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https://scholarship.shu.edu/student_scholarship/1017

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12/14/18
Public Health Law

The Model State Emergency Health Powers Act: Balancing Public Safety and Civil Liberties

I. Background

Society is rapidly changing, and so too must public health safety laws. Most current state public health emergency laws date back to the early 20th century and are largely based on outdated scientific principles. New diseases and threats must be accounted for, biotoxins are easily weaponized, novel strains of viruses have emerged, and advances in technology and healthcare must be considered when planning for future emergencies.¹

The states have the ultimate authority to regulate public health safety through the state police powers, but the federal government has become increasingly involved.² Although lacking express authority, the federal government can and does influence public health policy via its spending and commerce powers. Through the Centers for Disease Control and Prevention (CDC), a federal agency that aims to protect against public health threats, the federal government has taken a leadership role in the reform of public health preparedness.³ The CDC, in collaboration with health law scholars from Johns Hopkins University and Georgetown University, drafted “The Model State Emergency Health Powers Act” (from here on, the “Model Act”) in 2001 as a nonbinding blueprint for the states to follow when revising their public health emergency laws.⁴

¹ Daniel S. Reich, *Modernizing Local Responses to Public Health Emergencies: Bioterrorism, Epidemics, and the Model State Emergency Health Powers Act*, 19 J. Contemp. Health L. & Pol’y 379 (2003).

² *Id.*

³ *Id.* at 382.

⁴ *Virtual Mentor*. 2010;12(9): 735-738. doi: 10.1001/virtualmentor.2010.12.9.pfor2-1009.

The Model Act's drafting was motivated by the 9/11 terrorist attacks, SARS outbreak, and anthrax scare, which alerted lawmakers to holes in the public health infrastructure. Republicans feared the United States' public health safety infrastructure was inadequate to deal with future emergencies. The state of public health emergency law has been regarded as "a house of cards that could crumble at any moment."⁵ Many feel the state health authorities still lack the authority and flexibility to adequately deal with new threats, and so the Model Act gained popularity.⁶

Lawrence Gostin, public health law scholar and the Model Act's leading author, has identified four purposes for the Model Act. First, the Model Act recognizes a need for modernized response procedures to modern health threats.⁷ No longer should obsolete diseases like polio and smallpox be the focus of health emergency preparedness. New medical treatments have developed to fight and contain illnesses, and less restrictive means of achieving public health goals are available. Even the human immune system has evolved. Older state laws may not take into account contemporary understandings of certain diseases, or the medical treatments available to deal with those diseases.⁸ Second, the Model Act aims to standardize the emergency procedures among the states. Lack of uniformity could hinder needed coordination between the states. Emergencies demand the sharing of personnel and resources. Inconsistencies between state laws has also exacerbated the damage of past epidemics. For example, during the H1N1 "Swine Flu" Epidemic

⁵ Daniel S. Reich, Modernizing Local Responses to Public Health Emergencies: Bioterrorism, Epidemics, and the Model State Emergency Health Powers Act, 19 J. Contemp. Health L. & Pol'y 379 (2003).

⁶ Eleanor E. Mayer, Preparing For The Worst: Protecting Civil Liberties In The Modern Age of Bioterrorism, 11 U. Pa. J. Const. L. 1053 (2009) .

⁷ Joshua L. Friedman, Emergency Powers of the Executive: The President's Authority When All Hell Breaks Loose, 25 J.L. & Health 265 (2012).

⁸ Gostin, Lawrence & D (Hon, Ll & G Hodge, James. (2018). State Public Health Law Assessment Report.

in 2009, differing patient reporting requirements between states allowed for unidentified infections to spill over into neighboring states, frustrating the ability of state and local authorities to contain the virus. Third, the Model Act encourages states to adopt a public health preparedness framework that is consistent with modern ethical, legal and constitutional norms.⁹ The legal and constitutional landscape is changing; health privacy, antidiscrimination, disability protection, and other modern developments must be factored into a modern public health preparedness laws. Fourth, the Model Act clarifies the roles of state authorities, private healthcare actors and individuals in the event of a potential public health emergency.¹⁰ By preparing authorities for what they can and cannot do, and putting the public on notice as to what may be expected or required of them, the Model Act purports to safeguard civil rights and due process.¹¹

Transparency is necessary for an ethical, legal and effective public health emergency plan. At a 2001 conference on “State Emergency Health Powers and the Bioterrorism Threat,” academics, lawyers and government officials emphasized the importance of a transparent and lawful governmental response to health emergencies.¹² Not only is transparency necessary to preserve our national virtues and commitment to justice at all times, but it will also allow for a more effective relationship between authorities and individuals by reducing the risk of public distrust and noncompliance. Public Trust is essential to an effective public health preparedness

⁹ L O Gostin et al., The Model State Emergency Health Powers Act: planning for and response to bioterrorism and naturally occurring infectious diseases. *Current neurology and neuroscience reports*. (2002).

¹⁰ Daniel S. Reich, Modernizing Local Responses to Public Health Emergencies: Bioterrorism, Epidemics, and the Model State Emergency Health Powers Act, 19 *J. Contemp. Health L. & Pol'y* 379 (2003).

