PLENARY SESSION I
PUBLIC HEALTH LAW: YEAR IN REVIEW--2012

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Section I: Heath Reform Litigation

A. The ACA Goes to Court: *National Federation of Independent Business v. Sebelius*, 132 S.Ct. 2566 (2012)

1. With Chief Justice Roberts casting the deciding vote, the Supreme Court held that the Affordable Care Act's individual mandate was a constitutional exercise of Congress' taxing authority.
2. Five justices found that the mandate was not constitutional under the Commerce Clause on the theory that Congress can regulate but cannot compel commerce.
3. In the most surprising development, seven justices held that Congress cannot require states to accept the Affordable Care Act's Medicaid expansion, as it would be unduly coercive on the states to withhold all Medicaid funds for states that refuse to expand their program.
4. With Chief Justice Roberts again casting the deciding vote, a five-justice majority concluded that the Medicaid expansion can continue as an option for the states.

B. The Impact of *National Federation of Independent Business v. Sebelius*

1. On health reform: unless the next President and Congress repeal it, ACA implementation will proceed, but due to the Medicaid ruling fewer people may be insured than was originally anticipated.
2. On other public health laws: the majority's Commerce Clause analysis is not likely to have a significant impact on other public health laws, but the Medicaid decision may.
3. Significant litigation can be anticipated to test the reach of the Court's Medicaid decision. Other Spending Clause laws that affect public health may be challenged.

Section II: ACA Implementation and Data Sharing

A. Medicaid Expansion

1. Under the Affordable Care Act federal payments would provide 100 percent of the needed expansion funding from 2014–2016, gradually transitioning to 90 percent of needed funding for 2020 and future years.
2. This arrangement would allow states to increase the number of insured people by an average of 25 percent, with an increased state cost of less than 3 percent.
3. According to the National Governors Association and the National Association of State Budget Officers spring 2012 survey, Medicaid represents the largest portion of total state spending, accounting for an estimated 23 percent of state spending in fiscal year 2011.[i]

4. Regional growth rates for Medicaid expenditures from 2007-2011
    a. *West region growth was almost twice as high as the national rate at 41.7 percent*; the
    b. South rate was just 8.4 percent, and
    c. Midwest and East were slightly less than the national average.
5. In terms of states' views on the fiscal implications of the Medicaid expansion on states' budget planning, GAO survey found that across fiscal years 2012 to 2020, the majority of state budget directors believe that three aspects of Medicaid expansion will contribute to costs: (1) the administration for managing Medicaid enrollment, (2) the acquisition or modification of information technology systems to support Medicaid, and (3) enrolling previously eligible but not enrolled individuals in Medicaid.[ii]
6. After the decision in **National Federation of Independent Business v. Sebelius**, a handful of states are considering only partially expanding their Medicaid programs under the federal health-care overhaul—an added wrinkle on how states are interpreting the Supreme Court's ruling on the law. *Indiana, New Mexico and Wisconsin* are among the states asking the federal government to let them omit from the Medicaid expansion residents whose incomes put them just above the poverty level. The states hope to take advantage of provisions in the Affordable Care Act that offer a federal subsidy to help these residents buy private insurance, starting in 2014.

B. Public Health Reporting Through Health Information Exchanges

1. Health Insurance Exchanges mobilize healthcare information electronically across organizations within a region, community, or hospital system by moving clinical information electronically among different health care information systems.
2. Health Information Technology for Economic and Clinical Health (HITECH) Act promotes the ***meaningful use*** of health information technology to improve the quality of healthcare.
3. The American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111-5) amended Titles XVIII and XIX of the Social Security Act (the Act) to authorize incentive payments to eligible professionals [EPs], eligible hospitals, and Critical Access Hospitals [CAH's], and Medicare Advantage (MA) Organizations to promote the adoption and ***meaningful use*** of Certified Electronic Health Record Technology [CEHRT]. In the July 28, 2010 **Federal Register** (75 FR 44313 through 44588) CMS published a final rule entitled "Medicare and Medicaid Programs; Electronic Health Record Incentive Program," that specified the Stage 1 criteria that EPs, eligible hospitals, and CAHs must meet in order to qualify for an incentive payment, calculation of the incentive payment amounts, and other program participation requirements referred to as the Stage 1 final rule. (75 FR 44316).) In that final rule, CMS also detailed that the Medicare and Medicaid EHR Incentive Programs will consist of 3 different stages of meaningful use requirements.

