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134th General Assembly

Final Analysis

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Primary Sponsors: Reps. Fraizer and Holmes

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UPDATED VERSION*

SUMMARY

Insurance coverage of telehealth services

- Expands Ohio insurance law on telemedicine services (renamed as telehealth services) to apply to numerous specified health care professionals rather than only physicians, physician assistants, and advanced practice registered nurses.
- Prohibits a health benefit plan from imposing cost sharing for telehealth services that exceeds the cost sharing for comparable in-person services and prohibits cost sharing for communications that meet specified criteria.
- Requires a health benefit plan to reimburse a health care professional for a covered telehealth service, but does not require the reimbursement to be a specific amount.
- Allows the Superintendent of Insurance to adopt rules as necessary to carry out the above provisions.

Provision of telehealth services by health care professionals

- Permits specified health care professionals to provide telehealth services.
- Requires telehealth services to be provided according to specified conditions and standards.

* This version reflects a Revised Code number change by the LSC Director (PDF) under R.C. 103.131. The Director has designated the act's R.C. 3721.60 as R.C. 3721.69. The designation is posted among the documents for H.B. 122 on the General Assembly's website, legislature.ohio.gov, via the link, "Codification Number Change."

- Permits certain health care licensing boards to adopt rules as necessary to carry out the above provisions, subject to specified parameters.
- Provides that a health care professional is not liable in damages under a claim that telehealth services provided do not meet the standard of care that would apply if services were provided in-person.
- Permits a health care professional to negotiate with a health plan issuer to establish a reimbursement rate for fees associated with the administrative costs of providing telehealth services.
- Declares that it is the intent of the General Assembly to expand access to and investment in telehealth services.
- Permits a physician authorized to recommend medical marijuana to use telehealth services to conduct a patient examination required before medical marijuana may be recommended.
- Specifies that the act's provisions are not to be interpreted as altering any law or rule related to the practice of dentistry.

Medicaid coverage of telehealth services

- Provides that specified health care practitioners may provide telehealth services to Medicaid recipients and are eligible to submit claims to the Department of Medicaid for payment for telehealth services rendered.
- Establishes requirements that must be satisfied when providing telehealth services to a Medicaid recipient.
- Requires the Medicaid Director to adopt rules authorizing the directors of other state agencies that administer portions of the Medicaid program to adopt rules regarding the provision of telehealth services.

Certified community mental health, addiction services providers

- Permits community mental health services providers and community addiction services providers certified by the Ohio Department of Mental Health and Addiction Services (OhioMHAS) to provide services through telehealth.
- Specifies requirements and standards that must be satisfied when telehealth services are provided.
- Permits OhioMHAS to adopt rules necessary to carry out the above provisions.

Video-conference visitation in long-term care facilities

- Specifies that during a declared disaster, epidemic, pandemic, public health emergency, or public safety emergency, long-term care facilities must provide residents and their families with video-conference visitation options.

Assistance at health care appointments

- Provides that during a declared disaster, epidemic, pandemic, public health emergency, or public safety emergency, an individual with a developmental disability or other permanent disability may have a parent or guardian present during a health care procedure, test, or other care visit.

Medicaid credentialing program

- Requires the Department of Medicaid to establish a credentialing program to review the competence, professional conduct, and quality of care provided by Medicaid providers.

Medical Board One-Bite Program

- Allows certain licensure applicants to participate in the State Medical Board's One-Bite Program.

Suspension of open enrollment and other insurance programs

- Extends to January 1, 2026 (from January 1, 2022), the suspension of the operation of certain programs operated under the state's insurance laws that are duplicative of the Affordable Care Act.

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DETAILED ANALYSIS

Insurance coverage of telehealth services

The act expands provisions of Ohio's insurance law regarding coverage of telemedicine services (renamed telehealth services under the act) to include additional types of health care professionals: psychologists and school psychologists, including school psychologists licensed under State Board of Education rules; audiologists and speech-language pathologists; occupational therapists and physical therapists; occupational therapy assistants and physical therapist assistants; professional clinical counselors, independent social workers, and independent marriage and family therapists; independent chemical dependency counselors; certified Ohio behavior analysts; dietitians; optometrists licensed to practice under a therapeutic pharmaceutical agents certificate; pharmacists; chiropractors; respiratory care professionals; and genetic counselors. Previously, these provisions applied only to physicians, physician assistants, and advanced practice registered nurses.

