INDIANA ACADEMY OF FAMILY PHYSICIANS
ANNUAL REPORT OF THE COMMISSION ON LEGISLATIVE AND GOVERNMENTAL AFFAIRS

French Lick, IN **July 21, 2017**

Richard Feldman, MD, Chairman

This was a very busy budget session of the General Assembly for the IAFP. There were a number of important bills that were tracked and addressed to help ensure that they not pass, and others that we supported into law. Your legislative team worked diligently to protect the interests of family physicians and our patients. Thanks to our new legislative team at Ice Miller for all their efforts this year. I always received excellent thoughtful recommendations. Also thanks to Missy Lewis and our commission members who actively participated in the development of our positions. We were well served again this year. Special thanks to Anne Doran and John Hammond at Ice Miller who I worked most closely with this session.

Our legislative commission met during the session to set priorities and define specific positions on bills that we were following. We worked effectively on issues with other organizations and communicated and coordinated with the ISMA on several particular bills. Additionally, the IAFP held another successful legislative reception during the session which was well attended.

Once again this year I was privileged to be appointed as a lay member to the Interim Study Committee on Public Health, Behavioral Health, and Human Services of the Indiana General Assembly. Always an interesting experience. The next Interim Committee should be most interesting this year and hope to be re-appointed.

I personally testified on a number of bills. Please see the legislative summary attached to this report for details of the bills of interest to the IAFP. The following are ones I that I would like to also provide some explanation:

Although we supported the telemedicine bill (HB 1337), the IAFP raised concern that the bill as written would enable the telemedicine physician to prescribe controlled medications without a licensed health-care provider first seeing the patient in person. I raised the concern with a couple of the Senators on the committee who had the same concerns and was asked to submit amendment language to require a face-to-face encounter requirement. Our lobbyists worked with the stakeholders and we were able to amend the bill to include this language. The bill allows prescribing controlled medications excluding opioids (but including buprenorphine). The rationale to allow the prescribing controlled medications was to specifically enhance psychiatric treatment with medications through telemedicine which the IAFP supported in concept.

The IAFP strongly supported the cigarette tax increase in HB 1578 at $1.50 per pack. This passed out of committee but eventually died because a cigarette tax increase was included in the budget bill, initially at $1.00 per pack, then reduced to 0.60 cents. The tax was eventually removed from the bill. I testified in committee on 1578 and later was invited to speak at a Smoke Free Indiana Statehouse rally late in the session. No cigarette tax increase passed this year. Disappointing!

A very contentious bill was HB 1409, which would have allowed nurse practitioners to practice and prescribe independently in Indiana. Along with the ISMA, we strongly opposed this measure. I made a couple of calls to committee members as did our lobbyists and other opposing organizations. Amendments were written to increase support for the bill, but these were not discussed in committee, and ultimately the committee chair did not call the bill for a vote. The independent practice/prescribing

for nurse practitioners legislation will probably be raised again next year.

The IAFP supported SB 303 regarding Direct Primary Care. This bill will remove concerns that this model of practice may be subject to insurance regulations and requirements. The IAFP provided brief testimony regarding general support of DPC.

We placed a one word amendment into HB 1069 (immunization requirement for meningococcus for college entry) to clarify the language which was vague. The clarification will assure the requirement is consistent with routine CDC recommendations.

Two other immunization bills (SB 51 and HB 1540) were of interest. Working with the ISMA we were able to get language changed that would make the State Health Commissioner responsible for standing orders for pharmacies to administer certain vaccinations (none of which were for children less than 11 years of age) rather than a privately contracted medical director with the pharmacy. The one remaining problem that could not be successfully changed was a provision in HB 1540 which will allow pharmacists to dispense prescription smoking cessation medications for customers without a prescription. This will be a onetime event and further prescriptions will have to written by the PCP. The medications dispensed by pharmacists will have to be approved by the State health Commissioner. Commissioner Adams has given us assurance that he will not approve any of these prescription medications. Hopefully this will serve as a precedent for future Commissioners. We strongly opposed this portion of the bill along with the ISMA.

Take special note in the legislative summary of SB226 (opioid prescribing limits for acute pain) and HB 1273 (did not pass and will be referred to a summer study committee) requiring physicians to notify patients, when referring out or ordering tests, that the accepting entity or physician may be out of network and that the patient may incur additional costs. I expressed concerns that this responsibility was being dumped on primary care physicians but could not get any resolution on the issue. The written notice would have been a routine notice given at checkout and part of documents already given to patients. It could not be part of blanket consents which are signed by the patient as a new patient or prior to being seen.

