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Who Stands to Benefit? Right to Try Law Provisions and Implications

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Abstract

As of late November 2016, 32 states had adopted right to try laws. These laws are intended to allow terminally ill patients pre-approval, or "compassionate," access to drugs, devices, or biologics that are in development and have not yet been approved by the United States Food and Drug Administration (FDA). While the laws' intentions and their impact have been examined, little has been written about variations among the state laws. An examination of the specific provisions in and differences among the 32 statutes, and who stands to gain from them, suggests that the benefits of right to try laws are largely rhetorical. So, although the laws have been heralded as pro-patient, they ought to be understood as merely masquerading as patient-centric legislation. We call for a re-examination and amendment or, ideally, repeal of these laws in order to prevent the very real risk of patient harm caused by both some of the laws' provisions and patients' confusion arising from these misleading statutes.

Keywords

right to try; right to try law; compassionate use; expanded access; FDA; ethics

Introduction

The FDA has a process in place for patient use of experimental products outside of clinical trials. Its Expanded Access Program,[1] established in 1987, is a set of policies created to allow terminally and seriously ill people, both individually and in larger groups, to gain access to investigational products before they have been approved by the agency. Over the years there have been critics of expanded access, most recently the Goldwater Institute, a 501(c)3 organization that strives for "constitutionally limited government."[2] In 2014 the institute launched the "right to try" movement, through which terminally ill patients can access investigational medical products without FDA oversight. It drafted a model bill[3] and actively promoted it to state legislators, patient groups, and audiences sympathetic to the plight of terminally ill patients and/or the idea of individual liberty trumping governmental power. The institute's president wrote a popular-press book that uses patient vignettes to argue that right to try legislation is needed to speed up the process of providing investigational medical products to dying patients who are ill-served by the FDA expanded access process.[4] The increase in speed would come from abandoning the current requirement that the FDA authorize all uses of investigational medical products within the US. According to right to try advocates, it takes 100 hours on average for a physician to complete the FDA form for compassionate use. Then there is the time spent waiting for the FDA to evaluate and respond to the request. Thus, the logic behind right to try laws is that they would remove the FDA from the approval process, thereby shortening the amount of time it takes to get the drugs to the patients who wish to try them.

The first law was signed in Colorado in May 2014, and as of late November 2016, 32 states had enacted right to try laws, with extremely limited opposition. A California bill was vetoed by the state's governor in October 2015, but a reintroduced bill was enacted in September 2016. Hawaii's governor vetoed his state's right to try legislation in April 2016. Aside from these anomalies, each of the 32 bills was sent to its respective governor with near majority support from both parties; 4 states have bills pending. While these laws' intentions and impact have been examined, very little has been written about how the laws differ from state to state and who stands to benefit from these variations (aside from Vulcano's detailed analysis when there were just 11 such laws[5]). Although the vast majority of state right to try laws echo the model bill's language, no two are the same. Spotlighting the laws' specifics and whom these provisions benefit ultimately shows that the legislation's benefits for patients are largely rhetorical. Although right to try laws have been heralded as patient-centric legislation, they may, sadly, be best understood as legislation that offers little to patients and may, in fact, harm them. Widespread

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amendment of the laws would be necessary to refocus them on the welfare of patients. The task is so daunting that repeal may be the preferable course of action.

Right to Try Laws: Commonalities

State right to try laws all show the hallmarks of the Goldwater Institute's model legislation. Every law[i] but one echoes the model in setting completion of the first phase of clinical testing as the required point at which an investigational product (drug, biologic, device) can be requested by a terminally ill person. Almost all of the state laws require the product to be in active clinical trials; likewise, almost all of the laws stipulate that patients must have considered all other treatment options before requesting access to an experimental product. All states specify that physicians may not be disciplined for recommending or prescribing an unapproved product and that terminally ill patients may try such products after providing written informed consent. A vast majority of states have provisions for parents or guardians to give consent for minor patients. All laws but one contain language warning patients that they may incur costs when obtaining products under right to try. Likewise, almost all of the laws explicitly state that insurers are not required to pay costs associated with the product.

