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TurningPoint

Collaborating for a New Century in Public Health

Model State Emergency Health Powers Act Commentary

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PREFACE

This publication is a product of a relationship between the *Center for Law and the Public's Health* and the Turning Point Public Health Statute Modernization Collaborative that predated the events of September 11, 2001. Funded by the Robert Wood Johnson Foundation, the Collaborative grew out of the Turning Point Initiative begun by the Robert Wood Johnson Foundation and the W. K. Kellogg Foundation in 1997. The purpose of Turning Point is to transform and strengthen the public health system in the United States to make the system more effective, more community-based, and more collaborative.

Formed in April 2000, the Public Health Statute Modernization Collaborative is a partnership comprised of representatives from five states and nine national organizations and government agencies. Its mission is to transform and strengthen the legal framework for the public health system through a collaborative process to develop a model public health law. During its four-year life span, the Collaborative will carry out this mission by developing the Model State Public Health Act and related tools to assist state and local governments to assess their existing public health laws and update the laws to effectively address the entire range of modern public health issues. The authors of this publication work under contract to the Collaborative to provide legal expertise in the area of public health law.

After the September 11 terrorist attacks and the subsequent anthrax contamination of mail raised national awareness of the need for public health authorities to mobilize and take action quickly during a crisis, the Centers for Disease Control and Prevention (CDC) asked the *Center for Law and the Public's Health* at Georgetown and Johns Hopkins Universities to prepare draft legislation that states could use in reviewing their existing laws related to response to bioterrorism and other potentially catastrophic public health emergencies. In October 2001 CDC commissioned the *Center for Law and the Public's Health* to produce the Model State Emergency Health Powers Act. While the Collaborative was not involved in the CDC-funded drafting of the Model State Emergency Health Powers Act, the Collaborative's earlier work in planning the emergency powers section of the Model State Public Health Act served as a basis for the Model State Emergency Health Powers Act. Much of the content of the Model State Emergency Health Powers Act will be incorporated into the Model State Public Health Act.

Because the Model State Emergency Health Powers Act is so closely intertwined with the Collaborative's work, the Collaborative commissioned this Brief Commentary to provide background and history related to the Model State Emergency Health Powers Act and to describe its relationship to the Model State Public Health Act. This document also provides an overview describing the purpose and intent of each section of the Model State Emergency Health Powers Act and a discussion of the major concerns raised by the public, policy makers, lawmakers, and national organizations during and since the development of the Model State Emergency Health Powers Act.

Table of Contents

Introduction

There is perhaps no duty more fundamental to American government than the protection of the public's health. Beginning on September 11, 2001, the state's obligation to safeguard public safety took on new urgency. The destruction of the World Trade Towers in New York City and a portion of the Pentagon in Washington, DC resulted in a the loss of 2,600 to 2,900 lives and exposed the country's vulnerability to catastrophic acts of war. In the ensuing weeks of fall 2001, public health and law enforcement officials discovered that some person or group had intentionally contaminated letters with potentially deadly anthrax spores. These letters were mailed to individuals in government and the media in several states and the District of Columbia. Thousands of persons were tested for exposure, hundreds were treated, and five persons died from inhalational anthrax. To date, the persons responsible for disseminating anthrax through the mail have not been identified. Government officials predict the potential for additional bioterrorism attacks as the "war on terrorism" continues.

The anthrax exposures confirmed weaknesses in the nation's public health system and fueled apprehension among government officials and the public about future bioterrorism attacks. Many members of the public believe a subsequent biological or chemical attack on the United States will occur in 2002. Fears of bioterrorism and emerging infectious diseases are justifiable. Many groups or individuals may have access to and use biological agents as weapons to inflict harm on a population-wide basis. Multiple infectious agents, including smallpox, tularemia, plague, viral hemorrhagic fever, anthrax, and genetically-enhanced agents, may be used. Table 1, on page 8, summarizes what bioterrorism experts suggest are the five deadliest biological agents suitable for bioterrorism attacks.

Bioterrorists may infect individuals through multiple routes:

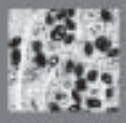
- intentional spread of contagious diseases through individual contact;
- airborne dissemination of some infectious agents; or
- contamination of transportation systems, buildings, or other public places, as well as water, food, controlled substances, or other widely distributed products.

The knowledge and equipment needed to manufacture biological weapons is easy to obtain and conceal. Concentrations of people in large urban centers, as well as modern rapid transit systems, facilitate the spread of infectious diseases.

Public health authorities, along with private sector health care workers and primary care institutions, may lack the infrastructure, resources, knowledge, coordination, and tools to effectively respond to intentional and possibly mass exposure to infectious disease. For many of the most serious agents of bioterrorism, there is inadequate technology for detection, testing, vaccination, and treatment. Prior to September 11, federal and state public health authorities had allocated limited resources and engaged in limited planning for a major bioterrorism event. Congress authorized the spending of more than $500 million early in 2001 for bioterrorism preparedness through the Public Health Threats and Emergencies Act. According to a nation-wide Department of Justice assessment of local public health agencies in 2000, additional commitments to improve surveillance of unusual diseases or clusters, train health care workers, increase existing

Table 1 - The Deadliest Five Biological Agents

The Five Deadliest

	Description	Symptoms	Fatality Rate	Treatment
 **(Inhalational) Anthrax** ***Bacillus anthracis***	Inhaled spores germinate and release toxins, causing swelling in chest cavity. Possible blood and brain infection.	Fever, fatigue, and malaise, starting within two to 46 days; progresses to chest pain, cough, rapid deterioration of health.	Kills more than 85 percent of those it infects, often within one to three days after symptoms appear.	Antibiotics (preferably ciprofloxacin) should be given before symptoms appear. Vaccine available, though not to civilians.
 **Smallpox** ***Variola Virus***	Very contagious, airborne disease.	About 12 to 14 days after infection. Fever, aches, vomiting, rash of small red spots that grow into larger, painful pustules covering the body.	Fatal in 30 percent of unvaccinated patients.	No treatment. U.S. has vaccine for about 6 million people. Only a fraction of those vaccinated before 1972 still protected.
 **(Pneumonic) Plague** ***Yersinia Pestis***	Natural, flea-borne form causes bubonic plague. Gravest threat is posed by aerosol, leading to pneumonic plague.	High fever, headache, and bloody cough; progresses to labored breathing, bluish-grayish skin color, respiratory failure and death.	If untreated, a person with pneumonic plague will almost always die within one to two days after symptoms begin.	Various antibiotics including streptomycin and gentamicin. Isolate patients.
 **Viral Hemorrhagic Fever**	Highly infectious RNA viruses including Ebola, Marburg, Lassa, and dengue fever. Spread by rodents, ticks, mosquitoes.	Vary from one type of HFV to the next. include fever, muscle aches, exhaustion, internal bleeding.	Varies. Death rate from dengue is as low as 1 percent. Ebola fatality rates have reached 90 percent.	Mainly supportive therapy. Anti-viral drug ribavirin useful in treating some viruses but not others (Ebola, Marburg).
 **(Inhalational) Botulism** ***Clostridium botulinum***	Produces toxin that blocks nerve signals, inhibits muscle movement. Weapon would most likely aerosolize toxin.	Difficulty swallowing food, mental numbness, muscle paralysis, possible breathing failure.	Inhalational form: Difficult to say since only a handful of cases have been recorded.	Patients with respiratory paralysis should be placed on ventilator. Antitoxin given early may prevent progression.

Source: Centers for Disease Control and Prevention/U.S. Army Military Research Institute of Infectious Diseases. www.jhu.edu/~jhumag/0299web/germ2.html.

vaccination and treatment supplies, and collaborate across state boundaries are needed to improve the public health infrastructure. The federal Office of Public Health Preparedness and the Centers for Disease Control and Prevention (CDC) have begun to distribute nearly a billion dollars of federal aid to states to better plan for, prepare for, and respond to bioterrorism.

For state and local public health agencies that may find themselves on the frontline of defense against a bioterrorism event, planning is essential. As part of its distribution of federal funds to states, CDC requires states to prepare systematic response plans. Many states had not previously addressed bioterrorism in their emergency response plans. Advance planning is key, but it presupposes that public health authorities are legally empowered to respond to potential or actual bioterrorist threats. Some states (e.g., Colorado) had passed laws or regulations to address bioterrorism before September 11. In many states, however, modern legal standards for bioterrorism response are absent, antiquated, fragmented, or insufficient.

Following the September 11 attacks on the World Trade Center and Pentagon and the dispersal of anthrax in October, the CDC asked the *Center for Law and the Public's Health* at Georgetown and Johns Hopkins Universities to prepare draft legislation that states could use in reviewing their existing laws related to response to bioterrorism and other potentially catastrophic public health emergencies. On that basis, the *Center* drafted what it terms the Model State Emergency Health Powers Act (MSEHPA).

The Act reflects its authors' professional judgment regarding statutory provisions states should have in place for effective public health response to bioterrorism and other public health emergencies. The Act was developed in collaboration with members of national partner organizations including the National Governors Association, National Conference of State Legislatures, Association of State and Territorial Health Officials, National Association of County and City Health Officers, and the National Association of Attorneys General. It presents a modern synthesis of public health law for controlling infectious diseases during emergencies that balances public health needs with the rights and dignity of individuals. The Act was completed in December 2001 and is available at the *Center's* website [www.publichealthlaw.net]. A copy of the Act is also included as Appendix 3 to this report.

The MSEHPA has been widely used by state and local law- and policy-makers, health officials, and representatives in the private sector as a guide for considering reforms of existing legal protections. As of June 1, 2002, it has been used by most states in assessing their existing laws regarding public health emergencies. It has been introduced in whole or part through legislative bills or resolutions in 33 states, and passed in 15 states. For more detailed information, see Appendix 1: The Model State Emergency Health Powers Act - State Legislative Activity.

An essential challenge to drafting the MSEHPA was to create a modern series of legal provisions that equip public health authorities with necessary powers to respond to catastrophic public health emergencies, including bioterrorism events, while also respecting individual and group rights. The Act vests state and local public health authorities with modern powers to track, prevent, and control disease threats resulting from bioterrorism or other public health emergencies. These powers include measures that may infringe individual civil liberties including the rights to due process, speech, assembly, travel, and privacy. However, the exercise of these powers, which include testing, treatment, and vaccination programs, isolation or quarantine powers, and travel restrictions, is restricted in time, duration, and scope. Coercive public health powers, particularly isolation and quarantine, are exercised on a temporary basis, only so long as reasonably

necessary, and only among persons who may justifiably be considered to pose a risk to others because of their contagious conditions. In addition, the dignity of individuals is respected. For example, their rights to contest the coercive use of public health powers, even during an emergency, are secured.

Although the MSEHPA was drafted as a stand-alone model act, it was previously conceived as part of a larger, multi-year project convened by the *Turning Point Public Health Statute Modernization National Collaborative,* [www.hss.state.ak.us/dph/deu/turningpoint/nav.htm] (hereinafter National Collaborative) to develop a Model State Public Health Act. Through intensive research and consensus building among national, state, and local experts and public health representatives, the Collaborative is working to produce a Model State Public Health Act that provides widely accepted legislative language concerning public health administration and practice by public health agencies at the state and local levels. The National Collaborative, comprised of a multi-disciplinary panel of experts in public health, law, and ethics, has already developed various portions of the multi-chapter, comprehensive model public health act for states. For more information on the content of the larger model act, see Appendix 2: The Model State Public Health Act - Preface. Many of the provisions of the MSEHPA will become part of the larger model act, which is scheduled for completion in 2003.

In this brief report, we first explain the need for public health law reform to better prepare for bioterrorism and other public health emergences. We further describe the process and content of the MSEHPA, including discussion of the ways that it balances individual liberties and public health during times of public health emergencies.

The Need for Public Health Law Reform

Law has long been considered an essential tool for improving public health outcomes, especially among state governments that have traditionally been the repositories of public health powers. Statutory laws and administrative rules generally guide the activities of public health authorities, assign and limit their functions, authorize spending, and specify how authorities may exercise their delegated authority. Laws can establish norms for healthy behavior and create the social conditions in which people can be healthy. However, obsolescence, inconsistency, and inadequacy in existing state public health laws expose flaws and can render these laws ineffective, or even counterproductive.

State public health statutes have frequently been constructed in layers over time as lawmakers responded to varying disease threats such as tuberculosis, polio, malaria, and HIV/AIDS. Consequently, existing statutory laws may not reflect contemporary scientific standards for disease surveillance, prevention, and response, nor for current legal norms for protection of individual rights. Administrative regulations may supplement existing statutes with more modern public health approaches, but also be limited by original grants of delegated rule-making authority.

Existing public health laws may predate vast changes in constitutional and statutory law that have altered social and legal conceptions of individual rights. Contemporary standards of equal protection and due process in constitutional law and of disability discrimination, privacy, and civil rights in statutory law must be reflected in public health law. Public health authorities acting pursuant to outdated provisions may be vulnerable to legal or ethical challenges on grounds that their actions are unconstitutional or preempted by modern federal or state laws.

The independent evolution of health codes across states, tribal authorities, and territories has led to variation in the structure, substance, complexity, and procedures for detecting, controlling, and preventing disease. Without a coordinated national public health system, disease detection and reporting systems, response capabilities, and training capacity differ extensively among jurisdictions. These differences could hamper coordination and efficient responses in a multi-state public health emergency, a likely scenario with modern bioterrorism threats. Confusion and complexity among inconsistent state public health laws may create ambiguities that also prevent public health authorities from acting rapidly and decisively in an emergency. Public health authorities may be unsure of the extent of their legal authority, the chain of command during an emergency, or the proper exercise of existing legal powers.

Reforming current state public health laws is particularly important to strengthen key elements of public health preparedness:

Planning, Coordination, and Communication. Most state statutes do not require public health emergency planning or establish response strategies. Essential to the planning process is the definition of clear channels for communication among responsible governmental officials in public health, law enforcement, and emergency management, and between the government and the private sector including private sector health care workers and institutions, the pharmaceutical industry, and non-governmental organizations. Coordination among the various levels (e.g., federal, tribal, state, and local) and branches (e.g., legislative, executive, and judicial) of government is also critical. State public health laws can implement systematic planning processes that involve multiple stakeholders. However, many public health statutes not only fail to facilitate communication, but may actually proscribe exchange of vital information among principal agencies due to privacy concerns. Some state laws even prohibit sharing data with public health officials in adjoining states. Laws that complicate or hinder data communication among states and responsible agencies could impede a thorough investigation and response to public health emergencies.

Surveillance. Ongoing, effective, and timely surveillance is an essential component of public health preparedness. In many bioterrorist threats, the dispersal of pathogens may not be evident. Early detection could save many lives by triggering an effective containment strategy that includes testing, vaccination, treatment, and, if needed, isolation or quarantine. Existing state laws may thwart effective surveillance activities. Many states do not require timely reporting for the most dangerous agents of bioterrorism (see Table 1, on page 8). Most states do not require immediate reporting for all the critical agents identified by the CDC. At the same time, states do not require, and may actually prohibit, public health agencies from monitoring data collected through the health care system. Private information held by hospitals, managed care organizations, and pharmacies that might lead to early detection of a public health threat, such as unusual clusters of fevers or gastrointestinal symptoms, may be unavailable to public health officials because of insufficient reporting mechanisms or privacy concerns.