SB 408 included language that would have required physicians to check INSPECT before prescribing any controlled medications to a patient and every 90 days thereafter. I testified in both the House and Senate expressing that this would be burdensome to family physicians since it takes about 5 minutes to check INSPECT and would be most burdensome to physicians who do not utilize an EMR. There may be an integration of INSPECT with the EMR through grant money the state of Indiana might receive, but this is not assured. Although the IAFP is in favor of physicians checking INSPECT, the legislative team felt we could not support the requirements until further study was conducted on how best for the state to proceed. The bill died in committee but will probably be reviewed in a summer study committee.

HB 1438 will allow a county or city to approve needle exchange programs. Thanks to Amanda Smith, MD who testified in favor of this measure for both the IAFP and the ISMA (upon their request). Dr. Smith gave excellent testimony and the State Health Commissioner and the ISMA were very appreciative of her involvement. Dr. Smith is a member of our COL and one of my graduating 3rd year residents! I look forward to her future involvement on the COL.

Some other highlights of our legislative involvement:

Our family medicine residency funding is preserved at current funding levels.

The scholarship fund created for Hoosier Marian University College of Osteopathic Medicine students

continued to be problematic and severely underutilized. The scholarships were the subject of an IAFP resolution last year. Consistent with the resolution, I actively worked for eliminating the underserved practice requirement while leaving the scholarship just to practicing primary care in Indiana. Working with Marian university, we were successful in removing the underserved practice requirement. In addition the scholarships will be opened to out-of-state students (as a second priority) and also made available retroactively when the student decides to take the scholarship in the latter years of medical school (at a discounted amount). I talked with Marian President Dan Elsener, Dean Don Sefcik , Marian's lobbyist Lou Belch and I also had three meetings with Sen. Luke Kenley. Our lobbyist talked with Chairman Tim Brown. All supported these changes.

I have three recommendations to the Congress:

There were many bills this session on the legalization of marijuana, although none made it very far this year. This will be a continuing issue at the legislature and it would be good to review our positions regarding recreational and medical uses. Twenty-nine states have legalized medical marijuana and 8 states have legalized recreational use**.** Although there are both pros and cons to the legalization of marijuana, there is obviously growing acceptance nationally. **I recommend that the IAFP support the legalization of medical marijuana for high-quality evidenced-based therapeutic uses and to maintain our present position supporting the decriminalization of the possession and personal use of recreational marijuana (per AAFP policy).** I propose this position only as a starting point for discussion.

Eighteen states have joined the Interstate Medical Licensure Compact. This Compact enables a standardized and expedited licensure process for practice in one's home state but also in other Compact member states. Legislation may be introduced in Indiana in the future and it would be wise to have IAFP discussion at the Congress on this matter**. I recommend that the Congress refer this issue to the Board of Directors for research, discussion, and formulation of a policy position.**

Last year, the IAFP Congress of delegates passed a resolution supporting legislation lowering the legal blood-alcohol level while driving to 0.05. This same resolution was presented at the ISMA and was defeated. I continue to believe this lower level is reaching too far and will only serve to drag responsible people into the legal system with adverse consequences with little benefit to public safety.

Although there are conflicting opinions and data from foreign countries on this matter, only about 1 percent of traffic fatalities involve a driver within the disputed BAC interval of .05 and .08. Individuals who cause accidents while under the influence of alcohol generally have much higher blood levels. Seventy percent of alcohol-related traffic fatalities are caused by drivers with BACs above .15 — almost twice the current legal limit. In fact, the average BAC level of a drunken driver involved in a fatal crash is 0 .19. I **recommend that the resolution passed in the 2016 Congress of Delegates regarding the legal blood alcohol level be rescinded.**

I want to again express my gratitude to the members of the legislative commission for their time, advice, and expertise. Thanks also to those IAFP members who volunteered their time as Physician of the Day and to those who generously gave to the IAFP Political Action Committee. Legislators continue to very much appreciate our presence in the physician of the day program.

Please refer to the legislative summary (attached) for further details on the bills that we followed.

Respectfully submitted,

Richard Feldman, MD
Chair, Commission on Legislation & Government Affairs

Committee:
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