

2015 State Legislative Summary

The Association of State and Territorial Health Officials (ASTHO) tracks state legislation that impacts state health agencies and public health and supports a 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 2015 state legislative sessions.

Prescription Drug Abuse

Comprehensive Prescription Drug Abuse Plans

Minnesota (SF 1458) and North Carolina (HB 97) established coordinated, statewide responses to curb prescription drug abuse. Minnesota created an opioid prescribing workgroup while North Carolina established a Prescription Drug Abuse Advisory Committee. The workgroup and committee are both instructed to develop statewide plans to address prescription drug abuse.

Mandatory Education for Providers

North Carolina (HB 97) requires continuing education (CE) on prescription drug abuse and pain management as a condition of licensure for prescribing controlled substances. Physicians in Connecticut (HB 6856) must complete at least one-hour of CE on prescribing controlled substances every six years.

Medication Assisted Treatment (MAT)

Florida (SB 706), Illinois (HB1), Indiana (HB 1448), and New Jersey (S 2015) expanded access to MAT. Florida made it easier to license new providers by reducing needs assessment requirements. Illinois and Indiana required state Medicaid programs to cover MAT without utilization controls. New Jersey appropriated over seven million dollars for its Medication Assisted Treatment Initiative and required addiction services providers to enroll as Medicaid providers. In Illinois (HB 1448), the legislature appropriated \$488,800 for a pilot study of MAT in publically-funded treatment programs. Kentucky (SB 192) encouraged the Cabinet of Health and Family Services to study the possibility of expanding Medicaid to cover MAT and developing best practice guidelines.

States also integrated MAT within the criminal justice system. Indiana (SB 1006) included MAT into programs for recidivism reduction and mental health and addiction. The bill also requires education and training about MAT programs for judges, prosecutors, and public defenders. Missouri (HB 10) appropriated one million dollars to reduce recidivism rates for offenders with substance abuse disorders through evidence-based programs including MAT. New Jersey (NJ S 2380) required the provision of MAT in correctional facilities and community transition programs. In addition, through S 2381, New Jersey clarified that offenders in MAT can complete special probation drug court programs. West Virginia (HB 2880) created a pilot program to provide MAT to individuals in the criminal justice system.

Access to Clean Syringes

California (SB 75) now allows the state department of health to purchase sterile needles and syringes on behalf of county and municipal syringe exchange programs. In response to an HIV outbreak in May 2015, Indiana passed SB 461, authorizing county and municipal programs to access clean syringes in public health emergencies. SB 461 requires collaboration between the state health commissioner, the local health authorities, and the local governing body before a syringe exchange program can begin. SB 192 in Kentucky also authorized clean syringe programs upon the approval of local governments. In addition,

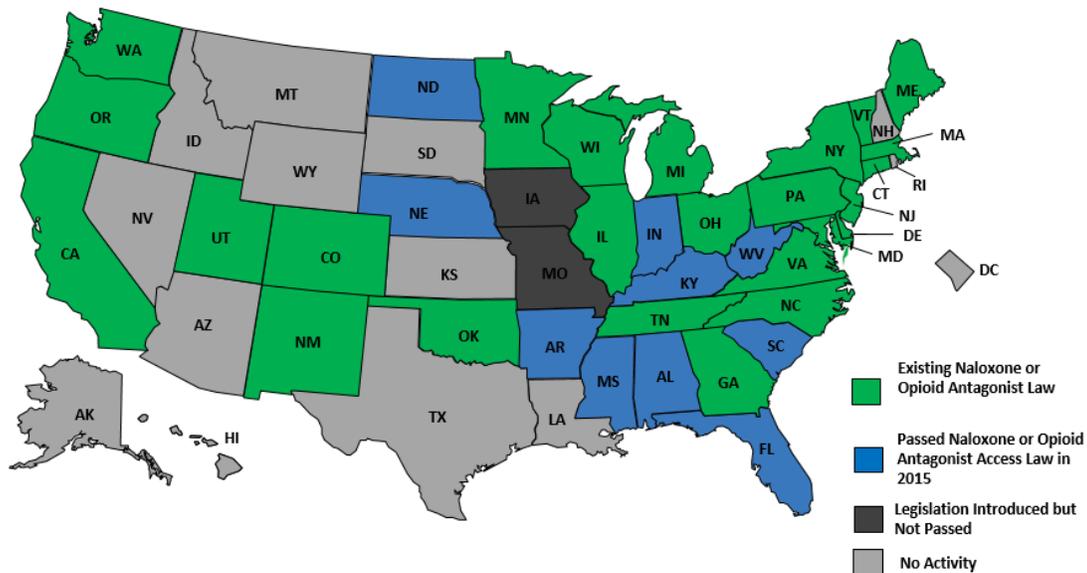
Illinois passed SB 793 to require the department of public health develop guidelines to dispose of syringes and other sharps and encourage the use of safe disposal programs.