Managing Property and Protecting Persons. Authorization for the use of coercive powers is the most controversial aspect of public health laws. Nevertheless, their use may be necessary to manage property or protect persons in a public health emergency. There are numerous circumstances that might require management of property in a public health emergency, e.g., decontamination of facilities; acquisition of vaccines, medicines, or hospital beds; or use of private facilities for isolation, quarantine, or disposal of human remains. In the recent anthrax attacks, public health authorities had to close various public and private facilities for decontamination. Consistent with legal, fair safeguards, including compensation for takings of private property used for public purposes, clear legal authority is needed to manage property to contain a serious health threat.

There may also be a need to exercise powers over individuals to avert significant threats to the public's health. Vaccination, testing, physical examination, treatment, isolation, and quarantine each may help contain the spread of infectious diseases. Although most people will comply with these programs during emergencies for the same reason they comply during non-emergencies (i.e., because it is in their own interests or desirable for the common welfare), compulsory powers may be needed for those who will not comply and whose conduct poses risks to others or the public health. These people may be required to yield some of their autonomy or liberty to protect the health and security of the community.

The Model State Emergency Health Powers Act

Process/Input

The MSEHPA provides a modern illustration of a public health law for controlling infectious diseases during emergencies that balances the needs of public health with the rights and dignity of individuals. Though developed quickly following the anthrax exposures in fall 2002, the Act's provisions and structure are based on existing federal and state laws and public health practice. Principal drafters at the *Center for Law and the Public's Health* turned first to existing state public health laws for language that presented a model approach to key areas in the Act. Many provisions of the Act denote the existing legislative source for all or part of their content (see Appendix 3, on page 39, for a complete copy of the MSEHPA).

Although some have suggested that the MSEHPA sets forth new and expansive powers for public health authorities, this is actually not the case. The Act does not create new powers for public health authorities; each of the Act's provisions are based on existing theory and practice of public health law. Rather, the MSEHPA organizes and modernizes these legal powers to facilitate a coordinated approach to public health emergency response. A rough index for the MSEHPA was derived from the work of experts in law, public health, emergency management, and national security who convened at the Cantigny Conference Center (outside of Chicago, Illinois) prior to September 11 to examine potential policy dilemmas underlying a bioterorrism event. An earlier draft of the model act was vetted and critiqued through national partners and heads of government agencies, legislators, public health officials, legal practitioners, scholars, non-governmental organizations, and members of the general public. The existing draft of the Act was also reviewed by the National Collaborative.

Central Purposes

The MSEHPA addresses each of the key elements for public health preparedness discussed in the section above (see The Need for Public Health Law Reform). Among its central purposes, the Act:

- Sets a high threshold definition of what constitutes a "public health emergency" [Article I];
- Requires the development of a comprehensive public health emergency response plan that includes coordination of services, procurement of necessary materials and supplies, housing, feeding, and caring for affected populations, and the administration of vaccines and treatment [Article II];
- Authorizes the collection of data and records and access to communications to facilitate the early detection of a health emergency [Article III];
- Vests the power to declare a public health emergency in the state governor, subject to appropriate legislative and judicial checks and balances [Article IV];
- Grants state and local public health officials the authority to use and appropriate property to care for patients, destroy dangerous or contaminated materials, and implement safe handling procedures for the disposal of human remains or infectious wastes [Article V];

- Authorizes officials to care for and treat ill or exposed persons, to separate affected individuals from the population at large to prevent further transmission, collect specimens, and seek the assistance of in-state and out-of-state private sector health care workers during an emergency [Article VI];
- Requires public health authorities to inform the population of public health threats through mediums and language that are accessible and understandable to all segments of the population [Article VII]; and
- Authorizes the governor to allocate state finances as needed during an emergency, and creates limited immunities for some state and private actors from future legal causes of action [Article VIII].

Table 2, below, summarizes the specific sections of the MSEHPA.

Table 2 - MSEHPA Legislative Specifications

Article I Title, Findings, Purposes, and Definitions

Sec.	Title and Brief Description
§ 101	Short title - provides a short title for the Act.
§ 102	Legislative findings - provides a sample set of findings underlying the need for protecting the public health in an emergency.
§ 103	Purposes - summarizes the purposes of the Act, namely to provide the governor, public health authority, and other state and local authorities with the powers and ability to prevent, detect, manage, and contain emergency health threats without unduly interfering with civil rights and liberties.
§ 104	Definitions - provides key definitions, including "public health emergency," "bioterrorism," "public health authority (PHA)," and "public safety authority."

Article II Planning for a Public Health Emergency

Sec.	Title and Brief Description
§ 201	Public Health Emergency Planning Commission - authorizes governor to establish a Commission to begin planning for a public health emergency.
§ 202	Public Health Emergency Plan - within six months of enactment of the Model Act, the Commission shall develop a comprehensive detection and response plan involving the PHA, public safety agencies, and others. The plan shall be reviewed and revised annually.

Article III Measures to Detect and Track Public Health Emergencies

Sec.	Title and Brief Description
§ 301	Reporting - requires health care workers, coroners, pharmacists, veterinarians, laboratories, and others to make written or electronic reports of suspect illnesses or conditions to the PHA to detect a potential serious threat to the public's health.
§ 302	Tracking - requires PHA to investigate and track potential serious threats to the public health.
§ 303	Information sharing - authorizes public health and safety authorities to share information within limits to detect and respond to serious public health threats.

Article IV Declaring a State of Public Health Emergency

Sec.	Title and Brief Description
§401	Declaration - governor can declare a state of public health emergency under a set of criteria and in consultation with the PHA or others.
§ 402	Content of declaration - requires governor to issue an executive order.
§ 403	Effect of declaration - triggers the public health and other response mechanisms in the Act, including a series of emergency powers.
§ 404	Enforcement - allows PHA to seek assistance of public safety authority.
§ 405	Termination of declaration - requires termination of the declaration of a state of public health emergency by executive order within 30 days, unless renewed by governor; allows state legislature to terminate declaration at any time via majority vote in both chambers.

Article V Special Powers During a State of Public Health Emergency: Management of Property

Sec.	Title and Brief Description
§ 501	Emergency measures concerning facilities and materials - allows PHA to close, evacuate, or decontaminate any facility or material that poses a danger to the public health without compensation to the owner.
§ 502	Access to and control of facilities and property - allows PHA broad access and use of private facilities or materials during a public health emergency with compensation to private owners in the event of a taking.
§ 503	Safe disposal of infectious waste - sets rules for the safe disposal of infectious waste to prevent the spread of an illness or health condition.
§ 504	Safe disposal of human remains - provides guidelines for the safe disposal of human remains that may pose a public health threat, including use of private facilities as needed.
§ 505	Control of health care supplies - authorizes PHA to procure, obtain, and ration needed health supplies (e.g., anti-toxins, serums, vaccines, antibiotics, and other medicines), as well as control their distribution during a public health emergency.
§ 506	Compensation - provides compensation for private owners whose property is taken during a public health emergency. Compensation does not occur if the public health agency is exercising police powers (e.g., a nuisance abatement), but only if there is a taking of property.
§ 507	Destruction of property - requires some civil procedures prior to the destruction of property where possible.

Article VI Special Powers During a State of Public Health Emergency: Protection of Persons

Sec.	Title and Brief Description
§ 601	Protection of persons - generally authorizes PHA to use every available means to control a threat to the public health during an emergency.
§ 602	Medical examination and testing - allows PHA to perform physical examinations and tests as necessary for the diagnosis or treatment of individuals during an emergency. Persons who refuse may be isolated or quarantined.
§ 603	Vaccination and treatment - PHA may require the vaccination of persons to prevent the spread of an infectious condition. Persons who refuse may be isolated or quarantined.
§ 604	Isolation and quarantine - empowers PHA to implement mandatory isolation (for infected persons) or quarantine (for exposed persons) measures for a limited period of time and consistent with a series of conditions and principles.
§ 605	Procedures for isolation and quarantine - outlines provisions for temporary isolation and quarantine measures, including notice, relief, recorded proceedings, appointment of counsel, and consolidation of claims, if and when possible.
§ 606	Collection of laboratory specimens; performance of tests - authorizes collection of lab specimens and performance of tests on living or deceased animals or persons and permits sharing information with public safety authorities to facilitate criminal investigations related to the public health emergency.
§ 607	Access to and disclosure of protected health information - allows access to records of persons under care of the PHA to persons with a need to know, but prohibits many disclosures of identifiable data outside the public health or safety setting without written, specific informed consent.
§ 608	Licensing and appointment of health personnel - requires in-state health care providers to assist with emergency treatment and preventative measures authorized by the Act, lifts licensing requirements to encourage out-of-state health care workers to participate in a public health emergency, and authorizes qualified individuals to assist with duties of state medical examiner and coroners.

Article VII Public Information Regarding a Public Health Emergency

Sec.	Title and Brief Description
§ 701	Dissemination of information - requires PHA to inform the population of threats to the public health during a state of public health emergency. Information shall be provided in multiple languages (where needed) and in a medium that is accessible to all parts of the population.
§ 702	Provision of access to mental health support personnel - mental health personnel shall be made available to address psychological responses to the public health emergency.

Article VIII Miscellaneous

Sec.	Title and Brief Description
§ 801	Titles - titles and subtitles in the Act are instructive, not binding.
§ 802	Rules and regulations - allows PHA to create administrative regulations or rules to further the purposes of the Act.
§ 803	Financing and expenses - authorizes governor, within specific limits, to transfer state funds to respond to a public health emergency without specific legislative authorization. Funds shall be repaid to existing state accounts as soon as possible. Expenses for a public health emergency shall be authorized by the governor, but shall not exceed a predetermined cap.
§ 804	Liability - creates general immunity for governor, PHA, and other state executive agencies or actors for their actions during a public health emergency. Some private actors are also statutorily immune in specific circumstances.
§ 805	Compensation - requires compensation for private property that is lawfully taken or appropriated by a PHA during a public health emergency in the amount of and pursuant to procedures typical of a taking proceeding in non-emergency situations.
§ 806	Severability - the provisions of the Act are severable; if any provision is rendered invalid, other provisions remain.
§ 807	Repeals - a placeholder for specific state laws which the Model Act repeals.
§ 808	Saving clause - state laws that do not conflict with the Model Act, or that provide greater protections, continue to have effect.
§ 809	Conflicting laws - as a model state law, the Act cannot preempt any federal law or regulation, but does preempt inconsistent state laws.
§ 810	Effective date - the Act takes effect upon passage by the legislature and signature of the governor.

Public Health Emergencies

Most of the public health powers granted to state and local public health authorities through the MSEHPA are triggered by the governor's declaration of a public health emergency in response to dire and severe circumstances. A declared state of emergency terminates as soon as the health threat is eliminated, or automatically after 30 days, unless reinstated by the governor or annulled through legislative or court action. Bioterrorism events involving intentional efforts to spread infectious diseases may present a scenario for a declaration of emergency. Public health emergencies can also arise through the spread of emerging infectious diseases through unintentional means. The MSEHPA covers either scenario under its inclusive definition of what constitutes a "public health emergency," summarized as (1) the occurrence or imminent threat of an illness or health condition caused by bioterrorism or a highly fatal biological toxin or novel or infectious agent (that was previously controlled or eradicated) that (2) poses a high probability of a significant number of human fatalities or incidents of serious, permanent, or long-term disability in the affected population.

Under this definition of public health emergency, it is inconsequential how an emerging infectious condition arose in the population. The potential that such infectious conditions may severely impact the morbidity and mortality of populations within a prescribed period of time is the key factor toward the declaration of an emergency.

Some civil libertarians and others have objected to the Act's emergency declaration. They view the declaration of a state of emergency as an authorization for public health authorities to do virtually anything to abate the existing threat. This includes infringing individual rights in the interests of protecting public health. Indubitably, during an emergency certain civil liberties may need to be restricted as compared to the exercise of these rights in non-emergencies. Yet, the Act specifically protects individual interests from authoritarian actions in government. The governor of a state may be empowered to declare a state of public health emergency, but the legislature, by majority vote, may discontinue the declaration at any time. Similarly, courts may review whether a governor's actions fail to comply with the standards and procedures in the MSEHPA. Thus, each branch of state government has a role in sustaining an emergency declaration consistent with constitutional principles of checks and balances.

Furthermore, the provisions of the MSEHPA better protect individuals than most existing state laws. Under the Act, a public health emergency is viewed as a distinct event that requires specific governmental responses. The Act sets a very high threshold for the declaration of a public health emergency and further conditions the use of a defined and limited set of powers on the declaration and continuation of the emergency status. In many state public health laws, however, there are no definitive statutory criteria for the declaration of a public health emergency. Rather, existing state emergency management laws may be used to broadly address public health emergencies. Declaring a general state of emergency in response to a bioterrorism event may allow government to act in indeterminable ways to address the public health threat. Lacking effective statutory guidance, public health authorities may have to rely on existing antiquated statutory laws, or regulations that are hastily created in specific response to potential or unknown threats.

Information Sharing and Surveillance Measures

The MSEHPA enhances existing state surveillance and reporting practices to facilitate the prompt detection of a potential or actual threat by requiring:

- Health care providers to report cases of bioterrorist-related or epidemic diseases that may be caused by any of 35 infectious agents listed in federal regulations or other non-listed agents;
- Coroners and medical examiners to report deaths that may have resulted from an emerging or epidemic infectious disease or from a suspected agent of bioterrorism;
- Pharmacists to report unusual trends in prescriptions for antibiotics and other medications used to treat infectious diseases in addition to substantial increases in the sale of various over-the-counter (OTC) remedies; and
- Veterinarians or veterinary laboratories to report animals having or suspected of having any diseases that may be potential causes of a public health emergency.

Reports are to be made within 24 hours to the appropriate health authority and should contain identifying information about the reporter and subject of the report. Upon receiving a report, public health officials can use the information to ameliorate possible public health risks. They may contact and interview individuals mentioned in the report and obtain names and addresses of others who may have been in contact or exposed to the individual. The Act encourages the sharing of this data among public safety and emergency management authorities at the federal, state, local, and tribal levels to prevent, treat, control, or investigate a public health emergency. To protect individual privacy, officials are restricted from sharing any more information than necessary to control or investigate the public health threat. Stricter regulations in the Act govern access to the medical records and charts of individuals under quarantine or isolation where individual privacy interests may be heightened.

Managing Property

Once a public health emergency has been declared, the MSEHPA allows authorities the power to seize private property for public use that is reasonable and necessary to respond to the public health emergency. This power includes the ability to use and take temporary control of certain private sector businesses and activities that are of critical importance to epidemic control measures. To safely eliminate infectious waste such as bodily fluids, biopsy materials, sharps, and other materials that may contain pathogens or otherwise pose a public health risk, authorities may take control of landfills and other disposal facilities. To assure safe handling of human remains, officials may control and utilize mortuary facilities and services. They are also authorized to take possession and dispose of all human remains. Health care facilities and supplies may be procured or controlled to treat and care for patients and the general public.

