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Ohio Legislative Service Commission

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H.B. 176*

134th General Assembly

Occupational Regulation Report

Click here for H.B. 176's Bill Analysis/Fiscal Note

Primary Sponsors: Reps. Carfagna and Hall

Impacted Profession: Athletic Training

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LSC is required by law to issue a report for each introduced bill that substantially changes or enacts an occupational regulation. The report must: (1) explain the bill's regulatory framework in the context of Ohio's statutory policy of using the least restrictive regulation necessary to protect consumers, (2) compare the regulatory schemes governing the same occupation in other states, and (3) examine the bill's potential impact on employment, consumer choice, market competition, and cost to government.[1]

LEAST RESTRICTIVE REGULATION COMPARISON

Ohio's general regulatory policy

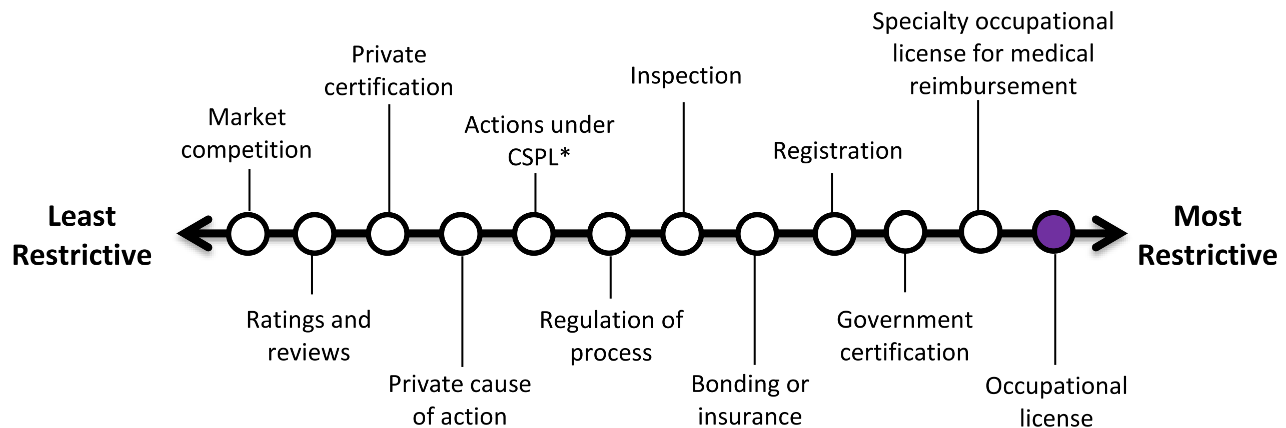
The general policy of the state is reliance on market competition and private remedies to protect the interests of consumers in commercial transactions involving the sale of goods or services. For circumstances in which the General Assembly determines that additional safeguards are necessary to protect consumers from "present, significant, and substantiated harms that threaten health, safety, or welfare," the state's expressed intent is to enact the "least restrictive regulation that will adequately protect consumers from such harms."[2]

The degree of "restrictiveness" of an occupational regulation is prescribed by statute. The following graphic identifies each type of occupational regulation expressly mentioned in the state's policy by least to most restrictive:

* This report addresses the "As Introduced" version of H.B. 176. It does not account for changes that may have been adopted after the bill's introduction.

[1] R.C. 103.26, not in the bill.

[2] R.C. 4798.01 and 4798.02, neither in the bill.



*CSPL – The Consumer Sales Practices Law

H.B. 176 modifies the existing licensure requirement for athletic trainers in ways that would seemingly broaden the scope of practice and expand employment options for individuals holding the license. However, the bill also establishes a new regulatory hurdle for licensees by requiring a collaboration agreement with a physician or podiatrist.

Necessity of regulations

According to sponsor testimony provided by Representatives Carfagna and Hall, the overarching purpose of H.B. 176 is to promote patient safety by elevating the quality of care. The testimony indicates that the bill's changes are needed to "modernize" the scope of practice for athletic trainers to better reflect the realities of the occupation. More than 80% of licensed athletic trainers in Ohio have a master's degree and the sponsors contend that the bill allows those individuals to more fully utilize their training and education. The sponsors suggest that allowing athletic trainers to provide additional services will streamline patient care and keep healthcare costs low.