¹¹ Gostin, Lawrence & D (Hon, LI & G Hodge, James. (2018). State Public Health Law Assessment Report.

¹² Cantigny Conference Series, State Emergency Health Powers and the Bioterrorism Threat 7 (2001).

plan. A public health framework must balance the need for strong emergency powers and the protection of individual liberties to foster public trust. Without public trust, compliance will diminish and so too will the efficacy of government measures to fight health threats.¹³ “Free people respond to leadership much more vigorously than a people held in place by power, fear and terror of their own government.”¹⁴ Excessive governmental coercion will not yield compliance. If the government is too forceful, people will not see the actions they are taking as beneficial (because why would they be if they require this much force) and compliance with safety measures will be stunted. For example, if mandatory testing will be followed by excessive penalties or imprisonment, people will not get tested and cases of virulent illnesses will go undetected. On the other hand, the government needs sufficient tools to fight time sensitive emergencies. Therefore, an effective preparedness plan allows authorities to act quickly and confidently while also respecting civil liberties. The constitution must bend in the face of emergencies, but only so far until compliance is lost. Public health law experts stress the importance of the individual actions of US citizens in preventing or maintaining the spread of contagious diseases.¹⁵ Authorities must obtain public trust to ensure coordination and cooperation with emergency procedures.

Under the Model Act, the circumstances that justify compulsory government action are broad and raise constitutional issues as to when these government actions are justified and whether the extent and scope of these compulsory government actions comply with Due Process. The Model Act grants broad authority to state authorities. It establishes provisions for reporting cases of certain diseases and other identifies conditions that can trigger the declaration of a public

¹³ Virtual Mentor. 2010;12(9): 735-738. doi: 10.1001/virtualmentor.2010.12.9.pfor2-1009

¹⁴ Joshua L. Friedman, Emergency Powers of the Executive: The President’s Authority When All Hell Breaks Loose, 25 J.L. & Health 265 (2012).

¹⁵ Lorena Matei, Quarantine Revision and the Model State Emergency Health Powers Act: Laws for the Common Good, 18 Santa Clara High Tech. L.J. 433 (2002).

emergency. The Model Act identifies circumstances that allow state governors to unilaterally declare a state of emergency, and that trigger compulsory government action including mandatory testing, treatment, quarantine and isolation.¹⁶

Does the Model Act properly balance the need for flexible governmental authority and the protection of civil liberties? The Model Act is promising and reflects the urgent need for updates in our public health framework. The federal government's use of a model act to align the states' public health infrastructures promises to solve some glaring inadequacies in current state laws. The nature of a public health emergency is unique in that it demands coordination and transparency between authorities, private healthcare actors, and individuals.

Although a solid foundation for which states can use to improve and modernize their public health infrastructures, the Model Act is overbroad in its emergency powers and does not properly balance civil liberty protections. A standardized response procedure for epidemics and bioterrorism is necessary to protect the public; however, extensive critique and identification of legal/ethical issues must take place before these procedures become effective as law. I will show how the states have received the recommendations of the Model Act by looking at which provisions have been adopted into state law, and which provisions have been left behind. I will also use secondary sources, and apply constitutional standards to these specific provisions. Despite the lack of available checks on executive authority, and even if the courts are truly unwilling to uphold and defend the constitution in times of emergencies, a comprehensive illustration of the roles and obligations of authorities and health actors in the event of potential emergencies is necessary not only from a legal and ethical standpoint, but also from an efficacy standpoint. But,

¹⁶ Joshua L. Friedman, Emergency Powers of the Executive: The President's Authority When All Hell Breaks Loose, 25 J.L. & Health 265 (2012).

were the government to be free to violate the constitution on every alarm of danger, public trust would diminish accordingly, and compliance will be stunted.¹⁷ My recommendation will identify which, if any, of the key Model Act provisions should be included in the future redrafting of the Model Act and how the provisions can be modified.

III. Analysis

Because the Model Act was designed for adoption into state law, a look at whether the states have actually adopted these provisions is an important indicator of the Model Act's success (or lack of). As of August 1, 2011, 40 states have incorporated a version of the Model Act's provisions into state law.¹⁸ However, only 28 states have adopted the Reporting Provision, 22 states have adopted the Declaration Provision, and 18 states have adopted the Medical Treatment Provision.¹⁹ This analysis will focus on the provisions above, discuss policy arguments, apply constitutional standards, and offer recommendations.

(A) The Reporting Provision

Sections 301 and 303 of the Model Act places a duty on healthcare workers to collect and report potential health emergencies to the respective authorities.²⁰ Section 301 identifies what triggers a healthcare worker's obligation to report a case to health authorities and what must be in

¹⁷ Daniel S. Reich, Modernizing Local Responses to Public Health Emergencies: Bioterrorism, Epidemics, and the Model State Emergency Health Powers Act, 19 J. Contemp. Health L. & Pol'y 379 (2003).

¹⁸ James G. Hodge, The Model State Emergency Health Powers Act Summary Matrix, The Network for Public Health Law (12AD), https://www.networkforphl.org/_asset/80p3y7/MSEHPA-States-Table-022812.pdf (last visited Dec 14, 2018).

