leading causes of infant deaths in the US. To detect potential cases of CCHD in newborns, pediatricians, other physicians, and nonphysician clinicians examine newborns with a pulse oximetry screen.

In 2011, the Secretary of the US Department of Health and Human Services adopted the recommendations set forth by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children (SACHDNC) to add newborn screening for critical congenital heart disease (CCHD) to the Recommended Uniform Screening Panel (RUSP).

That same year, the AAP issued Strategies for Implementing Screening for Critical Congenital Heart Disease, which provides guidance to physicians, nonphysician clinicians, and policymakers on implementing CCHD screening. Following this resource, AAP released its policy statement, Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease.

- Screening should be completed no earlier than 24 hours after birth and prior to the newborn being discharged from the hospital or birthing center.
- Screening should be conducted using motion-tolerant pulse oximeters that report functional oxygen saturation and have been cleared by the US Food and Drug Administration (FDA) for use in newborns. Disposable or reusable pulse oximeters may be used.
- Screening should be based on the recommended algorithm found in the AAP Strategies for Implementing Screening for Critical Congenital Heart Disease. The algorithm may need to be
- Screening should be performed by a qualified physician or nonphysician clinician who has been educated on the screening algorithm and trained in pulse oximetry monitoring in newborns.

- Nearly 7,200 newborns with CCHD are born in the US annually.
- Children with CCHD are more likely to develop impairments in motor functions, speech and language, visual-motor-perceptual functions, and executive functions.
- Children with CCHD are more likely to utilize social services.
- Pulse oximetry screening for CCHD is a noninvasive procedure and may take as little as 5 minutes to conduct.
- Recent estimates put the cost of screening for CCHD around \$6 per newborn.
- Recent estimates have demonstrated that newborn screening for CCHD is cost effective, with early detection leading to around \$40,000 per life year gained.

29 states-laws
requiring newborn
screening for CCHD
(\*CA law requires screening to be offered)

5 states-regulations

5 states-regulations or guidance on newborn screening for CCHD

 1 state-executive order requiring newborn screening for CCHD study

Additional Information:

2013 StateTrack Profile: Newborn Screening for CCHD

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- AAP Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease
  - http://pediatrics.aappublications.org/content/129/1/190.full.pdf
- AAP Strategies for Implementing Screening for Critical Congenital Heart Disease http://pediatrics.aappublications.org/content/128/5/e1259.full.pdf
- AAP Role of Pulse Oximetry in Examining Newborns for Critical Congenital Heart Disease:

  A Scientific Statement from the AHA and AAP
  - http://pediatrics.aappublications.org/content/124/2/823.full.pdf
- AAP Resources www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/PEHDIC/Pages/ Newborn-Screening-for-CCHD.aspx





**OVERVIEW** 

### Tanning Bed Restrictions

The popularity of tanning beds has increased steadily among adolescents-especially white teenage

The evidence associated the use of tanning beds with deadly forms of skin cancer has grown stronger over the past decade. Once known as a disease that largely effect the elderly, melanoma rates in the 15-39 year old white female population has risen 3% every year since 1992. Use of tanning devices has been associated with an increased incidence of skin cancer. Children and adolescents are at particular risk of developing melanoma and other forms of skin cancer by using tanning beds that utilize artificial ultraviolet rays (UVR), UVR exposure can also cause acute effects such as skin redness and sunburn. Other frequently reported effects include skin dryness, itching, nausea, and medication reactions. Exposure has also been shown to induce or worsen disease.

The Patient Protection and Affordable Care Act (ACA) instituted a 10% excise tax on indoor tanning services. However, additional state level actions are necessary to protect adolescents from skin

- The AAP recommends that children and adolescents younger than 18 years should be prohibited from using tanning beds.
- Federal, state, and local governments should mount campaigns to raise awareness among children, adolescents, and parents about the dangers of exposure to artificial sources of UVR and overexposure to sun.
- Federal, state, and local governments should work toward passing legislation to ban minors' access to tanning salons and should work to ensure that such legislation is enforced.

### FACTS

- Nearly 28 million people tan indoors in the US annually–2.3 million are teens. Studies have found a 75% increase in the risk of melanoma in those who have been exposed to UV radiation from indoor tanning, and the risk increases with each use.
- Indoor tanners have a 69% increased risk of early-onset basal cell carcinoma.
- It is estimated that as many as 29% of white teenage girls have used a tanning bed in the past year.
- Indoor tanning rates increase steadily as girls move through high school, peaking around age 18. By that age, 44% of white girls have used a tanning salon in the past year and 30% were frequent tanners, using the facilities 10 or more times in that period.

