

2014 State Legislative Summary

The Association of State and Territorial Health Officials (ASTHO) tracks state legislation impacting state health agencies and public health. We support the peer network of state health agency legislative directors to facilitate information sharing on trends and emerging issues. This document summarizes some of the issues ASTHO tracked and analyzed during the 2014 state legislative sessions.

ASTHO President's Challenge: Prescription Drug Abuse

ASTHO's 2014 President's Challenge was to reduce the rate of nonmedical use and the number of unintentional overdose deaths involving controlled prescription drugs [15 percent by 2015](#). States were encouraged to consider implementing or strengthening policies and programs to comprehensively address prescription drug misuse and abuse. A number of states strengthened their policies through the legislative process in 2014.

Prescription Drug Monitoring Programs (PDMPs)

This session, Missouri and the District of Columbia (DC) considered legislation to establish PDMPs and other states sought to make changes to their existing PDMPs. DC enacted B20 127, which requires the director of the department of health to establish, maintain, and administer an electronic system to monitor the dispensing of covered substances. The law also requires each dispenser to submit required reporting information for each covered substance within 24 hours of dispensing. Missouri remains the only state without a PDMP, as HB1233/SB 91 was not enacted.

Pennsylvania enacted SB 1180, which established the Achieving Better Care by Monitoring All Prescriptions (ABC-MAP) program. The law requires dispensers or pharmacies to submit all controlled substance prescription information to the database within 72 hours. Prescribers are required to query the database for each patient the first time they prescribed the patient a controlled substance or if the prescriber has any reason to believe that a patient may be abusing or diverting drugs. Under the law, the attorney general is permitted access to query the system on behalf of law enforcement for Schedule II controlled substances.

Colorado (HB 1283), Pennsylvania (SB 1180), and Rhode Island (HB 7574) granted practitioners the authority to designate others who can access the PDMP on their behalf. The Colorado and Rhode Island laws also require that the practitioner be a registered user of the database. The Colorado law allows its Department of Public Health and Environment to query the database for the purposes of population-level analysis (this access is subject to HIPAA). The law also requires the board of pharmacy to develop criteria for indicators of abuse, misuse, and diversion of controlled substances.

Maryland (HB 255) extended its existing PDMP to July 2019. This law allows the program to share PDMP data with another state's PDMP if the other state's program agrees to use the data in a manner consistent with Maryland law. The program may also develop the capability to transmit data to and receive it from other PDMPs. Maryland also enacted HB 1296, which allows the PDMP administrator to review PDMP data and report possible misuse or abuse to the prescriber or drug dispenser.

Florida enacted HB 7177, which revises provisions relating to public record exemption for certain information held by its department of health pursuant to the PDMP. The law specifies that certain

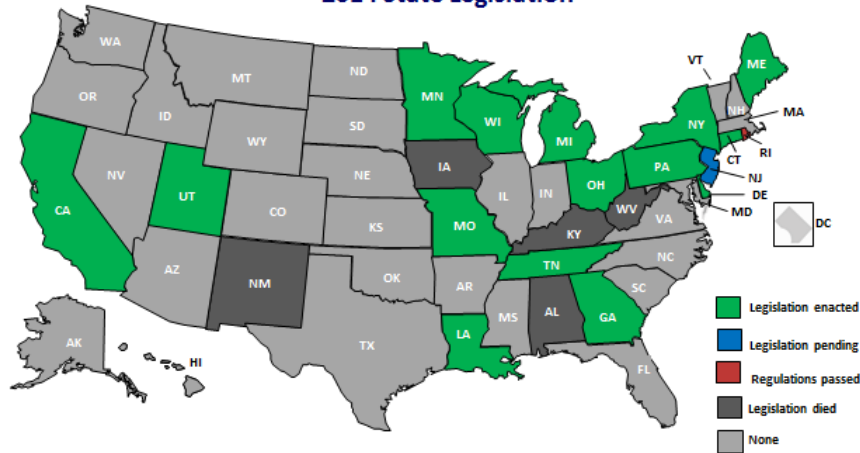
entities may disclose confidential and exempt information if such information is relevant to an active investigation. The bill also requires the disclosing person or entity to take steps to ensure the continued confidentiality of all confidential and exempt information.