¹⁹ *Id.*

²⁰ Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities, Model State Emergency Health Powers Act, Dec. 21, 2001.

those reports.²¹ Section 303 discusses information sharing after those reports are given to health authorities, regarding who the health authorities can share that information with.²²

Section 301 Reporting.

- a) Illness or health condition. A healthcare 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.
- 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
 - a. An unusual increase in the number of prescriptions or over the counter pharmaceuticals to treat conditions that the public health authority identifies through regulations;
 - b. An unusual increase in the number of prescriptions for antibiotics; and
 - c. Any prescription that treats a disease that is relatively uncommon or may be associated with bioterrorism.²³

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 suspicious event that may be the cause of a public health emergency, it shall immediately notify the public health authority.
- b) Whenever the public 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.²⁴

The Model Act represents a growing and critical effort to standardize the reporting and surveillance system of infectious disease in the United States. The collection of health data is

²¹ Id.

²² Id.

²³ Id.

²⁴ Id.

essential for state health authorities to “identify health risks, inform the public and intervene to prevent the spread of disease.”²⁵ The reporting provision furthers the purpose of the Model Act mentioned earlier to standardize laws between states. Inconsistent state laws have a dramatic effect in the reporting context because it prevents the state and federal government from understanding where the infectious conditions are most prevalent, how to allocate resources accordingly, and what steps to take to prevent or mitigate the spread of the disease.

For example, some states have required patients with positive blood samples for Salmonella be reported to the state authorities, while others only required such reporting as to Salmonella when the patient is symptomatic or shows sign of illness.²⁶ Patients infected by Salmonella are still contagious but may report symptoms months after exposure, or may not show symptoms at all.²⁷ The data produced was misleading because government authorities were not able to identify trends in the infection as to time and place. A patient infected with Salmonella is still contagious even if the patient experiences no symptoms, and the patient could be spreading the disease to local communities without evidence of the infection on record. Without data of all the infectious cases, local authorities were unable to isolate the disease or provide resources or information to local medical partnerships in preparation for a potential introduction of the contagious bacterial infection. This also prevented federal and state governments from understanding the gravity of the salmonella infection, and from allocating resources to

²⁵ Daniel S. Reich, *Modernizing Local Responses to Public Health Emergencies: Bioterrorism, Epidemics, and the Model State Emergency Health Powers Act*, 19 J. Contemp. Health L. & Pol’y 379 (2003).

²⁶ *Mandatory Reporting of Infectious Diseases by Clinicians*, Centers for Disease Control and Prevention, <https://www.cdc.gov/mmwr/preview/mmwrhtml/00001665.htm> (last visited Dec 15, 2018).

²⁷ *Id.*

communities or regions that would need it the most.²⁸ With differing standards as to what information must reach public health authorities, cases of novel or uncontrolled diseases can go undetected between state borders. If all states are on the same page with respect to what conditions are reportable and available to authorities, states will be able to communicate and coordinate, identify contagious health risks earlier, and prevent undetected cases from entering their borders and infecting their population. Reporting is also important because it enables the government to assess the success of certain disease prevention and response efforts. If one state does not report cases of infections and only reports when a patient is symptomatic, authorities will be unable to analyze the effectiveness of certain response strategies.

However, while the law must allow for the spread of this crucial information, protecting against unnecessary disclosure is also critical from a policy and legal standpoint. Health data is very personal, and can have major effects on someone's life if publicized without permission.²⁹ From a policy standpoint, if people don't trust their health information to remain private, they may avoid examination or treatment.³⁰

The Model Act is a good starting point but does not sufficiently limit what information must be reported, and who can access that information. In light of the massive changes in health privacy protections, the Model Act's reporting provisions raise constitutional problems. On its face, the Model Act imposes no "reasonable belief" requirement or an informed consent

²⁸ Mandatory Reporting of Infectious Diseases by Clinicians, Centers for Disease Control and Prevention, <https://www.cdc.gov/mmwr/preview/mmwrhtml/00001665.htm> (last visited Dec 15, 2018).

²⁹ Daniel S. Reich, Modernizing Local Responses to Public Health Emergencies: Bioterrorism, Epidemics, and the Model State Emergency Health Powers Act, 19 J. Contemp. Health L. & Pol'y 379 (2003).

³⁰ Id.

requirement.³¹ Healthcare providers are expected to immediately report any cases that “may be” a potential cause of a public health emergency.³² Healthcare providers are required to report their patient’s information based on their subjective belief of what “may” cause a public health emergency. The statute goes no further to give healthcare providers guidance as to when disclosure of confidential patient information is appropriate as to safeguard patient confidentiality. Rather, Section 301(a) uses broad language that a “healthcare provider . . . shall” report “all cases” that could potentially trigger an emergency.³³ Such broad language will cause doctors to err on the side of reporting more than is necessary. Under 301, pharmacists are put in an odd position to determine what might equate to a public health emergency, a definition for which the statute itself provides little clarity. A simple increase in drug prescriptions or antibiotics may trigger the reporting requirements. Furthermore, any “unusual increase in prescription” activity triggers a duty to report, giving pharmacists discretion to report almost anything with little guidance or limitations.³⁴ Even more problematic is the contents of these reports after a duty to report is triggered, sweeping in nearly everything identifiable about the patient involved: name, date of birth, race, occupation, and “any other information needed to locate the patient.”³⁵ The contents of these reports are hardly limited.