Of special note, the vast majority of these laws state that a company developing a medical product may make its product available to patients but is not required to do so. This lack of obligation to provide investigational medical products upon request underlies the charge, made by critics of these laws, that the legislation offers patients false hope rather than any new "right,"[6] in any sense of the word. In fact, in 2007, the US Court of Appeals for the District of Columbia Circuit ruled that patients have no constitutional right to unapproved drugs.[7]

Variations Among Right to Try Laws: Scope

While right to try laws are commonly assumed to deal only with terminally ill patients, there is disagreement about what constitutes "terminally ill," as shown in Table 1. Illinois requires a prognosis of death within 24 months, while Connecticut, Florida, and Nevada set the bar at 12 months and Oregon at 6 months. Arizona, Georgia, Louisiana, Mississippi, Missouri, and New Hampshire require a prognosis of death in the "near future," whereas in California it must be within "a matter of months." Arkansas stipulates that it occur in a "relatively short amount of time," Virginia that death be "imminent," and Utah that the terminal illness would "inevitably lead to the patient's death."

This conceptual fuzziness reflects the difficulty of predicting the prognoses of individual patients; however, the range, from imminent to two years, is also problematic on practical grounds. Having differing definitions of who qualifies as terminally ill (and thus who would be obtaining an experimental agent under the auspices of right to try) could sow confusion in patients as they seek one last chance to save their lives. For instance, a patient with a prognosis of a year to live who resides in a state that requires death to be imminent may spend precious time searching for a state better suited to his prognosis. And patient advocacy and support organizations will have to remain up-to-date on the variety of stipulations and restrictions if they are to be able to help patients who contact them from around the country.

Table 1. Variations in Definitions of "Terminally Ill" in Right to Try Laws.

Death expected to occur:	
Within 6 mo	OR
Within 12 mo	CT, FL, NV
Within 24 mo	IL
In "near future"	AZ, GA, LA, MS, MO, NH
Within "a matter of months"	CA
In "relatively short amount of time"	AR
Death is "imminent"	VA
Law also applies to:	
Those in permanent state of unconsciousness from which recovery is unlikely	AZ, CO, LA, ME, MS, MO, NH, ND, OK, TX, WV, WY
Those in persistent vegetative state	VA

In addition to discrepancies concerning when someone must be expected to die in order to be considered terminally ill, some states' laws apply to additional categories of persons. For example, in 12 states (Arizona, Colorado, Louisiana, Maine, Mississippi, Missouri, New Hampshire, North Dakota, Oklahoma, Texas, West Virginia, and Wyoming), the laws pertain to both those with a terminal illness and those with a disease or disability that will soon "result in . . . a state of permanent unconsciousness from which recovery is unlikely." The Michigan, South Dakota, and Tennessee laws use "advanced" illness instead of "terminal"; Virginia's law applies to the terminally ill and those in a persistent vegetative state and California's to those with an "immediately life-threatening disease."

Further muddying the waters when it comes to putting right to try laws into practice are discrepancies in who is authorized to deem a patient terminally ill. Most laws permit the patient's treating health care provider to make this determination. Florida and Louisiana require a terminal diagnosis to be confirmed by an independent evaluation conducted by a physician who is board-certified in an appropriate specialty for the patient's condition. Similarly, Virginia requires a second, independent examination by a physician not previously involved in the treatment of the patient in question, while California, New Hampshire, and Oregon physicians must have their diagnoses confirmed by a consulting physician. The requirement of a second opinion, though generally commendable as a precaution against a physician who, for whatever reason, is not acting in the best interest of her patient in certifying the patient as eligible to seek a product under right to try, may lead to problems for patients in rural states where no other, qualified specialist practices. Requiring patients to cross state lines for second opinions, appropriate specialist care, or access to an

Table 2. Puzzling Variations Among Right to Try Laws.

Primary care provider not allowed to request investigational product	AZ
Law does not apply to children 18 and younger	OR
Law does not apply to inpatients	CT, ND, OK, WV

Table 3. Ethically Troubling Stipulations of Some Right to Try Laws.

Investigational product must have completed only phase 1 testing	AL, AZ, AR, CA, CO, CT, FL, GA, ID, IL, IN, LA, ME, MI, MN, MS, MO, MT, NV, NC, NH, ND, OK, SC, SD, TN, TX, UT, VA, WV, WY
Patients may lose hospice coverage	AL, CA, CO, CT, FL, GA, ID, MI, MS, MT, NC, ND, SC, SD, TN, WV
Patients may be denied home health care coverage	CA, CO, CT, ND, OK, WV
Patients may lose health insurance; coverage can be denied for 6 mo after treatment ends	CO, CT, OK, WV
Insurers can deny coverage for treatment of harm caused by investigational product	UT

investigational medical product may easily create confusion about which law is in effect for a particular patient when each state has its own law with its own quirks. It would also disproportionately burden those who lack access to quality health care, the freedom and resources to travel, and access to transportation.

