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CHAPTER 1. CHRONIC DISEASE PREVENTION

In 2005 state lawmakers initiated action on a wide variety of bills related to chronic disease prevention. As illustrated in Figure 1, at least 466 bills were introduced in six subcategories.

![Figure 1: Legislative Action By Chronic Disease Prevention Categories](chart)

Legislation in the obesity and reproductive health subcategories accounted for approximately 62 percent of all measures introduced, while heart disease, stoke and diabetes initiatives had the smallest number of new bills. 2005 marked the first year of a two-year legislative session in many states, and 25 states allowed legislation introduced in 2005 to carry over into 2006. Slightly less than half of all bills introduced, 219, fall into this category. Of the remaining 242 bills that did not carry over, roughly 36 percent were adopted.

**LEADING STATES**

With the exception of Delaware, legislators in all of the states introduced measures related to at least one of the six subcategories. By a wide margin, lawmakers in New York introduced more chronic disease prevention bills than those in any other state. However, fewer than five of the 51 measures introduced in the state gained final approval in 2005. Consideration of the remaining bills was delayed until the 2006 session. After New York, California, Connecticut, Hawaii and Minnesota led the way in terms of number of bills introduced. Each of these states put forth 20 or more new measures. Lawmakers in the majority of states (34) introduced fewer than 10 new chronic health prevention bills, but Alabama, Maine, Utah and Wyoming were the only states to introduce just one new bill. Excluding New York, states that took up chronic disease prevention issues in 2005 introduced an average of eight bills. Figure 2 depicts the number of chronic disease prevention bills introduced in each state.
HEART DISEASE, STROKE AND DIABETES

Lawmakers in 18 states introduced at least 41 bills addressing heart disease, stroke and diabetes. Ten of these measures were adopted, 15 failed and 16 carried over to 2006. This legislative activity is displayed in Figure 3.

Of the 18 bills introduced related to heart disease, 12 sought to expand availability and access to automatic external defibrillators (AEDs). Three of these measures were adopted: Arkansas H.B. 1231, California H.B. 1507 and New Jersey S.B. 2567. The Arkansas statute shields citizens who use AEDs “in good faith and without compensation” from civil liability related to their use. The bills enacted in California and New Jersey require health and fitness facilities to install the devices and train employees how to use them. Similar legislation failed in Mississippi (H.B. 1748). Massachusetts, Minnesota, New York and North Carolina carried over AED legislation to 2006.
Lawmakers in Arkansas, New Jersey, New Mexico and North Carolina introduced seven bills related to stroke. The four adopted bills generally provide more funding to stroke facilities or funding for statewide efforts to combat stroke. A bill in North Carolina (S.B. 385) to fund a public awareness and education campaign was carried over. Of the bills introduced, only New Jersey S.B. 2582 failed outright. This measure called for more specific neuroimaging guidelines for primary stroke centers.

Only three of the 16 bills related to diabetes gained final approval. Texas H.B. 984 requires elementary and secondary schools to develop individualized treatment plans for diabetic students. The statute also calls for a number of school staff to be trained as “unlicensed diabetes care assistants” and makes provisions for students to independently monitor and treat their diabetes. Illinois H.B. 1581 creates an income tax checkoff fund for diabetes research, and Pennsylvania adopted H.R. 414, recognizing November 2005 as “National Diabetes Month.”

Other legislation introduced addressed diabetes risk assessment and screening for students, the creation of task forces to study the disease and more funding for prevention programs. Lawmakers in Louisiana offered a bill to provide a tax credit for parents of children with diabetes (H.B. 624), but the measure died in committee.

**Obesity**

Legislation seeking to combat the problem of obesity made up a significant portion of all legislation in the chronic disease prevention category. Thirty-six states introduced at least 123 bills on a wide range of obesity-related topics. Twenty-seven of these initiatives were enacted in 19 states, 48 bills failed and another 48 were carried over to 2006. Figure 4 depicts this legislative activity.

![Figure 4: Obesity Legislation](image-url)
Efforts to restrict civil actions, class action lawsuits or other legal liability claims based on obesity made up a large percentage of 2005 obesity-related legislation. At least 30 such bills were introduced in 24 states. Of these measures, 10 bills were enacted in 10 states: Georgia, Kansas, Kentucky, Maine, New Mexico, North Dakota, Oklahoma, Oregon, Texas and Wyoming. Ten of the remaining proposals failed, and another 10 carried over to 2006.

Lawmakers were active in proposing the creation of task forces or councils to develop nutrition policies. Lawmakers in 18 states introduced 30 bills to establish such panels, but only four were adopted (Rhode Island H.B. 5563, Illinois H.B. 211, Nevada S.B. 197 and West Virginia H.B. 2816). Initiatives that deal with school nutrition and youth obesity issues also figured prominently in 2005 legislative activity. These actions are described further in Chapter 3, Adolescent and School Health.