## PROGRESS

 6 states-laws banning tanning bed use by minors younger than 18 years (per AAP guidelines)

 15 states-laws requiring minors to be at least 14 years to use tanning beds ening Red for Minore Range

Additional Information:

2013 StateTrack Profile: Tanning Bed for Minors Bans

- AAP Policy Statement-Ultraviolet Radiation: A Hazard to Children and Adolescentshttp://pediatrics.aappublications.org/content/127/3/588.full
- AAP Technical Statement-Ultraviolet Radiation: A Hazard to Children and Adolescentshttp://pediatrics.aappublications.org/cgi/content/abstract/peds.20092121v1
- AAP Recommendations to Parents AAP Recommendations on Limiting Sun Exposure in Children and Supporting Legislation to Prohibit Salon Tanning by Minors—Healthy Children.org www.healthychildren.org/English/news/Pages/AAP-Recommendations-on-Limiting-Sun-Exposurein-Children-and-Supporting-Legislation-to-Prohibit-Salon-Tanning-by-Minors.aspx
- American Academy of Dermatology-Indoor Tanning Factswww.aad.org/media-resources/stats-and-facts/prevention-and-care/indoor-tanning



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OVERVIEW

### **Concussion Management:** Return to Play

Sports-related concussions in athletes are underreported. Coaches, parents, and teachers often fail to recognize the signs of concussions in young athletes.

Proper management of concussions, including cognitive and physical rest, is imperative to ensure that the student athlete does not suffer long-lasting effects of injury.

associations, and professional sports teams have led efforts to pass state laws requiring that coaches, teachers, and athletic trainers have training in the identification of concussion in youth athletes and that athletes suspected of concussion be cleared to play by the child or adolescent athlete's pediatrician and medical team prior to returning to the field.

- Coaches and athletic trainers should be trained in the identification of concussions, and refer pediatrician, neurologist, primary care sports medicine specialist, or neurosurgeon with
- Pediatricians and other physicians can be an important resource in educating coaches, athletic trainers, and other adults that work with young athletes in recognizing the signs of concussion injuries and when to seek medical attention for their athletes.
- A team approach consisting of the child or adolescent athlete's pediatrician and medical team, the school team, and the family team to assist the student in his or her return to learning is

- Almost 500,000 emergency department visits for traumatic brain injury are made annually by children ages 0 to 14 years.
- 40% of sports-related concussions involved children between the ages of 8 and 13 years.
- Although participation in organized sports has declined slightly, team-related concussions doubled between 1997 and 2007 in 8- to 13-year-olds and more than doubled in older teens.
- Concussions affect child athletes beyond impact sports like football and hockey; sports less commonly considered potential sources of head injury include volleyball, soccer, and cheerleading
- Football has the highest rate of concussion in sports.
- Girls have higher concussion rates than boys in similar sports.

 49 states-laws addressing concussion management: return to play \*= Alahama and Tayas have return to play laws that requires a physician to provide clearance for

Additional Information: 2013 Statetrack Profile: Concussion/Return to Play

\* = Alabama and Texas have return to play laws that requires a physician to provide clearance for return to play.

- American Academy of Pediatrics Clinical Report-Sports-Related Concussion in Children and Adolescents
  - http://aappolicy.aappublications.org/cgi/content/full/pediatrics;126/3/597
- American Academy of Pediatrics Clinical Report–Returning To Learning Following A Concussion– http://pediatrics.aappublications.org/content/132/5/948.abstract
- American Academy of Neurology Position Statement on Sports Concussions www.aan.com/globals/axon/assets/7913.pdf
- American Medical Association (AMA) Policy-Return to Play After Suspected Concussion https://ssl3.ama-assn.org/apps/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=% 2fresources%2fdoc%2fPolicyFinder%2fpolicyfiles%2fHnF%2fH-470 959 HTM

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### E-Cigarettes

OVERVIEW

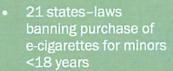
E-cigarettes, also called Electronic Nicotine Delivery Systems (ENDS) or personal vaporizers (PV), present another way for smokers to ingest nicotine. E-cigarettes are increasingly being marketed to young adults and adolescents. They are also touted as a "safer" alternative to smoking, and a way to either quit smoking cigarettes, or to smoke in places where cigarette smoking is not allowed. However, these products are not regulated by the US Food and Drug Administration (FDA), and no rigorous scientific studies have shown that they are safe for use.

In September 2013, 41 state attorneys general wrote the FDA asking the agency to swiftly regulate the products to curb the marketing and sale to children younger than 18. Until the FDA acts to regulate e-cigarettes, states will continue to introduce legislation to restrict purchase by minors, marketing, and use of the devices in public places.