A number of states restrict eligibility for right to try. For example, Oregon's law does not apply to children under 18 years of age. While Arizona's law does not specify exclusion of any particular population of terminally ill patients, it does require that the patient's primary care provider not be the one to request the investigational medicine. Thus, the primary care provider may be able to declare a patient terminally ill, but the process of seeking an investigational agent (and presumably of administering it to the patient) would have to be overseen by a different physician. And, in one of the more puzzling stipulations (Table 2), the laws of Connecticut, North Dakota, Oklahoma, and West Virginia don't allow terminally ill inpatients to receive experimental products.

Arkansas, Connecticut, Colorado, North Dakota, Oklahoma, and West Virginia all restrict eligibility to patients who are either unable to participate in a clinical trial within 100 miles of their homes or who have not been accepted into a trial within a week of completing the trial's application process. California also has the 1-week restriction, but the law applies to the "nearest clinical trial" to the patient's home. Maine's law includes only the "accepted into a trial" stipulation, while Mississippi and Missouri require patients to have considered "all relevant clinical trials conducted" in their respective states. Unlike the restrictions on hospital inpatients, which seem to make little medical or ethical sense, limiting the right to try to those patients for whom clinical trial enrollment is impossible or impractical is laudable. A major criticism of the right to try effort is that it could divert patients away from clinical trials, a consequence that would slow the testing of investigational drugs and could threaten eventual approval of new treatments for all in need.[8] Restricting right to try to those for whom clinical trial participation is not a realistic option would significantly blunt this threat. Likewise, it would reassure pharmaceutical companies, health care providers, and patient advocates that the drug development system set up to benefit patient populations would not be sacrificed in an effort to rescue a small number of sick patients.

Special Ethical Issues Raised by Some Laws

The prospect of imminent death may skew one's ability to weigh the risks and benefits associated with potential therapies. Thus, for those who are terminally ill and seeking access to an experimental product, truly informed consent is challenging. Thirty-one states require that a product need only have completed phase 1 of the clinical trials process. Informed consent for patients in these states, then, will be all the more difficult because of the limited data on safety and virtually none on efficacy for them and their physicians to evaluate.[9] Nodding to such concerns, Missouri's and Mississippi's laws require consent forms for products obtained via right to try to be as comprehensive as those used in the clinical trials of the agent, a commendable ethical provision.

The quality of informed consent is not the only, or even the direst, ethical issue raised by these laws. Given that they deal predominantly with terminally ill patients, it is shocking that 16 laws state that patients, upon beginning treatment with an experimental therapy, may become ineligible for hospice care,[ii] and 6 warn that home health care may be denied to patients in this context.[iii] Further, 4 states—Colorado, Connecticut, Oklahoma, and West Virginia—warn that patients undergoing treatment with an experimental therapy obtained under right to try may lose health insurance, and that coverage can be denied for as long as 6 months after the experimental treatment ends. Utah allows insurers to deny coverage for treatment for harm caused by use of the investigational product, and Nevada warns that "future benefits" may be affected by a patient's use of an investigational product. Table 3 highlights especially troubling provisions of some right to try laws.

It is morally reprehensible to threaten terminally ill individuals with loss of their health insurance, home health care benefits, and/or hospice care. In the US, terminal patients can legally seek access to investigational products outside of clinical trials (indeed, the entire point of right to try is to make this quest faster and easier), so there is no basis for subjecting these patients to harsh consequences for their choice to try to live longer. On a practical level, these stipulations pose potentially absurd situations: imagine discharging a dying patient from hospice to another facility that can both maintain the patient and give her the desired experimental treatment while, at the

Table 4. Unique Provisions of Right to Try Laws.

Patients suspected of having psychological or psychiatric disorder causing impaired judgment must be referred for treatment	OR
Hospice eligibility determined solely by prognosis/treatment goals	OR
1 of 2 required consent witnesses cannot be entitled to portion of patient's estate	OR
Must file records documenting adverse events and positive outcomes, cost of treatment, patient demographics	OR
Investigational product must be in at least phase 2 testing	OR
Manufacturers cannot charge for treatment	TX

same time, her health insurance is canceled; or discharging her from hospice to home, in a state that excludes right to try coverage to inpatients, but then denying coverage for a home health aide. Since the benefits of these provisions do not accrue to the patient, it stands to reason that the benefactor is the insurer.