Whenever health authorities take private property to use for public health purposes, constitutional law requires that the property owner be provided just compensation. That is, the state must pay private owners for the use of their property. Correspondingly, the Act requires the state to pay just compensation to the owner of any facilities or materials temporarily or permanently procured for public use during an emergency. Where public health authorities, however, must condemn and destroy any private property that poses a danger to the public (e.g., equipment that is contaminated with anthrax spores), no compensation to the property owners is required although states may choose to make compensation if they wish. Under existing legal powers to abate public nuisances, authorities are able to condemn, remove, or destroy any property that may harm the public's health.

Other permissible property control measures include restricting certain commercial transactions and practices such as price gouging to address problems arising from the scarcity of resources that often accompanies public emergencies. The MSEHPA allows public health officials to regulate the distribution of scarce health care supplies and to control the price of critical items during an emergency. In addition, authorities may seek the assistance of health care providers to perform medical examination and testing services.

Protection of Persons

Section 601 of the MSEHPA states: "During a state of public health emergency, the public health authority shall use every available means to prevent the transmission of infectious disease and to ensure that all cases of contagious disease are subject to proper control and treatment." The MSEHPA allows public

health authorities to ask any person to be vaccinated or submit to a physical exam, medical testing, or treatment, or provide a biological sample. Each of these measures may be needed to assist the individual and evaluate the epidemiologic consequences of an emerging condition during an emergency. These measures may be taken without any form of due process including right to a hearing because individuals are free to choose to participate or not. Any person who may be impacted by the declaration of the public health emergency that gives rise to systematic vaccination or testing programs may challenge the basis for declaring the emergency in court.

Although participation in vaccination, testing, or treatment programs is voluntary, those who choose not to participate and whose contagious condition may pose risks to others may be subject to isolation or quarantine measures. The Act's quarantine and isolation provisions may be used to limit the freedom of individuals exposed to or infected with a contagious disease, respectively, to circulate in the general public. Quarantine and isolation are classic public health powers. During non-emergencies, their practice is typified by limiting the transgressions of a very small number of persons whose behavior may lead to infecting others with a serious, contagious disease such as tuberculosis or other potential harms. During a public health emergency, where potentially thousands of persons are exposed or infected with a contagious disease, the use of quarantine or isolation powers may be widespread to protect community populations.

The MSEHPA attempts to balance the welfare and dignity of individuals with communal interests in implementing quarantine or isolation measures. Accordingly, public health authorities must:

- Use the least restrictive means necessary to prevent the spread of a contagious or possibly contagious disease to others. Arbitrary or discriminatory quarantines will not satisfy this standard;
- Maintain safe, hygienic conditions for persons in isolation or quarantine that minimize the risk of further disease transmission;
- Provide adequate food, clothing, medication, health care, means of communication, and other necessities; and
- Adhere to strong due process protections for affected individuals.

Except where failure to quarantine or isolate persons immediately may significantly jeopardize the health of others, public health officials must obtain a court order before implementing these measures. The court can approve the use of isolation or quarantine only if the public health authority can show the measures are reasonably necessary to prevent or limit the transmission of a contagious or possibly contagious disease to others. Persons or groups subject to quarantine or isolation must receive written copies of orders accompanied by an explanation of their rights. They are entitled to be represented by counsel at individual or collective hearings to challenge the order generally or the conditions, terms, and treatment of their confinement. Even in cases of immediate quarantine or isolation, a court order must promptly be sought as soon as possible.

These procedural safeguards protect individuals from arbitrary or unjust detention. Even with such protections in place, the psychological toll on society occasioned by isolation and quarantine should not be underestimated. The MSEHPA recognizes the need for mental health support, and requires that public health authorities provide information about and referrals to mental health support personnel to address psychological problems arising from the public health emergency.

Private sector health care workers are encouraged to assist in vaccination, testing, examination, treatment, quarantine, and isolation programs. The Act allows public health authorities to condition future licensing status of in-state health care workers on their providing assistance (where possible), and to waive licensing requirements for out-of-state health care workers who are willing to help. Thus, the Act does not compel any private health care worker to participate in public health measures during an emergency. It does provide some strong incentives to encourage participation because of the critical role of private sector health care workers during a public health emergency.

Health Information Privacy

In the events leading to or during a public health emergency, the MSEHPA envisions the need for a wide variety of federal, state, and local actors in the public and private sectors to share information that may relate to an individual's health status. For example, private sector health care workers may need to report identifiable health data to public health authorities who may need to share this data with law enforcement officials to respond to a potential bioterrorism threat. Although there is a strong need to share such data for public health purposes, the MSEHPA respects the privacy interests of individuals concerning their health data. The Act:

- Limits the amount of information that may be conveyed to that which is necessary to respond to the public health emergency;
- Limits access to such data during an emergency to those persons having a legitimate need to acquire or use the information to provide treatment, conduct epidemiologic research, or investigate the causes of transmission; and
- Prohibits most disclosures outside the public health context.

Additional privacy protections originally set forth in the *Model State Public Health Privacy Act* [www.critpath.org/msphpa/privacy.htm] are to be replicated in the comprehensive Model State Public Health Act to supplement the provisions of the MSEHPA.

Conclusion

Preparing for existing and future bioterrorism events in the United States requires a strong national public health infrastructure. Federal, state, tribal, and local public health authorities must collaborate with law enforcement and emergency management personnel in preparedness planning and emergency response. Working to improve public health detection, prevention, and response capabilities requires effective training, additional resources, use of existing and new technologies, and public health law reform. Inadequacies in existing state public health laws fail to authorize, or may even thwart, effective public health action. Law reform is needed to improve public health planning, detection, and response capabilities.

The MSEHPA presents a modern statutory framework of public health powers that allows public health authorities to better plan, detect, manage, and control public health emergencies. These provisions of the Act are balanced against the need to safeguard individual rights and property interests. Balancing individual rights with the interests of the community in protecting the public health during emergencies is not easy. There continue to be sharp debates about the extent to which the state should restrict individual rights to safeguard the public's health and safety. Reaching an acceptable balance that allows government to fulfill its duty to protect the public's health while respecting individual rights is important. Legal reform may not be a panacea for the unforeseeable conflicts between individual and community interests that may arise during an emergency, but it presents an opportunity for resolving some of the difficult legal and ethical issues that history and experience suggest we will face.

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Appendix 1: The Model State Emergency Health Powers Act - State Legislative Activity

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THE MODEL STATE EMERGENCY HEALTH POWERS ACT STATE LEGISLATIVE ACTIVITY

As of June 1, 2002

STATE	LEGISLATIVE STATUS UPDATE
AL	An Executive Order (2002 Ala. E.O. 2) establishing the Office of Homeland Security for Alabama and the Alabama Defense Security Council was introduced on November 1, 2001. One component of their mission is to coordinate state efforts to ensure public health preparedness for a terrorist attack, including reviewing vaccination policies as well as the adequacy of vaccine and pharmaceutical stockpiles and hospital capacity.
AK	State health officials have circulated the model act widely for review and consideration. The legislature was asked by Gov. Knowles to appropriate additional funds for anti-terrorism activities in January 2002. Additional legislative activity concerning the model act may soon follow.
AZ Intro Passed	On February 4, 2002, Senator Sue Gerard introduced S.B. 1400, amending several sections of state code in response to public health emergencies. Several provisions are related to similar text in the Model Act. The bill passed the Senate, and the legislative session ended on May 23, 2002, without further action by the House.On April 9, 2002, House Bill 2044, which set standards for the Board of Dental Examiners, passed the House and was transmitted to the Senate. In the Senate, the bill was amended to include bioterrorism and surveillance provisions similar to those in the Model Act. The bill was signed by the Governor on May 23, 2002.
CA Intro	A version of the Model Act was introduced by Assemblyman Keith Richman (R) on January 8, 2002. See Assembly Bill 1763. It was referred to Committees on Health and Government Organization on Jan. 14, 2002, and on April 9, 2002, the bill was heard in the Assembly Health Committee. On April 22, 2002, the bill was re-referred to the Committee on Appropriations.
CT Intro	Members of the Connecticut General Assembly have closely examined and studied the Model Act. To date, however, no Member has introduced a bill based on its provisions. On February 13, 2002, the Joint Public Health Committee introduced a bill in the General Assembly that includes many provisions similar to those in the Model Act. On May 3, 2002, the bill passed the House and was sent to the Senate and tabled for the calendar on May 4, 2002. The legislative session ended on May 8, 2002, without further action by the Senate [2002 CT H.B. 5286].

STATE	LEGISLATIVE STATUS UPDATE
DE Intro	A bill based on the Model Act was introduced January 16, 2002, by Rep. Maier (2001 DE H.B. 377), and passed the House on May 2, 2002. The bill was referred to the Senate Health & Social Services Committee on May 7, 2002.
FL Intro Passed	Several bills have been introduced that express the legislature's intent to enact legislation authorizing the Florida Dept. of Health to coordinate the state's response to bioterrorism and to respond to threats of bioterrorism and events that endanger the public's health. 2002 FL SB 1262; 2002 FL SB 1264. SB 1264 passed the Senate but died in the House. SB 1262 passed both houses and was signed by the governor on May 23, 2002.
GA Intro Passed	Gov. Roy Barnes' bill on Public Health Emergencies was introduced as Senate Bill 385 on February 4, 2002 by Senate sponsors Thompson, Stokes, and Tanksley. An amended version of the bill passed the Senate on Feb. 18, 2002 and was referred to the House Committee on Judiciary on Feb. 26, 2002. On April 5, 2002, the bill passed both Houses and was signed by Gov. Barnes on May 16, 2002.
HI Intro Passed	A bill based on the Model Act was introduced in the House on January 24, 2002 by Rep. Say (2001 HI H.B. 2521) and in the Senate on January 23, 2002 by Sen. Bunda (2001 HI S.B. 2779). House Bill 2521 passed both houses and was transmitted to the governor on May 8, 2002. Senate Bill 2779 passed the Senate on March 5, 2002 and was referred to three House committees on March 12. The legislature adjourned on May 2, 2002, without taking further action on this bill.
ID Intro	House Bill 517 amends existing law to revise the governor's powers in disaster emergencies respecting the quarantine of persons and animals and controlling modes of transportation and destinations. HB 517 passed the House on Feb. 2, 2002 and was referred to the Senate Committee on State Affairs on Feb. 26, 2002. The legislative session ended on March 15, 2002, without further action taken on the existing bill.
IL Intro	Sen. Madigan introduced Senate Bill 1529 (2001 S.B. 1529), a virtual replication of the Oct. 23 version of the Model Act, to the Illinois Legislature on Nov. 13, 2001. SB 1529 was introduced and referred to the Senate Committee on Rules on November 13, 2001. Another version of the Model Act was introduced January 18, 2002 by Rep. Feigenholtz (2001 IL H.B. 3809). House Bill 3809 was referred to the House Committee on State Government Administration on Feb. 13, 2002. The bill will be amended to allow the state Emergency Management Agency to share powers with the state Department of Public Health during emergencies. House Bill 3809 was re-referred to the Rules Committee on April 5, 2002, but has subsequently been dropped.
KS Intro	Senate Bill 597 would provide the governor and other officials with many of the same authorities during a "disaster emergency" as those granted by the MSEHPA during a "state of public health emergency." SB 597 applies to all states of "disaster emergency" whether they are caused by terrorism or natural events. The bill was referred to the Senate Judiciary Committee on Feb. 14, 2002, and died in committee on May 31, 2002, when the legislative session ended.

STATE	LEGISLATIVE STATUS UPDATE
KY Intro	Rep. Steve Nunn (R) introduced House Bill 370, An Act Relating to the Model State Emergency Health Powers Act [available at http://162.114.4.13/2002rsrecord/hb370.htm] on Jan. 16, 2002. This bill is a virtual reproduction of the Model Act. The bill was assigned to the House State Government Committee on January 17, instead of the Health and Welfare Committee [where it may have received stronger initial activity, including an early hearing]. Despite working closely with the Health and Welfare Committee to provide technical assistance, HB 370 was withdrawn on Feb. 25, 2002. A bill that calls for assessment and strengthening of strategies to combat an act of bioterrorism was introduced Jan. 8, 2002, [KY HB 88]. The bill also requires the public health authority to address the needs of education for health care workers, laboratory and communication capabilities, and reporting and surveillance in the event of a bioterrorism event. This bill passed the House on Jan. 24 and was re-referred to the Senate committee on Appropriations and Revenue on April 2, 2002. The legislative session ended on April 15, 2002, without further action taken on the existing bill.
ME Intro Passed	House Paper 1656, which includes many provisions of the Model Act, was introduced March 11, 2002 and referred by the House to the Joint Committee on Health and Human Services and the Joint Committee on Judiciary. The Senate concurs with the House's references (2001 ME H.P. 1656). On April 4, 2002, LD 2164 [as the bill was renumbered] passed both Houses and was signed by the Governor on April 11, 2002.
MD Intro Passed	On January 18, 2002, several Senators (including Sen. Hollinger) introduced S.B. 234, entitled "An Act Concerning Catastrophic Health Emergencies - Powers of the governor and the Secretary of Health and Mental Hygiene." Several of the Act's provisions are based on the Model Act. SB 234 passed both Houses and was signed by the governor on April 9, 2002. SB 239, entitled the "Maryland Emergency Management Assistance Compact," and SB 240, "An Act concerning State Government - Access to Public Records - Public Security Documents" also passed both Houses and were signed by the governor on April 9, 2002. The latter bill allows for the restriction of vulnerable governmental information that could be used for the purposes of planning or executing a terrorist attack. House Bill 303 grants special powers to and places responsibilities on the governor, health officers and the Secretary of Health and Mental Hygiene under specified circumstances. This bill passed both Houses and was signed by the governor on April 9, 2002. House Bill 296, based on the Model Act, grants special emergency powers to the governor and the Secretary of Health and Mental Hygiene whenever an imminent threat of extensive loss of life or of serious disability exists. This bill has passed both Houses and was enrolled April 5, 2002. On May 15, 2002, the governor vetoed House Bill 296, but the cross-filed bill Senate Bill 234 (referred to above) was signed.
MA Intro	Sen. Moore introduced a version of the Model Act, (2001 Mass. S.B. 2173), a.k.a. "The Massachusetts Emergency Health Powers Act," on Nov. 8, 2001. A subsequent version of the Model Act was introduced November 26, 2001, by Sen. Moore (2001 Mass. S.B. 2194). SB 2173 and SB 2194 were both referred to the Senate Ways and Means Committee on Nov. 26, 2001. On Jan. 15, 2002 the governor announced the creation of a new Bioterrorism Council led by the Director of Commonwealth Security (2001 MA S.B. 2).