Prescription Drug Monitoring Programs (PDMPs)

Thirteen states altered their drug monitoring programs in 2015. Arizona (SB 1370), Louisiana (SB 143), Maine (LD 1170), North Dakota (HB 1149), New Jersey (S 1998), Oklahoma (HB 1948), and Virginia (HB 1249) made PDMP mandatory. Arkansas (SB 129 and SB 698), California (AB 679), Maryland (SB 757), North Carolina (HB 97), Virginia (SB 817), and Washington (HB 1637) allowed law enforcement, health departments, or other designated entities to access information from PDMPs. Virginia (HB 1810) and Utah (SB 119) now prohibit disclosure of information in PDMP databases. Arkansas (SB 717), Arizona (SB 1032), and Illinois (HB 1) created new oversight mechanisms to identify and resolve questionable prescribing patterns.

Naloxone and Good Samaritan Provisions

astho™ Naloxone and Opioid Antagonist Legislation in 2015 State Laws and Pending Legislation



In 2015, 39 states considered 172 bills related to access to opioid antagonists, and 55 of those bills became law. The policy surveillance tool, LawAtlas, has a comprehensive, longitudinal dataset of opioid antagonist laws. It identifies key provisions including prescriptive authority and liability issues and links to statutes and regulations. As states continue to evaluate the effectiveness of their laws and make changes, this LawAtlas dataset can provide insight into the breadth of policy options states are using.¹

¹ Public Health Law Research. "Naloxone Overdose Prevention Laws Map." Available at <http://lawatlas.org/query?dataset=laws-regulating-administration-of-naloxone>. Accessed 12-16-2015.

Medical Marijuana

In Louisiana, SB 143 tasked the Board of Pharmacy with promulgating rules for prescription and dispensation of medical marijuana. California enacted the Medical Marijuana Regulation and Safety Act (AB 266, AB 243, and SB 643) creating a Bureau of Medical Marijuana Regulation in the Department of Consumer Affairs to oversee the licensing of medical marijuana production and sales. The department of public health is responsible for developing standards for manufacturing, testing, and labeling edible marijuana products. In Washington state, HB 2136 brought medical marijuana within the sale and taxation framework of retail recreational marijuana.

Cannabidiol (CBD)

Georgia (HB 1), Nebraska (LB 310), Oklahoma (HB 2154), Texas (SB 339), Virginia (S 1235), and Wyoming (HB 32) passed laws allowing patients access to CBD. Citing public health and safety concerns over implementation, Idaho's governor vetoed CBD legislation, but promised to task the health department to explore ways to allow patients with severe epilepsy to access CBD as treatment.²

Recreational, Adult-Use Marijuana

Voters in Ohio defeated a ballot initiative to legalize medical and recreational marijuana in late 2015. Additionally, Washington and Colorado, refined their recreational marijuana regimes. In Colorado, voters passed a ballot initiative allowing the government to spend excess tax revenue generated from the sale of recreational marijuana to support school construction, youth and substance abuse programs, and other discretionary programs.³ In Washington state, HB 1413 sought to decrease the existing buffer zone between marijuana businesses and certain public spaces and areas where children are likely to be present (e.g., schools, playgrounds, and parks) from 1,000 to 500 feet, while HB 1335 would allow local jurisdictions to reduce the buffer zone to 500 feet. These bills illustrate the on-going need for a public health voice and perspective in shaping a regulatory system around recreational marijuana that is responsive to public health concerns.