Section 303 is slightly different because it involves information sharing between authorities, rather than information sharing from healthcare provider to health authorities. Section 303 requires public health authorities and public safety authorities” exchange all relevant

³¹ Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities, Model State Emergency Health Powers Act, Dec. 21, 2001.

³² Id.

³³ Id.

³⁴ Id.

³⁵ Id.

information.”³⁶ Once a reportable case reaches the health authorities, that report is immediately disclosed to every state authority involved, health or safety. Section 303’s only limit as to what information can be shared between authorities is that the “sharing of information . . . shall be restricted to the information necessary for the treatment, control, investigation, and prevention of a ‘public health emergency’”.³⁷

In Whalen v. Roe, the Supreme Court ruled that mandatory medical reporting for public safety is constitutional only if sufficient safeguards of patient privacy are in place to limit both who can access the information, and what information can be reported without the patient’s permission.³⁸ The expectation of privacy must be balanced against the safety of the community.³⁹ The Court upheld a New York statute requiring the state keep a centralized computer database containing the names and addresses of all persons prescribed a specified list of controlled substances. Justice Brennan, in his concurrence, explained that the reports were only available to a small number of persons within the state health authority, and that “broad dissemination” of that information would violate the constitutionally protected privacy rights unless there exists a “compelling state interest” for doing so.⁴⁰ The majority also emphasized the extensive safeguards employed in Whalen to uphold the statute, noting that access to the database of computer information was limited and only accessible to authorities outside the health authority when an

³⁶ Id.

³⁷ Id.

³⁸ Whalen v. Roe, 429 U.S. 589, 97 S. Ct. 869 (1977)

³⁹ Id.

⁴⁰ Daniel S. Reich, Modernizing Local Responses to Public Health Emergencies: Bioterrorism, Epidemics, and the Model State Emergency Health Powers Act, 19 J. Contemp. Health L. & Pol’y 379 (2003).

investigation is launched, giving the state authorities probable cause to furnish the reports contained in the database.⁴¹

The Reporting Provision does not comport with the constitutional standard of privacy set forth in Whalen. The Model Act is distinguishable from the statute in Whalen. In Whalen, all mandatory medical reports were to be destroyed after 5 years and contained only names, ages, and addresses, and access to the reports was confined to a limited number of health department personnel.⁴² Unlike the statute in Whalen, the Model Act contains hardly any safeguards on either who has access to sensitive information, and what information is available. The electronic database in Whalen automatically deleted the data of a patient five years after it was collected.⁴³ Under the Model Act, there is no time limit or time constraint on the retention of these medical records, nor are there even any procedures as to how the medical records shall be managed within the database to maintain some degree of privacy protection. In Whalen, the electronic database was protected both by programming safety codes and physical protection of the database hardware.⁴⁴ Not only did the statute upheld in Whalen adequately limit how and when sensitive health information can be *collected* and *stored*, but it also limited when sensitive health information can be *shared* after it is collected.⁴⁵ The majority in Whalen noted that investigatory authorities, or other authorities outside the health authority, were only allowed access to the database after an investigation was launched involving a particular patient included in the database.⁴⁶ On the contrary, the Section 303 of the Model Act allows the sharing of information between all authorities immediately, without

⁴¹ Whalen v. Roe, 429 U.S. 589, at 595.

⁴² Id. at 58.

⁴³ Id.

⁴⁴ Id.

⁴⁵ Id.

⁴⁶ Id.

cause, reasonable belief, or following an investigation.⁴⁷ Where in Whalen the reports were limited to specific personnel within the health authority, the Model Act would require immediate dissemination to state and federal safety authorities under Section 303.⁴⁸ The Model Act encompasses the kind of broad dissemination of private health data that Justice Brennan warned about in his concurrence.

The reports under the Model Act sweep in a lot more than just name and address, including race, occupation, and any information needed to locate the patient.⁴⁹ The list of reportable illnesses and patient information that will be collected under the provisions is massive.

The reports are not narrowly tailored to protect against unnecessary disclosures because the reporting provisions do not need to be triggered by an emergency declaration and would be effective immediately if adopted into state law.⁵⁰ Certainly, in the face of an emergency, broader dissemination of critical health data will be justified as the safety interest of the community increases. However, to require healthcare providers furnish these reports based on their subjective belief of what may be the cause of a future public health emergency, and without limits as to how far that information can go after it is furnished, would allow for the widespread violation of the Whalen constitutional standard of privacy. It is not farfetched to say that millions of cases will be reported unnecessarily, in scenarios where potential health emergencies are feared but never actually occur. The Model Act should least insure that if the broad reporting provisions are to be effective as law, they must be justified in the first instance by requiring a heightened standard for when a healthcare provider should furnish a report to the state health authorities. The Model Act

⁴⁷ Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities, Model State Emergency Health Powers Act, Dec. 21, 2001.

⁴⁸ Id.

⁴⁹ Id.