STATE	LEGISLATIVE STATUS UPDATE
MN Intro Passed	Rep. Thomas Huntley introduced the Minnesota Emergency Health Powers Act, a version of the Model Act, on January 4, 2002, (2001 MN H.F. 2619). It was referred to the Committee on Health and Human Services Policy January 29, 2002. The same version of the Model Act was introduced in the Senate on February 4, 2002 by Sen. Hottinger (2001 MN S.F. 2669) [www.revisor.leg.state.mn.us/unoff/house/ccr/ccrhf3031.html]. On March 26, 2002, SF 2669 was substituted with HF 3031, introduced by Rep. Mulder on Feb. 7, 2002, (2001 MN HF 3031). An amended version of HF 3031 passed the House on March 22, 2002, and the Senate on April 3, 2002. The governor signed the bill on May 22, 2002, and it will go into effect on August 1, 2002. A summary of the Act is available at: www.house.leg.state.mn.us/hrd/bs/82/HF3031.html.
MS Intro	A version of the Model Act was introduced in both the House [January 21, 2002, by Rep. Watson, 2002 MS H.B. 1348] and the Senate [on January 21, 2002, by Sen. Furniss, 2002 MS S.B. 2737]. HB 1348 was referred to the Judiciary and Appropriations Committees on Jan. 21, 2002, and died in committee on Feb. 5. SB 2737 passed the Senate on Feb. 13, 2002, and was referred to the House Judiciary and Appropriations Committees but died in committee on March 5, 2002.
MO Intro Passed	A version of the Model Act was introduced January 9, 2002 by Senators Singleton and Sims (2002 MO S.B. 712). It passed the Senate on Feb. 20, 2002 and passed the House on May 16, 2002. It was delivered to the governor on May 28, 2002. Another version of the Model Act was introduced in the House [on January 31, 2002, by Reps. Barry & Reid (2002 MO H.B. 1771)] and the Senate [January 22, 2002, by Sen. Dougherty (2002 MO S.B. 1000)]. This version does not follow the Model Act as closely as the Singleton/Sims version. HB 1771 was referred to the House Committee on Children, Families, and Health on Feb. 14, 2002. On April 4, 2002, a public hearing was held on HB 1771. SB 1000 was referred to the Senate Health and Welfare Committee on Jan. 28, 2002. On January 9, 2002, Sen. Gross introduced a bill to create a "Governor's Expert Emergency Epidemic Response Committee" to develop a plan concerned with the public health response to acts of bioterrorism. (2002 MO S.B. 854). SB 854 was referred to the Committee on Pensions and General Laws on March 11, 2002. On March 1, 2002, Sen. Rohrbach introduced a bill based on the Model Act that would expand the applicability of the emergency powers of the governor to acts of bioterrorism. The bill was referred to the Senate Committee on Pensions and General Laws on March 12, 2002, and a hearing was conducted on March 20 (2002 MO S.B. 1280).
NE Intro	On January 22, 2002, Sen. Pam Brown of Omaha introduced a version of the Model Act in the Nebraska Legislature as LB 1224 [www.unicam.state.ne.us]. The bill was referred to the Health and Human Services Committee on January 25, 2002. A hearing on the bill was scheduled for Feb. 13, 2002, and indefinitely postponed on April 19, 2002.
NH Intro Passed	A bill based on the Model Act was introduced in the House on February 14, 2002. It was referred to the Committee on Health, Human Services and Elderly Affairs. An amended version of the bill was presented to the House on March 21, 2002. The bill passed the House and the Senate and was signed by the governor [2001 NH H.B. 1478]. On Feb. 14, 2002, a concurrent resolution was introduced that cites the CDC's recognition of the critical importance of public health organizations in responding to bioterrorism. The resolution was adopted by the Senate on March 21 and by the House on April 17, 2002, [2001 NH S.C.R. 3].

STATE	LEGISLATIVE STATUS UPDATE
NJ Intro	The New Jersey Public Health Emergency Study Commission was established on November 8, 2001, (per 2000 Bill Text NJ A.B. 3802) to study, evaluate, and develop recommendations re: the state of preparedness and the development and utilization of available resources to respond to a public health emergency in the event of an attack employing biological or chemical weapons, or a public health emergency created by an outbreak of disease, a natural disaster, or other causes not related to terrorist actions. A bill based on the Model Act was introduced in the Assembly on Feb. 11, 2002, and in the Senate on Feb. 21 [2002 NJ A.B. 1773]; [2002 NJ S.B. 1042]. On Feb. 28, 2002 Sen. Matheussen introduced the "Public Health Preparedness Act" that would allow the Commissioner of Public Health to provide comprehensive statewide planning, coordination and supervision of all activities related to public health preparedness for, and response to, a public health emergency [2002 NJ S.B. 1223]. The same bill was introduced by Rep. DiGaetano in the General Assembly on Feb. 4, 2002, [2002 NJ A.B. 1746]. (Similar to 2000 NJ A.B. 4060 introduced on Dec. 20, 2001).
NM Intro Passed	A joint memorial was introduced by Rep. Dede Feldman for the Legislative Health and Human Services Committee and the Legislative Health Subcommittee and adopted on Feb. 13, 2002. The memorial specifically cites the MSEHPA and creates a working group to evaluate existing law and make recommendations for state preparedness [2002 NM S.J.M. 62]; [2002 NM HJM 34]. An act that allows the public health authority to quarantine individuals infected with a "threatening communicable disease" was introduced on Jan. 22, 2002, and enacted on March 5, 2002, [2002 NM HB 195].
NY Intro	On November 20, 2001, Assemblyman Robin Schimminger introduced Assembly Bill 9508 [SB 5841] that replicates many of the Model Act's provisions [assembly.state.ny.us/leg/?bn=A09508]. Assembly Bill 9508 was amended in committee and presented to the General Assembly on March 5, 2002. Senate Bill 5841 was also amended in committee and presented to the committee on March 4. A committee hearing was held on March 14, 2002 in NYC.
OK Intro	The Oklahoma House of Representatives passed HB 2765 [An Act relating to the Catastrophic Emergency Health Powers Act] on March 6, 2002, (SB 1659) [www2.lsb.state.ok.us/2001-02hb/hb2765_cs.rtf]. HB 2765 and SB 1659 passed both houses with amendments. On May 23, 2002, the measures presented by the conference committee failed in the House.The House passed a bill making bioterrorism illegal on March 6, 2002. The definition of "bioterrorism" is taken directly from the Model Act [2001 OK H.B. 2764].
PA Intro	A version of the Model Act was introduced by Rep. Sturla on December 21, 2001, [2001 PA H.B. 2261]. The bill was referred to the Committee on Veterans Affairs and Emergency Preparedness on January 2, 2002. A bill that would give county health departments authority to plan for and respond to public health emergencies was introduced by Rep. Santoni on Feb. 12, 2002. It was referred to the Committee on Health and Human Services on Feb. 13, 2002, [2001 PA H.B. 2371]. On March 11, 2002, Sen. Orie introduced a bill based on the Model Act. It was referred to the Senate committee on Public Health and Welfare on March 11, 2002, [2001 PA S.B. 1338].

STATE	LEGISLATIVE STATUS UPDATE
RI Intro	A version of the Model Act was introduced by Rep. Henseler and referred to the House Committee on Health, Education and Welfare on February 5, 2002. On May 29, 2002, the committee recommended passage, and the bill was placed on the House calendar [2001 RI H.B. 7357]. Another similar version based on the Model Act was introduced by Rep. Dennigan in the House the same day and referred to the Committee on Finance [2001 RI H.B. 7563]. A bill entitled "Rhode Island State Emergency Health Powers Act" and based on the Model Act was introduced by Sen. Tassoni on March 7, 2002. It was referred to the Senate Committee on Health, Education & Welfare on the same date. On May 29, 2002, the committee recommended passage, and the bill was placed on the Senate calendar [2001 RI S.B. 2865]. House Bill 7305 and Senate Bill 2304 would allow the governor to "declare a health emergency and take action to prevent the introduction of epidemic, contagious, or infectious disease in the state." The House bill was referred to House Committee on Health, Education and Welfare on Feb. 2, 2002, and scheduled for a hearing and/or consideration on March 27, 2002. The Senate bill was referred to the Senate Committee on Health, Education and Welfare on January 29, 2002.
SD Intro Passed	On Feb. 25, 2002, South Dakota enacted a bill that defines a "public health emergency" and gives the secretary of health, with the consent of the governor, the power to declare a state of public health emergency. The bill also requires that certain specifications be included in the declaration, consistent with the language of the Model Act. [2002 S.D. H.B. 1304]. On Feb. 27, 2002, South Dakota enacted a bill to revise the governor's emergency powers in the event of a terrorist or bioterrorist attack. While not including all the provisions of the Model Act, the bill grants powers to the governor that are specifically addressed in the Model Act [2002 SD H.B. 1303].
TN Intro Passed	On January 17, 2002, Rep. Bowers and Sen. Dixon introduced a bill that is based on the Model Act (2001 TN S.B. 2392; 2001 TN H.B. 2271). Senate Bill 2392 was passed by the Senate on April 3, 2002. On April 10, 2002, House Bill 2271 was substituted with Senate Bill 2392, and Senate Bill 2392 was passed by the House on April 25, 2002. Senate Bill 2392 was signed by the governor on May 22, 2002.
UT Intro Passed	A version of the Model Act was enacted on March 18, 2002, [2002 UT H.B. 231].
VT Intro	A bill including provisions based on the Model Act was introduced on March 12, 2002, [2001 VT S.B. 298]. This bill was passed by the Senate on April 16, 2002, and passed the House on May 16, 2002. On May 23, 2002, S.B. 298 was referred to a conference committee.
VA Intro Passed	House Bill 882 would create a bioterrorism unit within the VA Dept. of Health, although the duties of the unit are not consistent in substance or language with the duties of the "Public Health Emergency Planning Commission" or other provisions of the MSEHPA. H.B. 882 was referred to the Committee on Appropriations on January 31, 2002. On February 8, 2002, the house voted for the bill to be continued to 2003 in Appropriations. Virginia passed a bill requiring physicians and laboratory directors to report diseases that could be caused by bioterrorism within 24 hours of diagnosis or identification. This bill was signed by the governor on April 7, 2002, and will become effective July 1, 2002.

STATE	LEGISLATIVE STATUS UPDATE
WA Intro	A bill was introduced on January 30, 2002, by Rep. Schual-Berkeem creating an "emergency management council" similar to the "Commission" described in the Model Act (2001 WA H.B. 2854). This bill passed the House on Feb. 16, 2002, and was approved by the Senate Committee on Health and Long-term Care on March 1, 2002. House Bill 2854 was returned to the House Rules Committee on March 14, 2002. The legislative session ended on March 14, 2002, without further action taken on the existing bill.
WI Intro	Sen. Rosenzweig and legislative and executive counsels have throughly reviewed and compared WI state law concerning provisions of the Model Act. Proposals for some amendments/editions to existing state law are under consideration by a legislative committee. A bill based on the Model Act was introduced on February 25, 2002, and referred to the Committee on Public Health [2001 WI A.B. 849, 850]. On March 26, 2002, A.B. 849 failed to pass. Assembly Bill 850 passed the Assembly on March 7, 2002, and was referred to the Senate Committee on Health, Utilities, Veterans, and Military Affairs on March 8, 2002. The legislative session ended on May 30, 2002, without further action taken on the existing bills.
WY Intro	On February 12, 2002, Sen. Scott introduced a bill to amend the Wyoming Emergency Management Act based on portions of the Model Act. The bill was amended and adopted by the Senate on February 28. On March 1, it was presented to the House Committee on Minerals, Business and Economic Development [2002 WY S.F. 67]. The legislative session ended on March 13, 2002, without further action taken on the existing bills.

Intro – States that have introduced a legislative bill or resolution based in whole or part on the Model Act

Passed – States that have enacted a legislative bill or resolution based in whole or part on the Model Act.

Appendix 2: The Model State Public Health Act - Preface

Turning Point Public Health Statute Modernization National Excellence Collaborative

The Model State Public Health Act

[www.hss.state.ak.us/dph/deu/turningpoint/publications.htm]
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THE MODEL STATE PUBLIC HEALTH ACT – PREFACE

As of June 1, 2002

The purpose of the Turning Point Public Health Statute Modernization National Collaborative is to transform and strengthen the legal framework for the public health system through a collaborative process to develop a model state public health law.

Through intensive research and consensus building among national, state, and local public health representatives, the Model State Public Health Act (hereinafter "Act") presents a comprehensive model state law that sets forth statutory language concerning public health administration and practice for consideration by existing public health agencies at the state and local levels. The Act's provisions are consistent with modern constitutional, statutory, and case-based law at the national and state levels, and reflect current scientific and ethical principles underlying modern public health practice.

The Act is presently divided into ten (10) Articles with various Sections (see Table of Contents below). It utilizes a systematic approach to the implementation of public health responsibilities and authorities. The Act focuses on the organization and delivery of essential public health services and functions based on their definition in *Public Health in America*.[1] It establishes a fundamental mission for state and local public health agencies that is carried out in collaboration with

[1] www.health.gov/phfunctions/public.htm
Adopted: Fall 1994, Source: Public Health Functions Steering Committee, Members (July 1995): American Public Health Association·Association of Schools of Public Health·Association of State and Territorial Health Officials·Environmental Council of the States·National Association of County and City Health Officials·National Association of State Alcohol and Drug Abuse Directors·National Association of State Mental Health Program Directors·Public Health Foundation·U.S. Public Health Service —Agency for Health Care Policy and Research·Centers for Disease Control and Prevention·Food and Drug Administration·Health Resources and Services Administration·Indian Health Service·National Institutes of Health·Office of the Assistant Secretary for Health·Substance Abuse and Mental Health Services Administration

various actors within the public health system. Much of the substance of the Act focuses on the traditional powers of public health agencies. These powers, however, are framed within a modern public health infrastructure that seeks to balance the protection of public health with respect for individual rights.

Though comprehensive, the scope of the Act is limited in the following ways:

• The Act does not cover some distinct areas of law despite their strong public health relevance. For example, the laws relating to mental health, alcohol and substance abuse, and regulation of health care industries are not specifically addressed. Some key issues that are not typically within the domain of public health are touched upon. Thus, while environmental protection is not covered in the Act, environmental health services (e.g., public water supplies, hazardous wastes, vector controls, and indoor air pollution) are addressed in § 6-102.

• Correspondingly, the Act does not include model provisions for all existing laws that impact the public's health (e.g., seat belt provisions, DUI laws, and tobacco control regulations).

• Nor does the Act include extensive language concerning areas of the law that are traditionally covered elsewhere in state statutes (e.g., tax provisions, administrative procedures, disabilities protections). Rather, the Act attempts to incorporate these provisions by reference.

• As a model statutory law, the Act does not specify regulatory details underlying public health practice. These details are left to the discretion of executive agencies through the promulgation of administrative regulations authorized by the Act.

The organizational content of the Act is summarized as follows (see the text of the Act itself for precise language and comments).

TABLE OF CONTENTS

ARTICLE VIII. PUBLIC HEALTH INFORMATION PRIVACY

Section

ARTICLE IX. ADMINISTRATIVE PROCEDURES, CIVIL AND CRIMINAL ENFORCEMENT, AND IMMUNITIES

Section

ARTICLE X. MISCELLANEOUS PROVISIONS

Section

Appendix 3: The Model State Emergency Health Powers Act

(as of December 21, 2001)

A Draft for Discussion Prepared by

The Center for Law and the Public's Health

at Georgetown and Johns Hopkins Universities

For the Centers for Disease Control and Prevention [CDC]

To Assist

National Governors Association [NGA],
National Conference of State Legislatures [NCSL],
Association of State and Territorial Health Officials [ASTHO], and
National Association of County and City Health Officials [NACCHO]

The Model State Emergency Health Powers Act[1]

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[1] Members of the National Association of Attorneys General (NAAG) also provided input and suggestions to the drafters of the Model Act. The language and content of this draft Model State Emergency Health Powers Act do not represent the official policy, endorsement, or views of the Center for Law and the Public's Health, the CDC, NGA, NCSL, ASTHO, NACCHO, or NAAG, or other governmental or private agencies, departments, institutions, or organizations which have provided funding or guidance to the Center for Law and the Public's Health. This draft is prepared to facilitate and encourage communication among the various interested parties and stakeholders about the complex issues pertaining to the use of state emergency health powers.