Stages of Meaningful Use

Stage 1: Meaningful use criteria focus on:	Stage 2: Meaningful use criteria focus on:	Stage 3: Meaningful use criteria focus on:
Electronically capturing health information in a standardized format	More rigorous health information exchange (HIE)	Improving quality, safety, and efficiency, leading to improved health outcomes
Using that information to track key clinical conditions	Increased requirements for e-prescribing and incorporating lab results	Decision support for national high-priority conditions
Communicating that information for care coordination processes	Electronic transmission of patient care summaries across multiple settings	Patient access to self-management tools
Initiating the reporting of clinical quality measures and public health information	More patient-controlled data	Access to comprehensive patient data through patient-centered HIE
Using information to engage patients and their families in their care		Improving population health[iii]

4. HITECH requirements
    a. **Enforcement,** under HITECH, mandatory penalties will be imposed for "willful neglect." Civil penalties for willful neglect are increased under the HITECH Act. These penalties can extend up to $250,000, with repeat/uncorrected violations extending up to $1.5 million. HHS is now required to conduct periodic audits of covered entities and business associates.
    b. **Notification of Breach,** the HITECH Act requires that patients be notified of any unsecured breach. If a breach impacts 500 patients or more then HHS must also be notified. Notification will trigger posting the breaching entity's name on HHS' website. Under certain conditions local media will also need to be notified. Furthermore, notification is triggered whether the unsecured breach occurred externally or internally.
    c. **Electronic Health Record Access, i**n the case where a provider has implemented an EHR system, the Act provides individuals with a right to obtain their PHI in an electronic format (i.e. ePHI). An individual can also designate that a third party be the recipient of the ePHI. The Act provides that only a fee equal to the labor cost can be charged for an electronic request.
    d. **Business Associates and Business Associate Agreements, u**nder the HITECH Act, business associates are now directly required to comply with the safeguards contained in the HIPAA Security Rule (SR).

C. Health Insurance Exchanges [HIX]

1. Under the ACA, each state has the option to develop a health insurance exchange, an organized marketplace for the purchase of health insurance in the small-group and nongroup insurance markets. The ACA also provides considerable state flexibility in exchange development and design. If, a state chooses not to develop its own exchange or is unable to demonstrate its ability to effectively do so, the federal government will operate an exchange in that state.
2. Fifteen states and the District of Columbia have established state-based health insurance exchange marketplaces. Participating states must set up a call center as well as a Web site that allows people to easily find and understand health plans, in much the way that travel websites help people find airline flights. States must declare their plans to the Department of Health and Human Services by Nov. 16, 2012. In addition to the fifteen 15 states that are setting up marketplaces, three states have decided to partner with the federal government in forming the exchanges. Seven [7] have opted to leave the task exclusively to federal authorities. Another Sixteen [16] states have not yet committed to a health insurance exchange strategy, but are continuing planning efforts.[iv]
3. **State Progress in Implementing Health Insurance Exchanges 10 State Analyses also see** State-specific reports on case study states can be found at www.rwjf.org and www.healthpolicycenter.org.[v]
4. In order to establish and begin building a state-based exchange, states need legal **authority** through either a governor's executive order or enacted legislation. Rhode Island, Kentucky and New York are examples of states that used executive orders to establish their exchanges.
5. Secondly, a mode of **governance** must be established for the HIX. The HIX may be a Quasi-public entity established by state law, usually overseen by a governing board appointed by the governor and/or legislature, and which operate with some degree of independence from the state. Or a non-profit organizations completely independent of government agencies and usually governed by a board of directors. Non-profits do not have authority to issue state regulations. New Mexico and Michigan appear to be headed toward the non-profit exchange route if they choose to develop their own exchanges. Finally, the HIX may be a government agency within either an existing or newly established arm of the state's executive or legislative branch.
6. Finally, the State must **design** the HIX. Decisions on essential health benefits and the basic health program are two examples of decisions that states reported delaying due to late or still unavailable guidance from the federal government. Maryland and Oregon have made the most progress on many of the basic design features. For example, California and Washington State will require coverage of acupuncture. Arkansas wants prevention counseling for women at high risk of breast cancer but not coverage of expensive infertility treatment. Oregon opted against covering bariatric surgery for obesity but insurers will have to cover cochlear implants for hearing. These are some of the decisions states have made as they determine what minimum insurance benefits millions of their residents will be entitled to in 2014 under the federal health law. The decisions – which affect people who will buy individual and small group policies -- are being closely watched because they'll determine how comprehensive the plans are and affect how much they cost.

