California Cardiovascular Legislation 2014

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[Rev Cardiovasc Med. *2014;15(3):266-270 doi: 10.3909/ricm15-3CAACC]*

The California Chapter of the American College of Cardiology (CA ACC) is a heterogeneous organization. Its members are drawn from a diverse population with a variety of political affiliations, practice locations, and educational backgrounds. From Newport Beach (2.79 conservatives/liberals) to Berkeley (11.13 liberals/conservatives), private practitioner to hospital employee, and surgeon to cardiovascular assistant; the CA ACC is indeed made up of a diverse group of individuals. Serving this heterogeneous group in a diverse state with multifaceted issues can often be complex. To handle the evolving problems and proposed legislative solutions in California, the CA ACC maintains an active legislative force with a full-time professional lobbyist, schedules regular office visits with our state representatives, attends candidate fund-raising events, selects special candidates for political action committee (PAC) contributions, provides consulting services to legislative and regulatory agencies, and serves on state commissions and advisory panels. This background activity ramps up each year when a new batch of several thousand proposed bills is dropped into the Legislative Box each February by the politicians who represent 38 million Californians.

It takes only 3 to 4 "no" votes in one committee to defeat a bill and at least 58 to 75 "aye" votes to pass a bill through four committees and the two houses of the California Legislature. Passing a bill is thus much harder than defeating a bill. This process helps to weed out most of the unneeded bills and only bills with widespread and strong support can survive. Passage will require a 9-month gestation and orchestrated delivery process. However, defeat can be achieved by a defined surgical strike in a single committee. The following is a tale of three bills and one proposition that were introduced in 2014.

SB-830 (Galgiani), Public Reporting of Interventional and Cardiac Surgery Outcomes[1]

Background: Hospital and operator coronary artery bypass graft outcomes have been reported in California for several years. The California Society of Thoracic Surgeons (CSTS) wanted similar reporting requirements for percutaneous coronary intervention (PCI) and transcatheter aortic valve replacement (TAVR) procedures.
Proponents: CSTS
Opponents: California Interventionists

The CA ACC surveyed its membership and found both support and opposition to this measure. Therefore, CA ACC picked a neutral position with an offer

to consult with the author on the language of this bill. The CA ACC would neither oppose nor strongly support this bill. However, if the bill passed then CA ACC wanted to ensure that the public reporting was fair, accurate, and derived from a capable clinical database such as the NCDR®. After discussions with CSTS, California Hospital Association (CHA), and the Society for Cardiac Angiography and Interventions (SCAI), acceptable language was achieved and the bill passed the Senate Health, Senate Appropriations, and Assembly Health Committees. However, financing for the monitoring and audits ($2 million annually) was not found and the bill died (on Suspense) in the Assembly Appropriations Committee.

SB-1000 (Monning), Public Health: Sugar-sweetened Beverages: Safety Warnings[2]

This bill provided a label warning on high-sugar soft drinks. It required nondiet sodas to carry a warning that consuming sugary drinks contributes to obesity, diabetes, and tooth decay.

Background: The CA ACC previously worked with the California Department of Education and legislators to improve exercise and reduce access to high-sugar soft drinks in California Schools (Pupil Nutrition, Health, and Achievement Act of 2001). SB-1000 would expand that effort by adding the following warning label to all high-sugar soft drinks sold in California: *Drinking beverages with added sugar(s) contributes to obesity, diabetes, and tooth decay.*

Proponents: Community and health care organizations (CA ACC)

Opponents: Soda manufacturers and distributors

By early April, the American Beverage Association had hired a lobbyist to fight this bill. The Coca-Cola Company also added a second lobbying firm to its arsenal. Despite community and health care support, concerns over label costs and implementation led the Assembly Health Committee to defeat this bill on June 4, 2014 (2 aye, 3 no, and 4 abstain). These concerns will need to be addressed before considering resubmission in 2015.

SB-1215 (Hernandez), Healing Arts Licensees: Referrals[3]

Background: Applies the physician self-referral prohibition to advanced imaging (including cardiac computed tomography [CT] and magnetic resonance imaging [MRI]), anatomic pathology, radiation therapy, or physical therapy for a specific patient that is performed within a licensee's office, or the office of a group practice and that is compensated on a fee-for-service basis, and defines "advanced imaging" for these purposes.

Proponents: Hospital and consumer groups

Opponents: Private practice imaging offices

The bill was initially referred to the Senate Health committee chaired by the bill's author. It was then withdrawn and re-referred to the Senate Committee On Business, Professions And Economic Development on April 3, 2014. The CA ACC had opponents (private practice) and proponents (hospital cardiologists) but decided to oppose this bill. The target was the Business and Professions Committee members using letters and phone calls. Additional individual meetings were arranged with committee members. Before the hearing, the CA ACC governor-elect and a private patient flew into Sacramento to testify. This testimony and the prior letters, phone calls, and meetings led to the defeat of this bill in the committee (1 aye, 3 no) on April 28, 2014.