⁵⁰ Id.

should also provide more guidelines as to how the information should be stored and maintained once it reaches the health authority, and more guidelines or limits as to when the health authorities may be authorized to share those reports with investigatory or safety authorities. Section 303's information sharing provision should at least be effective only after the governor has declared a state of emergency, as to prevent potentially harmful disclosures from reaching inappropriate hands.

Daniel Reich suggests a "two step" approach to the compulsory reporting requirements to bring the provision within constitutional bounds.⁵¹ This would involve unique numeric identifiers of initial reports as between healthcare providers and patients under Section 301. If the health authorities identify a case that could cause a public health emergency, they can request the rest of the information from the provider with probable cause.⁵² This approach would both add an additional safeguard to privacy protection, while also transferring the duty to determine what "may be" a public health emergency from the healthcare providers to the health authorities, who are more qualified to make such determinations. This approach also seems consistent with the approach in Whalen, where investigatory authorities could only reach the information within the database once a criminal investigation was underway.⁵³

(B) The Declaration Provision

Under the Model Act, state governors are given nearly exclusive authority to decide the timing and duration of a state of emergency. A large minority of states (22) have adopted the

⁵¹ Daniel S. Reich, Modernizing Local Responses to Public Health Emergencies: Bioterrorism, Epidemics, and the Model State Emergency Health Powers Act, 19 J. Contemp. Health L. & Pol'y 379 (2003).

⁵² Id.

⁵³ Whalen v. Roe, 429 U.S. 589, at 595.

declaration provision into state law.⁵⁴ Sections 403 of the Model Act authorizes state governors to declare a state of emergency either in the event of a bioterrorist attack or upon discovery of a particularly virulent virus or disease, when either poses a “high probability” of leading to a large number of deaths, serious disability, or exposure to infectious agents.⁵⁵ Once declared, the state governor is empowered to suspend statutory provisions regulating the conduct of state business, when strict compliance would “prevent, hinder, or delay necessary action,” utilize all available state and local resources “as reasonably necessary to respond to the emergency”, and mobilize the militia.⁵⁶ Consultation with health or other experts is not required before a declaration when the “situation calls for prompt and timely action.”⁵⁷ Governors can unilaterally extend the state of emergency (that is, without legislative approval) under Section 405, so long as the above standard continues to apply to the circumstances.⁵⁸

Section 403’s “high probability” standard is too deferential and strays from the federal standard for lawful declaration of a state of emergency. This provision’s only legal check on the governor’s actions is found in Section 405(c), providing that state legislatures *may* terminate the state of emergency, by majority vote in both chambers, if Section 403’s “high probability standard” no longer applies to the state’s circumstances.⁵⁹ In its current form, the declaration provision does not require any legislative involvement in the ongoing regulation of a public health emergency.

⁵⁴ James G. Hodge, The Model State Emergency Health Powers Act Summary Matrix, The Network for Public Health Law (12AD), https://www.networkforphl.org/_asset/80p3y7/MSEHPA-States-Table-022812.pdf (last visited Dec 14, 2018).

⁵⁵ Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities, Model State Emergency Health Powers Act, Dec. 21, 2001.

⁵⁶ Id.

⁵⁷ Id.

⁵⁸ Id.

⁵⁹ Id.

Civil liberties must give way in the face of emergencies, and government actors need some of the flexibility the Model Act promises to deal with time sensitive problems. Lawrence Gostin explains that because the Model Act is designed to prepare for unanticipated threats, Section 403 and 405's broad language and deferential executive standards are justified.⁶⁰ However, a constitutionally sound emergency plan must not grant the government an unfettered license to violate civil liberties.

The Model Act's Declaration Provision must be modified to avoid public distrust. Declaration of a state of emergency is a massive executive power, and has often been employed abusively.⁶¹ The public is already suspicious of executive power and overreach. The Model Act's Declaration Provision opens the door for abuse because it triggers most of the Model Act's compulsory powers. The ACLU is particularly concerned with the Model Act's declaration provision and its potential for abuse of vulnerable populations, fearing majoritarian executives will neglect the needs of religious groups, minorities, etc.⁶² The ACLU also expresses concern with the executive's unchecked authority to declare a state of emergency without judicial oversight.⁶³ Executive authority under the Constitution is at its highest during emergency conflicts involving other countries. Judicial oversight can impede the need for a coordinated and singular response to international crises, and so the courts have historically yielded to executive authority in times of international and wartime emergencies. International issues like war are more political and so less legislative or judicial oversight in executive actions is appropriate. Individual rights are less

⁶⁰ Id.

⁶¹ Q & A On the Model State Emergency Health Powers Act, American Civil Liberties Union, <https://www.aclu.org/other/model-state-emergency-health-powers-act> (last visited Dec 15, 2018).

⁶² Id.

⁶³ Id.

implicated, as issues bear more on our representations and interactions with outsiders. Although the legislature and judiciary's ability to check executive authority in the context of wartime emergencies is limited, the same justification does not apply to public health emergencies. Bioterrorism is an act of war, but the Model Act goes way beyond that to cover naturally occurring threats of disease and illness. The Model Act applies to situations outside of bioterrorism and foreign policy and therefore, the Model Act should incorporate more judicial and legislative oversight to comply with our system of checks and balances. George Annas criticizes the Model Act as an invasion of states' rights and a violation of constitutional federalism.⁶⁴ Although the Act was originally designed to address threats in bioterrorism, which is within the purview of federal jurisdiction, it goes way beyond biological warfare and covers all threats of infectious or virulent illnesses.⁶⁵ Judicial and legislative oversight might not be realistic in the event of a real emergency, but nonetheless a statute with such wide government authority over individual rights (and not political determinations) should incorporate as much involvement from the other branches of government.