Naloxone and Good Samaritan Provisions

In 2013, we reported that 10 states enacted legislation expanding access to naloxone, an antidote that can reverse an opioid overdose. This trend continued in 2014, with 15 states enacting legislation related to naloxone. States varied in their approach to increasing naloxone access by making it available either to law enforcement and other trained first responders or more broadly to friends and/or families of potential overdose victims. States allowing law enforcement, peace officers, or first responders to administer naloxone included Delaware (HB 388), Louisiana (HB 754), Minnesota (SF 1900), Missouri (HB 2040), Pennsylvania (SB 1164), and Wisconsin (AB 446). States taking the broader distribution approach included Georgia (HB 965), Maine (LD 1686), Michigan (HB 5407), New York (AB 8637/SB 6477), Ohio (HB 170), Tennessee (SB 1631), and Utah (HB 119). Minnesota's law allows staff in community-based health disease prevention or social service programs to administer naloxone and Georgia's law allows for the prescribing of naloxone to pain clinics and harm reduction organizations. California SB 1438, as enacted, authorizes the Emergency Medical Services Authority to adopt training and standards for prehospital emergency medical care personnel regarding the statewide use and administration of naloxone (or another opioid antagonist) and authorizes a trial study of its use. In March, Rhode Island issued emergency regulations expanding access to naloxone by allowing licensed prescribers to issue non-patient specific orders to organizations, such as police departments and treatment facilities; prescribe naloxone to a family member or friend of an individual at risk of experiencing an opioid-related overdose; and dispense naloxone to family members or others during an office or emergency department visit.

The majority of these naloxone laws also provided immunity from liability for those who administer naloxone in good faith. Connecticut enacted HB 5486, which provides liability protection for any person who in good faith believes that another person is experiencing an opioid-related drug overdose and acts with reasonable care to administer an opioid antagonist. Georgia's law provides that any person who in good faith seeks medical assistance for a person (or himself or herself) experiencing or believed to be experiencing a drug overdose shall not be arrested, charged, or prosecuted for a drug violation if the evidence for the violation resulted solely from seeking such medical assistance.

Naloxone Access 2014 State Legislation



Neonatal Abstinence Syndrome (NAS)

This session, three states enacted bills related to making NAS a reportable condition and two states enacted bills that allow criminal prosecution for pregnant women who use narcotics. Indiana enacted SB 408, which requires the state department of health to meet with a group of stakeholders to study and make recommendations on issues concerning NAS and provide a report to the legislature. The bill also allows the department of health to establish one or more pilot programs to implement appropriate and effective models for NAS identification, data collection, and reporting with hospitals that consent to participate. Kentucky enacted SB 47, which requires the department for public health to report, on at least an annual basis, de-identified data on the number of NAS diagnoses. Ohio enacted HB 315, which requires maternity units, newborn care nurseries, and maternity homes to report to the department of health how many of their residents' newborns are opioid-dependent at birth. These reports must withhold all patient-identifying information and cannot be used for law enforcement purposes or be disclosed to law enforcement authorities.

South Carolina enacted HB 3102, which requires women who give birth to an infant with the medical diagnosis of NAS to be entered into the central registry for child abuse and neglect, unless the presence of the substance was the result of a medical treatment administered to the mother during birth or to the infant. Tennessee enacted SB 1391, which provides that a woman may be prosecuted for assault for the illegal use of a narcotic drug while pregnant, if her child is born addicted or harmed by the drug.

Zohydro

In October 2013, FDA approved Zohydro, the first extended-release, single-entity hydrocodone-containing drug product. Due to its high potency and lack of abuse-deterrent features, attorneys general from 29 states requested that FDA reconsider the drug's approval, and several states took steps to restrict its use. Massachusetts declared a public health emergency and took steps to ban prescribing and dispensing Zohydro. The ban was ultimately struck down, with the court holding that it was preempted by federal law. With the ban lifted, other restrictions were put in place including one by the Massachusetts board of medicine, which requires prescribers to complete a risk assessment and pain management treatment agreement before prescribing. Vermont announced emergency rules that

require patients to provide informed consent and prescribers to follow a number of specific practices, including drug testing and follow-up care. Several states considered legislation that would have moved Zohydro to Schedule I, including Kentucky (HB 51), New Hampshire (HB 584), Ohio (HB 501), Pennsylvania (HB 2203). However, none of the bills were enacted.

Right to Try

A number of states enacted legislation that allows the terminally ill to obtain access to experimental drugs, without the drugs having received FDA approval. These proposals were advanced by patient advocates frustrated by the long federal approval process for experimental drugs. This legislation was introduced in 10 states this year, and was enacted in half of those states, to include: Arizona (HCR 2005), Colorado (HB 1281), Louisiana (HB 891), Michigan (SB 991) and Missouri (HB 1685). Arizona's law established a legislative referendum, proposition 303, which voters passed in November.

Marijuana

Cannabidiol

Eleven states enacted legislation in 2014, legalizing the use of cannabidiol (CBD), a non-psychoactive cannabis component that is low in tetrahydrocannabinol (THC). Parents of children with severe epilepsy strongly advocated for legalizing the use of CBD oil. The 11 states include: Alabama (SB 174), Florida (SB 1030), Iowa (SF 2360), Kentucky (SB 124), Missouri (HB 2238), Mississippi (HB 1231), North Carolina (HB 1220), South Carolina (S 1035), Tennessee (SB 2531), Utah (HB 105), and Wisconsin (AB 726). While many state health departments regulate cannabidiol programs, some states control cannabidiol use and testing using a university located within the state. Georgia and New York have reached agreements with GW Pharmaceuticals to conduct clinical trials on their drug, Epidiolex, a pharmaceutical-grade CBD product.