Federal Impact on State-led Marijuana Initiatives

In early June, the House of Representatives reauthorized the Rohrabacher-Farr amendment to prohibit the Department of Justice (DOJ) from preventing any state from "implementing their own laws that authorize the use, distribution, possession, or cultivation of medical marijuana." The Drug Enforcement Administration (DEA) interpreted the 2014 version of the amendment as preventing federal action against states, but allowing enforcement against private individuals and companies. In October, the U.S. District Court for the Northern District of California in *MAMM vs. U.S. DOJ* refuted the DEA interpretation and ruled that the DEA is prohibited from prosecuting individual medical marijuana patients or providers who are in a compliance with their state's laws.

² Cotterell A, Ritter-Saunders E. "Idaho Governor Vetoes Bill Allowing Marijuana-Based Epilepsy Treatment." *Boise State Public Radio*. April 16, 2015. Available <http://boisestatepublicradio.org/post/idaho-governor-vetoes-bill-allowing-marijuana-based-epilepsy-treatment>. Accessed 12-16-2015.

³ Frank, J. "Colorado Allowed to Spend Marijuana Tax Money as Voters Reject Refunds." *The Denver Post*. 11-03-2015. Available http://www.denverpost.com/election/ci_29066651/colorado-again-asks-voters-how-spend-marijuana-tax. Accessed 12-16-2015.

Synthetic Drugs

In October, the District of Columbia council enacted DC ACT 21-146, enabling the mayor to revoke business licenses over the sale of synthetic drugs, law enforcement to seal the premises of businesses that sold synthetic drugs for 96 hours, and the health department to designate synthetic drugs as a *per se* imminent danger to health and safety. Under SB 106 in New Hampshire, the Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment, and Recovery must prepare annual reports outlining strategies for public awareness, education, and policy development to address synthetic drugs. SB 106 also increased penalties for businesses selling synthetic drugs, including increased fines, license revocation, and denial of ticket sales by the lottery commission.

Though not enacted, states looked at additional policies on this issue. Several states, including Hawaii (HB 137) and Indiana (SB 93) introduced bills to redefine "intoxicants" to make it easier for law enforcement to stop individuals from driving under the influence of synthetic drugs. Additionally, legislatures considered, but did not pass, bills to establish emergency rules to schedule new synthetic compounds immediately to provide governments with a way to quickly respond when manufactures alter the molecular structure of the compounds to circumvent existing rules.

Food Safety

Cottage Food

In Montana, HB 478 excluded "cottage food operations" from the definition of "retail food establishment," so they are not subject to the same licensure and regulation. Cottage food operations must register with the local health department and comply with rules for labeling and food handling. Local health departments must submit the registered cottage food operations list to the state department of health. Illinois (HB 2486) allowed baked goods to be sold as cottage food. Washington state (HB 1622) defined baked goods and stovetop candy as "non-potentially hazardous foods."

Genetically Modified Organisms (GMO) Labeling

In 2015, legislatures considered over 75 bills and 20 resolutions focused on GMO labeling. Idaho (HJM 6), Michigan (HR 89), and North Dakota (SCR 4020) passed resolutions advocating for a voluntary, national food labeling system. In addition, Maine (ME LD 456) and Connecticut (HB 6886) exempted non-alcoholic malt beverages from their GMO labeling requirements.

Health System Reform

Data

New Jersey enacted S 3220, which enhances access to data across different government departments and agencies. The bill creates a statewide Integrated Population Health Database housed in Rutgers's University Center for State Health Policy and overseen by a governing board. By facilitating access to diverse and robust sources of data, researchers, policymakers, and healthcare providers can identify patterns, strategies, and interventions that improve the health of the state.

Medicaid Expansion

In April 2015, Montana passed SB 405, expanding Medicaid under a modified plan that outsourced administrative functions to a third-party administrator and required premiums amounting to 2 percent of enrollee's income. The modified plan required a 1115 waiver, which HHS approved on Nov. 2.

