2016 State Advocacy Report
2016 State Advocacy Report

The 2016 State Advocacy Report reviews action-to-date on 24 priority child health issues.

Check back throughout 2017 at www.aap.org/stateadvocacy for regular updates on these and other issues via our State AdvocacyFOCUS resources.

State AdvocacyFOCUS resources provide an overview of each issue, explain the AAP position, offer key facts and data, and monitor progress in each state. Our 2017 State Advocacy Outlook highlights important state pediatric policy trends in 2017 and can assist chapters with planning and strategy development.

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Introduction

The American Academy of Pediatrics (AAP) is an organization of 66,000 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.

AAP state level advocacy work is a partnership between chapters, committees, councils, sections, and the national organization. Consultation, technical assistance, and strategic guidance on state advocacy activities is provided by the Division of State Government Affairs staff at the AAP headquarters office in Elk Grove Village, Illinois.

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 advocacy learning and engagement opportunities throughout the year. Division staff monitor state policy related to pediatrics and alert chapters to important developments and bill introductions on numerous topics. The division keeps chapter leaders, executive directors, and lobbyists informed with the latest state advocacy issues and news about state governments through numerous resources, including:

- State AdvocacyFOCUS Resources
- StateView-A Look at Advocacy Around the Country
- Advocacy Action Guides for AAP Chapters
- State Advocacy Infographics
- 2017 State Advocacy Outlook
- State Advocacy Planning Resources for AAP Chapters
- State Health Care System Transformation
- Poverty and Child Health State Advocacy Resources
- All resources and information available at www.aap.org/stateadvocacy

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State laws are amended on a frequent basis. The charts and summaries contained in the American Academy of Pediatrics 2016 State Advocacy Report are not to be considered legal advice or a restatement of the law. Readers of the 2016 State Advocacy Report are strongly encouraged to consult a local attorney regarding the applicability of these laws to specific situations.
In 46 states, 1 party will control both chambers of the state legislature in 2017.
In total, Republicans will preside over 66 state legislative chambers, Democrats 31, 1 (Nebraska) is a nonpartisan single-chamber legislature, and 1 legislative chamber (Connecticut Senate) will be tied.
CHILDHOOD IMMUNIZATIONS

Childhood immunizations are vital to the health of children as individuals and to supporting community immunity. Outbreaks of vaccine preventable diseases like measles and pertussis have shown how important it is to shield the community with vaccines, and what can happen when vaccination rates fall below community immunity thresholds. However, the delivery and administration of immunizations in our evolving health care landscape presents a series of challenges to the integrity of the pediatric medical home and the children served by it. And while most parents protect their children with vaccines, a small number do not, and in doing so, place their own children—and their communities—at risk.

Issues to Consider
- Implementing new AAP policy recommendations to eliminate nonmedical exemptions to school entry immunization requirements.
- Ensuring that vaccine purchasing and delivery systems support pediatricians providing vaccines in the medical home setting.
- Making school vaccination rates and nonvaccination rates transparent by making them publicly available to parents.
- Enhancing interoperability of immunization registries/Immunization Information Systems (IIS) across state lines.

AAP Resources
- State AdvocacyFOCUS | Childhood Immunizations
- AAP Immunization Initiatives

MEDICAID PAYMENT AND PAYMENT/SYSTEM REFORMS

Inadequate Medicaid payment for pediatric services remains a policy challenge in many states. While 16 states maintained the Affordable Care Act (ACA) 2013-2014 Medicaid payment increase with state funds into 2016 (to at least some higher percentage of Medicare), other states struggle with low Medicaid payment and related access issues. The final federal Medicaid Access Rule provides states an opportunity to document access to care in the Medicaid fee-for-service environment, but questions remain about whether the rule will result in changes to state practices that truly affect access. The final Medicaid Managed Care Rule also provides an opportunity for strengthening of consumer protections. Meanwhile, a growing number of state Medicaid programs are trying new value based or other alternate payment models, and acting as true drivers of delivery system change by establishing Accountable Care Organizations (ACOs) or other structures.

Issues to Consider
- Advocating for appropriate Medicaid payment to ensure access.
- Experimenting with payment and delivery system reforms that include: a transition to population health, an emphasis on social determinants of health, value based payment and other alternate payment models, and system restructuring such as the creation of Accountable Care Organizations (ACOs).
- Activities to ensure that these new models of paying for and delivering care are optimized for children and pediatrics.

AAP Resources
- State AdvocacyFOCUS | Medicaid Payment Increase
- Medicaid Access Rule | Advocacy Action Guide for AAP Chapters
- Medicaid Managed Care | Advocacy Action Guide for AAP Chapters
NETWORK ADEQUACY AND BALANCE BILLING
Recently, health insurance plans have offered more "narrow" networks, which limit access to physicians, hospitals, and other health care providers in an attempt to keep costs low. Narrow networks can create barriers for children and families as they try to access needed pediatric primary, medical subspecialty, and surgical specialty care. The inability to access necessary care for children can also result in families incurring higher out of pocket costs if they are forced to obtain out-of-network care. In addition to the debate over the adequacy of networks, states are beginning to consider laws on surprise or balance billing of families when they inadvertently receive out-of-network care at in-network facilities.

Issues to Consider
- Ensuring that state regulation of health plan provider network adequacy appropriately includes pediatric primary, specialty, and subspecialty care.
- Requiring the use of objective measures by which to document network adequacy, such as time and distance standards and provider/covered person ratios for pediatric primary, specialty, and subspecialty care.
- Addressing how payment for out-of-network care at in-network facilities will be adjudicated, with an emphasis on protecting families from surprise balance bills.

AAP Resources
- Network Adequacy | Advocacy Action Guide for AAP Chapters
- AAP Annotated Bibliography | Benefits of Pediatric v Adult Specialty Care

POVERTY AND CHILD HEALTH
Although the child poverty rate decreased in 2015, there are still more than 19 million children that live in poverty in the US. Children living in poverty face increased health, education, and socioeconomic risks. In recent years, states have focused on efforts to improve the lives of those children and their families by addressing related issues. In 2016, California and New York increased their minimum wage levels and New York adopted paid family leave. States can take measures to assist children living in poverty by ensuring access to care, access to early education services, strengthening state public benefit programs, and supporting strategies that not only help children in poverty but also work to ensure their parents and family members have access to programs and services that help to improve their health, education, and socioeconomic status.