Medical Marijuana

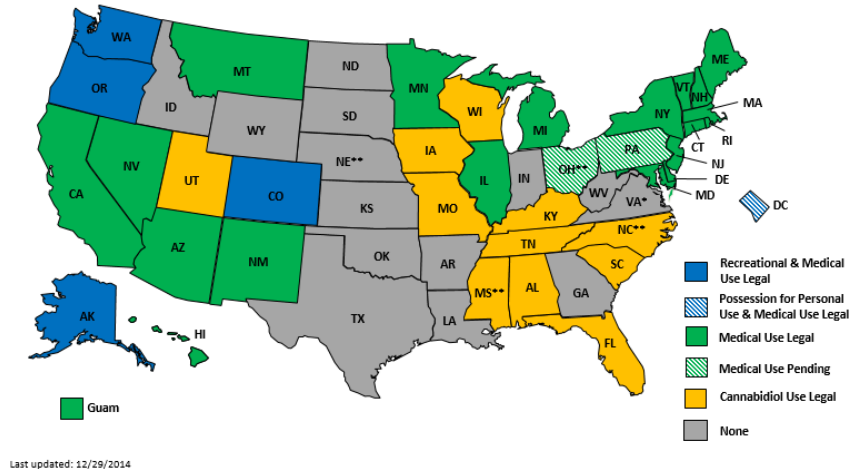
Two states approved bills that legalized medical marijuana. Minnesota enacted SF 2470, which authorizes the medicinal use of marijuana, excluding use by smoking. The statute also established a taskforce to conduct observational research on the use of medical marijuana in the state. New York enacted A06357, which legalizes the "certified medical use" of marijuana. However, similar to Minnesota, "certified medical use" does not include smoking. Two territories, Guam and the U.S. Virgin Islands, approved ballot measures related to medical marijuana. Voters in Guam approved a ballot measure that authorizes the use of medical marijuana. Voters in the U.S. Virgin Islands approved a non-binding ballot measure requesting that the legislature consider medical marijuana legislation. Twenty-five states and territories have legalized medical marijuana. In December, an amendment included in the FY2015 appropriations bill would prohibit the U.S. Department of Justice from interfering with state-level medical marijuana laws.

Recreational, Adult-Use Marijuana

In November, voters in Alaska, Oregon, and DC, approved ballot measures that either legalized recreational marijuana or the personal possession of marijuana. Alaska and Oregon approved ballot measures legalizing recreational marijuana, joining Colorado and Washington as the only states to legalize recreational marijuana. Similarly, voters in DC approved a ballot measure legalizing the personal possession of marijuana in certain quantities. However, Congress reached an agreement in December

on a 2015 spending bill that includes a measure that prohibits the use of federal or local funds to carry out D.C.'s marijuana initiative. The impact of the spending agreement on the DC law is still unclear.

Legalization of Marijuana and Cannabidiol Current Status



Food Safety

Cottage Food

In 2014, 15 states considered cottage food bills, and eight states enacted legislation. Cottage food is non-potentially hazardous food produced by cottage food operators in home kitchens for direct sale to purchasers. Several states required cottage food producers to either register with the state or label their food products. Alabama enacted SB 159, which exempts cottage food production operations from regulation. However, the Alabama Department of Public Health may issue a stop sale, seize, or hold order for food suspected of causing a foodborne illness. Additionally, the health department may issue regulations that require such foods be labeled. California enacted AB 1990, which allows community food producers to sell whole uncut fruits and vegetables or unrefrigerated shell eggs directly to the public, so long as the produce is labeled with the name and address of the community food producer. Community food producers must register with the state of California, and enforcement officers have authorization to inspect producing operations when responding to a food safety complaint. DC enacted B20 168, which allows cottage food businesses to operate without a license. However, such operations must register with the Cottage Food Business Registry. The bill also establishes storage and labeling requirements, and authorizes department inspections. Missouri enacted SB 525, which allows nonprofit organizations to sell home-prepared foods at charitable fundraising events. The preparer may place a visible placard informing buyers that the food was not prepared in a kitchen subject to state regulation. The Missouri Department of Health and Senior Services may also conduct investigations. New Hampshire enacted HB 177, which requires homestead food operations that are exempt from licensing requirements to label their food as such.