Under the act, a health benefit plan (a policy, contract, certificate, or agreement offered by a health plan issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services) may not impose a cost-sharing requirement for telehealth services that exceeds the cost-sharing requirement for comparable in-person health care services (services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease).

In addition, the act prohibits a health benefit plan from imposing a cost-sharing requirement for a communication when all of the following apply:

- The communication was initiated by the health care professional;
- The patient consented to receive a telehealth service from that provider on any prior occasion;
- The communication is conducted for the purposes of preventive health care services only.

If the communication is coded based on time, then only the time the health care professional spends engaged in the communication is billable. The act specifies that its provisions do not require a health plan issuer to provide coverage for asynchronous communications that differs from the coverage described in the health benefit plan.

The act expressly requires a health plan issuer to reimburse a health care professional for a covered telehealth service, but does not require a specific reimbursement amount.

The act allows the Superintendent of Insurance to adopt rules as necessary to carry out the act's requirements relating to insurance coverage of telehealth services. It exempts these rules from the law requiring an agency to remove two rules for each new rule it adopts.

Under prior law, telemedicine provisions applied to health benefit plans issued, offered, or renewed on or after January 1, 2021. The act instead applies to all health benefit plans in effect as of March 23, 2022, which is the act's effective date, and to any health benefit plan issued, renewed, modified, or amended on or after that date.

Lastly, the act renames the prior law term "telemedicine services" as "telehealth services," but substantively retains the same definition: providing health care services through the use of information and communication technology by a health care professional, within the professional's scope of practice, who is located at a site other than the site where the recipient (either the patient or a consulting health care professional) is located.[1]

Provision of telehealth services by health care professionals

Authorized providers

The act specifies that certain health care professionals may provide their services as telehealth services, subject to several requirements:[2]

- Advanced practice registered nurses;
- Optometrists licensed to practice under a therapeutic pharmaceutical agents certificate;
- Pharmacists;
- Physician assistants;
- Physicians;
- Psychologists and school psychologists, including school psychologists licensed under State Board of Education rules;
- Chiropractors;
- Audiologists and speech-language pathologists;
- Occupational therapists and physical therapists;
- Occupational therapy assistants and physical therapist assistants;
- Professional clinical counselors, independent social workers, and independent marriage and family therapists;
- Independent chemical dependency counselors;

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[1] R.C. 3902.30, 4743.09(A)(6), and Section 5 of the act; R.C. 121.95 and 3922.01, not in the act.

[2] R.C. 4743.09(A)(3); see also R.C. 3319.2212, 4723.94, 4725.35, 4729.285, 4730.60, 4731.741, 4732.33, 4734.60, 4753.20, 4755.90, 4757.50, 4758.80, 4759.20, 4761.30, 4778.30, and 4783.20.

- Certified Ohio behavior analysts;
- Dietitians;
- Respiratory care professionals;
- Genetic counselors.

A licensing board that has jurisdiction over any of these health care professionals must permit them to provide their services as telehealth services. Each board may adopt rules that it considers necessary for implementing the act's provisions as it relates to those services.[3] The rules are exempt from the law requiring an agency to remove two rules for each new rule it adopts.[4]

Any rules adopted by a health care professional licensing board must generally establish a standard of care for telehealth services that is equal to the standard of care for in-person services. The act permits a licensing board to require an initial in-person visit before a health care professional may prescribe a schedule II controlled substance to a new patient. However, a board is prohibited from requiring this initial in-person visit for a new patient if the patient's medical record indicates that the patient (1) is receiving hospice or palliative care, (2) is receiving medication-assisted treatment or other medication for opioid-use disorder, (3) is a patient with a mental health condition, or (4) as determined by the clinical judgment of a health care professional, is in an emergency situation.[5]

The act further provides that beginning on its March 23, 2022, effective date, a health care professional licensing board covered under the act may suspend enforcement of any rules it has in effect regarding the provision of telehealth and in-person services by a health care professional under its jurisdiction, and requirements for prescribing controlled substances, while the board amends or adopts new rules that are consistent with the act.[6]

Conditions for providing telehealth services

The act establishes several conditions regarding providing telehealth services by a health care professional. Each professional may use synchronous or asynchronous technology to provide telehealth services to a patient during an initial visit if the appropriate standard of care for an initial visit is satisfied. Additionally, a professional may use synchronous or asynchronous technology to provide telehealth services during a patient's annual visit if the appropriate standard of care for an annual visit is satisfied. A health care professional also may deny any patient telehealth services and instead require an in-person visit.[7]

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[3] R.C. 4743.09(B)(1).