TABLE OF CONTENTS

PREAMBLE

In the wake of the tragic events of September 11, 2001, our nation realizes that the government's foremost responsibility is to protect the health, safety, and well being of its citizens. New and emerging dangers—including emergent and resurgent infectious diseases and incidents of civilian mass casualties—pose serious and immediate threats to the population. A renewed focus on the prevention, detection, management, and containment of public health emergencies is thus called for.

Emergency health threats, including those caused by bioterrorism and epidemics, require the exercise of essential government functions. Because each state is responsible for safeguarding the health, security, and well being of its people, state and local governments must be able to respond, rapidly and effectively, to public health emergencies. The Model State Emergency Health Powers Act (the "Act") therefore grants specific emergency powers to state governors and public health authorities.

The Act requires the development of a comprehensive plan to provide a coordinated, appropriate response in the event of a public health emergency. It facilitates the early detection of a health emergency by authorizing the reporting and collection of data and records, and allows for immediate investigation by granting access to individuals' health information under specified circumstances. During a public health emergency, state and local officials are authorized to use and appropriate property as necessary for the care, treatment, and housing of patients, and to destroy contaminated facilities or materials. They are also empowered to provide care, testing, and treatment, and vaccination to persons who are ill or who have been exposed to a contagious disease, and to separate affected individuals from the population at large to interrupt disease transmission.

At the same time, the Act recognizes that a state's ability to respond to a public health emergency must respect the dignity and rights of persons. The exercise of emergency health powers is designed to promote the common good. Emergency powers must be grounded in a thorough scientific understanding of public health threats and disease transmission. Guided by principles of justice, state and local governments have a duty to act with fairness and tolerance towards individuals and groups. The Act thus provides that, in the event of the exercise of emergency powers, the civil rights, liberties, and needs of infected or exposed persons will be protected to the fullest extent possible consistent with the primary goal of controlling serious health threats.

Public health laws and our courts have traditionally balanced the common good with individual civil liberties. As Justice Harlan wrote in the seminal United States Supreme Court case of *Jacobson v. Massachusetts*, "the whole people covenants with each citizen, and each citizen with the whole people, that all shall be governed by certain laws for the 'common good.'" The Act strikes such a balance. It provides state and local officials with the ability to prevent, detect, manage, and contain emergency health threats without unduly interfering with civil rights and liberties. The Act seeks to ensure a strong, effective, and timely response to public health emergencies, while fostering respect for individuals from all groups and backgrounds.

Although modernizing public health law is an important part of protecting the population during public health emergencies, the public health system itself needs improvement. Preparing for a public health emergency requires a well trained public health workforce, efficient data systems, and sufficient laboratory capacity.

ARTICLE I TITLE, FINDINGS, PURPOSES, AND DEFINITIONS

Section 101 Short title. This Act may be cited as the "Model State Emergency Health Powers Act."

Section 102 Legislative findings. The [*state legislature*] finds that:

(a) The government must do more to protect the health, safety, and general well being of its citizens.

(b) New and emerging dangers, including emergent and resurgent infectious diseases and incidents of civilian mass casualties, pose serious and immediate threats.

(c) A renewed focus on the prevention, detection, management, and containment of public health emergencies is needed.

(d) Emergency health threats, including those caused by bioterrorism, may require the exercise of extraordinary government powers and functions.

(e) This State must have the ability to respond, rapidly and effectively, to potential or actual public health emergencies.

(f) The exercise of emergency health powers must promote the common good.

(g) Emergency health powers must be grounded in a thorough scientific understanding of public health threats and disease transmission.

(h) Guided by principles of justice and antidiscrimination, it is the duty of this State to act with fairness and tolerance towards individuals and groups.

(i) The rights of people to liberty, bodily integrity, and privacy must be respected to the fullest extent possible consistent with maintaining and preserving the public's health and security.

(j) This Act is necessary to protect the health and safety of the citizens of this State.

Section 103 Purposes. The purposes of this Act are:

(a) To require the development of a comprehensive plan to provide for a coordinated, appropriate response in the event of a public health emergency.

(b) To authorize the reporting and collection of data and records, the management of property, the protection of persons, and access to communications.

(c) To facilitate the early detection of a health emergency, and allow for immediate investigation of such an emergency by granting access to individuals' health information under specified circumstances.

(d) To grant State and local officials the authority to use and appropriate property as necessary for the care, treatment, vaccination, and housing of patients, and to destroy contaminated facilities or materials.

(e) To grant State and local officials the authority to provide care, treatment, and vaccination to persons who are ill or who have been exposed to contagious diseases, and to separate affected individuals from the population at large to interrupt disease transmission.

(f) To ensure that the needs of infected or exposed persons are properly addressed to the fullest extent possible, given the primary goal of controlling serious health threats.

(g) To provide State and local officials with the ability to prevent, detect, manage, and contain emergency health threats without unduly interfering with civil rights and liberties.

Section 104 Definitions.

(a) **"Bioterrorism"** is the intentional use of any microorganism, virus, infectious substance, or biological product that may be engineered as a result of biotechnology, or any naturally occurring or bioengineered component of any such microorganism, virus, infectious substance, or biological product, to cause death, disease, or other biological malfunction in a human, an animal, a plant, or another living organism in order to influence the conduct of government or to intimidate or coerce a civilian population.

(b) **"Chain of custody"** is the methodology of tracking specimens for the purpose of maintaining control and accountability from initial collection to final disposition of the specimens and providing for accountability at each stage of collecting, handling, testing, storing, and transporting the specimens and reporting test results.

Notes

(c) **"Contagious disease"** is an infectious disease that can be transmitted from person to person.

(d) **"Health care facility"** means any non-federal institution, building, or agency or portion thereof, whether public or private (for-profit or nonprofit) that is used, operated, or designed to provide health services, medical treatment, or nursing, rehabilitative, or preventive care to any person or persons. This includes, but is not limited to, ambulatory surgical facilities, home health agencies, hospices, hospitals, infirmaries, intermediate care facilities, kidney treatment centers, long term care facilities, medical assistance facilities, mental health centers, outpatient facilities, public health centers, rehabilitation facilities, residential treatments facilities, skilled nursing facilities, and adult day-care centers. This also includes, but is not limited to, the following related property when used for or in connection with the foregoing: laboratories; research facilities; pharmacies; laundry facilities; health personnel training and lodging facilities; patient, guest, and health personnel food service facilities; and offices and office buildings for persons engaged in health care professions or services.

(e) **"Health care provider"** is any person or entity who provides health care services including, but not limited to, hospitals, medical clinics and offices, special care facilities, medical laboratories, physicians, pharmacists, dentists, physician assistants, nurse practitioners, registered and other nurses, paramedics, emergency medical or laboratory technicians, and ambulance and emergency medical workers.

(f) **"Infectious disease"** is a disease caused by a living organism or other pathogen, including a fungus, bacteria, parasite, protozoan, or virus. An infectious disease may, or may not, be transmissible from person to person, animal to person, or insect to person.

(g) **"Infectious waste"** is:

(i) **"biological waste,"** which includes blood and blood products, excretions, exudates, secretions, suctioning and other body fluids, and waste materials saturated with blood or body fluids;

(ii) **"cultures and stocks,"** which includes etiologic agents and associated biologicals, including specimen cultures and dishes and devices used to transfer, inoculate, and mix cultures, wastes from production of biologicals and serums, and discarded live and attenuated vaccines;

(iii) **"pathological waste,"** which includes biopsy materials and all human tissues, anatomical parts that emanate from surgery, obstetrical procedures, necropsy or autopsy and laboratory procedures, and animal carcasses exposed to pathogens in research and the bedding and other waste from such animals, but does not include teeth or formaldehyde or other preservative agents; and

(iv) **"sharps**,**"** which includes needles, I.V. tubing with needles attached, scalpel blades, lancets, breakable glass tubes, and syringes that have been removed from their original sterile containers.

(h) **"Isolation"** is the physical separation and confinement of an individual or groups of individuals who are infected or reasonably believed to be infected with a contagious or possibly contagious disease from non-isolated individuals, to prevent or limit the transmission of the disease to non-isolated individuals.

(i) **"Mental health support personnel"** includes, but is not limited to, psychiatrists, psychologists, social workers, and volunteer crisis counseling groups.

(j) **"Organized militia"** includes the State National Guard, the army national guard, the air national guard, or any other military force organized under the laws of this state.

(k) **"Protected health information"** is any information, whether oral, written, electronic, visual, or any other form, that relates to an individual's past, present, or future physical or mental health status, condition, treatment, service, products purchased, or provision of care, and that reveals the identity of the individual whose health care is the subject of the information, or where there is a reasonable basis to believe such information could be utilized (either alone or with other information that is, or should reasonably be known to be, available to predictable recipients of such information) to reveal the identity of that individual.

(l) **"Public health authority"** is the [*insert the title of the state's primary public health agency, department, division, or bureau*]; or any local government agency that acts principally to protect or preserve the public's health; or any person directly authorized to act on behalf of the [*insert the title of the state's primary public health agency, department, division, or bureau*] or local public health agency.

Notes

(m) A **"public health emergency"** is an occurrence or imminent threat of an illness or health condition that:

(1) is believed to be caused by any of the following:

(i) bioterrorism;

(ii) the appearance of a novel or previously controlled or eradicated infectious agent or biological toxin;

(iii) [*a natural disaster*;]

(iv) [*a chemical attack or accidental release; or*]

(v) [*a nuclear attack or accident*]; and

(2) poses a high probability of any of the following harms:

(i) a large number of deaths in the affected population;

(ii) a large number of serious or long-term disabilities in the affected population; or

(iii) widespread exposure to an infectious or toxic agent that poses a significant risk of substantial future harm to a large number of people in the affected population.

(n) **"Public safety authority"** means the [*insert the title of the state's primary public safety agency, department, division, or bureau*]; or any local government agency that acts principally to protect or preserve the public safety; or any person directly authorized to act on behalf of the [*insert the title of the state's primary public safety agency, department, division, or bureau*] or local agency.

(o) **"Quarantine"** is the physical separation and confinement of an individual or groups of individuals, who are or may have been exposed to a contagious or possibly contagious disease and who do not show signs or symptoms of a contagious disease, from non-quarantined individuals, to prevent or limit the transmission of the disease to non-quarantined individuals.

(p) **"Specimens"** include, but are not limited to, blood, sputum, urine, stool, other bodily fluids, wastes, tissues, and cultures necessary to perform required tests.

(q) **"Tests"** include, but are not limited to, any diagnostic or investigative analyses necessary to prevent the spread of disease or protect the public's health, safety, and welfare.

(r) **"Trial court"** is the trial court for the district in which isolation or quarantine is to occur, a court designated by the Public Health Emergency Plan under Article II of this Act, or to the trial court for the district in which a public health emergency has been declared.

Legislative History. The definition for "bioterrorism" was adapted from its definition in 18 U.S.C.A. § 178 (West 2000) and from definitions used by the General Accounting Office. The definitions of "chain of custody," "specimens," and "tests" were adapted from ALA. CODE § 25-5-331 (2000). The definition of "health care facility" was adapted from ARK. CODE ANN. § 20-13-901 (Michie 2000); CAL. BUS. & PROF. CODE § 4027 (West 2001); FLA. STAT. ANN. § 159.27 (West 2000). The definition of "health care provider" was adapted from OKLA. STAT. ANN. tit. 74, § 1304 (West 2001). The definition of "infectious waste" was adapted from OR. REVain. STAT. § 459.386 (1999). The definition for "organized militia" was adapted from NY CLS MILITARY § 1 (2001), MISS CODE ANN § 33-1-1 (2001), O.C.G.A. § 38-2-2 (2000), and CONN. GEN. STAT. § 27-141 (2001). The definitions of "public health authority" and "protected health information" were adapted from LAWRENCE O. GOSTIN AND JAMES G. HODGE, JR., THE MODEL STATE PUBLIC HEALTH PRIVACY ACT OF 1999. The definition of a "public health emergency" was adapted from COLO. REV. STAT. ANN. § 24-32-2103(1.5) (West 2001).

ARTICLE II PLANNING FOR A PUBLIC HEALTH EMERGENCY

Section 201 Public Health Emergency Planning Commission. The Governor shall appoint a Public Health Emergency Planning Commission ("the Commission"), consisting of the State directors, or their designees, of agencies the Governor deems relevant to public health emergency preparedness, a representative group of state legislators, members of the judiciary, and any other persons chosen by the Governor. The Governor shall also designate the chair of the Commission.

Legislative History. Section 201 is adapted from COLO. REV. STAT. ANN. § 24-32-2104 (West 2001); 2001 ILL. LAWS 73(5).

Section 202 Public Health Emergency Plan.

(a) **Content**. The Commission shall, within six months of its appointment, deliver to the Governor a plan for responding to a public health emergency, that includes provisions or guidelines on the following:

Notes

(1) Notifying and communicating with the population during a state of public health emergency in compliance with this Act;

(2) Central coordination of resources, manpower, and services, including coordination of responses by State, local, tribal, and federal agencies;

(3) The location, procurement, storage, transportation, maintenance, and distribution of essential materials, including, but not limited to, medical supplies, drugs, vaccines, food, shelter, clothing, and beds;

(4) Compliance with the reporting requirements in Section 301;

(5) The continued, effective operation of the judicial system including, if deemed necessary, the identification and training of personnel to serve as emergency judges regarding matters of isolation and quarantine as described in this Act;

(6) The method of evacuating populations, and housing and feeding the evacuated populations;

(7) The identification and training of health care providers to diagnose and treat persons with infectious diseases;

(8) The vaccination of persons, in compliance with the provisions of this Act;

(9) The treatment of persons who have been exposed to or who are infected with diseases or health conditions that may be the cause of a public health emergency.

(10) The safe disposal of infectious wastes and human remains in compliance with the provisions of this Act;

(11) The safe and effective control of persons isolated, quarantined, vaccinated, tested, or treated during a state of public health emergency;

(12) Tracking the source and outcomes of infected persons;

(13) Ensuring that each city and county within the State identifies the following:

(i) sites where persons can be isolated or quarantined in compliance with the conditions and principles for isolation or quarantine of this Act;

(ii) sites where medical supplies, food, and other essentials can be distributed to the population;

(iii) sites where public health and emergency workers can be housed and fed; and

(iv) routes and means of transportation of people and materials;

(14) Cultural norms, values, religious principles, and traditions that may be relevant; and

(15) Other measures necessary to carry out the purposes of this Act.

(b) **Distribution.** The Commission shall distribute this plan to those who will be responsible for its implementation, other interested persons, and the public, and seek their review and comments.

(c) **Review.** The Commission shall annually review its plan for responding to a public health emergency.

Legislative History. Section 202 is adapted from COLO. REV. STAT. ANN. § 24-32-2104 (West 2001); 2001 ILL. LAWS 73(5).

ARTICLE III MEASURES TO DETECT AND TRACK PUBLIC HEALTH EMERGENCIES

Section 301 Reporting.