Issues to Consider
- Advocating for state policies that can help alleviate poverty among children and their families, including minimum wage increases, access to paid sick leave and paid family leave, creating or strengthening state child and dependent care tax credits and state earned income tax credits.
- Supporting efforts to alleviate poverty by connecting and working with state and local antipoverty organizations.

AAP Resources
- Poverty and Child Health State Advocacy Resources
- AAP Poverty and Child Health

FIREARMS RESEARCH AND DATA SURVEILLANCE
With current limitations on Centers for Disease Control and Prevention (CDC) research on firearms, states are beginning to address the gaps in firearm research themselves. The National Violent Death Reporting System (NVDRS) is a state-based, CDC-funded surveillance system that links data from multiple state agencies including law enforcement, coroners and medical examiners, vital statistics, and crime laboratories to assist each participating state in targeting interventions. Thirty-two (32) states currently participate in the program and data are used by state and local violence prevention practitioners to guide their programs and policies, to identify trends and patterns in violence, and help devise strategies for prevention. States are also considering using state funding to conduct firearm research. California became the first state to fund a firearm research center in the country at University of California-Davis Medical Center.

Issues to Consider
-Addressing the need for more research on gun violence prevention by supporting efforts to include their state in the National Violent Death Reporting System (NVDRS).
- Supporting other efforts to coordinate gun violent prevention research through state agencies and state universities.
- Using state child death review (CDR) data to illustrate how gun violence disproportionately affects children.

AAP Resources
- AAP Policy | Firearm-Related Injuries Affecting the Pediatric Population
- State Advocacy Engagement on Firearm Data Collection
TOBACCO 21
The majority of tobacco and/or electronic nicotine device systems (ENDS) users began use of the products before the age of 21. The 2015 Institute of Medicine (IOM) report Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products notes that raising the minimum legal age of purchase of tobacco products would reduce youth smoking initiation, particularly among children ages 15 to 17, leading to substantial reductions in tobacco use, improve the health of Americans across lifespan, and save millions of lives.

Issues to Consider
- Advocating for laws that raise the minimum purchase age of tobacco and Electronic Nicotine Device Systems (ENDS) products to 21.

AAP Resources
- State AdvocacyFOCUS | Raising the Tobacco and ENDS Purchase Age to 21
- AAP Policy Statement | Public Policy Strategies to Protect Children From Tobacco, Nicotine, and Tobacco Smoke
- AAP Policy Statement | Clinical Practice Policy to Protect Children From Tobacco, Nicotine, and Tobacco Smoke
- AAP Julius B Richmond Center of Excellence

ZIKA VIRUS
Travel-related and local transmission of the Zika virus in the US is continuing. In addition to ongoing federal efforts to support a response, states have taken action. Numerous policy responsibilities on Zika—from sharing patient lab results to aerial spraying—are within the policy jurisdiction of state and local governments. With the risk of microcephaly and other more subtle developmental issues for infants, pediatricians and AAP Chapters have an essential role to play in state Zika response.

Issues to Consider
- Assisting state level efforts on disaster and emerging disease preparedness to ensure that the needs of children are being considered, and emphasizing the importance of a strong and well-funded public health infrastructure.
- Enhancing access to outpatient management and early intervention services for babies testing positive for Zika or believed to be exposed to the virus in utero.
- Engaging in dialogue with state and local health officials about 2017 preparation efforts, including prevention, education, surveillance, environmental health impact, public response efforts, and care and treatment.

AAP Resources
- Zika Resources from the AAP Disaster Preparedness Advisory Council (DPAC)

PRESCRIPTION DRUG COSTS
The recent focus on the very high cost of epinephrine autoinjectors has brought prescription drug costs to the forefront of state policy, but the same market dynamics influence the price of other pediatric prescription drugs. Increases in cost sharing requirements in many health plans have magnified these cost increases and further burdened families with unexpected out of pocket expenses. While industry led efforts to provide rebates or other cost savings for patients, inflated drug prices are ultimately absorbed by insurers and passed back onto insureds in the form of higher insurance premiums.

Issues to Consider
- Establishing legislative commissions or requiring state agencies to study the issue.
- Advocating for caps on copays for prescription drugs or requiring price transparency when prescription drug costs increase.
- Urging the state attorneys general and/or consumer protection agencies to take action through existing or new authority.

AAP Resources
- State Advocacy Engagement on Epinephrine Autoinjector Costs

Additional Resources
- National Conference of State Legislatures | Pharmaceutical Costs and Access
- Consumers Union | Promoting Access to Affordable Prescription Drugs
Assault Weapons Bans

The federal assault weapons ban, which prohibited the sale and manufacture of certain military-style semiautomatic weapons and high capacity magazines in the US, expired in 2004. Despite AAP advocacy to restore the ban, efforts have languished in Congress. Meanwhile, states have enacted their own bans on assault weapons along with high-capacity detachable magazines—typically defined as those which hold more than 10 rounds of ammunition at a time.

High capacity rifle and pistol magazines have been 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), Newtown (Connecticut), Chattanooga (Tennessee), Charleston (South Carolina), San Bernardino (California), and Orlando (Florida).

AAP POSITION

- 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.
- To prevent gun-related death and injuries, the AAP recommends that pediatricians provide firearm safety counseling to patients and their families.
- 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.

A growing number of retailers, including Walmart, have discontinued sales of assault weapons and high-capacity magazines.

7 states—laws banning assault weapons.

For information on current law or pending legislation in your state, please contact the AAP Division of State Government Affairs at stgov@aap.org.

AAP Policy—Firearm-Related Injuries in the Pediatric Population—http://pediatrics.aappublications.org/content/130/5/e1416.full
Brady Campaign to Prevent Gun Violence—www.bradycampaign.org
Law Center to Prevent Gun Violence—http://smartgunlaws.org
Everytown for Gun Safety—www.everytown.org

Division of State Government Affairs | stgov@aap.org | www.aap.org/stateadvocacy

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Bullying Prevention

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.

State officials are concerned about the long-term effects of bullying and many now require that schools address both in-school and out-of-school bullying. State legislators have also recognized that bullying does not always take place only between classmates and have introduced legislation that would address bullying that takes place outside of the school administrator’s purview.

AAP POSITION

- The AAP recommends that pediatricians advocate for bullying awareness by teachers, education administrators, parents, and children, and supports adoption of evidence-based prevention programs.
- 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 (i.e., 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.