[4] R.C. 4743.09(B)(1); R.C. 121.95, not in the act.

[5] R.C. 4743.09(B)(2).

[6] Section 6.

[7] R.C. 4743.09(C)(1), (2), and (4).

When a health care professional is providing telehealth services, the act requires the professional to comply with all state and federal laws concerning the protection of patient information. Additionally, a health care professional must ensure that any username or password information and electronic communications transmitted between the professional and a patient are securely transmitted and stored.[8]

The act authorizes a physician, physician assistant, or advanced practice registered nurse to provide telehealth services to a patient located outside Ohio if the health care professional is permitted to do so by the laws of the state where the patient is located. They also may provide telehealth services through the use of medical devices that enable remote monitoring of a patient.[9]

With regard to a pharmacist providing telehealth services, the pharmacist may not use telehealth mechanisms or other virtual means to perform any actions involved in dispensing a dangerous drug, unless specifically authorized under State Board of Pharmacy rules.[10]

The act notes that its provisions do not eliminate or modify any other provisions of the Revised Code that require a health care professional who is not a physician to practice under the supervision of, in collaboration with, in consultation with, or pursuant to the referral of another health care professional.[11]

Immunity from liability

When a patient has consented to receiving telehealth services, the act specifies that a health care professional who provides those services to that patient is not liable in damages under any claim alleging that the services provided do not meet the same standard of care that would apply if the services were provided in-person.[12]

Fees and billing

Under former law, a health care professional (physician, physician assistant, or advanced practice registered nurse) was prohibited from charging a health plan issuer any of the following: a facility fee, an origination fee, or any fee associated with the cost of equipment used to provide telehealth services. The act prohibits any of the health care professionals it covers from charging any of the above-described fees to either a patient or a health plan issuer covering telehealth services. In addition, it clarifies that the prohibition against charging a fee associated with the cost of equipment applies to equipment used at a provider site to provide telehealth services. A health care professional is permitted to charge a health plan issuer for

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[8] R.C. 4743.09(C)(3).

[9] R.C. 4743.09(C)(5).

[10] R.C. 4729.285.

[11] R.C. 4743.09(F).

[12] R.C. 4743.09(D).

durable medical equipment used at a patient or client site, including remote monitoring devices.[13]

Under the act, a health care professional may negotiate with a health plan issuer to establish a reimbursement rate for fees associated with the administrative costs incurred in providing telehealth services. This negotiation may not place any responsibility for this fee on a patient.[14]

The act also specifies that a health care professional must obtain a patient's consent before billing for the cost of the telehealth services provided. The requirement to obtain this consent applies only once.[15]

Legislative intent

The act specifies that it is the intent of the General Assembly to expand access to and investment in telehealth services in congruence with the expansion and investment in telehealth services that was made during the COVID-19 pandemic.[16]

Recommending medical marijuana

The act authorizes a physician to use telehealth services to conduct patient examinations required by continuing law before recommending treatment with medical marijuana. Prior law had required the examinations to be in person.[17]

The act further provides that for purposes of a health care professional licensing board adopting rules requiring a health care professional to conduct an in-person visit of a new patient before prescribing a schedule II controlled substance, as discussed above, medical marijuana is not considered a schedule II controlled substance.[18]

By way of background, Ohio's medical marijuana law authorizes a physician who holds a certificate to recommend medical marijuana from the State Medical Board to recommend treatment with medical marijuana to a patient with a qualifying medical condition. Before recommending treatment with medical marijuana, a physician must establish a bona fide physician-patient relationship with the patient, which means that the physician has examined the patient, reviewed the patient's medical history, and there is an expectation of providing and receiving ongoing care. A recommendation for treatment with medical marijuana is valid for

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[13] R.C. 4743.09(A)(1) and (E)(1). See also R.C. 4723.94 and 4731.2910 (prior versions).

[14] R.C. 4743.09(E)(2).

[15] R.C. 4743.09(E)(3).

[16] R.C. 4743.09(G).

[17] R.C. 4731.30(C)(1)(b)(i) and (D)(2).