Several states required cottage food producers to obtain a permit or license prior to selling food products. Georgia enacted HB 101, which excludes from “food service establishments” those establishments preparing edible products if the preparation occurs on the site of the event or on the

property of a party that provided written consent. Even though these events are not considered “food service establishments,” counties and municipalities must issue permits for such events. Illinois enacted HB 5354, which defines “home kitchen operation” as the production of non-potentially hazardous food in a kitchen of a domestic resident for direct sale. The producer must notify the purchaser that the product was produced in a home kitchen. The Illinois Department of Public Health may inspect the home kitchen operation in the event of a complaint or disease outbreak.

Genetically Modified Organisms (GMO) Labeling

Over 80 bills were introduced around GMO labeling this session. However, Vermont was the only state to enact legislation. HB 112 requires, by July 1, 2016, that all retail sellers of food label their products as produced entirely or in part from genetic engineering, if the food was produced with genetic engineering. The bill describes specific labeling requirements depending on the type of food for sale and whether the food is separately packaged. If food is genetically engineered, a retail seller may not label the food as being natural. Violations of the GMO labeling requirement may result in a civil penalty of no more than \$1,000 per day, per product. The Grocery Manufacturers Association, National Association of Manufacturers, International Dairy Foods Association, and the Snack Foods Association are challenging the law on the grounds that it exceeds state authority and violates manufacturers’ First Amendment rights.

Health Equity

In 2014, nine states and DC considered legislation to promote health equity and reduce health disparities, and two states and DC enacted legislation. Hawaii enacted HB 1616, which establishes a commitment to reduce health disparities by addressing social determinants of health. The purpose of the legislation was to amend the Hawaii State Planning Act to include the elimination of health disparities. Hawaii also enacted HB 2320, which describes the legislature’s findings that health disparities cause the state to experience increased financial and social costs. The legislature recognizes social determinants of health as the cause of health disparities, which it states are “in large part preventable,” and made health equity a goal of the Hawaii State Department of Health. The District of Columbia enacted B20-0572, which established the Commission on Health Disparities to analyze diseases, conditions, and health indicators in each ward and submit comprehensive recommendations and an action plan to address existing health disparities. Indiana enacted HB 1358, which extends the office of minority health until 2017.

Minnesota released a comprehensive legislative report which outlines the current status of health disparities in the state and lays the groundwork to attain better health equity. Included in the report are numerous recommendations for advancing health equity, such as using a health in all policies approach, using health impact assessments (HIAs), and conducting cross-agency policy examinations for structural inequities. As a result, the importance of cross-sector collaboration led to increased focus on HIAs and interagency workgroups to ensure that actions by all sectors result in positive health outcomes.

Health System Reform

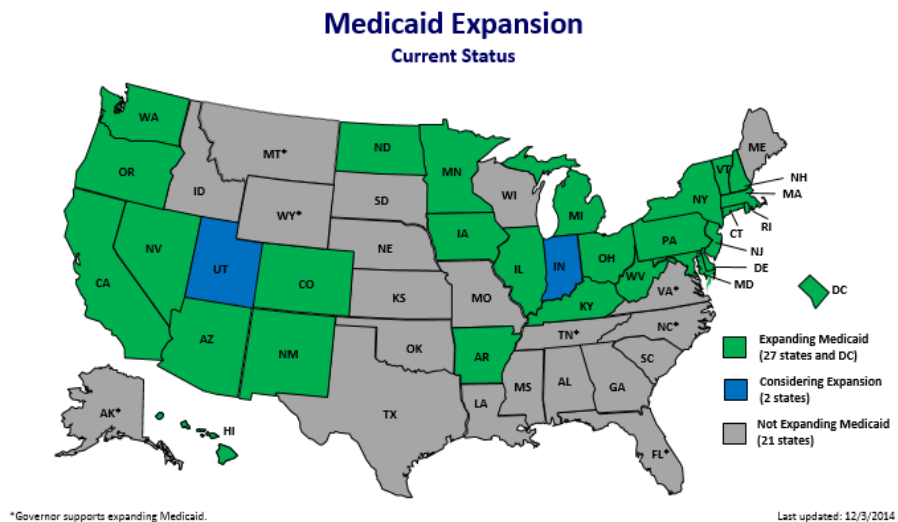
Medicaid Expansion

Currently, 27 states and DC have expanded Medicaid under the Affordable Care Act (ACA). Of the 17 states that considered Medicaid expansion bills in 2014, six states passed varying pieces of legislation. New Hampshire enacted SB 413, which uses a premium assistance model to expand Medicaid beginning

January 1, 2016. The bill, however, contains a provision that states if federal medical assistance percentage falls below 100 percent before December 31, 2016, the commissioner of the department of health and human services must declare the statute repealed. Maine passed LD 1578, which expanded the state’s Medicaid program, but Governor LePage vetoed the bill. Nebraska did not yet pass LR 601, which authorizes a study of the impact of Medicaid expansion, but the legislature scheduled the bill for a hearing in December 2014.