22 states—comprehensive bullying prevention laws

For information on current law or pending legislation in your state, please contact the AAP Division of State Government Affairs at stgov@aap.org.

MORE

- 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
Outdoor air pollution is linked to respiratory problems in children, including decreased lung function, coughing, wheezing, more frequent respiratory illness, and asthma exacerbation. In 1970, Congress passed the federal Clean Air Act to address these and other concerns about America’s worsening air quality.

The Clean Air Act is now being extended to reduce carbon emissions from power plants, with final rulemaking underway. The Environmental Protection Agency (EPA) Clean Power Plan seeks to allow states to meet carbon reduction targets via 1 or more state-determined compliance strategies.

These actions are essential to limit immediate impacts on child respiratory health and in curtailing global climate change.

While Clean Power Plan implementation activities by EPA have been delayed by a US Supreme Court Ruling, states can continue to plan for implementation and work with regulators and power producers to limit carbon emissions.

- The American Academy of Pediatrics (AAP) is dedicated to ensuring that children have an optimal environment in which to live, learn, and play.
- The AAP strongly supports the EPA’s work to reduce carbon pollution and urges states to set a path to reduce carbon emissions via the EPA Clean Power Plan.
- State legislatures and regulatory agencies have a critical role in implementing the plan and meeting state and regional carbon emission reduction targets.
- Building political will for implementation of the EPA Clean Power Plan is an important child advocacy objective.
- Pediatricians should understand the threat of global climate change, anticipate their effects on children’s health, and participate as children’s advocates for strong mitigation and adaptation strategies now.
- AAP chapters are uniquely positioned to educate legislators and regulators about the unique environmental health needs of children and the importance of reducing power plant carbon emissions. By limiting carbon emissions, the air children breathe today will be cleaner, and will help to forestall global climate change in the future.
- AAP chapter advocates can also work with local and state health departments to strengthen public health infrastructure, disease surveillance and reporting, and disaster preparedness.
• By 1990, the Clean Air Act prevented 205,000 premature deaths, 18 million childhood respiratory illnesses, and the loss of 10.4 million IQ points for children from lead exposure. After the Clean Air Act Amendments of 1990, emissions of 6 common pollutants dropped 41% through 2008.
• Over 80% of the current health burden from the changing climate is on children younger than 5 years. These burdens include injury and death from natural disasters, increases in climate-sensitive infectious diseases, increases in air-pollution related illness, and other heat-related illness.
• If fully implemented by 2030, the proposed EPA rule for existing power plants will result in 6,600 fewer premature deaths, 150,000 fewer child asthma attacks, and 180,000 fewer missed school days.

FACTS

• 21 states—state/regional carbon emission reduction plan established
• 1 state—executive order prohibits development of Clean Power Plan

PROGRESS

For information on current law or pending legislation in your state, please contact the AAP Division of State Government Affairs at stgov@aap.org.

MORE

• AAP Policy—Global Climate Change and Children's Health—http://pediatrics.aappublications.org/content/136/5/992
• AAP Policy—Ambient Air Pollution: Health Hazards to Children—http://pediatrics.aappublications.org/content/114/6/1699
• Pediatric Environmental Health Specialty Units—www.pehsu.net
• EPA Clean Power Plan Toolbox for States—www2.epa.gov/cleanpowerplantoolbox
Child Passenger Safety

OVERVIEW

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.

AAP POSITION

- Infants and toddlers should ride facing the rear of the vehicle until they are at least 2 years old.
- 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 National Highway Traffic Safety Administration (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 enforcement.
More than 1,100 children in the US, ages 14 years and younger, died as occupants in motor vehicle crashes, and approximately 165,000 were injured, in 2013.

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.

3 states—laws include 4 of 5 AAP recommended child passenger safety provisions

17 states and DC—laws include 3 of 5 AAP recommended child passenger safety provisions

For information on current law or pending legislation in your state, please contact the AAP Division of State Government Affairs at stgov@aap.org.

AAP Policy—Child Passenger Safety
http://pediatrics.aappublications.org/content/127/4/788.full

http://pediatrics.aappublications.org/content/127/4/e1050.full

HealthyChildren.org Car Seat Guide for Families

*Indicates that the state has a rear-facing until age 2 requirement.
Childhood Immunizations

OVERVIEW

Routine childhood immunization is one of the crown achievements in public health over the past 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 measles, pertussis, 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.

AAP POSITION

- The American Academy of Pediatrics (AAP) has long supported preventive care, including immunizations, in the medical home setting as a major component of pediatric health care and disease prevention and believes 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 decision makers about the importance of routine child immunization and actively counters misinformation about vaccine safety and efficacy.

- The AAP recommends that state laws permitting nonmedical exemptions to school entry immunization requirements should be eliminated.

- 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.
72.2% of children between the ages of 19 and 35 months were immunized according to ACIP/AAP/AAFP/ACOG recommendations in 2015.

18,166 cases of whooping cough (pertussis) were reported in the US in 2015.

A multistate outbreak of measles linked to an amusement park in California led to 188 cases in 24 states from January 1 to August 21, 2015. Most measles patients were unvaccinated against the disease.

1.6% of children entering kindergarten across the country in the 2015-2016 school year had nonmedical exemptions from immunization requirements. Oregon has the highest rate at 6.2% and Mississippi, the lowest at 0%.

16 states—laws allowing philosophical/conscientious exemptions to school entry immunization requirements

8 states—laws requiring risk communication to exemption applicants about vaccine preventable disease

For information on current law or pending legislation in your state, please contact the AAP Division of State Government Affairs at stgov@aap.org.

AAP Immunization Resources—www.aap.org/immunization/


AAP Policy—Medical Versus Nonmedical Immunization Exemptions for Child Care and School Attendance—http://pediatrics.aappublications.org/content/138/3/e20162145

Child Vaccination Across America—https://immunizations.aap.org
Confidentiality for Adolescents and Young Adults Insured as Dependents

Increasing numbers of adolescents and young adults are insured as dependents as a result of a provision of the Affordable Care Act that extends such coverage to age 26. Although the coverage itself is vital, the privacy of their health information may be at risk.

Confidentiality is vital to services beyond reproductive health—substance abuse, tobacco cessation, and mental health treatment, as well as abuse, neglect, and intimate partner violence, and other services should be private and not compromised via billing procedures.