D. APPS and HIPAA

1. On July 21, 2011 the FDA issued for comment Draft Guidance for Industry and Food and Drug Administration Staff; Mobile Medical Applications.[vi]
2. Given the rapid expansion and broad applicability of mobile apps, FDA issued this draft guidance to clarify the types of mobile apps to which FDA intends to apply its authority. At this time, FDA intends to apply its regulatory requirements to a subset of mobile apps that the Agency is calling mobile medical apps. FDA has already cleared a handful of mobile medical apps used by health care professionals, such as a smartphone-based ultrasound and an application for iPhones and iPads that allows doctors to view medical images and X-rays.
3. Submit either electronic or written comments on the draft guidance by October 19, 2011.

Section III: Accreditation and Community Health Needs Assessments

A. Accreditation Roll Out

1. Public Health Accreditation Board (PHAB) launched September 2011
2. Currently 98 health departments moving toward PHAB accreditation
3. PHAB Standards & Measures contain 12 Domains
4. Domain #6 covers Enforce Public Health Laws

B. Accreditation Overlaps w. ACA Nonprofit Hospital Requirements

1. PHAB prerequisites require Community Health Assessment (CHA), Community Health Improvement Plan (CHIP), and Department Strategic Plan (SP)
2. 50% of States already require at least one of these 3 PHAB prerequisites (See http://nnphi.org/CMSuploads/Accred.Pre-req.Laws.pdf)
3. Significant overlap with new ACA requirements for nonprofit hospitals

C. Community Health Needs Assessments: IRS Requirements for Nonprofit Hospitals

1. ACA requires nonprofit hospitals to conduct similar CHA every 3 years
   a. Hospitals must seek input from broad interests of the community
   b. Hospitals must seek input from local health departments
2. Rules on Community Benefit Requirements remain in place

D. Opportunities for Collaboration

1. IRS Guidance allows competing hospitals to collaborate with each other on CHAs
2. Significant opportunity for health departments to collaborate with hospitals

E. Challenges

1. Geographical alignment of health departments and hospitals
2. Creating "backbone organizations" to sustain these collaboration activities
3. Strict deadlines for meeting the IRS requirements
   See https://www.networkforphl.org/_asset/fqmqxr/CHNAFINAL.pdf

Section IV: Tobacco Control and Women's Reproductive Health

A. Tobacco Litigation

1. Under the Family Smoking Prevention and Tobacco Control Act, Pub. L. No. 111-31, 123 Stat. 1776 (2009), the FDA has ordered that all cigarette boxes and advertisements bear graphic labels.
2. In *R. J. Reynolds Tobacco Co. v. FDA,* 2012 U.S. App. LEXIS 17925 (D.C. Cir., Aug. 24, 2012), the U.S. Court of Appeals for the District of Columbia found that the FDA's regulations violated the First Amendment's protection against compelled speech.
3. In another challenge, however, the Sixth Circuit upheld most of the regulations, except those limiting the use of color in advertisements. *Discount Tobacco City & Lottery, Inc., v. U.S.*, 674 F.3d 509 (6th Cir. 2012).
4. Local tobacco control laws have also been challenged in court. E.g., *23-34 94th St. Grocery Corp. v. New York City Bd. of Health,* 685 F.3d 174 (2d Cir. 2012)(holding that a city advertising control was pre-empted by the federal act).

B. Women's Reproductive Health

1. DHHS regulation requires health insurance plans to cover contraceptives. Compromise requires that coverage be paid for by insurers, rather than employers with religious objections.
2. At least 24 lawsuits have been filed. In *Newland v. Sebelius,* 2012 WL 3069154 (D. Colo. July 27, 2012) the court issued a preliminary injunction against the regulation finding that the challengers were likely to prevail on their Religious Freedom Restoration Act claim. In *O'Brien v. HHS*, 2012 U.S. Dist. LEXIS 140097 (E.D. Mo. Sept. 28, 2012), the court dismissed claims under the Religious Freedom Restoration Act and the First Amendment.
3. HHS Sec. Sebelius overruled an FDA decision to allow girls 16 and younger to access the morning after pill without a prescription.
4. The state of Texas banned state funding of Planned Parenthood. In *Planned Parenthood Ass'n of Hidalgo Texas, Inc. v. Suehs,* No. 12-50377, 2012 WL 3573642 (5th Cir. Aug. 21, 2012) the court vacated an injunction, allowing the ban to go forward.
5. Abortion: numerous states continued to pass laws regulating abortion. Several states now require a woman to have an ultra-sound before having an abortion.
6. In *McCormack v. Hiedeman,* 2012 U.S. App. LEXIS 19051 (9th Cir. Sept. 12, 2012), the court held that Idaho could not prosecute a woman who purchased over the internet medication that could cause an abortion if she used the medication.