Several other states requested Section 1115 waivers from the Centers for Medicare and Medicaid Services (CMS). In September, Pennsylvania received final approval from CMS for the five-year Healthy Pennsylvania Medicaid expansion demonstration program. Healthy Pennsylvania’s coverage will begin on January 1, 2015. Utah enacted HB 401, which authorizes the Health Reform Task Force to determine available options for expanding Medicaid. In August, Indiana submitted a Section 1115 waiver to CMS for including Medicaid expansion within the existing Healthy Indiana Plan. In December, Utah’s Governor Herbert announced details of the three-year pilot program, which includes expanding Medicaid to roughly 95,000 individuals and requiring minimal cost sharing. The Utah legislature must approve the final agreement in 2015.

While several states took steps to expand Medicaid, others enacted legislation that requires legislature approval to do so. Georgia enacted HB 943 and HB 990, which prevent state or local governments from advocating for Medicaid expansion and prevent Medicaid expansion without the legislature’s approval. Both Kansas (HB 2552) and Tennessee (HB 937/SB 804) also enacted legislation that prevents the expansion of Medicaid without legislative approval.



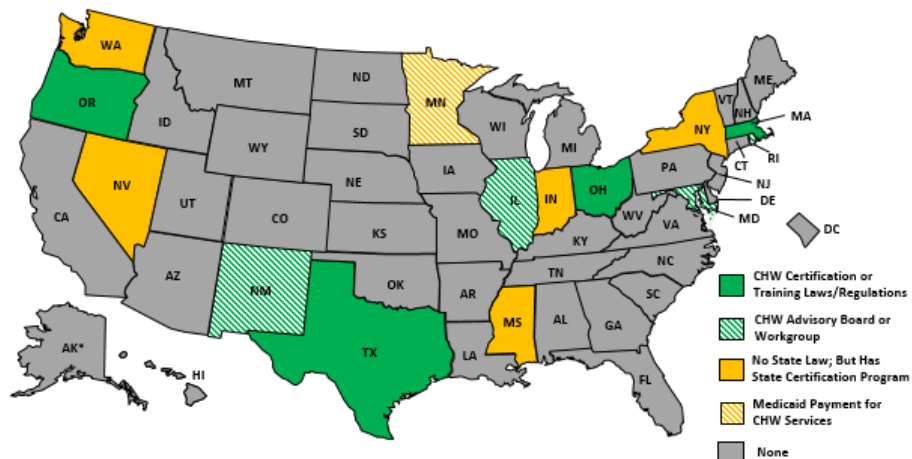
Licensure and Scope of Practice

Community Health Workers

The number of states with community health worker (CHW) certification and training standards grew in 2014, as several states created advisory boards and workgroups to provide recommendations for CHW certification requirements. Community health workers have a deep knowledge of the communities they serve, and act as a link between health services and the community. Four states enacted CHW certification laws in 2014. Illinois enacted HB 5412, which established an advisory board to develop core

competencies for the training and certification of CHWs. Maryland enacted HB 856, which created a stakeholder workgroup to submit recommendations about CHW training and certification to the department of health and insurance administration. New Mexico enacted SB 58, which authorizes the secretary of health to promulgate rules regarding CHW certification, including education, training, and experience requirements. Oregon enacted SB 1542, which authorizes the Oregon Health Authority to develop education and training requirements for CHWs.

Community Health Workers (CHWs) Certification Standards Current Status



* AK does not have a state-run CHW training program, but provides community health aide grants for third-parties to train community health aides.

Last updated: 12/3/2014

Dental Therapists

Maine enacted LD 1230, which provides for the reimbursement for dental hygiene therapists under the MaineCare program. The bill outlines the licensure requirements and scope of practice for dental hygiene therapists. Maine is the third state, along with Alaska and Minnesota, to establish dental therapists as a provider group to improve access to oral health.

Nurses

This session, several states reached compromises that allow nurse practitioners to practice independently after reaching a specified number of clinical practice hours, or years. Connecticut enacted the Governor’s bill, SB 36, which allows licensed advance practice registered nurses (APRNs) to practice independently after having practiced under a collaborative agreement with a licensed physician in the state for three years. Kentucky enacted SB 7, which allows APRNs to prescribe non-scheduled legend drugs without a collaborative practice agreement after four years of prescribing in collaboration with a physician. Minnesota enacted SF 511, which allows APRNs to practice independently after completing at least 2,080 hours under a collaborative practice agreement, within a hospital or integrated clinical setting, where APRNs and physicians work together to provide patient care. Under the state’s enacted budget for 2014-15, New York exempted nurse practitioners with 3,600 practice hours from the requirement to maintain a written practice agreement or protocols so long as they maintain

collaborative relationships with physicians or a hospital. In Nebraska, Governor Heineman vetoed LB 916, which would have eliminated the written practice agreement between physicians and nurse practitioners who have 2,000 hours of practice under such an agreement. Heineman indicated the bill went too far, too quickly.

