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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.

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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:

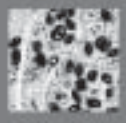
- intentional spread of contagious diseases through individual contact;
- airborne dissemination of some infectious agents; or
- contamination of transportation systems, buildings, or other public places, as well as water, food, controlled substances, or other widely distributed products.

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).

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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]