Section V: Public Health and Environmental Concerns

A. Fracking

1. At least 125 bills in 19 states have been considered this past legislative sessions that specifically address hydraulic fracturing.
2. Prominent trends include 9 states that have proposed chemical disclosure requirements, 8 states have proposed casing integrity, well spacing, setback, water withdrawal, flow back, or waste regulation requirements, or other measures to protect water resources, 11 states have

proposed legislation to impose new or amend existing severance taxes and 8 states have proposed hydraulic fracturing suspensions, moratoria or studies to investigate potential impacts of fracking.

3. The Bureau of Land Management (BLM) is proposing a rule to regulate hydraulic fracturing on public land and Indian land. The rule would (1) provide disclosure to the public of chemicals used in hydraulic fracturing on public land and Indian land, (2) strengthen regulations related to well-bore integrity, and (3) address issues related to flow back water. This rule is necessary to provide useful information to the public and to assure that hydraulic fracturing is conducted in a way that adequately protects the environment.[vii]
4. Fracking cases include West Virginia: In 2011, the City of Morgantown, WV, preempted from invoking an ordinance prohibiting fracking within the City boundaries and within a one-mile radius around the City.[viii] New York: There have been two decisions in trial courts in New York upholding local ordinances regulating fracking, finding no preemption.[ix] Maryland: Executive Order imposes ban on fracking that will last until at least 2014[x]: Ohio: There are a handful of local laws resulting in a prohibition on fracking in certain jurisdictions in Ohio. There is an open question as to whether there is preemption in Ohio.
5. Disclosure Law in Pennsylvania - Trade Secrets. PA law requires disclosure but protects certain information as trade secret. Doctors with a need for access to the trade secret information to diagnose/treat a patient are entitled to access but subject to a confidentiality agreement. Physician in PA filed a lawsuit.

B. States: Emergency Declarations and Preparedness Issues

1. Louisiana: Statewide public health emergency in effect until Oct. 3. In addition to Louisiana's public health emergency declaration Alabama, Florida, and Mississippi have declared public health emergencies in response to Hurricane Isaac, which struck the Gulf of Mexico in late August, 2012.
2. A Presidential State of Emergency was also declared for both Louisiana and Mississippi.
3. Community Emergency Response Team (CERT) Liability Guide.[xi]
4. Identifying Vulnerable Older Adults and Legal Options for Increasing Their Protection During All-Hazards Emergencies.[xii]
5. Social Distancing Law Project. With the support of Oregon's Public Health Preparedness Program, Shannon O'Fallon, Senior Assistant Attorney General for the Oregon Department of Justice collaborated with Josephine County, Oregon on a model memorandum of understanding (MOU). The MOU established the roles and responsibilities of public health officials and law enforcement in enforcing public health laws. The Law Enforcement-Public Health MOU was part of the Social Distancing Law Project, which was sponsored by the CDC and directed by the Association of State and Territorial Health Officials.

Section VI: Restructuring of State and Local Health Departments

A. The Current Setting

1. NACCHO data shows many LHDs remain in economic crisis mode http://www.healthreformgps.org/wp-content/uploads/Research-Brief-Final1.pdf
2. IOM Report (2011) on Revitalizing PH Law and Policy emphasized role of law in establishing structure, function, and authority of government public health agencies http://www.iom.edu/Reports/2011/For-the-Publics-Health-Revitalizing-Law-and-Policy-to-Meet-New-Challenges.aspx

B. 1st Dimension of Restructuring: Traditional LHD Governance/Organization Options

1. Cross Jurisdictional Sharing Arrangements
2. Merging of LHDs and other agencies into consolidated human service agencies
3. Changing or eliminating boards of health
4. Creation of quasi-independent public health authorities
5. Outsourcing of services to contractors; e.g., Detroit city health department conversion to nonprofit institute