Infectious Disease

Antimicrobial Resistance

Antimicrobial resistance is one of the world's most pressing public health problems. State health agency roles in addressing antimicrobial resistance include preventing infections and protecting patients across the healthcare system, tracking resistance, and improving antimicrobial prescribing and use (stewardship). This session California enacted SB 1311, which requires all general acute care hospitals to adopt and implement, by July 1, 2015, an antimicrobial stewardship policy to evaluate the judicious use of antibiotics, develop a physician supervised multidisciplinary antimicrobial stewardship committee, and report antimicrobial stewardship program activities to each appropriate hospital committee undertaking clinical quality improvement activities. The California legislature also passed SB 835, which would prohibit administration of a medically important antimicrobial drug through feed or drinking water, except pursuant to a veterinarian-client-patient relationship. The bill was vetoed by Governor Brown as he felt the bill codified a voluntary FDA standard phasing-out antibiotic use for growth promotion, which most major animal producers have already pledged to go beyond. California also considered AB 1473, which would have prohibited the sale of a livestock or poultry product in California if the product was administered as medically important antimicrobial for nontherapeutic use, such as growth promotion, feed efficiency, weight gain, or disease prevention. The bill died in committee.

Immunizations

Billing

Virginia enacted HB 305, which provides that in all cases when a child is covered by a health carrier, Medicare, Medicaid, Children's Health Insurance Program or Civilian Health and Medical Program of the Uniformed Services, the department of health shall see reimbursement from the health carrier for allowable costs associated with provision of the vaccine.

Exemptions

Colorado enacted HB 1288. Upon introduction, the bill sought to strengthen the state's personal belief exemption by requiring parents to complete an online vaccine education module, developed by state health officials, or obtain the signature of a physician or other vaccine provider certifying that the parent has received state-approved vaccine education. However, this provision was stripped from the final version of the bill, which as enacted, requires the state board of health to promulgate rules regarding immunization information, including exemption rates, that is publicly available. In addition, the department of public health and environment is required to establish a joint policy on immunization data collection and sharing.

Universal Purchase System

Massachusetts enacted SB 1971, which established the Vaccine Purchase Trust Fund to support a universal purchase system for routine childhood immunizations. The fund shall be expended to cover costs to purchase, store, and distribute vaccines for routine childhood immunizations and to administer the fund and immunization registry. Under regulations adopted by the commissioner of public health,

each surcharge payor in the commonwealth shall pay a routine childhood immunizations surcharge, assessed by the commissioner of public health, for deposit in the trust fund.

Maternal and Child Health

Breastfeeding

Several states considered legislation aimed at supporting breastfeeding. Alaska passed HCR 18, a resolution that encourages hospitals and birthing facilities in the state to receive the baby-friendly designation by implementing the Ten Steps to Successful Breastfeeding program. Washington considered HB 2329/SB 6298, which would have established a voluntary program to encourage and recognize hospitals, health care providers, workplaces, and day care centers that offer an optimal level of care for infant feeding. If the bill had been enacted, the department of health would have created the breastfeeding-friendly Washington designations and adopted rules to recognize levels of achievement. Ohio considered SCR 37, which would have encouraged hospitals and freestanding birthing centers to adopt policies and procedures that promote breastfeeding. However, it did not pass.