[18] R.C. 4743.09(B)(2)(c)(ii).

not more than 90 days and may be renewed for not more than three additional 90-day periods, after which the physician may issue a new recommendation only after examining the patient.[19]

Practice of dentistry

The act specifies that its provisions are not to be interpreted as altering any law related to the practice of dentistry or rule adopted by the State Dental Board in effect on its effective date.[20]

Medicaid coverage of telehealth services

Rulemaking

Continuing law requires the Department of Medicaid to establish, through rulemaking, standards for Medicaid payments for health care services that the Department determines are appropriate to be covered by Medicaid when those services are provided as telehealth services. The act additionally requires the Medicaid Director to adopt rules to authorize the directors of other state agencies that administer portions of the Medicaid program to adopt rules regarding Medicaid coverage of telehealth services. The act exempts these rules from the law requiring an agency to remove two rules for each new rule it adopts.[21]

Eligible providers

For purposes of the Medicaid program, the act provides that the following practitioners are eligible to provide telehealth services, to the extent permitted by the Medicaid Director's rules and federal law:[22]

- All of the health care professionals listed above in the section entitled "**Authorized providers**," except that certified registered nurse anesthetists are not included;
- Supervised practitioners and supervised trainees;
- Audiology aides and speech-language pathology aides;
- Practitioners who provide services through Medicaid school programs;
- Practitioners certified to provide services and supports through a community mental health services provider or a community addiction services provider;
- Any other practitioner considered eligible by the Medicaid Director.

The act also specifies the types of providers eligible to submit a claim for payment under the Medicaid program for providing telehealth services, to the extent permitted by the Medicaid Director's rules and federal law:[23]

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[19] R.C. 4731.30(C) and (D).

[20] R.C. 4715.438.

[21] R.C. 5164.95(B); R.C. 121.95, not in the act.

[22] R.C. 5164.95(C)(1).

- Any of the above-identified practitioners, except for a supervised practitioner or supervised trainee, an audiology aide or speech-language pathology aide, and an occupational therapy assistant or physical therapist assistant;
- A professional medical group;
- A federally qualified health center or federally qualified health center look-alike;
- A rural health clinic;
- An ambulatory health care clinic;
- An outpatient hospital;
- A Medicaid school program;
- A community mental health services provider or community addiction services provider;
- Any other provider type that the Medicaid Director considers eligible to submit a claim.

As a condition of providing telehealth services under the Medicaid program, the act requires a practitioner to comply with all state and federal laws concerning the protection of patient information. Practitioners also must ensure that any username or password information and electronic communications transmitted between a practitioner and a patient are securely transmitted and stored. Every practitioner site must have access to the medical records of a patient at the time that telehealth services are provided.[24]

Certified community mental health, addiction service providers

Requirements for providing telehealth services

The Ohio Department of Mental Health and Addiction Services (OhioMHAS) certifies community mental health service providers and community addiction service providers.[25] The act establishes several requirements that must be satisfied when they provide telehealth services. First, each provider must establish a written policy and procedures to ensure that staff who provide telehealth services are fully trained in using the equipment necessary to provide those services. The act requires providers to establish a contingency plan in the event that technical problems arise while providing telehealth services to a client.[26] Additionally, a mental health facility or unit serving as a client site must have appropriate staff on hand at the facility or unit in the event of an equipment malfunction.[27]

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[23] R.C. 5164.95(C)(2).

[24] R.C. 5164.95(D).

[25] R.C. 5119.36, not in the act.

[26] R.C. 5119.368(B) and (E).

[27] R.C. 5119.368(H).

Before providing telehealth services to a client, the act requires a provider to describe to the client the following potential risks associated with receiving treatment through telehealth: (1) the clinical aspects of receiving treatment through telehealth services, (2) security considerations when receiving treatment through telehealth services, and (3) confidentiality for individual and group counseling. Providers must document that the client has been provided with information regarding these risks and has agreed to assume those risks.[28]

In addition, each provider must maintain information regarding the local or national suicide prevention hotline, as well as the contact information for the local police and fire departments. Each provider must provide clients with information on how to access assistance in a crisis, including a crisis caused by an equipment malfunction or failure.[29]