According to sponsor testimony, the collaboration agreement required by the bill is designed to facilitate "team-based" care between athletic trainers and physicians. It provides for a greater degree of physician oversight into the practice of athletic trainers and might counterbalance concerns over the performance of additional activities and services by persons engaged in that profession.[3]

Restrictiveness of regulations

Licensure is the most restrictive of all regulatory options identified within the state's general policy on occupational regulations. Accordingly, the policy prescribes a narrow range of situations in which it is appropriate. Specifically, when all of the following circumstances are present: (1) the occupation involves providing a service regulated by both state and federal law,

[3] Reps. Rick Carfagna and Thomas Hall, H.B. 176 Sponsor Testimony, March 16, 2021.

(2) the licensing framework allows individuals licensed in other states and territories to practice in Ohio, and (3) the licensing requirement is based on uniform national laws, practices, and examinations that have been adopted by at least 50 U.S. states and territories.[4]

Ohio first required licensure of athletic trainers in 1991. Federal law does not prescribe licensing requirements for athletic trainers but it does reference the occupation in at least one instance. The "Sports Medicine Licensure Clarity Act of 2017" extends liability insurance coverage for medical professionals that provide treatment to an athlete, team, or staff member when competing outside the professional's state of licensure.[5]

Continuing law, unchanged by the bill, does not grant full reciprocity for all out-of-state licensees. However, the Athletic Training Section of the Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board is expressly permitted by statute to waive education, exam, training, character evaluation, and licensing fee requirements for individuals holding a current license in a state that has standards that are equal to, or greater than those in Ohio.[6]

According to the National Association of Athletic Trainers (NATA), 46 states require licensure of athletic trainers. Two states - New York and South Carolina – require a certification. Hawaii requires registration. California prescribes no state regulations.[7] There does not appear to be a uniform national athletic training licensure law. However, there is some degree of standardization in terms of education and training requirements. Ohio prescribes its own athletic training coursework requirements, but individuals who graduate from an athletic training program certified by the Commission on Accreditation of Athletic Training Education (CAATE) or the Commission on Accreditation of Allied Health Education Programs (CAAHEP) are deemed automatically to have met those requirements.[8] Ohio requires passage of the Board of Certification Exam for athletic trainers – a national exam recognized by 49 states – before granting licensure.[9]

Other regulatory policies

The bill modifies an established regulatory framework that applies to athletic trainers who practice in Ohio.[10] The law does not contain a general statement explaining the state's intent in regulating athletic trainers. However, the mission of the Ohio Occupational Therapy,

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[4] R.C. 4798.02, not in the bill.

[5] Section 12 of the "Sports Medicine Licensure Clarity Act of 2017," 15 United States Code 8601.

[6] R.C. 4755.62(C) and (D).

[7] NATA, Athletic Training State Regulatory Boards.

[8] Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board Athletic Trainers Section, Athletic Training Course Requirements, February 2017.

[9] Ohio Administrative Code (O.A.C.) 4755-43-02; Board of Certification for the Athletic Trainer, State Regulation.

[10] See, e.g., R.C. 4755.60 through 4755.65 and O.A.C. chapters 4755-1 through 48.

Physical Therapy, and Athletic Trainers Board is somewhat instructive in that regard – ". . . to promote and protect the health of Ohioans . . . ."[11]

IMPACT STATEMENT

Opportunities for employment

The bill may impact opportunities for employment for athletic trainers, if the requirement that athletic trainers work in collaboration with a physician or podiatrist makes it more difficult for athletic trainers to obtain licensure or employment. The bill may also increase opportunities for employment, if more patients are referred to athletic trainers for treatment as a consequence of the bill allowing additional medical professionals to issue athletic training referrals. As the bill eliminates the requirement that an athletic trainer be employed by an athletic or health care facility, educational institution, or professional or amateur organization, it is possible that the elimination of these restrictions might make it easier for athletic trainers to provide athletic training services to patients. These contradicting effects could partially or fully offset the impacts of each other.

Consumer choice and market competition

If the requirement that an athletic trainer work in collaboration with a physician or podiatrist results in increased difficulty of obtaining licensure, it is possible that consumer choice could be limited by a smaller population of practicing athletic trainers in the state. This smaller pool of providers could lead to decreased market competition within the profession. In contrast, the elimination of restrictions that athletic trainers be employed by specific entities and the enhanced referral privileges granted in the bill may increase consumer choice. This increase in the availability of athletic training services could, in turn, lead to increased market competition within the profession. The degree to which these different impacts of the bill may fully or partially offset is impossible to predict or observe with certainty.

Cost to government

For costs to government, please see the LBO fiscal note.