Truly Patient-Centric Provisions Overshadowed by Central Flaws in Right to Try Laws

Oregon's right to try law is unique in its comprehensiveness, detail, and focus on patients, as seen in Table 4. It is the only state that requires physicians to refer for treatment patients whose judgment they suspect may be impaired by a psychological or psychiatric disorder. The statute requires physicians to inform patients that the investigational product they seek may be available to them under the Code of Federal Regulations, and it bars one of the two required witnesses to the consent discussion from being entitled to any portion of the patient's estate. Oregon is also alone in stipulating that hospice eligibility be determined solely by a patient's prognosis and treatment goals, not by whether the patient is receiving, or has received, a drug via right to try.

Furthermore, Oregon requires physicians administering unapproved products to file records documenting both adverse events and positive outcomes, the cost of treatment, and patient demographics and has provisions to make the data publicly available. Such information could help patients and physicians assess benefits and risks when deciding whether to try an experimental medical product, and it would alert legislators to positive or negative consequences of the law. Finally, it is the only state to require that the investigational medical product be in at least phase 2 of clinical testing.

The Texas law has a provision that bars manufacturers from charging patients for investigational products (Table 4). While limiting a patient's cost would certainly be a benefit to the patient, this provision is interesting in that it is stricter than FDA regulations, which permit drug makers to charge patients for unapproved drugs, albeit with restrictions.[10] However, regardless of whether state or federal law governs, it is highly unlikely that a patient would be expected to pay for the product being sought. Companies often do not charge for such drugs, both out of concern for appearing heartless or mercenary and because putting a price on such drugs would make information about the cost of manufacturing the product publicly available—information that companies have a vested interest in keeping confidential. Thus, the Texas law's stipulation that a drug obtained under right to try must be given free of charge would provide little actual benefit to patients. That said, it is a rare example of a truly patient-centered provision in these laws.

Equally important, this highlights a legal question about the state right to try laws, which is whether they are preempted by federal regulation in this area. While commenters have opined that federal law preempts these state attempts to govern access to investigational medical products,[11] there can be no true resolution of the matter outside of the courts, unless federal law is changed. Right to try advocates are trying to do just this, having introduced to date two federal right to try bills.[12] However, until this question is settled, the legality of right to try legislation is suspect, conferring even more uncertainty and confusion on an area already replete with misunderstanding.

Another reality that right to try laws do not address is that even if a law allowed patients to receive investigational products for free, they would still be responsible for associated medical expenses or travel and lodging costs incurred in the administration of the treatment. They may also have to pay for child or elder care or other expenses. These costs can be considerable or prohibitive, but they are not mentioned in any right to try legislation. A supporter of Utah's right to try law addressed this shortcoming by creating the private Right to Try Foundation, which was set up to help patients in the state with annual household incomes below $75,000 to cover costs associated with procuring and using experimental medicines.[13] This philanthropy would offer a possible partial solution for Utah residents, but patients in other states must find their own ways to manage the ancillary expenses involved with accessing products through right to try laws. Patients must be made explicitly aware of these potential costs, both in discussions with their providers and in the consent document, if consent is to be considered truly informed.

The Laws' Beneficiaries

Although right to try laws are touted as benefiting patients, they do not give patients the right to try experimental drugs. The laws are very clear that they do not require manufacturers to provide the product being requested. Products in development are the exclusive property of the companies developing them, and only the companies have the authority to decide whether to provide their property to those asking for it. (The laws do give patients the right to try to convince companies to grant them access to drugs in development; however, patients already have this "right" under FDA rules that have been in effect for decades.) Thus, the legislation's promise of access to experimental drugs serves merely as a "feel-good" rhetorical device that in actuality gives patients nothing while protecting

companies' assets and development plans. Along these lines, Louisiana's governor signed HB 232 last June to "improve" the state's existing right to try law, not by adding patient protections but by providing "additional legal protections for manufacturers and healthcare workers."[14] Unfortunately, patients seem to believe the rhetoric that these laws are for their benefit, a very ethically troubling aspect of the legislation, given that, to date, there have been no substantiated cases of a patient receiving an investigational product because of a right to try law, although there have been instances of patients not receiving drugs they had hoped for under the legislation.[15]

Health care providers gain a specific, important benefit from right to try laws: liability protection. According to the model law, "A licensing board or disciplinary subcommittee shall not revoke, fail to renew, suspend, or take any action against a health care provider's license . . . based solely on the health care provider's recommendations to an eligible patient regarding access to or treatment with an investigational drug, biological product, or device,"[iv] and every law includes language mirroring this or to the same effect. However, the impact of this provision is muted by the fact that we are unaware of any instances in which a health care provider was sued for suggesting that a patient who had no other options try an investigational product.