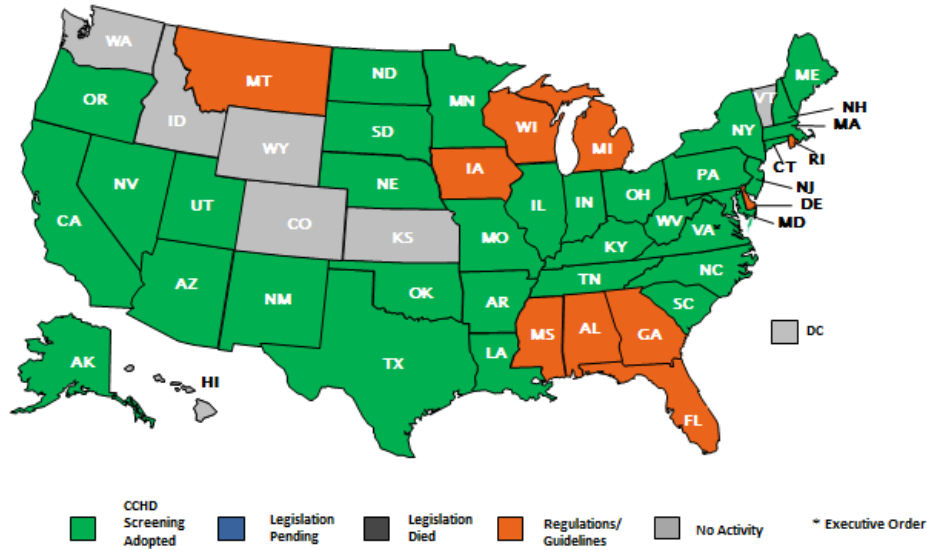
Newborn Screening

Minnesota enacted SF 2047, which modified the state's newborn screening program by authorizing the department of health to store infant blood samples and test results for an indefinite period of time, unless the parents or guardians of the infant choose to have the data destroyed. Blood samples and test results may be used for follow-up services for cases of heritable and congenital disorders identified through screening as well as studies related to infant screening, including developing new tests. This legislation was the result of efforts to restore the state's newborn screening program following the Minnesota Supreme Court's decision in the case of *Beader vs. State of Minnesota*, in which the court held that the department could retain the blood spots only as long as necessary for testing the samples for heritable and congenital disorders. The 2006 Genetic Information Act prohibited any other use, storage, or dissemination of blood samples unless there was written informed consent from parents or legal guardians.

Screening for Congenital Heart Defects (CCHD)

Last year, 20 states enacted legislation requiring pulse oximetry screening for congenital heart defects. Due to the number of states that successfully added screening for this condition in previous session, fewer states looked at this issue in 2014. However, Arizona (HB 2941), Massachusetts (SB 1919), New Mexico (HB 9), Pennsylvania (HB 1420), and Virginia (HB387/SB 183) enacted legislation that requires facilities to screen newborns for CCHD. The Pennsylvania and Virginia laws specify that screening should occur within 48 hours of birth. The Arizona, New Mexico, and Pennsylvania laws specify that screening should be done using pulse oximetry, while Massachusetts and Virginia allow for other tests as approved by the department of health or board of health, respectively. The Massachusetts law notes that hospital implementation of newborn screening protocols for CCHD will be reviewed as part of hospital and birthing facility licensure programs. Florida, Georgia, Mississippi, Montana, and Wisconsin added screening for CCHD through the regulatory process. Rhode Island hospitals have adopted CCHD screening as a standard of care.

Newborn Screening – Critical Congenital Heart Defects
Current Status



Essential Services for Local Health Departments

Connecticut enacted HB 5528, which requires all district departments of health and municipal health departments to provide a basic health program. The basic health program must include, but is not limited to, the following ten services: (1) monitoring health statuses to solve health problems, (2) investigating health problems and hazards,(3) educating the community on health issues,(4) mobilizing community partnerships to solve health problems, (5) developing policies and plans that support health efforts (6) enforcing laws and regulations that protect health, (7) connecting individuals to health services, (8) assuring a competent health care workforce, (9) evaluating the effectiveness, accessibility, and quality of health services, and (10) researching solutions to health problems.

Social Impact Bonds

Social impact bonds (SIBs), also known as pay-for-success contracts, allow states to enter into agreements with private investors whereby repayment is contingent on the achievement of specific, measureable outcomes. States are turning to SIBs to create savings and reduce the provision of long-term expensive services.

In 2014, states introduced 32 SIB bills; however, only seven were enacted. Many of the proposed bills either defined SIBs or developed pilot projects, while others granted state agencies the authority to enter into SIBs. The two most prominent issues addressed in the proposed bills were early childhood education and the reduction of recidivism. New York enacted AB 8553/SB 6353, which appropriates \$53 million for SIB projects, such as early childhood development, child welfare, health care, and public safety. Two states introduced, but did not pass, SIB legislation related to health. New Jersey introduced S 452/A 2771, which established a social innovation loan pilot program for preventive and early intervention health care services, as an effort to reduce expenditures. Washington introduced HB 2337, which created a steering committee tasked with establishing a pilot program to encourage public-private financing of health care prevention services. South Carolina, which is experiencing a high rate of

premature births, especially among Medicaid enrollees, has entered into a SIB agreement to reduce the rate of premature births, and thus reduce future Medicaid costs. Additional information on SIBs is available on CDC's [website](#).

Tobacco

In 2014, states proposed a number of policies to address tobacco use, which remains the leading preventable cause of death in the United States, and the emerging use of electronic nicotine delivery systems (ENDS). In terms of addressing tobacco, few bills enacted this year. Several states that have yet to enact smoke-free laws continue to pursue them. This year, smoke-free bills were considered in Alabama (SB 168), Kentucky (HB 173/117), Mississippi (HB 739/SB 2607), and South Carolina (HB 4553), but they failed to pass. A strategy to reduce tobacco use among young people, that gained traction in cities and counties this year, is to increase the minimum legal sale age for tobacco products. On the state level, New Jersey (S.752) and Utah (SB 12) considered this approach, but the bills were not enacted. In terms of successes, Hawaii successfully enacted SB 651, which prohibits smoking in and around public housing projects, state low-income housing projects under the jurisdiction of the Hawaii public housing authority, and in and around elder or elderly households.