SUMMARY OF PROPOSED REGULATIONS

H.B. 176 makes several changes to the law governing athletic training, including by requiring physician or podiatrist collaboration and authorizing an athletic trainer to perform additional activities or services.[12]

[11] Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board, Annual Report: Fiscal Year 2020, p. 4.

[12] R.C. 4755.60 and 4755.621.

Physician or podiatrist collaboration

The bill requires an athletic trainer to enter into a collaboration agreement with one or more physicians or podiatrists before engaging in the practice of athletic training. The agreement must address the following topics:

- The duties and responsibilities to be fulfilled by the athletic trainer when engaging in the practice of athletic training;
- Any limitations on the athletic trainer's practice of athletic training;
- A plan of care for patients treated by the athletic trainer.[13]

An athletic trainer who fails to practice under a collaboration agreement may be subject to Board discipline, which may include a fine, reprimand, or license suspension or revocation.[14]

Referrals and employment

The bill preserves existing law requiring an athletic trainer to practice on the referral of a physician, podiatrist, dentist, physical therapist, or chiropractor, but also recognizes referrals issued by physician assistants, nurse practitioners, and other athletic trainers. Referrals from other athletic trainers are recognized only if athletic training has already been recommended and referred by a health care professional other than an athletic trainer.[15]

The bill eliminates the requirement that an athletic trainer be employed by an educational institution, professional or amateur organization, athletic facility, or health care facility.[16]

Scope of practice

The bill revises the activities and services that an athletic trainer is permitted to perform.[17] The following table illustrates the bill's changes and additions.

Existing Law Activities and Services	H.B. 176 Activities and Services
Prevention, *recognition, and assessment of an athletic injury*	Prevention, *examination, and athletic training diagnosis of injuries or conditions resulting from physical activities that require physical skill and utilize strength, power, endurance, speed, flexibility, range of motion, or agility*

[13] R.C. 4755.621.

[14] R.C. 4755.64, not in the bill.

[15] R.C. 4755.60(A) and 4755.621(B).

[16] R.C. 4755.60(B).

[17] R.C. 4755.60(A).

Existing Law Activities and Services	H.B. 176 Activities and Services
Complete management, treatment, disposition, and reconditioning of *acute athletic injuries*	Same, but refers instead to *injuries or conditions resulting from physical activities*
No provision	Provision of emergent care, therapeutic interventions, and rehabilitation for injuries or conditions resulting from physical activities
No provision	Promotion of and education about wellness
Administration of *topical drugs* that have been prescribed by a licensed health professional authorized to prescribe drugs	Instead refers to *drugs* that have been prescribed by a prescriber and are administered under the prescriber's direction
Organization and administration of educational programs and *athletic facilities*	Same, but references *athletic training facilities*
No provision	Performance of athletic training research
Education of and consulting with the public as it pertains to athletic training	Same

COMPARISON TO OTHER STATES

None of the five states that neighbor Ohio require an athletic trainer to enter into a written collaboration agreement with a physician or podiatrist. However, each of the five mandates that an athletic trainer have a relationship with another practitioner, often a physician. These mandates can range from requiring a practitioner's referral before an athletic trainer may treat a patient to requiring an athletic trainer to be supervised or practice under a written protocol. The following table highlights the requirements.

State	Supervisory Relationship
Indiana (Ind. Code Ann. 25-5.1-1-4)	Requires an athletic trainer to practice under the direction of a physician, podiatrist, or chiropractor. If an athletic trainer practices in a clinic accessible to the general public, requires a referral and order from a physician, podiatrist, or chiropractor.
Kentucky (KRS 311.900)	Requires an athletic trainer to practice with the supervision of a physician. Defines "supervision" as advising, consenting to, and directing the activities of an athletic trainer through written or oral orders.

Michigan (MCLS 333.17901)	Requires an athletic trainer to practice under the direction of, on the prescription of, or in collaboration with a physician, which may include an osteopathic physician.
Pennsylvania (63 PS 271.7a, 63 PS 422.51a, 49 Pa. Code 18.509)	Requires an athletic trainer to practice under the referral or prescription of physician, dentist, or podiatrist and in consultation with the referring physician, dentist, or podiatrist. Also requires the athletic trainer to comply with a written treatment protocol developed by a supervising physician.
West Virginia (W. Va. Code 30-20A-3 and 30-20A-5)	Requires an athletic trainer to practice under the general supervision of a physician, podiatrist, chiropractor, or physical therapist. “General supervision” includes a referral by prescription and the supervising practitioner being physically present or readily available for consultation by direct communication, radio, phone, or other electronic means.

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