North Dakota enacted HB 1035, HB 1037, and SB 2174. HB 1035 authorizes a study of the North Dakota healthcare delivery system, including Medicaid reforms. HB 1037 and SB 2174 require the department of human services to study options for income-based cost-sharing for Medicaid and Medicaid expansion. Arkansas enacted SB 96, creating the Arkansas Health Reform Legislative Task Force to evaluate options for continuing Medicaid expansion and other issues surrounding health reform. The law also requires legislative action to continue with Medicaid expansion after its 1115 waiver expires on January 1, 2017.

Public Health System Reform

Oregon enacted a comprehensive framework (HB 3100) to align the public health system's capabilities and programs. Under HB 3100, local public health authorities must have the "foundational capabilities" (i.e., the "knowledge, skill, or ability that is necessary to carry out a public health activity") to implement "foundational programs" (i.e., "a public health program that is necessary to assess, protect, or improve the health of the residents of this state"). The Oregon Health Authority is responsible for adopting and updating a statewide community health assessment and implementing a statewide community health improvement plan. The Oregon Health Authority must distribute funds to local health authorities, coordinate administration of the foundational programs, approve local plans to apply foundational capabilities and programs, monitor the progress of local health authorities in meeting statewide public health goals, and develop incentives to encourage effective and equitable public health services.

Health Equity

ASTHO's 2016 President's Challenge "Advancing Health Equity and Optimal Health for All," will guide ASTHO's health equity efforts over the coming year. Many states have already started engaging on policies around health equity.

Finding a need for stronger data to address health and other disparities faced by lesbian, gay, bisexual, and transgendered populations, California passed AB 959, requiring several government entities including the department of healthcare services and the department of public health to collect self-identified demographic data about sexual orientation and gender. Texas created the Texas Health Improvement Network through HB 3781 to evaluate and eliminate health disparities, including racial, ethnic, geographic, and income or education related.

Minnesota passed comprehensive legislation to address health disparities. Under SF 1458, the legislature re-defined meaningful use for health information technology to include a role in reducing health disparities. The bill required the commissioner of health to stratify at least five health quality measures by factors like race and ethnicity, which reliably correlate to health disparities, in order to provide insight into gaps in public health and healthcare services in specific communities. SF 1458 also formed a Task Force on Healthcare Financing to reduce health disparities through innovative financing mechanisms. As part of this process, the state also created a program for enhanced payments for healthcare providers that serve patients experiencing health disparities.

In addition, Minnesota enacted HF 1535 which created the Cultural and Ethnic Communities Leadership Council within the department of human services to advise the commissioner on reducing disparities affecting racial and ethnic groups. In 2014, Minnesota's legislature appropriated \$500,000 for a competitive health equity grant program. In 2015, the legislature passed HB 1458, which allows the commissioner to consider evidence of a promising strategy with the same weight as research or

evidence-based strategies when awarding these grants. This new language permits grants to be used to test innovative ideas that may not have evidence of their value or outcomes.