Insurance claim processing procedures vary by state, market, and insurer. While consumers expect and deserve transparency about the costs of services covered by insurers, one of the consequences of this expectation is a potential loss of privacy for insured dependents, particularly for confidential services.

- Confidentiality, both in determining whether youth receive what they need and whether there are opportunities for private patient-physician time during health care visits, is a major factor that affects quality of care for many youth.

- Confidentiality is key to addressing many types of preventive care for adolescents and young adults because fear of disclosure, diagnosis, and treatment may cause them to delay or even avoid needed care.

- State governments should ensure that adolescent confidentiality is preserved and/or protected as electronic health records are implemented more broadly and as new billing procedures are adopted by health insurance plans.
In more than half of states, issuance of an Explanation of Benefits (EOB) is not required or explicitly addressed in state insurance law.

Nationally, 2/3 of adults with dependent children have employer based or other private coverage.

In addition to action by state legislatures, state insurance commissioners can use existing authority or nonbinding agreements with insurers to prevent issuance of an EOB for preventive services where no balance is due, set policies requiring that EOBs are sent directly to the patient seeking care (rather than the policyholder), prohibit issuance of an EOB for screening of sexually transmitted infection (STI), or implement other best practices to preserve patient confidentiality.

2 states—EOB not required if zero balance is due

7 states—laws requiring insurers to prevent disclosure of confidential communications*

For information on current law or pending legislation in your state, please contact the AAP Division of State Government Affairs at stgov@aap.org.

Joint AAP-SAHM Policy—Confidentiality Protections for Adolescents and Young Adults in the Health Care Billing and Insurance Claims Process—www.adolescenthealth.org/SAHM_Main/media/Advocacy/Positions/Confidentiality-Position-Statement.pdf

AAP Policy—Contraception for Adolescents—http://pediatrics.aappublications.org/content/134/4/e1244

AAP Policy—Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth—http://pediatrics.aappublications.org/content/132/1/198


*Colorado law does not apply to minors who are insured dependents. Illinois requires confidential communications in its Medicaid program, but not for private insurers.
Distracted Driving

The National Transportation Safety Board (NTSB) recommends 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.

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.
 Nearly 2,200 US 16-19 year olds were killed by motor vehicle crash injuries, and approximately 243,000 were treated in emergency departments for motor vehicle crash injuries in 2013.

 Nearly 3,200 people in the US died, and 424,000 were injured, in crashes that involved a distracted driver in 2013.

 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.

 In 2013, nearly 20% of all crashes in which someone was injured involved a driver who was distracted.

 8 states—laws prohibiting minors from texting while driving

 40 states and DC—laws prohibiting minors from using mobile phones and texting while driving

 For information on current law or pending legislation in your state, please contact the AAP Division of State Government Affairs at stgov@aap.org.

 AAP Policy—The Teen Driver—http://pediatrics.aappublications.org/content/118/6/2570.full
 Parent-Teen Driving Agreement—www.healthychildren.org/English/ages-stages/teen/safety/Pages/Teen-Driving-Agreement.aspx
 Centers for Disease Control and Prevention (CDC)—Distracted Driving—www.cdc.gov/motorvehiclesafety/distracted_driving
 National Highway Transportation Safety Administration (NHTSA)—Distracted Driving—www.distraction.gov

Division of State Government Affairs | stgov@aap.org | www.aap.org/stateadvocacy
Electronic Nicotine Delivery Systems (ENDS)

Electronic Nicotine Delivery Systems (ENDS), also called e-cigarettes or personal vaporizers (PV), present another way for smokers to ingest nicotine. ENDS are increasingly being marketed to young adults and adolescents. They are also touted by some users 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 May 2016, the FDA finalized a new rule to extend its tobacco regulating authority to ENDS. The rule restricts sales to minors younger than 18, requires health warnings on packaging, prohibit vending machine sales, and prohibit marketing the products as healthy or safe. These proposed FDA rules do not address the use of candy and fruit flavors which appeal to youth and would not go into effect until at least 2 years after the rule is finalized. In absence of strong federal regulation, states have been acting to restrict ENDS purchases by minors, marketing targeted at children and adolescents, and use of the devices in public places.

AAP POSITION

- Sales of ENDS to minors younger than 21 years should be prohibited.
- Candy and fruit flavored ENDS, which encourage youth smoking initiation, should be banned.
- Federal, state, and local governments should enact and enforce laws that mandate the provision of smoke-free environments, including ENDS vapor, in all public places and require employers to provide smoke-free/ENDS vapor-free work environments for their employees.
- Advertising of ENDS in the media, on the internet, and in point of sale locations that can be viewed by youth, should be banned.
Nicotine is highly addictive and has negative effects on brain development from the prenatal period into adolescence.

Additional research is needed to determine whether ENDS promote cessation and help smokers quit, or whether they promote experimentation, initiation or dual use of tobacco products and perpetuate addiction to nicotine. Initial evidence shows that ENDS use does not improve successful quit rates.

According to 2014 data from the Centers for Disease Control and Prevention (CDC), use of ENDS among high school and middle school students tripled from 2012 to 2013, with more than 2 million students reporting that they had used the device in the past 30 days.

According to the CDC, nearly 250,000 youth who had never smoked tried ENDS in 2013—a 3-fold increase from 2011.

In 2014, more teenagers used ENDS and personal vaporizers than all forms of tobacco products.

9 states—laws prohibiting use of ENDS in all workplaces, bars, and restaurants

For information on current law or pending legislation in your state, please contact the AAP Division of State Government Affairs at stgov@aap.org.

AAP Policy—Electronic Nicotine Delivery Systems—http://pediatrics.aappublications.org/content/early/2015/10/21/peds.2015-3222.full.pdf+html

AAP Policy—Public Policy to Protect Children from Tobacco, Nicotine, and Tobacco Smoke—http://pediatrics.aappublications.org/content/early/2015/10/21/peds.2015-3109.full.pdf+html

AAP Julius B. Richmond Center of Excellence—www2.aap.org/richmondcenter

Campaign for Tobacco Free Kids—www.tobaccofreekids.org

Essential Health Benefits

The Affordable Care Act (ACA) requires the establishment of an “essential health benefits (EHB) package” for certain health insurance plans including qualified health plans (QHPs) and the Medicaid expansion population. In 2011, the Secretary of the US Department of Health and Human Services (HHS) determined states should define and update the EHB package by choosing among 4 benchmarks provided by the Center for Medicare and Medicaid Services (CMS), and supplementing those benchmarks to ensure all 10 categories of EHB are met.