Under the act, providers have the responsibility to ensure that equipment used to provide telehealth services meets the following standards: (1) confidential communication between provider and client, (2) interactive communication between provider and client, and (3) in the case of telehealth services using synchronous technology, video or audio sufficient to enable real-time communication between provider and client.[30] The act specifies that it is a provider's responsibility to ensure that any entity the provider contracts with that is involved in the transmission of information through telehealth does so in a manner that maintains the confidentiality of client information.[31] Telehealth services that are provided by interactive videoconferencing must (1) begin with the verification of the client through use of a username and password or personal identification number and (2) be provided in accordance with state and federal law. Each provider must comply with all state and federal laws concerning protection of patient information and must ensure that any username or password information and electronic communications transmitted between a provider and a client are securely transmitted and stored.[32]

Rulemaking

The act allows OhioMHAS to adopt rules as necessary to carry out its requirements regarding telehealth services provided by community mental health and addiction services providers. These rules are exempted from the law requiring an agency to remove two rules for each new rule it adopts.[33]

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[28] R.C. 5119.368(C).

[29] R.C. 5119.368(F).

[30] R.C. 5119.368(G).

[31] R.C. 5119.368(D).

[32] R.C. 5119.368(I).

[33] R.C. 5119.368(J); R.C. 121.95, not in the act.

Video-conference visitation in long-term care facilities

The act specifies that during any declared disaster, epidemic, pandemic, public health emergency, or public safety emergency, every long-term care facility must provide each resident and their family with a video-conference visitation option, if the Governor, the Director of Health, another governmental official or entity, or the long-term care facility itself determines that allowing in-person visits at the facility would create a risk to the health of the facility's residents. This requirement applies to the following types of long-term care facilities: (1) a nursing home, assisted living facility, home for the aging, nursing facility, or skilled nursing facility, (2) a residential facility licensed by OhioMHAS, (3) a residential facility licensed by the Ohio Department of Developmental Disabilities, and (4) a facility operated by a hospice care program or any facility in which a hospice care program provides care for hospice patients.[34]

Assistance at health care appointments

The act also specifies that during any declared disaster, epidemic, pandemic, public health emergency, or public safety emergency, any individual with a developmental disability or other permanent disability who needs surgery or another health care procedure, a medical or other health care test, or any clinical care visit must have the opportunity to have at least one parent or legal guardian present during the procedure, test, surgery, or other care visit if the parent or guardian's presence is necessary to help alleviate a negative reaction by the individual. To enforce this provision, the act authorizes the Director of Health to take any action the Director considers necessary.[35]

Medicaid credentialing program

The act requires the Department of Medicaid to establish a credentialing program that includes a credentialing committee. The purpose of the program and the committee is to review the competence, professional conduct, and quality of care provided by Medicaid providers. The act specifies that the activities performed by the credentialing committee are considered activities of a peer review committee of a health care entity and are subject to Ohio law governing those committees, including immunity and confidentiality.[36]

In implementing the credentialing program and committee, the act permits the Medicaid Director to adopt rules. The rules must be consistent with the federal law credentialing requirements that apply to Medicare Advantage organizations.[37]

[34] R.C. 3721.69.

[35] R.C. 3701.1310.

[36] R.C. 5164.291; see also R.C. 2305.25 to 2305.253, not in the act.

[37] See 42 Code of Federal Regulations 422.204.

State Medical Board One-Bite Program

H.B. 145 of the 132nd General Assembly in 2018 required the State Medical Board to establish a confidential program known as the "One-Bite Program" for the treatment of impaired practitioners regulated by the Board.[38] The program allows a practitioner who has not previously participated in the program or been sanctioned by the Board for impairment as a result of drugs, alcohol, or other substances to avoid discipline if specified conditions are met, including completing treatment. Continuing law requires the Board to contract with one organization to conduct the One-Bite Program and perform monitoring services.

In addition to the practitioners authorized by continuing law to participate in the program, the act permits an applicant for licensure as any of the following to participate:[39]

- Physician assistant;
- Physician;
- Podiatrist;
- Limited branch of medicine practitioner;
- Dietitian;
- Anesthesiologist assistant;
- Respiratory care professional;
- Acupuncturist;
- Radiologist assistant;
- Genetic counselor.

Applicants authorized to practice in another jurisdiction

Under the act, two categories of applicants for licensure are eligible to participate in the One-Bite Program: applicants who are authorized to practice in another jurisdiction and applicants who are not authorized to practice in another jurisdiction (see "**New applicants**," below). An applicant for licensure who is authorized to practice in another jurisdiction is not subject to disciplinary action and may participate in the One-Bite Program upon the satisfaction of several specified conditions.