As seen above, no state requires insurers to pay for right to try access to an investigational product, and a few states allow insurers to deny patient coverage altogether, which is particularly significant given the expense of end-of-life care. Other benefits to insurers are not having to cover hospice care and/or home health care in some states.

The clearest benefit that right to try laws offer patients may well be the increased awareness of the possibility that investigational medical products may be procured outside of clinical trials and before they come to market, through the FDA's Expanded Access Program. For individual patients, this may be a highly important benefit. However, as a matter of policy, it must be asked whether a similar or even higher level of awareness of the option of accessing investigational drugs outside of clinical trials could have been achieved by means of an educational campaign directed at patients and/or health care providers. If increased awareness is the sole benefit accrued to patients, is that sufficient to justify the costs of the right to try movement—the costs of lobbying and legislative efforts and that of creating legal uncertainty between federal regulation and state legislation, which, of course, has implications for those patients and health care providers who are trying to navigate the process of requesting access?

Conclusion

Advocates of right to try legislation say the laws offer terminally ill patients a better chance at accessing investigational products than they have currently through clinical trials or the FDA's program. This claim is highly implausible, given that the laws do not require manufacturers to provide investigational products to those requesting them. In the more than two and a half years since the first law was signed, there have been no documented cases of anyone receiving access, because of a right to try law, to an experimental product that would not have been available via the FDA's Expanded Access Program. As mentioned, if tested in court, state right to try laws could be preempted by federal regulations under the Supremacy Clause of the US Constitution, which holds that state laws generally cannot supersede federal legislation.[16]

Even if the laws were to work as intended, they would still merit re-review and thorough scrutiny. Their liability protections and assurances pertain to doctors, companies developing medical products, and insurance providers, not patients. They do offer educational benefit in that they may have alerted some patients and doctors to the existence of expanded access programs. And certain of the laws appear to have patient welfare in mind—specifically, Oregon's, with its stipulation that patients cannot be denied hospice care as a result of trying an experimental product, and the Texas law, with its provision that patients cannot be charged for investigational medical products. At the same time, unfortunately, most right to try laws strip away patient benefits such as insurance, hospice, or home health care coverage.

After analyzing the laws' provisions, it is clear that these laws masquerade as patient-friendly legislation while doing very little for patients. Indeed, we fear that the laws are more likely to subject patients to possible harm in other ways than to offer benefit, such as in the case of a quack taking advantage of the laws to sell unexamined, potentially dangerous nostrums to desperate patients. Completion of a phase 1 trial is too low a bar at which to allow investigational medical products to reach patients outside of clinical trials without the sort of individualized review offered by FDA oversight, and the requirement that the product be under ongoing study is virtually meaningless for anyone determined to exploit desperate patients. Notably, the laws do not require that the physician overseeing the experimental attempt have specific training in the experimental treatment's administration, manufacture, or action or in how to address treatment-related adverse events. The laws do not even require that such attempts be conducted in a setting where expert help would be available to address side effects, adverse events, or other problems. Finally, having a patchwork of policies concerning which patients are eligible, by whose determination, and with what potential risks to the patient makes it difficult for physicians, hospitals, and patient advocacy organizations to counsel patients about what their rights are and how to best utilize those rights.

A lofty-sounding title—"right to try"—and supporters' genuine desire to help patients facing the ends of their lives do not negate the fact that these laws are more rhetoric than substance. A thorough review of the laws is needed. The most egregious stipulations ought to be amended, and the laws should be made consistent with one another if they are to approach being patient-centric. Barring that, they ought to be repealed altogether.