Most benchmark plans did not include coverage for the categories of habilitative services and pediatric oral and vision care, which were required to be supplemented in a benchmark plan using HHS guidance.

Because each state chooses its own EHB benchmark plan, uniformity is lacking, resulting in inconsistent coverage for children.

- The most appropriate package for children, such as Medicaid’s Early and Periodic Screening, Diagnosis and Treatment (EPSDT) or Children’s Health Insurance Program (CHIP) benefits should be the benchmark for children in EHB packages to ensure all children receive the care they need.

- Habilitation services should be offered at parity with rehabilitation services.

- In instances where states need to supplement the pediatric oral or vision services in the EHB benchmark plan, states should use the most robust option available for these services.

- States should prohibit benefit substitution within EHB categories. If permitted, substitutions should be extremely limited and ensure the benefits meet the needs of children.
An EHB package must include the following 10 benefits:
1) ambulatory patient services, 2) emergency services, 3) hospitalization, 4) maternity and newborn care, 5) mental health and substance use disorder services, 6) prescription drugs, 7) rehabilitative and habilitative services and devices, 8) lab services, 9) preventive and wellness services and chronic disease management, and 10) pediatric services, including oral and vision care.

States can select EHB benchmark plans from:
- the largest plan by enrollment in any of the state’s 3 largest small group insurance products;
- any of the 3 largest state employee health plans by enrollment;
- any of the 3 largest national Federal Employee Health Benefit Plan (FEHBP) plan options by enrollment;
- the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) in the state.

If a benchmark plan is not chosen, the state defaults to the largest small group insurance product.

[State choices for 2017 plan year]
- 46 states and DC—largest small group product
- 1 state—largest HMO product
- 3 states—state employee product

For information on current law or pending legislation in your state, please contact the AAP Division of State Government Affairs at stgov@aap.org.

- The ACA’s Pediatric Essential Health Benefit Has Resulted in a State-By-State Patchwork Of Coverage With Exclusions – http://content.healthaffairs.org/content/33/12/2136.full.pdf
Health Insurance Marketplaces

The Patient Protection and Affordable Care Act (ACA) created 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 2015, 4.8% of all US children were uninsured; down from 6% in 2014. 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 November 15, 2014 and provide coverage options for those without access to affordable employer based coverage. Open enrollment period for the 2017 plan year is November 1, 2016 through January 31, 2017.

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.

Enrollment figures indicate that 12.7 million individuals enrolled for private coverage through marketplaces at the end of the last open enrollment period, and as many as 73.1 million are enrolled in Medicaid and CHIP as of September 2016.

16 states and DC– declared a state based marketplace (SBM)
28 states– declared a federally facilitated marketplace (FFM)
6 states– declared a partnership marketplace (PM)

For information on current law or pending legislation in your state, please contact the AAP Division of State Government Affairs at stgov@aap.org.

AAP ACA Marketplace Resources – www.aap.org/ACAMarketplace
Making Health Insurance Exchanges Work for Kids (First Focus Report) – http://firstfocus.org/resources/fact-sheet/making-health-insurance-exchanges-work-for-kids/
Marijuana is very harmful to adolescent health and development. Short- and long-term recreational use of marijuana in adolescents can cause mental health problems, decrease lung function, lead to substance abuse disorders, increase use of other illicit drugs, and decrease the likelihood of completing high school or obtaining a college degree.

In 2012, Colorado and Washington voted by ballot initiative to legalize the sale by and possession of marijuana for recreational use. Though marijuana is illegal under federal law, the US Department of Justice announced in 2013 that the agency would not challenge state recreational marijuana as long as the states enforce strict rules about the sale and distribution of the drug. Since that time, Alaska, California, Maine, Massachusetts, Nevada, Oregon, and Washington, DC have followed suit and enacted ballot initiatives legalizing marijuana.

- Given the data supporting the negative health and brain development effects of marijuana in children and adolescents, ages 0 through 21 years, the American Academy of Pediatrics (AAP) is opposed to marijuana use in this population.

- The AAP opposes legalization of marijuana because of the potential harms to children and adolescents. The AAP supports studying the effects of recent laws legalizing the use of marijuana to better understand the impact and define best policies to reduce adolescent marijuana use.

- In states where marijuana legalization is currently legal, pediatricians should advocate that states regulate the product as closely as possible to tobacco and alcohol, with a minimum age of 21 years for purchase. These regulations should include strict penalties for those who sell marijuana products to those younger than 21 years, education and diversion programs for those younger than 21 years who possess marijuana, point-of-sale restrictions and other marketing restrictions. Marijuana should be sold in childproof packaging.
Even with age restrictions, any policy that leads to increased adult use of marijuana is likely to lead to increased adolescent use, despite attempts to restrict sales to underage youth.

Research shows that the younger an adolescent begins using marijuana, the more likely that a drug addiction or dependence will develop in adulthood.

Marijuana alters mood control, coordination, judgment, which may contribute to unintentional deaths and injuries.

Marijuana is linked to psychological problems, poor lung health, and a likelihood of drug dependence in adulthood.

Legalization creates a lucrative and dangerous opportunity for industry to commercialize and market marijuana to children.

8 states and DC—laws allowing the sale of recreational marijuana

For information on current law or pending legislation in your state, please contact the AAP Division of State Government Affairs at stgov@aap.org.


Smart Approaches to Marijuana (SAM)—http://learnaboutsam.org/


National Institute on Drug Abuse (NIDA)—www.drugabuse.gov
Medicaid Expansion

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 the Medicaid expansion 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 AAP 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 AAP 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.
In states that may not expand Medicaid, 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.

31 states and DC—currently participating in Medicaid expansion

19 states—currently not participating in Medicaid expansion

For information on current law or pending legislation in your state, please contact the AAP Division of State Government Affairs at stgov@aap.org.


Division of State Government Affairs | stgov@aap.org | www.aap.org/stateadvocacy
Medicaid Payment Increase

The Patient Protection and Affordable Care Act (ACA) included 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, raised 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 those 2 years. Subspecialists boarded under 1 of the aforementioned specialty member boards—as well as other subspecialists practicing primary care who could support this with a claims history—were also eligible for the Medicaid payment increase.

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

The ACA Medicaid payment increase ended December 31, 2014, without renewal by Congress. However, a number of states have acted to extend the increase with state funds.