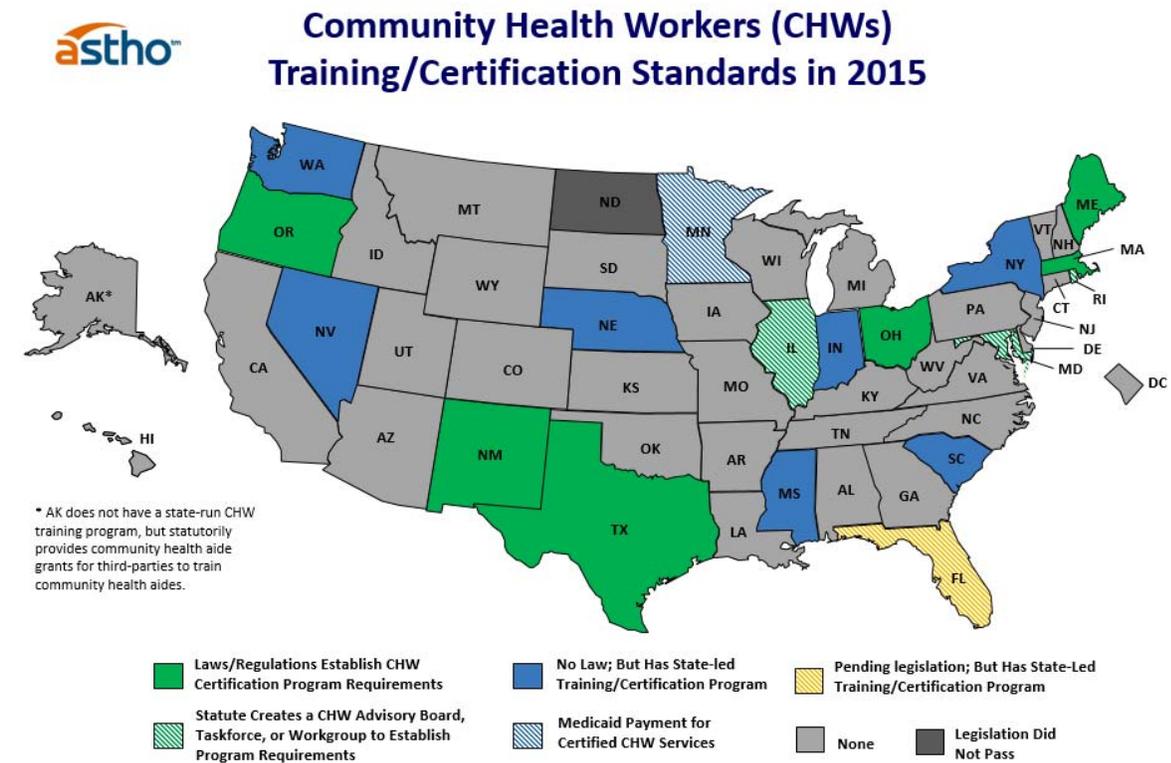
Oregon included health equity and cultural responsiveness as a foundational capability of public health in H 3100. To achieve that capability, local health authorities, must (1) support public health policies that promote health equity, (2) implement processes that create health equity, (3) recognize and address health inequities that impact specific populations, (4) communicate with the public and stakeholders inclusively and transparently, (5) provide access to epidemiologic and assessment data and findings as appropriate, and (6) engage diverse populations in community health planning. In Maryland, the legislature passed HB 580 to encourage healthcare providers to take continuing education courses on cultural and linguistic competency, health literacy, and health disparities.

Licensure and Scope of Practice

Interstate Medical Licensure Compact

Eighteen states considered legislation to join the Interstate Medical Licensure Compact, and the measures were successful in twelve (Alabama, Iowa, Idaho, Illinois, Minnesota, Montana, Nevada, South Dakota, Utah, West Virginia, Wisconsin, and Wyoming). The compact is meant to improve access to physicians by streamlining licensure across states and facilitating telemedicine.

Community Health Workers (CHWs)



Maine enacted LD 1426, which established a registry for direct care workers including CHWs. The bill has two major elements: (1) it creates a voluntary program through which direct care workers can be designated as “registered direct care workers,” and (2) requires registered direct care workers to meet education, training, and experience standards under a program to be developed by the department of health. Nevada enacted SB 498, which requires business entities, either individuals or organizations, which employ CHWs to apply for a business license.

Additionally, Florida introduced legislation to create a voluntary, third party credentialing program for CHWs. Under both HB 285 and SB 482, third party entities would be responsible for core credentialing functions, while the health department would be responsible for approving third party organizations that demonstrated they could fulfill those functions. Although these bills did not pass in 2015, SB 244 was pre-filed in advance of the 2016 session.

Dental Therapists

The North Dakota legislature directed the Legislative Management Committee to study oral health in the state, particularly the effectiveness of case management and infrastructure to use mid-level or other providers to improve access. Findings from this report will be provided to the 65th legislative session.

Nurses

Illinois and Nebraska expanded the scope of practice for advanced practice nurse practitioners (APRNs). Under HB 421 in Illinois, APRNs can practice without a collaborative practice agreement with a physician. In Nebraska (LB 107), APRNs have full practice authority, meaning they can evaluate patients, make diagnosis, order and interpret diagnostic tests, and prescribe without a collaborative agreement.