- The sale or dispensing of e-cigarettes, which imitate smoking while delivering nicotine to the user, should be banned.
- Recognizing that a ban on e-cigarettes may not be feasible in all states, sales to minors younger than 18 should, at a minimum, be prohibited.
- The use of e-cigarettes should be regulated as all other tobacco products and prohibited in all indoor and outdoor public places.
- Federal, state, and local governments should enact and enforce laws that mandate the provision of smoke-free environments, including e-cigarette vapor, in all public places and require employers to provide smoke-free/e-cigarette vapor-free work environments for their employees.

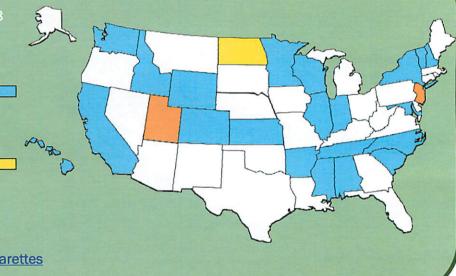
- The FDA and many leading public health organizations generally agree on the need for further scientific study to assess unproven safety claims about e-cigarettes and to determine the overall public health impact of their use.
- Potentially harmful constituents have been documented in some e-cigarette cartridges, including diethylene glycol, genotoxins, and animal carcinogens.
- Large-scale epidemiologic research is needed to determine whether these products promote
  cessation and help smokers quit, or whether they promote experimentation, initiation or dual
  use of tobacco products and perpetuate addiction to nicotine.
- Sales of e-cigarettes have grown rapidly in the US, and after doubling every year since 2008. Sales in 2013 were projected to reach \$1.7 billion.
- Use of e-cigarettes among high school and middle school students doubled from 2011 to 2012, with an estimated 1.8 million students reporting they've tried the device, according to 2013 Centers for Disease Control and Prevention (CDC) data.

2 states-laws
banning purchase of
e-cigarettes for minors <18
years; use prohibited in all
work places, bars, and
restaurants



 1 state-law banning use of e-cigarettes in all workplaces, bars, and restaurants

Additional Information:
2013 StateTrack Profile: E-Cigarettes



- AAP Policy-Tobacco Use: A Pediatric Diseasewww2.aap.org/richmondcenter/pdfs/2009PolicyStatement.pdf
- AAP Julius B. Richmond Center of Excellence www2.aap.org/richmondcenter
- Campaign for Tobacco Free Kids
   – www.tobaccofreekids.org
- The Public Health Law Center www.publichealthlawcenter.org/topics/tobacco-control/product-regulation/e-cigarettes



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#### **Childhood Immunizations**

OVERVIEW

Routine childhood immunization is one of the crown achievements in public health in the last century, A 2013 New England Journal of Medicine study estimated that childhood vaccination programs have prevented 103.1 million cases of diphtheria, hepatitis A, measles, mumps, pertussis, polio and rubella since 1924. A 2005 Archives of Pediatric and Adolescent Medicine study estimated that for every dollar spent in the US, vaccination programs saved more than \$5 in direct costs and approximately \$11 in additional costs to society.

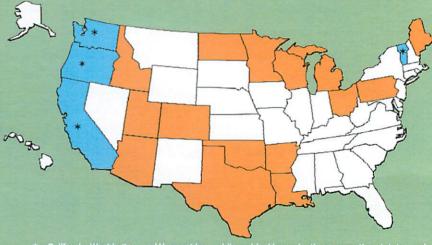
However, challenges remain. Outbreaks of pertussis, measles, Hib, and other vaccine preventable diseases are returning. Numerous factors-including the cost of acquiring and administering vaccines, an increasingly complex delivery system, as well as a small but growing number of parents who are forgoing vaccination for their children-put success in jeopardy.

- The AAP has long supported preventive care, including immunizations, in the medical home setting as a major component of pediatric health care and disease prevention. The AAP believes that economic barriers should not restrict access to immunizations or other forms of preventive care for children. The AAP works to educate the public and key decisionmakers about the importance of routine child immunization, and actively counters misinformation about vaccine safety and efficacy.
- The AAP and its state chapters advocate for school entry immunization policies that ensure full immunization in the school setting according to current recommendations and discourage
- While the Patient Protection and Affordable Care Act (ACA) mandates insurance coverage of preventive services without copay, including immunizations, gaps in coverage remain. The AAP advocates for appropriate funding for public immunization programs, and works to promote reform of the vaccine delivery and payment system to ensure that children have access to vaccines and that administrative and financial burdens on physician practices are reduced.