C. 2nd Dimension of Restructuring: Movement Towards Outcome-Based Health Care & Billing Arrangements

1. Collaborations with Federally Qualified Health Centers
2. Collaborations with hospitals
3. Alignment with new ACA entities
4. Adding or removing clinical care

D. Areas of Legal Assistance and Training Related to Restructuring

1. Health care information/electronic data sharing issues
2. Delegation of governmental "police power" functions to contractors
3. Compliance with health care service reimbursement rules
4. Affordable Care Act implications for LHDs
5. Creation of "backbone organizations" to sustain new collaborative efforts. See "collective impact theory" at http://www.ssireview.org/blog/entry/channeling_change_making_collective_impact_work

Section VII. Injuries and Drugs

A. Concussions and Sports

1. Thirty-two states have laws addressing student-athlete concussions and several others could eventually follow suit, according to the National Conference of State Legislatures.
2. Most legislation requires an athlete to leave competition or practice when a concussion is suspected, returning to play only when a doctor or other medical expert consents. Most also require school athletic officials to educate coaches, athletes and parents about concussion.[xiii]

3. The Concussion Awareness Act was approved during the 2011 Nebraska legislative session. Education Under any reasonable suspicion of concussion, coaches will remove youth athletes from play. Youth athletes will not be allowed to return to play, including games, scrimmages and practices of any kind, until written approval from an appropriate licensed healthcare professional AND the youth's parent or guardian is obtained.

B. Distracted Driving

1. In the month of June 2011, more than 196 billion text messages were sent or received in the US, up nearly 50% from June 2009. Sending or receiving a text takes a driver's eyes from the road for an average of 4.6 seconds, the equivalent-at 55 mph-of driving the length of an entire football field, blind.[xiv]
2. 39 states, the District of Columbia, and Guam ban text messaging for all drivers. Twelve of these laws were enacted in 2010 alone. 10 states, the District of Columbia, and the Virgin Islands prohibit all drivers from using handheld cell phones while driving.[xv]

C. Synthetic Drugs

1. State legislatures are outlawing two classes of synthetic drugs: synthetic cannabinoids (a.k.a. "Spice" or "K2") and substituted cathinones (a.k.a. "bath salts"). At least 44 states have already banned one or both of these substances. Legislation in 2009 and 2010 targeted specific versions of the drugs. [xvi]
2. However, minor changes to the chemical make-up of these substances can create new but very similar drugs not covered in the law. In response, 2011 and 2012 legislation targets entire classes of substances and aims to prevent new formulations of synthetic drugs from remaining unregulated, while still allowing the substances for approved medical and research purposes.
3. On July 9, 2012, the federal Synthetic Drug Abuse Prevention Act of 2012 was signed into law. The law adds certain classes of synthetic cannabinoids and two substituted cathinones-—mephedrone and MDPV—to the federal controlled substances act.[xvii]

Section VIII. Obesity and HIV

A. HIV

1. With the lifting of the travel ban, the international AIDS conference was held in Washington, D.C.
2. With studies showing that early treatment can improve clinical outcomes and reduce transmission, treatment is now seen as a form of HIV prevention: The US revised its guidelines to recommend treatment for everyone who is HIV positive.
3. In July 2012, the FDA approved first medication for pre-exposure prophylaxis
4. In July 2012, the FDA also approved first HIV test for home use.
5. Changing state laws. Massachusetts and Pennsylvania ended the requirement for written informed consent. Kansas now requires screening of pregnant women, with an opt-out provision. California expanded access to syringes. Illinois amended its statute criminalizing HIV transmission to apply only to unsafe sex.

B. Obesity

1. NYC amended NYC Health Code Art. 81, §81.53 to ban the sale of sugary drinks more than 16 ounces by food service establishments.
2. FDA's menu labeling regulation promulgated pursuant to the ACA is anticipated in fall 2012. Although the ACA's menu labeling requirement has been in effect since 2010, the FDA has said it will not be enforced until a final regulation is issued.
3. More lawsuits are being filed against food companies for deceptive labeling. Some courts have found state laws preempted by the Nutrition and Education Labeling Act of 1990. *E.g., Turek v. General Mills, Inc.*, 662 F.3d 423 (7th Cir. 2011); *Yumul v. Smart Balance, Inc.*, 2011 WL 1045555 (C.D. Cal. Mar. 14, 2011).
4. Richmond and El Monte, California to vote on soda taxes in November