OVERVIEW

- 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 final rule implementing the Medicaid “equal access” provision was released in November 2015. While it requires states to examine access to care in the Medicaid fee-for-service context, it does not require Medicaid payment rates to be raised to a specific benchmark rate.
- The AAP supports efforts at the state and federal levels to raise Medicaid payment rates for all physician services to those that are at least equivalent with Medicare rates.
- In October 2015, the federal CHIP match rate increased by 23 percentage points. Chapters were encouraged to advocate for utilization of freed up state dollars to increase Medicaid rates.

AAP POSITION
- The Medicaid payment increase applied 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 were 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 was used for calendar year 2013.

- 16 states – using state dollars to extend the increase in State Fiscal Year (SFY) 2017*

- 32 states – not using state dollars to extend the increase in SFY 2017

- 2 states – Medicaid rates at or higher than Medicare rates

**AAP Medicaid Payment Increase Resources** – www.aap.org/

*Implementation will vary by state. For example, Michigan Medicaid rates will be increased to 78% of Medicare.

**MORE**

- **CMS – Provider Payments** – www.medicaid.gov/AffordableCareAct/Provisions/Provider-Payments.html
Medical Liability Reform

OverView

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 decision making.

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.

AAP Position

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

- Reducing the statutes of limitation for minors for medical liability to a reasonable period for the patient and the physician.
- Limiting liability for noneconomic damages to a reasonable amount.
- Structuring periodic payments over $100,000 for future damages.
- Setting controls on attorney’s contingency fees to be fair to victims.
- Imposing reasonable punitive damages only with “clear and convincing” evidence and when the defendant is directly responsible.
- Tightening the requirements for expert witnesses in medical malpractice proceedings to improve its quality, obviate the use of spurious testimony, and hold experts accountable for what they say.
- Recognizing collateral sources of compensation to prevent plaintiffs from “double-dipping”.
- For states that have been unable to successfully enact comprehensive medical liability reform laws, the AAP supports state or local programs that use alternative methods, such as allocating federal grants to study state or local-based demonstration or pilot programs aimed at improving the current litigation climate expediting equitable dispute resolutions, reducing litigation costs, and minimizing the practice of defensive medicine.
1 in 4 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.
- 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 2003 and 2012 resulted in an average indemnity of greater than $394,000, placing pediatrics ahead of the $325,000 average for all specialties, and 4th among 28 specialties in total average payouts.

- Top reasons for child-related malpractice payments:
  - Failure to diagnose (18%)
  - Improper performance (9%)
  - Delay in diagnosis (9%)
  - Improper management (6%)

20 states—no caps on noneconomic damages in medical liability cases

For information on current law or pending legislation in your state, please contact the AAP Division of State Government Affairs at stgov@aap.org.


In recent years, states have enacted laws, passed ballot measures, and adopted public policies supporting the use of “medical marijuana” and the use of cannabis oil to treat, among other conditions, seizure disorders in children. The approved conditions that marijuana can treat, the amount of marijuana that the patient can possess, the cultivation process, and registration requirements vary widely.

Marijuana is classified a schedule I drug by the US Drug Enforcement Agency (DEA), signifying the drug has a high potential for abuse, no accepted medical use, and there is a lack of accepted safety for use of the drug or substance under medical supervision. Cannabinoids, which are components of marijuana, have been proven to be effective in treating of specific conditions in adults including nausea, vomiting, and chronic pain conditions. Currently, 3 pharmaceutical cannabinoids have been approved by the US Food and Drug Administration (FDA). Though anecdotal accounts have shown that certain cannabinoids could benefit children with certain chronic debilitating diseases, there has been no published studies about the effects on cannabinoids on the pediatric population.

- The American Academy of Pediatrics (AAP) opposes “medical marijuana” outside the regulatory process of the US Food and Drug Administration (FDA).

- The Academy recognizes that anecdotal accounts have shown that certain marijuana compounds could benefit some children with chronic life-limiting, debilitating conditions. For this reason, the AAP strongly supports research and development of pharmaceutical cannabinoids and supports a review of policies promoting research on the medical use of these compounds. The AAP recommends changing marijuana from a Drug Enforcement Agency (DEA) schedule I to a schedule II drug to facilitate this research.

- In states where marijuana is sold, either for medical or recreational purposes, regulations should be enacted to ensure that marijuana in all forms is distributed in childproof packaging to prevent accidental ingestion.
There are currently no published studies on the efficacy of marijuana as a medication in children.

While there are studies that have shown chemicals in marijuana do help patients with some chronic conditions, these studies have been done on adults. Children may respond differently.

Marijuana edibles, particularly those that look like baked goods or candy, present a poisoning risk to children. All forms of marijuana should be sold in childproof packaging to prevent unintentional ingestions.

No drug should ever be administered through smoking. Smoking marijuana has a well-documented negative effect on lung function.

Because marijuana is not regulated by the FDA and the purity and THC content cannot be consistently verified, the risk-benefit cannot be determined.

26 states and DC—laws allowing the use of “medical marijuana”

14 states—laws allowing the use of cannabis oil to treat seizures in children

For information on current law or pending legislation in your state, please contact the AAP Division of State Government Affairs at stgov@aap.org.
Newborn Screening for Critical Congenital Heart Disease

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. A pulse oximetry screen can be used to detect potential cases of CCHD in newborns.

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 American Academy of Pediatrics (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.

AAP POSITION

- 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 adjusted in high altitude areas.

- 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 between $5 and $14 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.

36 states and DC—laws requiring newborn screening for CCHD

12 states—regulations or guidance on newborn screening for CCHD

For information on current law or pending legislation in your state, please contact the AAP Division of State Government Affairs at stgov@aap.org.

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

AAP Strategies for Implementing Screening for Critical Congenital Heart Disease—http://pediatrics.aappublications.org/content/128/5/e1259.full

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

AAP Resources—www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/PEHDIC/Pages/Newborn-Screening-for-CCHD.aspx

*California’s law requires screening for CCHD to be offered prior to a newborn being discharged from a birthing center. Vermont’s regulation recommends all newborns be screened for CCHD using the current medical standard of care.
Raising the Tobacco and ENDS Purchase Age to 21

Preventing youth smoking initiation is an important strategy to reducing tobacco-related diseases. Electronic Nicotine Delivery Systems (ENDS), also called e-cigarettes or personal vaporizers (PV), present another way for smokers to ingest nicotine. Sold in fruit and candy-flavors, the products encourage smoking initiation by teenagers. The vast majority of people who become addicted to nicotine start using tobacco and ENDS products before the age of 21. Many high school students turn 18 (the legal age of tobacco/ENDS purchase in most states) during their senior year of high school and often purchase tobacco and ENDS products for younger students. As of August 2016, the US Food and Drug Administration (FDA) has extended its tobacco regulating authority to include ENDS products, restricting sales to minors younger than 18.