- 68.4% of children between the ages of 19 and 35 months were immunized according to ACIP/AAP/AAFP/ACOG recommendations in 2012.
- 48,000 cases of whooping cough (pertussis) were reported in the US in 2012. That's the highest number since 1955.
- 175 cases of measles-including 20 hospitalizations-were reported in 2013. That's about 3 times the usual number and more than 98% of measles patients were unvaccinated against the disease.
- 1.8% of children entering Kindergarten across the country in 2012 had nonmedical exemptions from immunization requirements. Oregon has the highest rate at 6.4% and Mississippi, the lowest at 0.0%

- 18 states-laws
   allowing philosophical/
   conscientious exemptions to
   school entry immunization
   requirements
- 4 states-laws
   requiring risk
   communication to
   exemption applicants about
   vaccine preventable disease

Additional Information: 2013 StateTrack Profile: Immunizations



\* = California, Washington, and Vermont have philosophical/conscientious exemption statutes and new risk communication requirements. Oregon does not have a philosophical/conscientious exemption statute, but its religious/medical exemption is broadly interpreted and used for many nonmedical exemption applications.

- AAP Immunizations Page-www2.aap.org/immunization/
- Combined ACIP/AAP/AAFP/ACOG immunization schedule aapredbook.aappublications.org/site/resources/IZSchedule.pdf
- AAP Policy-Increasing Immunization Coveragepediatrics.aappublications.org/content/125/6/1295
- Centers for Disease Control and Prevention National Immunization Survey www.cdc.gov/vaccines/stats-surv/nis/



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### **Medical Liability Reform**

Pediatricians and other physicians who care for children face unique medicolegal and actuarial consequences as a result of the extended period of patient care, the dynamics of child development and growth, and the role of parental and caregiver consent in clinical decisionmaking.

With state level reforms, courts can equitably balance the needs of parties alleging injury and those of physicians facing suit.

States have been innovators in finding policy solutions on this issue; the Medical Injury Compensation Reform Act (MICRA), California's 1975 landmark legislation, has a proven record of making medical liability insurance available and affordable.

In the absence of federal action, policy making on medical liability will likely continue to be addressed on a state-by-state basis.

The AAP believes that reform is needed on these liability issues:

- State statutes of limitation for minors
- Periodic payments of damages
- Caps on noneconomic damages
- Abolition of collateral source rules
- Use of a sliding scale for plaintiff lawyer fees
- "Fair share" rules that permit allocation of damage awards fairly and in proportion to degree of
- Limitations on punitive damages

the AAP supports state or local programs that use alternative methods, such as:

- Enhanced expert witness qualifications
- Health courts

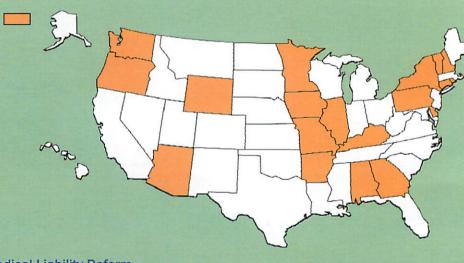
AAP POSITION

- Early disclosure and compensation programs based upon a compensation schedule
- Liability protections for use of evidence-based medicine guidelines

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- 1 in 3 pediatricians will be sued in the course of their career, including 1 in 10 for care delivered during training (residency/fellowship).
- Pediatrics ranks approximately 10th among 28 medical specialties in the number of closed malpractice claims.
- Pediatricians accounted for 2.9% of the more than 247,000 closed malpractice claims that occurred between 1985 and 2009.
- While child-related malpractice claims are only half as likely to result in payments as adult-related claims, payments from child-related claims tend to be significantly higher.
- Closed claims against pediatricians between 1985 and 2009 resulted in an average indemnity
  of greater than \$316,000, placing pediatrics far ahead of the \$121,000 average for all
  specialties.
- Top reasons for child-related malpractice payments:
  - Failure to diagnose (18%)
  - Improper performance (9%)
  - Delay in diagnosis (9%)
  - Improper management (6%)

 19 states-no caps on noneconomic damages in medical liability cases



Additional Information:

2013 StateTrack Profile: Medical Liability Reform

- AAP Position-Advocating for Medical Liability Reform –
   www.aap.org/en-us/professional-resources/practice-support/medical-liability/Pages/Advocating Medical-Liability-Reform.aspx
- American Academy of Pediatrics—Medicolegal Issues in Pediatrics, 7th edition—available from the AAP Bookstore at www.aap.org/en-us/aap-store

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