To participate in the program, an applicant authorized to practice in another jurisdiction must disclose to the State Medical Board, as part of the license application process, that impairment occurred while practicing in the jurisdiction where the applicant was authorized to practice. With this disclosure, an applicant must also (1) currently participate in a confidential

[38] H.B. 145 of the 132nd General Assembly. For more information regarding the State Medical Board's One-Bite Program, please consult the H.B. 145 Final Analysis, available here.

[39] R.C. 4731.251(A)(1).

treatment and monitoring program within the other jurisdiction, (2) agree to provide the Board or the monitoring organization operating the One-Bite Program with documentation of the applicant's current participation, and (3) waive any right to confidentiality that would ordinarily prevent the Board and monitoring organization from sharing that documentation with one another.[40]

The applicant must be in good standing with the other jurisdiction's licensing authority and confidential treatment and monitoring program, have not previously participated in the One-Bite Program, and have not been previously sanctioned by the Board for impairment.[41]

New applicants

Similarly, an applicant for licensure who is not authorized to practice in another jurisdiction is not subject to disciplinary action and may participate in the One-Bite Program by satisfying several conditions. To participate in the program, an applicant must disclose to the Board an impairment that occurred prior to the applicant's applying for licensure. Regarding the disclosed impairment, an applicant must (1) have participated in and successfully completed a treatment program, (2) agree to provide the Board or the monitoring organization operating the One-Bite Program with documentation of the applicant's participation and successful completion, and (3) waive any right to confidentiality that would ordinarily prevent the Board and monitoring organization from sharing that documentation with one another. An applicant must have not previously participated in the One-Bite Program or been previously sanctioned by the Board for impairment.[42]

Program requirements

Under the act, the monitoring organization operating the One-Bite Program must evaluate the records provided by an applicant to determine whether the applicant meets the eligibility standards for participating in the program, and promptly notify the Board if the records submitted by an applicant do not meet the program requirements.[43]

When the Board issues a license to an applicant, it must refer the newly licensed practitioner to the monitoring organization to participate in the One-Bite Program. Following this referral, the practitioner must enter into a monitoring agreement with the monitoring organization and the organization must determine the length and terms of the agreement. The practitioner must comply with all terms and conditions of the monitoring agreement and is responsible for all costs associated with participating in the program.[44]

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[40] R.C. 4731.253(B)(1)(a) and (b).

[41] R.C. 4731.253(B)(1)(c), (d), and (e).

[42] R.C. 4731.253(B)(2).

[43] R.C. 4731.253(C).

[44] R.C. 4731.253(D) and (E).

Suspension of open enrollment and other insurance programs

The act extends from January 1, 2022, to January 1, 2026, the suspension of certain program requirements under Ohio's Insurance Law. Section 3 of S.B. 9 of the 130th General Assembly suspended, beginning January 1, 2014, the operation of the following programs:

- Ohio's Open Enrollment Program;
- Ohio's Health Reinsurance Program;
- Option for conversion from a group to individual contract under an existing contract with a health insuring corporation (HIC);
- Option for conversion from a nongroup contract to a contract issued on a direct payment basis under an existing contract with a HIC;
- Option for conversion from a group policy to an individual policy under an existing policy with a sickness and accident insurer.[45]

Under the federal Patient Protection and Affordable Care Act of 2010 (ACA), because of the guaranteed availability of coverage in the individual and group markets, the programs suspended by S.B. 9, and outlined above, appear to be duplicative of the federal programs.[46] If the guaranteed availability of coverage and the requirements related to health insurance coverage under the ACA become ineffective before the suspension expires, the suspended programs outlined above, in either their present form or as they are later amended, again become operational.

HISTORY

Action	Date
Introduced	02-16-21
Reported, H. Insurance	03-25-21
Passed House (93-0)	04-15-21
Reported, S. Health	12-08-21
Passed Senate (33-0)	12-08-21
House concurred in Senate amendments (94-0)	12-09-21

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[45] Sections 3 and 4 (amending Section 3 of S.B. 9 of the 130th General Assembly, as subsequently amended by H.B. 49 of the 132nd General Assembly).

[46] 42 United States Code 300gg-1 and 300gg-6.