Telehealth

Commercial Health Insurance

Arkansas (SB 133), Colorado (HB 1029), Delaware (HB 69), Minnesota (SF 1458), New York state (AB 2552), and Nevada (AB 292) required commercial payers to cover and reimburse telehealth encounters the same as if they were delivered in-person. Nevada’s bill (AB 292) also allows the insurance commissioner to take into account the availability of telemedicine and telehealth services when making network adequacy determinations. In addition, North Dakota (BH 1038) allowed the state’s retirement system to cover telehealth or telemedicine services. The law sunsets on July 31, 2017, and the system is required to produce a report identifying cost and utilization trends for the legislature.

Medicaid

Several states also allowed their Medicaid plans to reimburse for certain telehealth services. Minnesota (SF 1458) allowed Medicaid to reimburse for telehealth services for behavioral health. Vermont (SB 139) and Nevada (AB 292) required payment parity between traditional and telehealth services for Medicaid. Additionally, Iowa (SF 505) required the department of human services to adopt rules for coverage of telehealth in Medicaid at the same rates as traditional, in-person encounters.

Infectious Disease

Outbreaks and Response: Ebola

As a result of the 2014 Ebola outbreak, states advanced legislation to create better tools to respond to future public health crises. Florida passed HB 697, which expanded the state health official’s authority to

issue public health advisories and order individuals into isolation, as well as quarantine. South Dakota (HB 1058) clarified its existing quarantine authority by removing outdated references to tuberculosis and adding new language aligned with reportable diseases. Connecticut (HB 6987) expanded the definition of infectious disease to include any disease designated as a potentially life threatening infectious disease by HHS. Finally, Texas (HB 2950) created a task force on infectious disease and response to assist the governor in handling infectious disease outbreaks.

Antimicrobial Resistance

California (SB 27) became the first state to enact legislation restricting the use of medically-important antibiotics in livestock. Beginning Jan. 1, 2018, such antibiotics can only be used when prescribed by a licensed veterinarian to treat, control, or prevent diseases. In addition, California passed SB 361 which requires continuing education on judicious antibiotic use for veterinarians. This law also expands a 2014 program that requires hospitals to adopt and implement antimicrobial stewardship programs to skilled nursing facilities. Although California was the only state to enact legislation, Maryland, Missouri, Montana, New Jersey, Oregon, and Pennsylvania considered similar bills.

In Missouri, SB 1066 requires hospitals to develop antimicrobial stewardship policies by August 2016. Additionally, the department of health must report to the legislature annually on the incidence, type, and distribution of antimicrobial-resistant infections in the state.

Immunizations

Exemptions

As a result of high-profile vaccine-preventable disease outbreaks, legislatures in seven states (California, Connecticut, Delaware, Illinois, Maine, Missouri, and Vermont) restricted access to vaccine exemptions or increased access to information about vaccination rates in schools. In West Virginia, an effort to add a religious exemption for childhood vaccination programs was unsuccessful. California (SB 277) and Vermont (H 98) eliminated personal belief exemptions for children entering schools or daycares. Vermont also established new requirements for medical exemptions and required disclosure of aggregate vaccination rates. In Missouri (SB 341) parents can request to be notified if exemptions are filed for children in a school or childcare facility.

Connecticut (HB 6949), Delaware (HB 91), and Illinois (SB 1410) imposed new requirements on parents or guardians seeking vaccination exemptions. Connecticut now requires that parents or guardians provide a notarized statement detailing the religious beliefs that prohibit vaccination. In Illinois, parents or guardians must receive counsel from a healthcare provider about the benefits of vaccination and obtain the healthcare provider's signature before obtaining an exemption. In Delaware, parents and guardians must acknowledge that they received information from the school district about the benefits and risk of vaccinations and that in the event of an outbreak of a vaccine-preventable illness, their unvaccinated child will be excluded from school.

In West Virginia, SB 286, as introduced, would have added a religious belief exemption. However, during the legislative process, the exemption language was removed, and the department of health and human resources gained authority to add or remove vaccinations from the immunization schedule and change dosages.

Universal Purchasing Programs

New Mexico (SB 121) established the Vaccine Purchasing Fund to purchase its vaccinations for all children in the state at discounted rates and then distributes them to providers free of charge. The fund is financed by appropriated funds and an assessment on health insurance companies in the state.