At the minimum, the Model Act should contain the same legislative checks that the federal government has in the context of war emergencies.⁶⁶ The War Powers Act contains substantially more safeguards against executive abuse than the Model Act. In order to extend a war time emergency, the War Powers Act requires the executive consult with Congress at every possible instance and report periodically.⁶⁷ The Model Act does not require state governors report to or

⁶⁴ Virtual Mentor. 2010;12(9): 735-738. doi: 10.1001/virtualmentor.2010.12.9.pfor2-1009.

⁶⁵ Id.

⁶⁶ Daniel S. Reich, Modernizing Local Responses to Public Health Emergencies: Bioterrorism, Epidemics, and the Model State Emergency Health Powers Act, 19 J. Contemp. Health L. & Pol'y 379 (2003).

⁶⁷ Id.

consult with state legislators. More importantly, the War Powers Act requires bicameral Congressional approval if the President's state of war declaration is to extend beyond sixty days.⁶⁸ As for natural disasters and state of emergencies, 50 U.S.C. § 1622(b) requires both the House and Senate issue a joint resolution before a state of emergency can exceed 6 months.⁶⁹ Under the Model Act, the legislature *can* terminate a state of emergency after the initial period through bicameral approval, but never is the legislature required to convene and address whether a state of emergency should continue or not. This provision encourages state legislators take a backseat once a potential health emergency arises.

Just as substantial legislative checks are in place in the contexts of war and natural disasters, the states should similarly impose more legislative oversight on executive authority before adopting the Model Act's Declaration Provision. Legislative involvement is important because it provides the public an opportunity to voice their concerns and interests through elected officials, whereas the executive branch is more so insulated. Protecting individual rights in the healthcare context is crucial because personal issues are implicated, such as the right to confidential medical information, the right to health, and the right to bodily integrity. The legislature is somewhat bipartisan and encompasses more opinions and viewpoints of the community, whereas the interests of the executive are more closely aligned with whoever is in power. Democratic accountability is a powerful check on government action and should not be taken lightly in this context where the liberties at stake are so high. Legislators want to be reelected and are therefore more accountable to the public. The legislature forms their ideas from a wider range of people and opinions, and respond to interest groups. The more democratic approach would be to require legislative approval.

⁶⁸ *Id.*

⁶⁹ 50 U.S. Code § 1622.

Section 104 of the Model Act defines a public health emergency as an occurrence of imminent threat of an illness or health condition that is believed to be caused by bioterrorism or the appearance of a novel or previously controlled or eradicated infectious agent or biological toxin, and poses a high probability of an of the following harms: a large number of deaths in the affected population; a large number of serious or long term disabilities in the affected population; or 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.⁷⁰

Section 104 raises constitutional problems because the subjective, “is believed to be caused” standard in 104(m)(a) does not safeguard against arbitrary or unnecessary declarations.⁷¹ State executives can find and declare a public health emergency based on their subjective belief of an appearance of a novel or “previously controlled” strain or bioterrorist attack. The “high probability” standard is also vague and lacks any real limitation. In conjunction with Section 403 above, the state executives do not even need to consult with health or medical experts if the situation calls for prompt and timely action.⁷² It is unclear why the Model Act’s drafters did not include at least an objective, “reasonable belief” standard in this Section. Without an objective standard or a legislative check, state executives are given almost unlimited discretion to declare a state of emergency. Section 104’s definition sweeps in more than is necessary. Influenza is a smart virus that adapts and mutates every year to bypass the human immune system, and vaccine companies race to develop new vaccines to immunize against those specific strains. Based on the language of the Model Act, because seasonal influenza sometimes appears as “a previously

⁷⁰ Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities, Model State Emergency Health Powers Act, Dec. 21, 2001.

⁷¹ Id.

⁷² Id.

controlled . . . infectious agent” that might pose a “high probability of widespread exposure/substantial future harm”, the governor would arguably be able to declare a state of emergency every flu season, without any political backlash. “Significant risk of substantial future harm” to “a large number of people” seems to sweep in novel influenza strains as well, which appear once every ten years. Although this might be a stretch of the standard, the standard is too broad and needs more specificity. State legislators of the Model Act should be more specific as to what can trigger a public health emergency. The Association of American Physicians and Surgeons has deemed the Model Act “a prescription for tyranny.”⁷³ The organization notes the expanded ability of the state to act as medical providers in the event of emergency. The state authorities would be unrestricted in their ability to treat anyone who has been exposed to the disease. Meaning, they could treat persons ill from any cause and unrelated to the specific condition that caused the emergency. Moreover, the association is concerned with the Model Act’s definition of “public health emergency” and what may trigger the compulsory powers mentioned above.⁷⁴

(C) The Medical Treatment and Testing Provisions

Under Sections 602 and 603, the Model Act empowers state authorities, during a state of public health emergency, to arrest, imprison and forcibly examine, vaccinate and medicate citizens without consent MSEHPSA §§ 602 and 603. But, under sections 603(a) and (b)(3), persons can refuse treatment or vaccination and remain isolated instead.⁷⁵ Authorities acting under these provisions will not be held liable for injuries caused, so long as state’s actions are “not reasonably

⁷³ REVISED DRAFT OF MODEL STATE EMERGENCY HEALTH POWERS ACT (DEC. 21) STILL A PRESCRIPTION FOR TYRANNY Various Physicians Oaths, <https://www.aapsonline.org/testimony/emerpowers2.htm> (last visited Dec 15, 2018).