(a) **Illness or health condition.** A health care provider, coroner, or medical examiner shall report all cases of persons who harbor any illness or health condition that may be potential causes of a public health emergency. Reportable illnesses and health conditions include, but are not limited to, the diseases caused by the biological agents listed in 42 C.F.R. § 72, app. A (2000) and any illnesses or health conditions identified by the public health authority.

(b) **Pharmacists.** In addition to the foregoing requirements for health care providers, a pharmacist shall report any unusual or increased prescription rates, unusual types of prescriptions, or unusual trends in pharmacy visits that may be potential causes of a public health emergency. Prescription-related events that require a report include, but are not limited to:

Notes

(1) an unusual increase in the number of prescriptions or over-the-counter pharmaceuticals to treat conditions that the public health authority identifies through regulations;

(2) an unusual increase in the number of prescriptions for antibiotics; and

(3) any prescription that treats a disease that is relatively uncommon or may be associated with bioterrorism.

(c) **Manner of reporting.** The report shall be made electronically or in writing within [*twenty-four (24) hours*] to the public health authority. The report shall include as much of the following information as is available: the specific illness or health condition that is the subject of the report; the patient's name, date of birth, sex, race, occupation, and current home and work addresses (including city and county); the name and address of the health care provider, coroner, or medical examiner and of the reporting individual, if different; and any other information needed to locate the patient for follow-up. For cases related to animal or insect bites, the suspected locating information of the biting animal or insect, and the name and address of any known owner, shall be reported.

(d) **Animal diseases.** Every veterinarian, livestock owner, veterinary diagnostic laboratory director, or other person having the care of animals shall report animals having or suspected of having any diseases that may be potential causes of a public health emergency. The report shall be made electronically or in writing within [*twenty-four (24) hours*] to the public health authority and shall include as much of the following information as is available: the specific illness or health condition that is the subject of the report; the suspected locating information of the animal, the name and address of any known owner, and the name and address of the reporting individual.

(e) **Laboratories.** For the purposes of this Section, the definition of "**health care provider**" shall include out-of-state medical laboratories, provided that such laboratories have agreed to the reporting requirements of this State. Results must be reported by the laboratory that performs the test, but an in-state laboratory that sends specimens to an out-of-state laboratory is also responsible for reporting results.

(f) **Enforcement.** The public health authority may enforce the provisions of this Section in accordance with existing enforcement rules and regulations.

Legislative History. In Section 301, the language used in Subsections (a)–(d) were adapted from 6 COLO. CODE REGS. § 1009-1, reg. 1 (WESTLAW through 2001), except that the lists of events in (b) was adapted from the *Bioterrorism Readiness Plan: A Template for Healthcare Facilities* (Prepared by APIC Bioterrorism Task Force & CDC Hospital Infections Program Bioterrorism Working Group). Subsection (e) was adapted from 6 COLO. CODE REGS. § 1009-1, reg. 3 (WESTLAW through 2001).

Section 302 Tracking. The public health authority shall ascertain the existence of cases of an illness or health condition that may be potential causes of a public health emergency; investigate all such cases for sources of infection and to ensure that they are subject to proper control measures; and define the distribution of the illness or health condition. To fulfill these duties, the public health authority shall identify exposed individuals as follows:

(a) **Identification of individuals.** Acting on information developed in accordance with Section 301 of this Act, or other reliable information, the public health authority shall identify all individuals thought to have been exposed to an illness or health condition that may be a potential cause of a public health emergency.

(b) **Interviewing of individuals.** The public health authority shall counsel and interview such individuals where needed to assist in the positive identification of exposed individuals and develop information relating to the source and spread of the illness or health condition. Such information includes the name and address (including city and county) of any person from whom the illness or health condition may have been contracted and to whom the illness or health condition may have spread.

(c) **Examination of facilities or materials.** The public health authority shall, for examination purposes, close, evacuate, or decontaminate any facility or decontaminate or destroy any material when the authority reasonably suspects that such facility or material may endanger the public health.

(d) **Enforcement.** The public health authority may enforce the provisions of this Section in accordance with existing enforcement rules and regulations. An order of the public health authority given to effectuate the purposes of this Section shall be enforceable immediately by the public safety authority.

Legislative History. In Section 302, the main text under "Tracking" was adapted from CAL. HEALTH & SAFETY CODE § 120575 (West 1996). Subsections (a) and (b) were adapted from FLA. STAT. ANN. § 392.54 (West 1998); CAL. HEALTH & SAFETY CODE § 120555 (West 1996); N.Y. COMP. CODES R. & REGS. tit. 10, § 2.6 (LEXIS through Oct. 12, 2001).

Notes

Section 303 Information sharing.

(a) Whenever the public safety authority or other state or local government agency learns of a case of a reportable illness or health condition, an unusual cluster, or a suspicious event that may be the cause of a public health emergency, it shall immediately notify the public health authority.

(b) Whenever the public health authority learns of a case of a reportable illness or health condition, an unusual cluster, or a suspicious event that it reasonably believes has the potential to be caused by bioterrorism, it shall immediately notify the public safety authority, tribal authorities, and federal health and public safety authorities.

(c) Sharing of information on reportable illnesses, health conditions, unusual clusters, or suspicious events between public health and safety authorities shall be restricted to the information necessary for the treatment, control, investigation, and prevention of a public health emergency.

Legislative History. Section 303 was adapted from 6 COLO. CODE REGS. § 1009-1, reg. 6 (WESTLAW through 2001).

ARTICLE IV DECLARING A STATE OF PUBLIC HEALTH EMERGENCY

Section 401 Declaration. A state of public health emergency may be declared by the Governor upon the occurrence of a "public health emergency" as defined in Section 1-103(m). Prior to such a declaration, the Governor shall consult with the public health authority and may consult with any additional public health or other experts as needed. The Governor may act to declare a public health emergency without consulting with the public health authority or other experts when the situation calls for prompt and timely action.

Legislative History. Section 401 is adapted from language contained in COLO. REV. STAT. ANN. §§ 24-32-2104(3)(a), 4 (West 2001); 42 U.S.C.A. § 247d (West 1991 & Supp. 2001).

Section 402 Content of declaration. A state of public health emergency shall be declared by an executive order that specifies:

(a) the nature of the public health emergency,

(b) the political subdivision(s) or geographic area(s) subject to the declaration,

(c) the conditions that have brought about the public health emergency,

(d) the duration of the state of the public health emergency, if less than thirty (30) days, and

(e) the primary public health authority responding to the emergency.

Legislative History. Section 402 is adapted from COLO. REV. STAT. ANN. § 24-32-2104(4) (West 2001); 2001 LA. ACTS 1148.

Section 403 Effect of declaration. The declaration of a state of public health emergency shall activate the disaster response and recovery aspects of the State, local, and inter-jurisdictional disaster emergency plans in the affected political subdivision(s) or geographic area(s). Such declaration authorizes the deployment and use of any forces to which the plans apply and the use or distribution of any supplies, equipment, and materials and facilities assembled, stockpiled, or available pursuant to this Act.

(a) **Emergency powers.** During a state of public health emergency, the Governor may:

(1) Suspend the provisions of any regulatory statute prescribing procedures for conducting State business, or the orders, rules and regulations of any State agency, to the extent that strict compliance with the same would prevent, hinder, or delay necessary action (including emergency purchases) by the public health authority to respond to the public health emergency, or increase the health threat to the population.

(2) Utilize all available resources of the State government and its political subdivisions, as reasonably necessary to respond to the public health emergency.

(3) Transfer the direction, personnel, or functions of State departments and agencies in order to perform or facilitate response and recovery programs regarding the public health emergency.

(4) Mobilize all or any part of the organized militia into service of the State. An order directing the organized militia to report for active duty shall state the purpose for which it is mobilized and the objectives to be accomplished.

(5) Provide aid to and seek aid from other states in accordance with any interstate emergency compact made with this State.

Notes

(6) Seek aid from the federal government in accordance with federal programs or requirements.

(b) **Coordination.** The public health authority shall coordinate all matters pertaining to the public health emergency response of the State. The public health authority shall have primary jurisdiction, responsibility, and authority for:

(1) Planning and executing public health emergency assessment, mitigation, preparedness response, and recovery for the State;

(2) Coordinating public health emergency response between State and local authorities;

(3) Collaborating with relevant federal government authorities, elected officials of other states, private organizations or companies;

(4) Coordinating recovery operations and mitigation initiatives subsequent to public health emergencies; and

(5) Organizing public information activities regarding public health emergency response operations.

(c) **Identification.** After the declaration of a state of public health emergency, special identification for all public health personnel working during the emergency shall be issued as soon as possible. The identification shall indicate the authority of the bearer to exercise public health functions and emergency powers during the state of public health emergency. Public health personnel shall wear the identification in plain view.

Legislative History. The main text of Section 403 was adapted from COLO. REV. STAT. ANN. § 24-32-2104(5) (West 2001); 2001 ILL. LAWS 73(11). Section 403, Subsection (a) was adapted from 2001 ILL. LAWS 73(7); except that paragraph (4) was adapted from ARIZ. REV. STAT. ANN. § 26-172 (West 2000). Subsection (b) was drafted in consideration of the Emergency Management Assistance Compact and Alaska's Interstate Civil Defense and Disaster Compact, As. § 26.23.130. Subsection (c) was adapted from KY. REV. STAT. ANN. § 39A.050(2)(d) (LEXIS through 2001 Sess.).

Section 404 Enforcement. During a state of public health emergency, the public health authority may request assistance in enforcing orders pursuant to this Act from the public safety authority. The public safety authority may request assistance from the organized militia in enforcing the orders of the public health authority.

Legislative History. Section 404 was adapted from ARIZ. REV. STAT. ANN. § 26-172 (West 2000).

Section 405 Termination of declaration.

(a) **Executive order.** The Governor shall terminate the declaration of a state of public health emergency by executive order upon finding that the occurrence of an illness or health condition that caused the emergency no longer poses a high probability of a large number of deaths in the affected population, a large number of incidents of serious permanent or long-term disability in the affected population, or a significant risk of substantial future harm to a large number of people in the affected population.

(b) **Automatic termination.** Notwithstanding any other provision of this Act, the declaration of a state of public health emergency shall be terminated automatically after thirty (30) days unless renewed by the Governor under the same standards and procedures set forth in this Article. Any such renewal shall also be terminated automatically after thirty (30) days unless renewed by the Governor under the same standards and procedures set forth in this Article.

(c) **State legislature.** By a majority vote in both chambers, the State legislature may terminate the declaration of a state of public health emergency at any time from the date of original declaration upon finding that the occurrence of an illness or health condition that caused the emergency does not or no longer poses a high probability of a large number of deaths in the affected population, a large number of incidents of serious permanent or long-term disability in the affected population, or a significant risk of substantial future harm to a large number of people in the affected population. Such a termination by the State legislature shall override any renewal by the Governor.

(d) **Content of termination order.** All orders or legislative actions terminating the declaration of a state of public health emergency shall indicate the nature of the emergency, the area(s) that was threatened, and the conditions that make possible the termination of the declaration.

Legislative History. Section 405 was adapted from COLO. REV. STAT. ANN. §§ 24-32-2104(3)(a), 4 (West 2001); 42 U.S.C.A. § 247d (West 1991 & Supp. 2001); 2001 LA. ACTS 1148.

Notes

ARTICLE V SPECIAL POWERS DURING A STATE OF PUBLIC HEALTH EMERGENCY: MANAGEMENT OF PROPERTY

Section 501 Emergency measures concerning facilities and materials. The public health authority may exercise, for such period as the state of public health emergency exists, the following powers over facilities or materials:

(a) **Facilities.** To close, direct and compel the evacuation of, or to decontaminate or cause to be decontaminated any facility of which there is reasonable cause to believe that it may endanger the public health.

(b) **Materials.** To decontaminate or cause to be decontaminated, or destroy any material of which there is reasonable cause to believe that it may endanger the public health.

Legislative History. In Section 501, Subsection (a) was adapted from GA. CODE ANN. § 38-3-51 (1995); Subsection (b) was adapted from COLO. REV. STAT. ANN. § 24-32-2104 (West 2001).

Section 502 Access to and control of facilities and property - generally. The public health authority may exercise, for such period as the state of public health emergency exists, the following powers concerning facilities, materials, roads, or public areas:

(a) **Use of materials and facilities.** To procure, by condemnation or otherwise, construct, lease, transport, store, maintain, renovate, or distribute materials and facilities as may be reasonable and necessary to respond to the public health emergency, with the right to take immediate possession thereof. Such materials and facilities include, but are not limited to, communication devices, carriers, real estate, fuels, food, and clothing.

(b) **Use of health care facilities.** To require a health care facility to provide services or the use of its facility if such services or use are reasonable and necessary to respond to the public health emergency as a condition of licensure, authorization or the ability to continue doing business in the state as a health care facility. The use of the health care facility may include transferring the management and supervision of the health care facility to the public health authority for a limited or unlimited period of time, but shall not exceed the termination of the declaration of a state of public health emergency.

(c) **Control of materials.** To inspect, control, restrict, and regulate by rationing and using quotas, prohibitions on shipments, allocation, or other means, the use, sale, dispensing, distribution, or transportation of food, fuel, clothing and other commodities, as may be reasonable and necessary to respond to the public health emergency.

(d) **Control of roads and public areas.**

(1) To prescribe routes, modes of transportation, and destinations in connection with evacuation of persons or the provision of emergency services.

(2) To control or limit ingress and egress to and from any stricken or threatened public area, the movement of persons within the area, and the occupancy of premises therein, if such action is reasonable and necessary to respond to the public health emergency.

Legislative History. In Section 502, Subsections (a) and (b) were adapted from GA. CODE ANN. § 38-3-51 (1995). Subsections (c) and (d) were adapted from 2001 LA. ACTS 1148; 2001 ILL. LAWS 73; except that (d)(2) also had GA. CODE ANN. § 38-3-51 (1995) as a source.

Section 503 Safe disposal of infectious waste. The public health authority may exercise, for such period as the state of public health emergency exists, the following powers regarding the safe disposal of infectious waste:

(a) **Adopt measures.** To adopt and enforce measures to provide for the safe disposal of infectious waste as may be reasonable and necessary to respond to the public health emergency. Such measures may include, but are not limited to, the collection, storage, handling, destruction, treatment, transportation, and disposal of infectious waste.

(b) **Control of facilities.** To require any business or facility authorized to collect, store, handle, destroy, treat, transport, and dispose of infectious waste under the laws of this State, and any landfill business or other such property, to accept infectious waste, or provide services or the use of the business, facility, or property if such action is reasonable and necessary to respond to the public health emergency as a condition of licensure, authorization, or the ability to continue doing business in the state as such a business or facility. The use of the business, facility, or property may include transferring the management and supervision of such business, facility, or property to the public health authority for a limited or unlimited period of time, but shall not exceed the termination of the declaration of a state of public health emergency.

Notes

(c) **Use of facilities.** To procure, by condemnation or otherwise, any business or facility authorized to collect, store, handle, destroy, treat, transport, and dispose of infectious waste under the laws of this State and any landfill business or other such property as may be reasonable and necessary to respond to the public health emergency, with the right to take immediate possession thereof.

(d) **Identification.** All bags, boxes, or other containers for infectious waste shall be clearly identified as containing infectious waste, and if known, the type of infectious waste.