Immunization Data Registries

In Arkansas, HB 1550 allows providers to update vaccine information in the state's immunization data registry for patients 22 years of age or older without consent. Indiana's law (SB 461) now requires schools to ensure that information in the immunization data registry is complete and allows all providers—not just physicians—and their designees to enter information into the registry.

Idaho, South Dakota, and Vermont passed laws to share information immunization data registry data. Idaho passed S 1121 to share immunization registry information with the Idaho health data exchange, and disclose the information in accordance with state and federal laws. In South Dakota, SB 1059 allows information from the immunization data registry to be shared with providers, healthcare facilities, federal and state health agencies, child welfare agencies, schools, and childcare facilities. Individuals in the registry can opt-out by having a signed refusal in their patient records. Vermont (HB 98) authorized the exchange of immunization data registry information with other states' registries and will allow researchers with Institutional Review Board approval to access registry information.

Pharmacists

South Carolina enacted S 413, which authorizes pharmacists to provide adult vaccinations without a prescription from a provider.

Maternal and Child Health

Newborn Screening

In Delaware, SB 58 codified existing newborn screening rules and regulations requiring an informed consent process to ensure that parents know and understand the purpose of newborn screening and the consequences of opting-out. The law prohibits research on the blood samples without parental consent, but excludes "population-based studies in which all identifying information is removed" and certain uses by the division of public health from the definition of research.

North Dakota's legislature enacted SB 2334, which requires regulatory rulemaking to formalize procedures for the storage, maintenance, and disposal of blood samples and other specimens. The department of health is tasked with selecting the screening laboratory and storing, maintaining, and disposing of samples. Finally, the law requires an Institutional Review Board process that includes a parent or guardian's authorization for research on blood spots, specimens, or registry information maintained by the health department.

Federal Impact on State Newborn Screening Programs

In September, HHS and other federal agencies issued a notice of proposed rulemaking (NPRM) to update the "Federal Policy for the Protection of Human Subjects," i.e., the Common Rule. Under the NPRM, newborn screening is considered a form of "exempted research," requiring certain limited protections that include specific recordkeeping, privacy safeguards, limited Institutional Review Board review, and consent requirements. Forms used to obtain broad consent must: (1) describe the bio specimen and

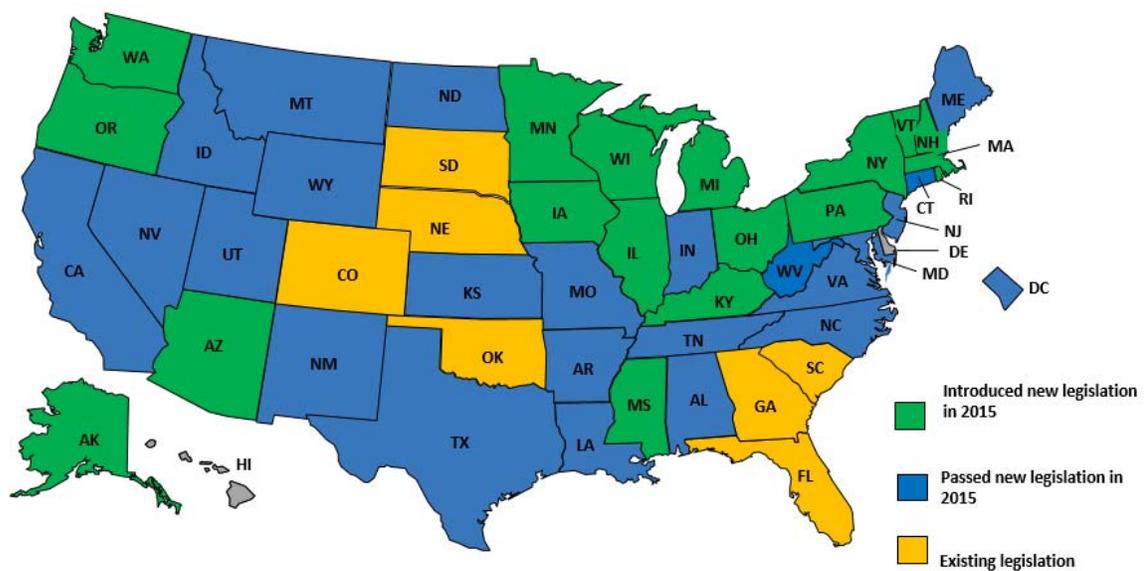
private information covered, (2) explain that subjects may withdraw consent without penalty, and (3) allow subjects to consent or decline to include their data in public databases. HHS plans to publish a broad consent form template at a future date.