⁷⁴ Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities, Model State Emergency Health Powers Act, Dec. 21, 2001.

⁷⁵ Id.

likely to lead to serious harm” and no willful malice. MSEHPSA § 804. Only a slim minority of states (18) have adopted Sections 602 and 603 into state law.⁷⁶

Opponents of the Model Act’s medical treatment and testing provisions are concerned with the Model Act’s imposing of criminal penalties for noncompliance. George Annas, an outspoken opponent of the Model Act, questions both the utility of the Model Act and the Model Act’s failure to properly safeguard civil liberties. Annas explains that the Model Act is “more appropriate for the United States of the 19th century than for the United States of the 20th century.”⁷⁷ Annas argues that all persons have a constitution right to refuse medical treatment today, and to be forcibly isolated “at the whim” of a public health official for refusing treatment is a violation of that right. Annas concludes that the Model Act is likely to undermine public trust, and will not effectuate its purpose in protecting the public through strict compliance with mandatory measures.⁷⁸ He argues that there is no precedent for requiring treatment of patients against their will under criminal penalties.⁷⁹

However, criminal penalties have been upheld for an individual’s refusal to undergo mandatory state medical treatment. In Jacobsen, the Supreme Court upheld the 5\$ penalty and misdemeanour for those who refused to undergo mandatory vaccination. Similarly, the extent of criminal sanctions under the Model Act is limited to a misdemeanour. The Supreme Court of the United States recognized that the Constitution does not provide an absolute right to be free from all restraint. In Jacobsen v. Massachusetts, the Supreme Court upheld a Massachusetts mandatory

⁷⁶ Id.

⁷⁷ Daniel S. Reich, Modernizing Local Responses to Public Health Emergencies: Bioterrorism, Epidemics, and the Model State Emergency Health Powers Act, 19 J. Contemp. Health L. & Pol’y 379 (2003).

⁷⁸ Id.

⁷⁹ Id.

smallpox vaccination regulation as a constitutional exercise of the state police powers. Justice Harlan’s opinion can be seen as imposing four constitutional requirements on state mandated medical procedures: public health necessity; reasonable means; proportionality; and avoidable harm. To be constitutional, the mandatory state regulation must be in furtherance of a public health necessity, must have a “real and substantial” relation between the necessity and the means employed, must impose penalties proportional to the harm of noncompliance, and must not be exercised in an “arbitrary, unreasonable manner or go beyond what is reasonably required for the safety of the public.”⁸⁰ The Court held that a mandatory smallpox vaccination, enforced through a \$5 penalty for noncompliance, was necessary for the “speedy extermination” of the communicable disease. Smallpox was, to an extent, still prevalent in some Massachusetts cities. The Court found the regulations were not unreasonable, considering the proportion of the \$5 penalty to the harm of compromising the communal immunity, and were not likely to be exercised arbitrarily because the decisions to vaccinate were required to first be approved by the independent local medical board and could be exempted.⁸¹

Jacobsen emphasized the use of the board of health to make medical appropriateness decisions to protect against the arbitrary use of compulsory government power and the potential for government abuse.⁸² The local board of health was comprised of independent physicians, employed strictly to decide whether forced medical treatment would or would not be appropriate in any particular case. The New York statute also made medical exemptions available. In Jacobsen, both the healthcare providers and health authorities operating under the statute were held to their ordinary standard of care as healthcare providers. With the protection of the healthcare provider’s

⁸⁰ Jacobson v. Massachusetts, 197 U.S. 11 (1905).

⁸¹ Id.

⁸² Id.

standard of care and an independent determination of medical appropriateness, the Jacobsen statute comported with the constitution because it did not enable the “arbitrary and oppressive” use of government power.⁸³

The Model Act’s mandatory treatment and testing provisions are not punitive when considered in light of the quarantine and isolation powers. The Model Act’s medical treatment and testing provisions work in conjunction with the quarantine and isolation provision and with the immunity provision. Under the Model Act, anyone who refuses to undergo medical examination or treatment can be forcibly quarantined. Critics of the Model Act argue that a lack of alternatives to mandatory testing as constitutionally problematic, despite the Model Act’s promise to uphold and protect individual rights to the fullest.⁸⁴ Daniel Reich challenges the constitutionality of the medical treatment provision when used with the quarantine and isolation powers in Section 602 of the Model Act. He argues that civil confinement is defensible from a Due Process challenge only as a public safety measure through the state police powers, but not as a punitive measure. Reich argues that the confinement power will be exercised as a punitive measure because it will be enforced against persons who object to the mandatory treatment or testing efforts. Reich states that “the presumption that individuals or groups refusing vaccination, treatment, testing or examination should be subject to quarantine and isolation leads to the problematic potential abuse of quarantine and isolation as a mechanism for enforcing compulsory public health measures.”⁸⁵ Reich explains that to confine an individual for refusing to undergo treatment or testing, rather than confining the

⁸³ Id.