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Notes

i. Texts of the state acts or bills, accessed May 28-30, 2016, unless otherwise noted, can be found through the following links: Alabama S.B. 357 (2015): http://alisondb.legislature.state.al.us/ALISON/SearchableInstruments/2015RS/PrintFiles/SB357-enr.pdf; Arizona Proposition 303 (2014): http://apps.azsos.gov/election/2014/Info/PubPamphlet/english/prop303.pdf; Arkansas S.B. 4 (2015): http://www.arkleg.state.ar.us/assembly/2015/2015R/Bills/SB4.pdf; California A.B. 1668/Chapter 684: http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1651-1700/ab_1668_bill_20160927_chaptered.htm (2016; accessed November 15, 2016); Colorado H.B. 1281 (2014): http://www.statebillinfo.com/bills/bills/14/1281_enr.pdf; Connecticut Public Act No. 16-214: https://www.cga.ct.gov/2016/ACT/pa/2016PA-00214-R00SB-00371-PA.htm (2016; accessed November 15, 2016); Florida C.S./C.S./H.B. 269 (2015): https://www.flsenate.gov/Session/Bill/2015/0269/BillText/er/PDF; Georgia H.B. 34 (2016): http://www.legis.ga.gov/Legislation/en-US/display/20152016/HB/34; Idaho H.B. 481 (2016): http://www.legislature.idaho.gov/legislation/2016/H0481.pdf; Illinois H.B. 1335 (2015): https://legiscan.com/IL/text/HB1335/2015; Indiana H.B. 1065 (2015): http://in.proxy.openstates.org/2015/bills/hb1065/versions/hb1065.05.enrh; Louisiana H.B. 891 (2014): https://legiscan.com/LA/text/HB891/id/1031672/Louisiana-2014-HB891-Chaptered.pdf; Maine L.D. 180 (2016): https://legiscan.com/ME/text/LD180/2015; Michigan Act 345 (2014): http://www.legislature.mi.gov/%28S%28fnrpzkdpdmipbrwmk1no31ho%29%29/documents/mcl/pdf/mcl-Act-345-of-2014.pdf; Minnesota S.F. 100 (2015): https://legiscan.com/MN/text/SF100/id/1212259/Minnesota-2015-SF100-Engrossed.pdf; Mississippi S.B. 2485 (2015): https://legiscan.com/MS/text/SB2485/id/1182333/Mississippi-2015-SB2485-Enrolled.html; Missouri H.B. 1685 (2014): http://www.house.mo.gov/billtracking/bills141/billpdf/truly/HB1685T.PDF; Montana S.B. 142 (2015): http://leg.mt.gov/bills/2015/billpdf/SB0142.pdf; Nevada A.B. 164 (2015): http://www.leg.state.nv.us/Session/78th2015/Bills/AB/AB164_EN.pdf; New Hampshire Chapter 206 (2016; accessed June 13, 2016): http://www.gencourt.state.nh.us/bill_status/billtext.aspx?txtFormat=html&v=CF&id=433; North Carolina H.B. 652 (2015): http://www.ncga.state.nc.us/Sessions/2015/Bills/House/HTML/H652v4.html; North Dakota S.B. 2259 (2015): https://legiscan.com/ND/text/2259/id/1201774/North_Dakota-2015-2259-Enrolled.pdf; Oklahoma H.B. 1074 (2015): https://legiscan.com/OK/text/HB1074/id/1203655/Oklahoma-2015-HB1074-Enrolled.pdf; Oregon H.B. 2300 (2015): https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/HB2300/Enrolled; South Carolina Act 230 (2016; accessed June 12, 2016): http://www.scstatehouse.gov/sess121_2015-2016/bills/4542.htm; South Dakota H.B. 1080 (2015): http://legis.sd.gov/docs/legsession/2015/Bills/HB1080ENR.pdf; Tennessee H.B. 143 (2015): https://legiscan.com/TN/text/HB0143/id/1084441/Tennessee-2015-HB0143-Draft.pdf; Texas H.B. 21 (2015): http://www.legis.state.tx.us/tlodocs/84R/billtext/pdf/HB00021F.pdf#navpanes=0; Utah Chapter 85 (2015): http://le.utah.gov/~2015/bills/hbillenr/HB0094.pdf; Virginia Chapter 655 (2015): https://lis.virginia.gov/cgi-bin/legp604.exe?151+ful+CHAP0655+pdf; West Virginia S.B. 416 (2016): http://www.legis.state.wv.us/Bill_Status/bills_text.cfm?billdoc=SB416%20ENR.htm&yr=2016&sesstype=RS&i=416; Wyoming Act 76 (2015): http://legisweb.state.wy.us/2015/Enroll/SF0003.pdf.

ii. Alabama, California, Colorado, Connecticut, Florida, Georgia, Idaho, Michigan, Mississippi, Montana, North Carolina, North Dakota, South Carolina, South Dakota, Tennessee, and West Virginia.

iii. California, Colorado, Connecticut, North Dakota, Oklahoma, and West Virginia.

iv. Right to try model legislation.

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