Screening for Congenital Heart Defects and Other Diseases

In 2015, four states (Colorado, Hawaii, Virginia, and Washington) and the District of Columbia enacted legislation on congenital heart defects to their newborn screening programs. In addition, Kentucky (SB 75) added Krabbe’s disease to its screening program. Finally, Connecticut (HB 5525) and Illinois (HB 184) strengthened screening for cytomegalovirus (CMV). Connecticut mandated testing for CMV if infants fail a hearing screening, and in Illinois, in the event that an infant fails a second hearing test, healthcare providers must provide parents with information about CMV testing and interventions. The Illinois department of public health is also responsible for creating educational materials about CMV.

Tobacco

Electronic Cigarette Legislation in 2015



Electronic Nicotine Delivery Systems

States were active in regulating electronic cigarettes in 2015. The most common laws focused on protecting children and young adults from electronic cigarettes and e-liquids. Fourteen states imposed age restrictions on the sale or use of electronic cigarettes, and ten states required that nicotine-containing liquids be sold in child-resistant containers. Eight states banned the use of electronic cigarettes in certain locations. Five states taxed electronic cigarettes, and South Dakota listed a tax on electronic cigarettes as a possible area of study. Five states imposed business licensure requirements for retailers. Additionally, four laws preempted local regulation around electronic cigarettes. The Tobacco

Control Legal Consortium and Public Health Law Center provides a 50-state survey of state laws regulating electronic cigarettes and vapor products.⁴

Federal Impact of Tobacco Deeming Regulations

FDA's Center for Tobacco Products submitted its final deeming regulations on cigars, electronic cigarettes, pipe tobacco, nicotine gels, hookah, and dissolvable products in October 2015. The regulation will determine the tobacco products that fall under FDA's regulatory authority as a result of the 2009 Family Smoking Prevention and Tobacco Control Act.

Raising the Legal Smoking Age

In June, Hawaii (SB 1030) became the first state to raise the legal age for using and purchasing tobacco products to 21 years old beginning in January 2016. Ten other states (California, Massachusetts, New Jersey, New York, Oregon, Pennsylvania, Rhode Island, Utah, Vermont, and Washington) and the District of Columbia considered bills to raise the smoking age.

Water

Above Ground Storage Tanks

In 2014, in response to the Elk River chemical spill, West Virginia passed a bill subjecting all above ground storage tanks to reporting and oversight requirements. During the 2015 session the legislature passed SB 423, limiting the regulations to tanks containing certain chemicals or located within five miles of a water intake system. Indiana passed SB 312 which requires owners of above ground storage tanks to submit reports with the tank location, materials stored, and capacity by Jan. 1, 2016. Owners are also required to implement surface water quality threat minimization and response plans.

Drinking Water

Several states made changes to the financing structures of their drinking water funds. In Arizona, HB 2142 limited the authority in charge of the Clean Water Revolving Fund from unilaterally changing existing agreements or implementing policies that would affect previous agreements. In California AB 496 allows the state department of education and school districts to access money from state and federal programs to increase access to drinking water, and AB 1531 authorized emergency regulations to better enforce state and federal water protection laws. In addition, it expanded the definition of "public agency" to allow municipalities to use money from state funds for water projects.

Water Quality

Colorado (HB 1249) codified regulations around storm water construction. Hawaii passed HB 393 streamlining the regulatory process to repurpose and restore traditional fishponds. Under the new law, applicants will need a water permit from the Department of Land and Natural Resources. In Vermont, the legislature passed H 35 to improve overall water quality in the state by regulating small farms.

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⁴ Tobacco Legal Consortium "U.S. E-Cigarette Regulation: a 50-State Review" Available at <http://publichealthlawcenter.org/sites/default/files/The-Legal-Landscape-for-Electronic-Nicotine-Delivery-Systems-07102015.pdf>. Accessed 12-16-2015.