SB-906 (Correa), Elective Percutaneous Coronary Intervention (PCI) Program[4]

Background: Noncardiac surgery hospitals in California requested extended PCI privileges. CA ACC reviewed the data and ACC guidelines and suggested a pilot program which was authorized under Senate Bill 891 (Correa) 6 years ago. The bill was extended for 1 year to allow time for more complete analysis with Senate Bill 357 (Correa). The 3-year data analysis from this pilot trial revealed almost similar safety and efficacy outcomes for PCI hospitals with offsite or onsite cardiac surgery. In January 2014, the CA ACC and California Hospital Association (CHA) began drafting a bill. The language from this draft was submitted to Senator Lou Correa's office and later introduced. The bill allowed pre-certified, noncardiovascular surgery hospitals that followed ACC, American Heart Association (AHA), and SCAI guidelines to perform both elective and emergent PCIs.

The California Legislature log of events for SB 906 (Correa) is shown in Table 1. The bill was officially introduced on January 21, 2014 and gradually made it through two committees and was passed by the Senate on May 15, 2014. The CA ACC and CHA testified and supported this bill in the Senate and no opposition was encountered. On May 15, 2014, it reached the Assembly and after a clarifying amendment, it was sent to the Health Committee, where it again passed without opposition on June 11, 2014. However, after smooth

TABLE 1

SB-906 (Correa) Legislative Journey

Date	Legislative Step
08/21/14	Assembly amendments concurred in. (Ayes 31. Noes 0.) Ordered to engrossing and enrolling.
08/20/14	In Senate. Concurrence in Assembly amendments pending.
08/20/14	Read third time. Passed. Ordered to the Senate.
08/19/14	Read second time. Ordered to third reading.
08/18/14	Read second time and amended. Ordered to second reading.
08/14/14	From committee: Do pass as amended. (Ayes 17. Noes 0.)
06/18/14	Set, first hearing. Referred to APPR suspense file.
06/11/14	From committee: Do pass and re-refer to APPR (Ayes 18. Noes 0.) (June 10). Re-referred to APPR.
06/04/14	From committee with author's amendments. Read second time and amended. Re-referred to HEALTH.
05/23/14	Referred to HEALTH.
05/15/14	In Assembly. Read first time. Held at Desk.
05/15/14	Read third time. Passed. (Ayes 36. Noes 0. Page 3468.) Ordered to the Assembly.
05/14/14	Ordered to special consent calendar.
05/13/14	Read second time. Ordered to third reading.
05/12/14	From committee: Do pass. (Ayes 5. Noes 0. Page 3441.)
05/02/14	Set for hearing May 12.
05/01/14	From committee: Do pass and re-refer to APPR with recommendation: To consent calendar. (Ayes 7. Noes 0. Page 3342.) (April 30). Re-referred to APPR.
04/17/14	Set for hearing April 30.
04/16/14	Set, first hearing. Hearing canceled at the request of author.
04/11/14	Set for hearing April 24.
04/10/14	Re-referred to HEALTH.
04/07/14	From committee with author's amendments. Read second time and amended. Re-referred to RLS.
02/06/14	Referred to RLS.
01/22/14	From printer. May be acted upon on or after February 21.
01/21/14	Introduced. Read first time. To RLS for assignment. To print.

APPR, Committee on Appropriations; HEALTH, Committee on Health; RLS, Committee on Rules.

sailing through the Senate and three committees, it immediately ran into trouble in the Assembly Appropriations Committee and was put on Suspense. The concerns were over the initial costs estimated at over $150,000. The CA ACC and CHA tried to assuage the cost concerns by pointing out that any costs could be limited to $150,000, shared by the participating hospitals, and would not increase the general state budget. An additional negative analysis was then released by the committee's legislative analyst who concluded that:

> Prestigious national health care quality entities recently highlighted elective PCI as one of five medical procedures with a high potential for overuse. Use

of medical treatments and interventions when not clinically appropriate can increase health care costs and expose patients to harm without providing benefit. A July 2013 paper titled "Proceedings from the National Summit on Overuse," describes findings of work group members that reviewed 72,000 elective PCIs; only 50% were classified as appropriate, 38% as uncertain, and 11.6% as inappropriate. Other studies have found that 6-8% of PCIs are not appropriate (performed in patients in whom that treatment was not necessary, or when a medical or surgical intervention would be more clinically effective).[4]

The analyst also pointed out that the final California Department of Public Health (CDPH) report due in February 2014 had not yet been released and that therefore the legislature could not determine whether CDPH wanted to continue the program.