⁸⁴ Daniel S. Reich, Modernizing Local Responses to Public Health Emergencies: Bioterrorism, Epidemics, and the Model State Emergency Health Powers Act, 19 J. Contemp. Health L. & Pol’y 379 (2003).

⁸⁵ Id.

individual for being ill or being exposed to a contagious disease, is a punitive measure to enforce the other provisions of the statute, rather than to further public safety.⁸⁶

However, this fear does not mean that mandatory isolation and quarantine measures would be punitive. Public safety can justify the containment of those who have a contagious condition or have shown signs of having a condition dangerous to the community as seen in Jacobsen. Individuals who refuse to undergo mandatory testing or treatment, at the time when a public health emergency is declared, have posed a risk to their community by refusing to undergo treatment or testing to prove they are otherwise safe. Considering a public health emergency is only triggered when virulent diseases are widespread and pose a high risk to the community, almost all individuals in the community can be said to pose a risk to the community unless proven otherwise. In the event of fast spreading diseases, individuals should allow authorities to identify whether they threaten the community. To refuse treatment or even testing altogether prevents authorities from getting crucial information to determine whether an individual is safe or might compromise the safety of his community, which does pose a threat to the safety of the public. The Model Act requires the least restrictive means of confinement be used, allowing confinement in an individual's home if possible.⁸⁷ Furthermore, the penalty for noncompliance is only a misdemeanor. It is arguable that the subsection of the medical treatment provision does comply with the Jacobsen constitutional standard. While a civil monetary penalty does not implicate the same rights as forced quarantine and isolation, the penalty measure upheld in Jacobsen was nonetheless a misdemeanor designed to enforce the rest of the statute for public safety. Freedom from bodily restraint is a fundamental interest and government actions that invade such a right

⁸⁶ Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities, Model State Emergency Health Powers Act, Dec. 21, 2001.

⁸⁷ Id.

must be reviewed with strict scrutiny.⁸⁸ The Model Act’s treatment and testing powers, however, are not triggered until a medical emergency is declared. While the emergency declaration power itself raises constitutional issues (as mentioned earlier), it is still important that the authorities can only exercise the power to detain individuals when a medical necessity exists and during a medical emergency, where courts would most likely find a compelling state interest. Gostin explains that the Model Act appropriately balances individual and communal rights because the broad emergency powers are available only on a temporary basis, and only when reasonably necessary. The quarantine and isolation powers are limited in time, scope and duration, and are therefore narrowly tailored to the means of preventing or containing a health emergency. Only those that pose a risk to others will be subjected to these powers, and the Model Act sufficiently protects individual rights to contest those coercive government actions.⁸⁹

There are other aspects of the Model Act’s treatment and testing provisions that do not comport with the Jacobsen constitutional standard for compulsory medical treatment. Unlike Jacobsen, all authorities exercising the Model Act’s compulsory powers would be immune from nearly all liability arising out of such actions. Under Section 804, “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.”⁹⁰ Time sensitive emergencies will no doubt hinder the ability of

⁸⁸ Heller v. Doe, 509 U.S. 312, 113 S. Ct. 2637 (1993).

⁸⁹ Joshua L. Friedman, Emergency Powers of the Executive: The President’s Authority When All Hell Breaks Loose, 25 J.L. & Health 265 (2012).

⁹⁰ Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities, Model State Emergency Health Powers Act, Dec. 21, 2001.

healthcare providers to make an adequate determination of medical appropriateness in every case before administering treatment, but to abandon the ordinary standard of care entirely encourages the “arbitrary” use of compulsory medical treatment powers contrary to the constitutional standards of Jacobsen. Without concern of being held liable for damages, health authorities will be incentivized to treat as many individuals as possible without the appropriate determination of medical appropriateness.

IV. Conclusion

Although a promising starting point to guide and encourage states to update their public health infrastructure, the Model Act does not adequately balance individual rights against government power and certain provisions must be modified before adoption into state law. 9/11 and the anthrax attacks alerted lawmakers to new problems. The United States was vulnerable, and in a world of terror, the weaponization of fast spreading contagions posed modern threats that older public health laws never considered. Some critics feel the Model Act is just a politically driven and emotional reaction aimed at expanding the executive powers. However, I argue that the Model Act is instead a good starting point towards resolving major problems mentioned earlier in this paper: the lack of clarity in the roles and duties of healthcare actors and officials; the problem of variation between state laws; and the outdated state of most current public health laws.

The conclusions of this research are intended to provide the public health practice community with information on the trajectory of public health emergency law. While I agree with the purpose of the Model Act and use of the Model Act to influence state reform, I assert that the Model Act goes too far in expanding government authority, and should be modified to better comport with the constitution and our democratic society.