Legislative History. In Section 503, Subsection (d) was adapted from OR. REV. STAT. § 459.390 (1999); MINN. STAT. ANN. § 116.78(2) (West 1997 & Supp. 2001); MONT. CODE ANN. § 75-10-1005 (2001).

Section 504 Safe disposal of human remains. The public health authority may exercise, for such period as the state of public health emergency exists, the following powers regarding the safe disposal of human remains:

(a) **Adopt measures.** To adopt and enforce measures to provide for the safe disposal of human remains as may be reasonable and necessary to respond to the public health emergency. Such measures may include, but are not limited to, the embalming, burial, cremation, interment, disinterment, transportation, and disposal of human remains.

(b) **Possession.** To take possession or control of any human remains.

(c) **Disposal.** To order the disposal of any human remains of a person who has died of a contagious disease through burial or cremation within twenty-four (24) hours after death. To the extent possible, religious, cultural, family, and individual beliefs of the deceased person or his or her family shall be considered when disposing of any human remains.

(d) **Control of facilities.** To require any business or facility authorized to embalm, bury, cremate, inter, disinter, transport, and dispose of human remains under the laws of this State to accept any human remains or provide the use of its business or facility if such actions are reasonable and necessary to respond to the public health emergency as a condition of licensure, authorization, or the ability to continue doing business in the state as such a business or facility. The use of the business or facility may include transferring the management and supervision of such business or facility to the public health authority for a limited or unlimited period of time, but shall not exceed the termination of the declaration of a state of public health emergency.

(e) **Use of facilities.** To procure, by condemnation or otherwise, any business or facility authorized to embalm, bury, cremate, inter, disinter, transport, and dispose of human remains under the laws of this State as may be reasonable and necessary to respond to the public health emergency, with the right to take immediate possession thereof.

(f) **Labeling.** Every human remains prior to disposal shall be clearly labeled with all available information to identify the decedent and the circumstances of death. Any human remains of a deceased person with a contagious disease shall have an external, clearly visible tag indicating that the human remains is infected and, if known, the contagious disease.

(g) **Identification.** Every person in charge of disposing of any human remains shall maintain a written or electronic record of each human remains and all available information to identify the decedent and the circumstances of death and disposal. If human remains cannot be identified prior to disposal, a qualified person shall, to the extent possible, take fingerprints and photographs of the human remains, obtain identifying dental information, and collect a DNA specimen. All information gathered under this paragraph shall be promptly forwarded to the public health authority.

Legislative History. In Section 504, Subsection (a) is adapted from CAL. HEALTH & SAFETY CODE § 102115 (West 1996); GA. CODE ANN. § 43-18-72(b) (1999). Subsection (b) is adapted from CAL. HEALTH & SAFETY CODE § 120140 (West 1996). Subsection (c) is adapted from OHIO REV. CODE ANN. § 3707.19 (Anderson 1999). Subsection (d) is adapted from KY. REV. STAT. ANN. § 39F.020(4) (LEXIS through 2001 Sess.). Subsection (f) is adapted from LA. REV. STAT. ANN. § 40:1099.1 (West 2001). Subsection (g) was adapted from OHIO REV. CODE ANN. § 313.08 (Anderson 1998 & Supp. 2000).

Section 505 Control of health care supplies.

(a) **Procurement.** The public health authority may purchase and distribute antitoxins, serums, vaccines, immunizing agents, antibiotics, and other pharmaceutical agents or medical supplies that it deems advisable in the interest of preparing for or controlling a public health emergency, without any additional legislative authorization.

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(b) **Rationing.** If a state of public health emergency results in a state-wide or regional shortage or threatened shortage of any product under (a), whether or not such product has been purchased by the public health authority, the public health authority may control, restrict, and regulate by rationing and using quotas, prohibitions on shipments, allocation, or other means, the use, sale, dispensing, distribution, or transportation of the relevant product necessary to protect the public health, safety, and welfare of the people of the State.

(c) **Priority.** In making rationing or other supply and distribution decisions, the public health authority may give preference to health care providers, disaster response personnel, and mortuary staff.

(d) **Distribution.** During a state of public health emergency, the public health authority may procure, store, or distribute any anti-toxins, serums, vaccines, immunizing agents, antibiotics, and other pharmaceutical agents or medical supplies located within the State as may be reasonable and necessary to respond to the public health emergency, with the right to take immediate possession thereof. If a public health emergency simultaneously affects more than one state, nothing in this Section shall be construed to allow the public health authority to obtain anti-toxins, serums, vaccines, immunizing agents, antibiotics, and other pharmaceutical agents or medical supplies for the primary purpose of hoarding such items or preventing their fair and equitable distribution among affected states.

Legislative History. In Section 505, Subsection (a) was adapted from N.H. REV. STAT. ANN. § 141-C-17 (1996). Subsection (b) was adapted from CONN. GEN. STAT. ANN. § 42-231 (West 1958).

Section 506 Compensation. The State shall pay just compensation to the owner of any facilities or materials that are lawfully taken or appropriated by a public health authority for its temporary or permanent use under this Article according to the procedures and standards set forth in Section 805 of this Act. Compensation shall not be provided for facilities or materials that are closed, evacuated, decontaminated, or destroyed when there is reasonable cause to believe that they may endanger the public health pursuant to Section 501.

Section 507 Destruction of property. To the extent practicable consistent with the protection of public health, prior to the destruction of any property under this Article, the public health authority shall institute appropriate civil proceedings against the property to be destroyed in accordance with the existing laws and rules of the courts of this State or any such rules that may be developed by the courts for use during a state of public health emergency. Any property acquired by the public health authority through such proceedings shall, after entry of the decree, be disposed of by destruction as the court may direct.

ARTICLE VI SPECIAL POWERS DURING A STATE OF PUBLIC HEALTH EMERGENCY: PROTECTION OF PERSONS

Section 601 Protection of persons. During a state of public health emergency, the public health authority shall use every available means to prevent the transmission of infectious disease and to ensure that all cases of contagious disease are subject to proper control and treatment.

Legislative History. Section 601 was adapted from CAL. HEALTH & SAFETY CODE § 120575 (West 1996).

Section 602 Medical examination and testing. During a state of public health emergency the public health authority may perform physical examinations and/or tests as necessary for the diagnosis or treatment of individuals.

(a) Medical examinations or tests may be performed by any qualified person authorized to do so by the public health authority.

(b) Medical examinations or tests must not be such as are reasonably likely to lead to serious harm to the affected individual.

(c) The public health authority may isolate or quarantine, pursuant to Section 604, any person whose refusal of medical examination or testing results in uncertainty regarding whether he or she has been exposed to or is infected with a contagious or possibly contagious disease or otherwise poses a danger to public health.

Legislative History. Section 602 was adapted from CAL. HEALTH & SAFETY CODE § 120580 (West 1996 & Supp. 2001); CAL. HEALTH & SAFETY CODE § 120540 (West 1996); N.Y. COMP. CODES R. & REGS. tit. 10, § 2.5 (LEXIS through Oct. 12, 2001).

Section 603 Vaccination and treatment. During a state of public health emergency the public health authority may exercise the following emergency powers over persons as necessary to address the public health emergency:

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(a) **Vaccination.** To vaccinate persons as protection against infectious disease and to prevent the spread of contagious or possibly contagious disease.

(1) Vaccination may be performed by any qualified person authorized to do so by the public health authority.

(2) A vaccine to be administered must not be such as is reasonably likely to lead to serious harm to the affected individual.

(3) To prevent the spread of contagious or possibly contagious disease the public health authority may isolate or quarantine, pursuant to Section 604, persons who are unable or unwilling for reasons of health, religion, or conscience to undergo vaccination pursuant to this Section.

(b) **Treatment.** To treat persons exposed to or infected with disease.

(1) Treatment may be administered by any qualified person authorized to do so by the public health authority.

(2) Treatment must not be such as is reasonably likely to lead to serious harm to the affected individual.

(3) To prevent the spread of contagious or possibly contagious disease the public health authority may isolate or quarantine, pursuant to Section 604, persons who are unable or unwilling for reasons of health, religion, or conscience to undergo treatment pursuant to this Section.

Legislative History. Section 603 was adapted from CAL. HEALTH & SAFETY CODE §§ 120175, 120575, 120605 (West 1996); CAL. HEALTH & SAFETY CODE § 120580 (West 1996 & Supp. 2001).

Section 604 Isolation and quarantine.

(a) **Authorization.** During the public health emergency, the public health authority may isolate (consistent with the definition of "isolation" in Section 103(h)) or quarantine (consistent with the definition of quarantine in Section 103(o)) an individual or groups of individuals. This includes individuals or groups who have not been vaccinated, treated, tested, or examined pursuant to Sections 602 and 603. The public health authority may also establish and maintain places of isolation and quarantine, and set rules and make orders. Failure to obey these rules, orders, or provisions shall constitute a misdemeanor.

(b) **Conditions and principles.** The public health authority shall adhere to the following conditions and principles when isolating or quarantining individuals or groups of individuals:

(1) Isolation and quarantine must be by the least restrictive means necessary to prevent the spread of a contagious or possibly contagious disease to others and may include, but are not limited to, confinement to private homes or other private and public premises.

(2) Isolated individuals must be confined separately from quarantined individuals.

(3) The health status of isolated and quarantined individuals must be monitored regularly to determine if they require isolation or quarantine.

(4) If a quarantined individual subsequently becomes infected or is reasonably believed to have become infected with a contagious or possibly contagious disease he or she must promptly be removed to isolation.

(5) Isolated and quarantined individuals must be immediately released when they pose no substantial risk of transmitting a contagious or possibly contagious disease to others.

(6) The needs of persons isolated and quarantined shall be addressed in a systematic and competent fashion, including, but not limited to, providing adequate food, clothing, shelter, means of communication with those in isolation or quarantine and outside these settings, medication, and competent medical care.

(7) Premises used for isolation and quarantine shall be maintained in a safe and hygienic manner and be designed to minimize the likelihood of further transmission of infection or other harms to persons isolated and quarantined.

(8) To the extent possible, cultural and religious beliefs should be considered in addressing the needs of individuals, and establishing and maintaining isolation and quarantine premises.

(c) **Cooperation.** Persons subject to isolation or quarantine shall obey the public health authority's rules and orders; and shall not go beyond the isolation or quarantine premises. Failure to obey these provisions shall constitute a misdemeanor.

Notes

(d) **Entry into isolation or quarantine premises.**

(1) **Authorized entry.** The public health authority may authorize physicians, health care workers, or others access to individuals in isolation or quarantine as necessary to meet the needs of isolated or quarantined individuals.

(2) **Unauthorized entry.** No person, other than a person authorized by the public health authority, shall enter isolation or quarantine premises. Failure to obey this provision shall constitute a misdemeanor.

(3) **Potential isolation or quarantine.** Any person entering an isolation or quarantine premises with or without authorization of the public health authority may be isolated or quarantined pursuant to Section 604(a).

Section 605 Procedures for isolation and quarantine. During a public health emergency, the isolation and quarantine of an individual or groups of individuals shall be undertaken in accordance with the following procedures.

(a) **Temporary isolation and quarantine without notice.**

(1) **Authorization.** The public health authority may temporarily isolate or quarantine an individual or groups of individuals through a written directive if delay in imposing the isolation or quarantine would significantly jeopardize the public health authority's ability to prevent or limit the transmission of a contagious or possibly contagious disease to others.

(2) **Content of directive.** The written directive shall specify the following: (i) the identity of the individual(s) or groups of individuals subject to isolation or quarantine; (ii) the premises subject to isolation or quarantine; (iii) the date and time at which isolation or quarantine commences; (iv) the suspected contagious disease if known; and (v) a copy of Article 6 and relevant definitions of this Act.

(3) **Copies.** A copy of the written directive shall be given to the individual to be isolated or quarantined or, if the order applies to a group of individuals and it is impractical to provide individual copies, it may be posted in a conspicuous place in the isolation or quarantine premises.

(4) **Petition for continued isolation or quarantine.** Within ten (10) days after issuing the written directive, the public health authority shall file a petition pursuant to Section 605(b) for a court order authorizing the continued isolation or quarantine of the isolated or quarantined individual or groups of individuals.

(b) **Isolation or quarantine with notice.**

(1) **Authorization.** The public health authority may make a written petition to the trial court for an order authorizing the isolation or quarantine of an individual or groups of individuals.

(2) **Content of petition.** A petition under subsection (b)(1) shall specify the following: (i) the identity of the individual(s) or groups of individuals subject to isolation or quarantine; (ii) the premises subject to isolation or quarantine; (iii) the date and time at which isolation or quarantine commences; (iv) the suspected contagious disease if known; (v) a statement of compliance with the conditions and principles for isolation and quarantine of Section 604(b); and (vi) a statement of the basis upon which isolation or quarantine is justified in compliance with this Article. The petition shall be accompanied by the sworn affidavit of the public health authority attesting to the facts asserted in the petition, together with any further information that may be relevant and material to the court's consideration.

(3) **Notice.** Notice to the individuals or groups of individuals identified in the petition shall be accomplished within twenty-four (24) hours in accordance with the rules of civil procedure.

(4) **Hearing.** A hearing must be held on any petition filed pursuant to this subsection within five (5) days of filing of the petition. In extraordinary circumstances and for good cause shown the public health authority may apply to continue the hearing date on a petition filed pursuant to this Section for up to ten (10) days, which continuance the court may grant in its discretion giving due regard to the rights of the affected individuals, the protection of the public's health, the severity of the emergency and the availability of necessary witnesses and evidence.

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(5) **Order.** The court shall grant the petition if, by a preponderance of the evidence, isolation or quarantine is shown to be reasonably necessary to prevent or limit the transmission of a contagious or possibly contagious disease to others.

(i) An order authorizing isolation or quarantine may do so for a period not to exceed thirty (30) days.

(ii) The order shall (a) identify the isolated or quarantined individuals or groups of individuals by name or shared or similar characteristics or circumstances; (b) specify factual findings warranting isolation or quarantine pursuant to this Act; (c) include any conditions necessary to ensure that isolation or quarantine is carried out within the stated purposes and restrictions of this Act; and (d) served on affected individuals or groups of individuals in accordance with the rules of civil procedure.

(6) **Continuances**. Prior to the expiration of an order issued pursuant to Section 605(b)(5), the public health authority may move to continue isolation or quarantine for additional periods not to exceed thirty (30) days each. The court shall consider the motion in accordance with standards set forth in Section 605(b)(5).

(c) **Relief from isolation and quarantine.**

(1) **Release.** An individual or group of individuals isolated or quarantined pursuant to this Act may apply to the trial court for an order to show cause why the individual or group of individuals should not be released. The court shall rule on the application to show cause within forty-eight (48) hours of its filing. If the court grants the application, the court shall schedule a hearing on the order to show cause within twenty-four (24) hours from issuance of the order to show cause. The issuance of an order to show cause shall not stay or enjoin an isolation or quarantine order.

(2) **Remedies for breach of conditions.** An individual or groups of individuals isolated or quarantined pursuant to this Act may request a hearing in the trial court for remedies regarding breaches to the conditions of isolation or quarantine. A request for a hearing shall not stay or enjoin an isolation or quarantine order.

(i) Upon receipt of a request under this subsection alleging extraordinary circumstances justifying the immediate granting of relief, the court shall fix a date for hearing on the matters alleged not more than twenty-four (24) hours from receipt of the request.