The 2015 Institute of Medicine (IOM) report *Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products* notes that raising the minimum legal age of purchase of tobacco products would reduce youth smoking initiation, particularly among children ages 15 to 17, leading to substantial reductions in tobacco use, improve the health of Americans across lifespan, and save millions of lives.

- The minimum age to purchase tobacco and electronic nicotine device systems (ENDS) should be increased to 21.
- Laws and regulations prohibiting the sale of tobacco and ENDS to minors should be vigorously enforced.
- Legislation to increase the minimum age of purchase can be implemented at the state and local government levels.
- Funding for enforcement activities can be provided from federal, state, or local revenues.
- Point-of-sale advertising of tobacco and ENDS products should be prohibited.
According to a 2012 Surgeon General’s Report, almost 1 in 4 high school seniors is a current smoker, 1 in 10 high school senior males is a smokeless tobacco user, and 1 in 5 high school senior males is a current cigar user.

Cigarette smoking is responsible for more than 480,000 deaths per year in the US, including nearly 42,000 deaths resulting from secondhand smoke exposure. This is about 1 in 5 deaths annually, or 1,300 deaths every day.

A 2015 Centers for Disease Control and Prevention (CDC) study showed that 75% of the American public, including 70% of current smokers, supported a minimum tobacco purchase age of 21.

4 states – laws banning sale of tobacco and ENDS products to youth younger than 19

2 states – laws banning sale of tobacco and ENDS products to youth younger than 21

For information on current law or pending legislation in your state, please contact the AAP Division of State Government Affairs at stgov@aap.org.

AAP Policy – Public Policy to Protect Children From Tobacco, Nicotine, and Tobacco Smoke – http://pediatrics.aappublications.org/content/early/2015/10/21/peds.2015-3109.full.pdf+html

AAP Policy – Clinical Practice Policy to Protect Children From Tobacco, Nicotine, and Tobacco Smoke – http://pediatrics.aappublications.org/content/early/2015/10/21/peds.2015-3108.full.pdf+html

AAP Julius B. Richmond Center of Excellence – www2.aap.org/richmondcenter/


Campaign for Tobacco-Free Kids – www.tobaccofreekids.org

Since the 1920s, milk sold in the US has been routinely pasteurized to kill harmful bacteria that poses a special threat to children and pregnant women. Proponents of raw milk claim that the pasteurization of milk destroys or neutralizes important nutrients in milk and claim health benefits of milk are inactivated by pasteurization. These claims have not been demonstrated in evidence-based studies and do not outweigh the risks of raw milk consumption.

The sale of raw milk across states is prohibited by the US Food and Drug Administration (FDA). However, a state can decide whether to allow the sale of raw milk within its borders by retailers or on farms. A growing movement has led to an influx of state bills that would loosen existing regulation and allow raw milk sale by retailers, on licensed or unlicensed farms, or through cow or herd share programs that allow consumers to pay a farmer to board and care for animals to produce raw milk for those consumers.

- Raw milk and milk products continue to be sources of bacterial infections attributable to a number of virulent pathogens, including Listeria monocytogens, Camplyobacter jejuni, Salmonella species, Brucella species, and Escherichia coli 0157.

- The American Academy of Pediatrics (AAP) endorses a ban on the sale of raw or unpasteurized milk in the US, including the sale of certain raw milk cheeses, such as fresh cheeses, soft cheeses, and soft-ripened cheeses.

- The AAP supports state bans on the sale of raw milk and milk products, including sales via farms and through cow or herd share programs.
Almost 1,000 people in the US became sick from drinking raw milk or eating cheese made from raw milk between 2007 and 2012 according to Centers for Disease Control and Prevention (CDC).

Unpasteurized milk is 150 times more likely to cause foodborne illness and results in 13 times more hospitalizations than illnesses involving pasteurized dairy products.

States that restrict the sale of nonpasteurized products have fewer foodborne illness outbreaks and illnesses. The number of US outbreaks caused by nonpasteurized milk increased from 30 between 2007 and 2009 to 51 between 2010 and 2012. Most outbreaks were caused by nonpasteurized milk purchased from states in which nonpasteurized milk sale was legal.

Virtually all national and international advisory and regulatory committees related to food safety have strongly endorsed the principles of only consuming pasteurized milk products.

No evidence-based studies have shown that drinking raw milk provides any greater health benefits to consumers than drinking pasteurized milk.

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22 states—laws allowing the sale of raw cow or goat milk on farms or through cow share or herd share programs

15 states—laws prohibiting the sale of all raw milk products

For information on current law or pending legislation in your state, please contact the AAP Division of State Government Affairs at stgov@aap.org.

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AAP Policy—Consumption of Raw or Unpasteurized Milk and Milk Products by Pregnant Women and Children—http://pediatrics.aappublications.org/content/133/1/175.full

US Food and Drug Administration (FDA)—The Dangers of Raw Milk: Unpasteurized Milk Can Pose a Serious Health Risk—www.fda.gov/Food/ResourcesForYou/consumers/ucm079516.htm

The Centers for Disease Control and Prevention (CDC)—Food Safety and Raw Milk—www.cdc.gov/foodsafety/rawmilk/raw-milk-index.html

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 exposed. “Anticipatory guidance” is a major component of pediatric care and helps patients and their families know what to watch for in the future. Such guidance covers multiple topics including child passenger safety seat use, drowning prevention, parental tobacco use, and developmental milestones.

- The American Academy of Pediatrics (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 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.
• About 1/3rd of American children live in homes with firearms, and of these households, 43% contain at least 1 unlocked firearm. Thirteen percent (13%) of households with guns contain at least 1 firearm that is unlocked and loaded or stored with ammunition.

• 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

For information on current law or pending legislation in your state, please contact the AAP Division of State Government Affairs at stgov@aap.org.