Electronic Nicotine Delivery Systems

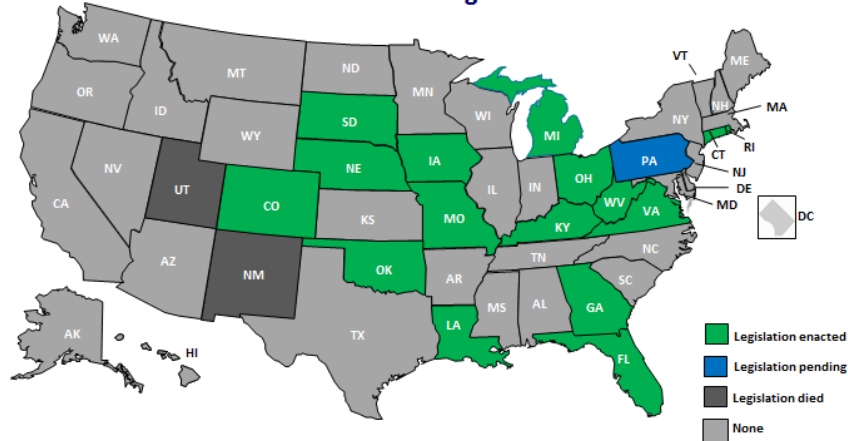
A number of policies were proposed this session to address ENDS, but state legislatures were hesitant to advance policy in anticipation of the FDA's proposed rule, extending its tobacco authority to include electronic cigarettes. Proposed policies at the state level included increasing the sales tax on ENDS (Indiana HB 1174, Kentucky HB 319, New Jersey S 1867, New York AB 8594/SB 6610, and Oklahoma HB 2989), prohibiting the sale of ENDS in vending machines (California SB 648, Kentucky HB 267, and Rhode Island HB 7021/SB 3095), making restrictions relating to smoking in public areas applicable to ENDS (New York AB 8178/SB 6562 and Maryland HB 1291), and establishing a fund to prevent use of tobacco and electronic smoking devices (NJ A 2980). With the exception of the Rhode Island legislation (RI HB 7021/SB 3095), none of these proposals were enacted. In addition to prohibiting the sale of ENDS in vending machines, the Rhode Island law also prohibits the use of coupons or vouchers for ENDS products and requires dealers and distributors to obtain a license annually from the department of health.

Illinois also successfully enacted two ENDS related bills this session. HB 5689 requires the department of public health to adopt rules that establish special packaging standards for the refilling of e-cigarette cartridges and liquids sold and marked for refilling these cartridges. In addition, Illinois enacted HB 5868, which provides that alternative nicotine products must be sold from behind the counter, in an age restricted area, or in a sealed display case.

Prohibiting the sale of e-cigarettes to minors was the most widely enacted policy on this issue in 2014. Sixteen states enacted this legislation including: Colorado (SB 18), Connecticut (SB 24), Delaware (HB 241), Florida (SB 224), Georgia (HB 251), Iowa (HF 2109), Kentucky (SB 109), Louisiana (SB 12), Michigan (HB 4997), Missouri (SB 841), Nebraska (LB 863), Ohio (HB 144), Oklahoma (SB 1602), Rhode Island (HB 7021/SB 3095), South Dakota (SB 181), Virginia (HB 218), and West Virginia (HB 4237). While the concept of banning the sale of ENDS to minors was widely supported, even by those in the industry, bills enacted in states such as Iowa and Missouri excluded e-cigarettes from the definition of tobacco, which health advocates argued could make it difficult to impose additional regulations. Missouri's Governor

Nixon vetoed SB 841, and stated, “[t]he bill appears to be nothing more than a thinly disguised and cynical attempt to exempt e-cigarettes from taxes and regulations protecting public health.” He also stated that “[u]ntil more is known about the health effects of these products, letting tobacco companies off the hook with special loopholes would pose a real threat to Missourians’ health now and in the future.” The Missouri legislature overrode his veto.

Prohibiting the Sale of E-Cigarettes to Minors 2014 State Legislation



Last Updated: November 2014

Water

In January 2013, 4-methylcyclohexane methanol (MCHM) was discovered leaking from a storage tank into the Elk River, affecting the Charleston, West Virginia water supply. As a result, SB 373, the Water Resources Protection Act was enacted. The bill requires that all above ground storage tanks in areas of critical concern must be registered with the department of environmental protection and are subject to annual inspections. Under the new law, West Virginia American Water is required to install an early monitoring system at its Elk River Plant and all water utilities are required to have a water source protection plan for emergency situations. The legislation also requires West Virginia’s Bureau for Public Health to engage CDC and other federal agencies to create, organize, and implement any long-term health effects resulting from the chemical spill.

For more information on ASTHO’s state health policy initiatives, please contact Andrea Garcia, director of state health policy, at agarcia@astho.org.