(ii) Otherwise, upon receipt of a request under this subsection the court shall fix a date for hearing on the matters alleged within five (5) days from receipt of the request.

(3) **Extensions.** In any proceedings brought for relief under this subsection, in extraordinary circumstances and for good cause shown the public health authority may move the court to extend the time for a hearing, which extension the court in its discretion may grant giving due regard to the rights of the affected individuals, the protection of the public's health, the severity of the emergency and the availability of necessary witnesses and evidence.

(d) **Proceedings.** A record of the proceedings pursuant to this Section shall be made and retained. In the event that, given a state of public health emergency, parties can not personally appear before the court, proceedings may be conducted by their authorized representatives and be held via any means that allows all parties to fully participate.

(e) **Court to appoint counsel and consolidate claims.**

(1) **Appointment.** The court shall appoint counsel at state expense to represent individuals or groups of individuals who are or who are about to be isolated or quarantined pursuant to the provisions of this Act and who are not otherwise represented by counsel. Appointments shall be made in accordance with the procedures to be specified in the Public Health Emergency Plan and shall last throughout the duration of the isolation or quarantine of the individual or groups of individuals. The public health authority must provide adequate means of communication between such individuals or groups and their counsel.

(2) **Consolidation.** In any proceedings brought pursuant to this Section, to promote the fair and efficient operation of justice and having given due regard to the rights of the affected individuals, the protection of the public's health, the severity of the emergency and the availability of necessary witnesses and evidence, the court may order the consolidation of individual claims into group or claims where:

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(i) the number of individuals involved or to be affected is so large as to render individual participation impractical;

(ii) there are questions of law or fact common to the individual claims or rights to be determined;

(iii) the group claims or rights to be determined are typical of the affected individuals' claims or rights; and

(iv) the entire group will be adequately represented in the consolidation.

Legislative History. Sections 604 and 605 were adapted from CAL. HEALTH & SAFETY CODE §§ 120130, 120225 (West 1996); N.H. REV. STAT. ANN. § 141-C:11 -14; CONN. GEN. STAT. ANN. § 19a-221 (West 1958).

Section 606 Collection of laboratory specimens; performance of tests. The public health authority may, for such period as the state of public health emergency exists, collect specimens and perform tests on living persons as provided in Section 602 and also upon deceased persons and any animal (living or deceased), and acquire any previously collected specimens or test results that are reasonable and necessary to respond to the public health emergency.

(a) **Marking**. All specimens shall be clearly marked.

(b) **Contamination.** Specimen collection, handling, storage, and transport to the testing site shall be performed in a manner that will reasonably preclude specimen contamination or adulteration and provide for the safe collection, storage, handling, and transport of such specimen.

(c) **Chain of custody.** Any person authorized to collect specimens or perform tests shall use chain of custody procedures to ensure proper record keeping, handling, labeling, and identification of specimens to be tested. This requirement applies to all specimens, including specimens collected using on-site testing kits.

(d) **Criminal investigation.** Recognizing that, during a state of public health emergency, any specimen collected or test performed may be evidence in a criminal investigation, any business, facility, or agency authorized to collect specimens or perform tests shall provide such support as is reasonable and necessary to aid in a relevant criminal investigation.

Legislative History. Section 606 was adapted from CAL. BUS. & PROF. CODE § 681 (LEXIS through Aug. 12, 2001); MISS. CODE ANN. § 71-7-9 (2000); GA. CODE ANN. § 34-9-415 (1998 & Supp. 2001); and CAL. PENAL CODE § 13823.11 (LEXIS through Aug. 12, 2001).

Notes

Section 607 Access to and disclosure of protected health information.

(a) **Access.** Access to protected health information of persons who have participated in medical testing, treatment, vaccination, isolation, or quarantine programs or efforts by the public health authority during a public health emergency shall be limited to those persons having a legitimate need to acquire or use the information to:

(1) provide treatment to the individual who is the subject of the health information,

(2) conduct epidemiologic research, or

(3) investigate the causes of transmission.

(b) **Disclosure.** Protected health information held by the public health authority shall not be disclosed to others without individual written, specific informed consent, except for disclosures made:

(1) directly to the individual;

(2) to the individual's immediate family members or personal representative;

(3) to appropriate federal agencies or authorities pursuant to federal law;

(4) pursuant to a court order to avert a clear danger to an individual or the public health; or

(5) to identify a deceased individual or determine the manner or cause of death.

Legislative History. Section 607 was adapted from Lawrence O. Gostin and James G. Hodge, Jr., The Model State Public Health Privacy Act of 1999.

Section 608 Licensing and appointment of health personnel. The public health authority may exercise, for such period as the state of public health emergency exists, the following emergency powers regarding licensing and appointment of health personnel:

(a) **Health care providers.** To require in-state health care providers to assist in the performance of vaccination, treatment, examination, or testing of any individual as a condition of licensure, authorization, or the ability to continue to function as a health care provider in this State.

(b) **Health care providers from other jurisdictions.** To appoint and prescribe the duties of such out-of-state emergency health care providers as may be reasonable and necessary to respond to the public health emergency.

(1) The appointment of out-of-state emergency health care providers may be for a limited or unlimited time, but shall not exceed the termination of the declaration of a state of public health emergency. The public health authority may terminate the out-of-state appointments at any time or for any reason provided that any such termination will not jeopardize the health, safety, and welfare of the people of this State.

(2) The public health authority may waive any or all licensing requirements, permits, or fees required by the State code and applicable orders, rules, or regulations for health care providers from other jurisdictions to practice in this State.

(3) Any out-of-state emergency health care provider appointed pursuant to this Section shall not be held liable for any civil damages as a result of medical care or treatment related to the response to the public health emergency unless such damages result from providing, or failing to provide, medical care or treatment under circumstances demonstrating a reckless disregard for the consequences so as to affect the life or health of the patient.

(c) **Personnel to perform duties of medical examiner or coroner.** To authorize the medical examiner or coroner to appoint and prescribe the duties of such emergency assistant medical examiners or coroners as may be required for the proper performance of the duties of the office.

(1) The appointment of emergency assistant medical examiners or coroners may be for a limited or unlimited time, but shall not exceed the termination of the declaration of a state of public health emergency. The medical examiner or coroner may terminate such emergency appointments at any time or for any reason, provided that any such termination will not impede the performance of the duties of the office.

(2) The medical examiner or coroner may waive licensing requirements, permits, or fees required by the State code and applicable orders, rules, or regulations for the performance of these duties.

(3) Any emergency assistant medical examiner or coroner appointed pursuant to this Section and acting without malice and within the scope of the prescribed duties shall be immune from civil liability in the performance of such duties.

Legislative History. Section 608(b) was adapted from FLA. STAT. ANN. § 768.13(2)(b)(1) (West 1997 & Supp. 2001). Subsection (c) was adapted from D.C. CODE ANN. § 2-1605 (2001); KAN. STAT. ANN. § 22a-226(e) (1995); GA. CODE ANN. § 45-16-23 (1990); COLO. REV. STAT. ANN. § 30-10-601 (West 1990).

ARTICLE VII PUBLIC INFORMATION REGARDING PUBLIC HEALTH EMERGENCY

Section 701 Dissemination of information. The public health authority shall inform the people of the State when a state of public health emergency has been declared or terminated, how to protect themselves during a state of public health emergency, and what actions are being taken to control the emergency.

(a) **Means of dissemination.** The public health authority shall provide information by all available and reasonable means calculated to bring the information promptly to the attention of the general public.

(b) **Languages.** If the public health authority has reason to believe there are large numbers of people of the State who lack sufficient skills in English to understand the information, the public health authority shall make reasonable efforts to provide the information in the primary languages of those people as well as in English.

(c) **Accessibility.** The provision of information shall be made in a manner accessible to individuals with disabilities.

Legislative History. In Section 701, the main text following the title "Dissemination of information" is adapted from 6 COLO. CODE REGS. § 1009-5, reg. 1 (WESTLAW through Aug. 2001). Subsection (a) is adapted from 2001 ILL. LAWS 73(3); ALASKA STAT. §§ 26.23.020, 26.23.200 (Michie 2000). Subsection (b) is adapted from CAL. ELEC. CODE § 14201(c) (West 1996).

Section 702 Access to mental health support personnel. During and after the declaration of a state of public health emergency, the public health authority shall provide information about and referrals to mental health support personnel to address psychological responses to the public health emergency.

Notes

Legislative History. Section 702 is adapted from the *Bioterrorism Readiness Plan: A Template for Healthcare Facilities* (Prepared by APIC Bioterrorism Task Force & CDC Hospital Infections Program Bioterrorism Working Group).

ARTICLE VIII MISCELLANEOUS

Section 801 Titles. For the purposes of this Act, titles and subtitles of Articles, Sections, and Subsections are instructive, but not binding.

Section 802 Rules and regulations. The public health authority and other affected agencies are authorized to promulgate and implement such rules and regulations as are reasonable and necessary to implement and effectuate the provisions of this Act. The public health authority and other affected agencies shall have the power to enforce the provisions of this Act through the imposition of fines and penalties, the issuance of orders, and such other remedies as are provided by law, but nothing in this Section shall be construed to limit specific enforcement powers enumerated in this Act.

Section 803 Financing and expenses.

(a) **Transfer of funds.** The Governor may transfer from any fund available to the Governor in the State treasury such sums as may be necessary during a state of public health emergency.

(b) **Repayment.** Monies so transferred shall be repaid to the fund from which they were transferred when monies become available for that purpose, by legislative appropriation or otherwise.

(c) **Conditions.** A transfer of funds by the Governor under the provisions of this Section may be made only when one or more of the following conditions exist:

(1) No appropriation or other authorization is available to meet the public health emergency.

(2) An appropriation is insufficient to meet the public health emergency.

(3) Federal monies available for such a public health emergency require the use of State or other public monies.

(d) **Expenses.** All expenses incurred by the State during a state of public health emergency shall be subject to the following limitations:

(1) No expense shall be incurred against the monies authorized under this Section, without the general approval of the Governor.

(2) The aggregate amount of all expenses incurred pursuant to this Section shall not exceed [*state amount*] for any fiscal year.

(3) Monies authorized for a state of public health emergency in prior fiscal years may be used in subsequent fiscal years only for the public health emergency for which they were authorized. Monies authorized for a public health emergency in prior fiscal years, and expended in subsequent fiscal years for the public health emergency for which they were authorized, apply toward the [*state amount*] expense limit for the fiscal year in which they were authorized.

Legislative History. In Section 803, Subsections (a) and (b) are adapted from GA. CODE ANN. § 38-3-51 (1995). Subsections (c) and (d) are adapted from ARIZ. REV. STAT. ANN. § 35-192 (West 2000).

Section 804 Liability.

(a) **State immunity.** Neither the State, its political subdivisions, nor, except in cases of gross negligence or willful misconduct, the Governor, the public health authority, or any other State or local official referenced in this Act, is liable for the death of or any injury to persons, or damage to property, as a result of complying with or attempting to comply with this Act or any rule or regulations promulgated pursuant to this Act during a state of public health emergency.

(b) **Private liability.**

1) During a state of public health emergency, any person owning or controlling real estate or other premises who voluntarily and without compensation grants a license or privilege, or otherwise permits the designation or use of the whole or any part or parts of such real estate or premises for the purpose of sheltering persons, together with that person's successors in interest, if any, shall not be civilly liable for negligently causing the death of, or injury to, any person on or about such real estate or premises under such license, privilege, or other permission, or for negligently causing loss of, or damage to, the property of such person.

Notes

(2) During a state of public health emergency, any private person, firm, or corporation and employees and agents of such person, firm, or corporation in the performance of a contract with, and under the direction of, the State or its political subdivisions under the provisions of this Act shall not be civilly liable for causing the death of, or injury to, any person or damage to any property except in the event of gross negligence or willful misconduct.

(3) During a state of public health emergency, any private person, firm or corporation and employees and agents of such person, firm or corporation, who renders assistance or advice at the request of the State or its political subdivisions under the provisions of this Act shall not be civilly liable for causing the death of, or injury to, any person or damage to any property except in the event of gross negligence or willful misconduct.

(4) The immunities provided in this Subsection shall not apply to any private person, firm, or corporation or employees and agents of such person, firm, or corporation whose act or omission caused in whole or in part the public health emergency and who would otherwise be liable therefor.

Legislative History. Section 804 is adapted from 2001 ILL. LAWS 73(15), (21).

Section 805 Compensation.

(a) **Taking.** Compensation for property shall be made only if private property is lawfully taken or appropriated by a public health authority for its temporary or permanent use during a state of public health emergency declared by the Governor pursuant to this Act.

(b) **Actions.** Any action against the State with regard to the payment of compensation shall be brought in the courts of this State in accordance with existing court laws and rules, or any such rules that may be developed by the courts for use during a state of public health emergency.

(c) **Amount.** The amount of compensation shall be calculated in the same manner as compensation due for taking of property pursuant to non-emergency eminent domain procedures, as provided in [*State to insert appropriate statutory citation*], except that the amount of compensation calculated for items obtained under Section 505 shall be limited to the costs incurred to produce the item.

Legislative History. Section 805 is adapted from COLO. REV. STAT. § 24-32-2111.5 (LEXIS through 2001 Sess.).

Notes

Section 806 Severability. The provisions of this Act are severable. If any provision of this Act or its application to any person or circumstances is held invalid in a federal or state court having jurisdiction, the invalidity will not affect other provisions or applications of this Act that can be given effect without the invalid provision or application.

Legislative History. Section 806 is adapted from the LAWRENCE O. GOSTIN AND JAMES G. HODGE, JR., THE MODEL STATE PUBLIC HEALTH PRIVACY ACT OF 1999.

Section 807 Repeals. The following acts, laws, or parts thereof, are explicitly repealed with the passage of this Act:

(a) [*To be inserted in each state considering passage of the Act*]

(b) [*To be inserted in each state considering passage of the Act*]

(c) [*To be inserted in each state considering passage of the Act*] . . .

Legislative History. Section 807 is adapted from the LAWRENCE O. GOSTIN AND JAMES G. HODGE, JR., THE MODEL STATE PUBLIC HEALTH PRIVACY ACT OF 1999.

Section 808 Saving clause. This Act does not explicitly preempt other laws or regulations that preserve to a greater degree the powers of the Governor or public health authority, provided such laws or regulations are consistent, and do not otherwise restrict or interfere, with the operation or enforcement of the provisions of this Act.

Legislative History. Section 808 is adapted from the LAWRENCE O. GOSTIN AND JAMES G. HODGE, JR., THE MODEL STATE PUBLIC HEALTH PRIVACY ACT OF 1999.

Section 809 Conflicting laws.

(a) **Federal supremacy.** This Act does not restrict any person from complying with federal law or regulations.

(b) **Prior conflicting acts.** In the event of a conflict between this Act and other State or local laws or regulations concerning public health powers, the provisions of this Act apply.

Legislative History. Section 809 is adapted from the LAWRENCE O. GOSTIN AND JAMES G. HODGE, JR., THE MODEL STATE PUBLIC HEALTH PRIVACY ACT OF 1999.

Section 810 Effective date. The provisions of this Act shall take effect upon signature of the Governor. [*State to insert language appropriate to its legislative process.*]

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