Section IX: Advocacy, Lobbying & Section 503 Appropriations Restrictions

A. Continuing General Trend of Courts to Protect "Free Speech"

1. *Sorrell v. IMS Health,* 131 S. Ct. 2653 (2011) Struck down Vermont's law barring the sale or use of doctors' prescription histories for commercial pharmaceutical marketing purposes
2. *Brown v. Entertainment Merchants Assn.,* 131 S. Ct. 2729 (2011) Invalidated California law prohibiting sale or rental of violent video games to minors

B. New Limitations Enacted on Use of Federal Funds for Advocacy & Lobbying

1. New "Section 503" restrictions are contained in December 20, 2011 Consolidated Appropriations Act, 2012, Section 503, Division F.
2. Historically, from 1982 - 2011 the federal anti-lobbying rules were clear and well understood: In general federal funds were not to be used to:
    a. Directly lobby a legislator about a specific piece of pending legislation, or
    b. Support "grassroots" efforts urging the public to contact their legislature regarding specific pending legislation

C. The New Section 503 Limitations Created Confusion

1. These new provisions blurred the previously clear distinctions between permitted advocacy and illegal lobbying activity.
2. The statutory language is extremely difficult to understand
3. Extensive confusion existed in the first half of 2012

D. Parallel Developments Challenging Public Health Advocacy

1. 2010-1012: Congressional concerns were raised to HHS about advocacy language contained in certain CDC Community Transformation Grants (CTG) and Communities Putting Prevention to Work (CPPW) grants
2. February 2012: Letters to various health departments from Cause of Action alleging violations of law in public health advocacy programs
3. June 2012: HHS OIG "Early Alert" letter sent to CDC regarding these issues

E. CDC Provided Helpful Clarification of New Section 503 Provisions in July 2012

1. These limitations apply only to the use of federal funds
2. The previous prohibitions now apply not only to lobbying of legislatures, but also to lobbying with respect to executive branch actions as well.
3. In general, the new Section 503 restrictions still permit:
   a. Normal executive-legislative communications of health departments
   b. The fostering of coalition-building on public health activities
   c. Educating the public on personal health behaviors and choices
4. However, public educational campaigns must be "balanced" in explaining the advantages & disadvantages of public policies. See generally the July 2012 CDC guidelines at http://www.cdc.gov/obesity/downloads/Anti-Lobbying-Restrictions-for-CDC-Grantees-July2012-508.pdf

F. Closing Thoughts on Public Health Advocacy & Lobbying

1. While some of the phrases in the new Section 503 language refer directly or indirectly to gun control or tobacco topics, the recent Congressional and special interest challenges focus on public health obesity prevention activities.
2. Despite the fact that the general trends are moving in the direction of fewer restraints on free speech, public health is facing more restrictions when engaging in public policy discussions. http://www.medpagetoday.com/PublicHealthPolicy/Washington-Watch/35031

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[i] National Governors Association and the National Association of State Budget Officers, *The Fiscal Survey of States* (Washington, D.C.: Spring 2012).

[ii] GAO-12-821 Medicaid Expansion; States' Implementation of the Patient Protection and Affordable Care Act August 2012

[iii] http://www.healthit.gov/providers-professionals/how-attain-meaningful-use

[iv] http://www.kff.org/healthreform/upload/8213-2.pdf

[v] ACA Implementation—Monitoring and Tracking: Cross-Cutting Issues http://www.healthreformgps.org/wp-content/uploads/74827.stateprogress090712.pdf

[vi] http://www.fda.gov/medicaldevices/deviceregulationandguidance/guidancedocuments/ucm263280.htm

[vii] http://www.doi.gov/news/pressreleases/loader.cfm?csModule=security/getfile&pageid=29391

[viii] http://www.frackinginsider.com/Tucker_Marcellus_Order.pdf

[ix] http://ecowatch.org/wp-content/uploads/2012/02/dryden.pdf

[x] http://www.governor.maryland.gov/executiveorders/01.01.2011.11.pdf

[xi] http://www.citizencorps.gov/cert/downloads/pdf/CERT_Liability_Guide.pdf

[xii] http://www.cdc.gov/aging/emergency/pdf/guide.pdf

[xiii] https://www.networkforphl.org/_asset/7xwh09/StateLawsTableConcussionsFINAL.pdf

[xiv] http://www.distraction.gov/content/get-the-facts/state-laws.html

[xv] http://www.ncsl.org/issues-research/transport/cellular-phone-use-and-texting-while-driving-laws.aspx

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