Faced with this first significant opposition, the CA ACC initiated a campaign to emphasize the positive advantages of this bill. The letter-writing campaign was initiated for selected hospitals with suggested templates and addressees. Telephone calls to targeted Appropriations Committee members from interested physicians, nurses, staff, and patients were then orchestrated. Selected hospital health care system CEOs were notified and asked to provide input to the Assembly Committee Members. Lobbyists for statewide Health Care Systems and individual hospitals were also notified and encouraged to contact committee members. There were numerous meetings between hospital CEOs, lobbyists, and committee members. Data from the C-PORT and MASS-COMM analyses, the PCI-CAMPOS Advisory Oversight Committee (AOC) recommendations, and the ACC presentation of the PCI-CAMPOS 3-year data were then submitted to Committee members. An editorial discussing the potential benefits of this bill was submitted and published in *Reviews in Cardiovascular Medicine*.[5] Copies were delivered to all committee members. Inquiries were then made to CDPH about the status of the final CDPH report.

Despite these efforts, the bill remained on the Suspense list through July. The concerns over the lack of a final CDPH report, the potential inappropriate use of PCIs, and the high cost of maintaining the program led to the bill staying on Suspense. With the negative evaluations, the committee members and staff felt that it was unlikely that this bill would make it through committee in its current form. On July 20, 2014, when it appeared unlikely that the bill would come off suspense, a suggestion was made to gut the current bill and replace it with an amended bill to extend the pilot program for 1 additional year. This amendment was being discussed with the CHA and CA ACC when, at the last hour of the last day before submission, the CDPH finally released the report of the analysis from the AOC. Based on the newly released report, which echoed the earlier findings of the AOC, the CHA and CA ACC made a decision to proceed with submission of the bill as originally written. The Appropriations committee then requested a new amendment to include unspecified CDPH requests and this was agreed by the CA ACC and CHA. The CHA suggested that additional letters related to the intent of the legislation be submitted if the bill passed. Following these agreements, the committee agreed to the added amendments for unspecified future CDPH requirements. On August 14, 2014, the bill passed the Appropriations Committee in the Assembly with 17 aye votes and 0 no votes. On August 18, the bill was read and amended by the Assembly. It was read the second time on August 19, and read the third time and passed by the Assembly (77 to 0) on August 19, 2014. On August 21, the Senate concurred with the Assembly amendments and it passed again with 31 aye votes and 0 no votes. The bill then proceeded to engrossing and enrolling before submission to the Governor.

In the end, it took 7 votes, 201 ayes, 0 noes, and 160,000 PCIs to place this bill on the Governor's desk in 2014. The Governor's finance office is still concerned about excess CDPH workloads. An August meeting was then convened at CDPH to discuss workloads and present the 3-year and 4-year PCI-CAMPOS data to the AOC.

By September 30, the Governor may sign or veto this bill.

Proposition 46, Drug and Alcohol Testing of Doctors. Medical Negligence Lawsuits. Initiative Statute.[6]

Background: For the past 20 years, trial attorneys have been trying to raise fees on medical malpractice. Attempts at introducing legislation have met with early opposition and defeat at the committee level. More recently, the proponents of increasing malpractice have resorted to gut-and-amend tactics. This strategy introduces a bill with completely unrelated topics and language to slide through the committees of the legislature. At the very last hour of the legislative session, the original bill language is gutted and replaced with new malpractice fee inflating language intended for a last hour vote before opponents

and legislators realize what is happening. Only hourly monitoring of last-minute changes has allowed our lobbyists to detect these efforts and mount an emergency defense. With repeated failures for both introduced and gut-and-amend bills, the trial attorneys finally developed a new strategy. This year, they designed focus groups to determine what appealed to voters. The leading voter appeal at focus groups was generated for clean (drug-free) physicians. They then combined the consumer choice (drug testing of physicians) with the trial lawyer's choice (increasing malpractice, pain and suffering cap from $250,000 to $1.1 million) in a new proposition (Proposition 46) that will entirely skirt the legislative process and proceed directly to consumers as a public vote in November 2014.

Proposition 46 will now be decided not by testimony and hearings, but by television advertisements and consumer-marketing campaigns costing millions of dollars. The CA ACC opposes this proposition. However, it is now favored by over 58% of California voters. Defeating this proposition will require major commitments. The CA ACC has joined with over 250 organizations representing all walks of life including professional, union, parent/teacher, and health care organizations. This consortium has begun to produce television ads, bumper stickers, buttons, and brochures for patients. Many of our voters are also our patients, and who could experience significant changes in the cost and access to health care if this proposition passes. This fight will obviously cost hundreds of millions of dollars for both sides. If only we could direct this money into better health care delivery, we would get much better results.

In California, it takes only a handful of no votes to defeat a bill, 100 aye votes to pass a bill, and tens of millions of votes to defeat or pass a proposition. As the California Legislative Session comes to a close, and the proposition battle begins to heat up, let's get ready to rumble. ■

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