• AAP Policy – Firearm-Related Injuries in the Pediatric Population – http://pediatrics.aappublications.org/content/130/5/e1416.full
• Everytown for Gun Safety – www.everytown.org
• Law Center to Prevent Gun Violence – http://smartgunlaws.org
School Physical Education and Activity

Though rates of childhood obesity have shown small improvements in the past few years, the number of healthy weight children in the US is still far from ideal. Increased awareness of the importance of healthy, active living through the “Let’s Move” campaign and federal efforts to improve school nutrition programs have made great strides in turning the tide of obesity, but state policymakers have an important role to play in this effort.

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 develop the knowledge, attitudes, motor skills, behavioral skills, and confidence required to adopt and maintain healthy active lifestyles.
- 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 2012. Similarly, the percentage of adolescents aged 12-19 years who were obese increased from 5% to 18% over the same period.

In 2012, 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—laws requiring only daily recess for grades K-6

For information on current law or pending legislation in your state, please contact the AAP Division of State Government Affairs at stgov@aap.org.
The popularity of tanning beds has increased steadily among adolescents—especially white teenage girls—over time.

The evidence associating 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 US Food and Drug Administration (FDA) has proposed a rule that would prohibit tanning bed use by children younger than 18. In the interim, states have been acting to prohibit tanning bed use by minors.

- The American Academy of Pediatrics (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.
• 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.

• 16 states and DC—laws banning tanning bed use by minors younger than 18 years (per AAP guidelines)

• 19 states—laws requiring minors to be at least 14 years to use tanning beds

For information on current law or pending legislation in your state, please contact the AAP Division of State Government Affairs at stgov@aap.org.

• AAP Policy—Ultraviolet Radiation: A Hazard to Children and Adolescents—http://pediatrics.aappublications.org/content/127/3/588.full


• American Academy of Dermatology—Indoor Tanning—https://www.aad.org/media/stats/prevention-and-care
Teen Driving

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 emotional mood swings, leading to crashes.

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 and drug-related crashes.

Seatbelt use matters. Teenage drivers wear restraints far less often than other drivers. More than half of the teenagers killed in automobile crashes in 2011 were not wearing seatbelts. Teens are also far more likely to text and drive and to become more easily distracted than other drivers.

**AAP POSITION**

- A learner 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 night.
- 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 curfew restrictions.
- Use of safety belts and appropriate child restraints by all occupants.
- 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.

- 4 states and DC—laws include 5 of 7 AAP GDL recommendations
- 12 states—laws include 4 of 7 AAP GDL recommendations
- 20 states—laws include 3 of 7 AAP GDL recommendations

For information on current law or pending legislation in your state, please contact the AAP Division of State Government Affairs at stgov@aap.org.

**AAP Policy–The Teen Driver** – http://pediatrics.aappublications.org/content/118/6/2570.full
**AAP Parent-Teen Driving Agreement** – www.healthychildren.org/English/ages-stages/teen/safety/Pages/Teen-Driver-Agreement.aspx
**Insurance Institute for Highway Safety (IIHS)** – www.iihs.org
**Governor’s Highway Safety Association (GHSA)** – www.ghsa.org
**National Safety Council** – www.nsc.org
Telehealth Care Payment

Telehealth care technology has the potential to transform how pediatricians and other physicians practice medicine in the rapidly changing health care environment. This technology promises to increase access to care and lower health care costs.

State legislators and regulators are actively engaged in developing telehealth care public policy in such areas as establishment of the physician-patient relationship, e-prescribing, and physician licensure.

Physician payment is an important telehealth care issue. Laws and policies regarding payment for telehealth care services by Medicaid and private insurance are decided by states. Currently, there is variability among these state laws and policies and many new measures on telehealth care payments have been under consideration in recent years.

- Physicians who deliver health care services through telehealth care should receive equitable payment to increase the availability of pediatric health care services for all children.

- Use of telehealth care services should be conducted within the context of the medical home, as such care offers continuity, efficiency, and the prudent use of health care resources. Fragmented care delivered outside the medical home must be avoided.

- Regulatory and licensing authorities should partner with medical organizations and other health care stakeholders to overcome administrative, financial, and legislative barriers to implement telemedicine and expand access to care.

- Revised policies on coding, billing, and payment are needed to ensure financial sustainability of health care delivered via telehealth care. Payer education and policy advocacy are needed to enact appropriate valuation of these services.
The absence of comprehensive payment policies is often cited as one of the greatest obstacles to integrating telehealth care into health care practice.

Medicare currently has a very narrow policy for payment of telehealth care services, which ultimately impacts both Medicaid and private insurance policy.

While Medicaid payment policies vary across states, more states pay for live video telehealth care services than for store-and-forward and remote patient monitoring.

Some Medicaid programs limit the type of facility that can be an originating site, often excluding the home as a payable site. A limited number of states require that patients be located in a medically underserved area.

Some states only require telehealth care payment for certain services, such as behavioral or mental health.

Not all laws regarding payment for telehealth care services mandate parity.

For information on current law or pending legislation in your state, please contact the AAP Division of State Government Affairs at stgov@aap.org.

AAP Policy – The Use of Telemedicine to Address Access and Physician Workforce Shortages – http://pediatrics.aappublications.org/content/136/1/202.full


Center for Connected Health Policy – http://cchpca.org

American Telemedicine Association – www.americantelemed.org
Universal Background Checks for Gun Purchases

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 regulations.

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.
- To prevent gun-related death and injuries, the AAP recommends that pediatricians provide firearm safety counseling to patients and their families.
- 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, purchase, ownership, storage, and use of firearms.
- 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.

• In states that require a background check for private handgun sales, there are 48% fewer firearm suicides, while the rates of suicide by other methods are nearly identical.

• According to Johns Hopkins University researchers, the 2007 repeal of Missouri’s background check requirement was associated with a 25% increase in the gun homicide rate.

• 88% of those surveyed in the US, including 85% of gun owners, favor universal background checks on sales of all weapons.

• 12 states and DC—laws requiring universal background checks for firearms purchases

For information on current law or pending legislation in your state, please contact the AAP Division of State Government Affairs at stgov@aap.org.

• AAP Policy—Firearm-Related Injuries in the Pediatric Population—http://pediatrics.aappublications.org/content/130/5/e1416.full
• Brady Campaign to Prevent Gun Violence—www.bradycampaign.org
• Everytown for Gun Safety—www.everytown.org
• Law Center to Prevent Gun Violence—http://smartgunlaws.org