CANCER

Legislators in at least 18 states introduced 55 bills related to cancer. A majority of these states (13) adopted legislation. Furthermore, almost twice as many bills were adopted in the cancer subcategory than failed. Seventeen measures were enacted, nine failed and 29 carried over. Figure 5 illustrates this legislative activity.

Lawmakers directed much of their attention to the creation of new screening or prevention programs. Two bills were enacted in Arkansas, H.B. 2323 and H.B. 2781, to establish colorectal screening programs. Pennsylvania H.B. 1606 will expand free breast and cervical cancer screenings to more women, and Arizona and New York adopted legislation aimed at reducing incidence of skin cancer (AZ S.B. 1297 and NY H.B. 7422). Five additional screening bills were carried over, and one failed — a California bill (S.B. 688) aimed at skin cancer prevention in schools.
Proposed legislation to require health insurance coverage for certain cancers also received a lot of legislative attention. Eleven measures to mandate coverage for a variety of services and treatments, including those related to lymphedema and breast, prostate and colon cancers, were introduced in 10 states. Two such initiatives were enacted, Texas H.B. 1485, which requires coverage for human papillomavirus (HPV) screening tests, and Louisiana H.B. 36, which provides for coverage for colorectal screening.

Other legislation called for the creation of cancer drug repository programs that enable individuals to donate unused medication and devices to uninsured or underinsured cancer patients. Colorado, Kansas, Nebraska and Minnesota all adopted such programs. Several other states focused on counseling programs for cancer patients and their families. California lawmakers adopted S.B. 650, which specifically targets prostate cancer patients for greater access to counseling. Bills in New York (H.B. 2069 and H.B. 7395) and Nebraska (L.B. 705) related to outreach programs were carried over to 2006.

HEALTH PROMOTION AND WELLNESS

Lawmakers in 36 states introduced 69 bills in the health promotion and wellness subcategory. Twenty-five of these initiatives were adopted, 27 carried over to 2006 and 17 failed. This activity is depicted in Figure 6.

Much of the legislative activity in this subcategory focused on issues tied to tobacco, such as excise tax increases or public smoking bans. At least seven states enacted legislation to raise taxes on cigarettes: Colorado, Kentucky, Maine, Minnesota, New Hampshire, Ohio and Washington. Additionally, tax hikes adopted in earlier legislative sessions took effect in Alaska, Montana, North Carolina, Oklahoma and Virginia. Bills to increase tobacco taxes introduced in Connecticut, Iowa, Louisiana, Maryland, Mississippi and South Dakota failed to advance.
Although many of the measures provide for some increase in funding for smoking cessation and prevention programs, most additional revenue will be deposited in states’ general funds to close budget gaps and prevent cuts in services.

Along with proposals to raise tobacco taxes, lawmakers also addressed the issue of secondhand smoke. Legislators in four states introduced comprehensive clean indoor air legislation to ban most public place smoking. Of these initiatives, Georgia S.B. 90, Montana H.B. 643 and North Dakota S.B. 2300 were enacted. Pennsylvania S.B. 602 was carried over to 2006. The three adopted bills offer numerous exemptions to the bans and permit smoking in such places as private residences, designated hotel and motel rooms, tobacco stores, private clubs and some healthcare facilities or long-term care homes.

Montana’s ban applies to all of the state’s restaurants and bars, but as part of a compromise, the businesses will be exempt until Sept. 30, 2009. North Dakota’s law affects restaurants but not bars, and Georgia’s law makes an exemption for bars and restaurants that do not serve or employ people under the age of 18.

Lawmakers in at least six additional states, Arkansas, New Jersey, Nevada, North Carolina, Rhode Island and Vermont introduced legislation to expand the list of places where smoking is prohibited. All of these measures, which typically remove exemptions from private clubs or extend restrictions to additional facilities such as university dormitories and health or child care facilities, were enacted.

Lawmakers in Florida, Idaho and Maine, on the other hand, moved to add exemptions to their current smoke-free laws. The bills gained final approval in Idaho and Maine, but Florida Gov. Jeb Bush (R) vetoed S.B. 1348, a measure designed primarily to exempt one specific historical bar from the ban.

In addition to tobacco-related issues, states were active in promoting worksite wellness programs and expanded health insurance coverage for preventative care. At least 15 bills were introduced on these topics as lawmakers proposed a mix of incentives and mandates aimed at reducing the onset of chronic health problems. The majority of these bills were carried over for future consideration.

**REPRODUCTIVE HEALTH**

Legislation covering a broad range of topics related to reproductive health was introduced in at least 32 states. With at least 124 bills introduced, this subcategory is the largest in terms of bill volume under the chronic disease prevention topic. Despite the relatively large number of bills introduced, however, very few were adopted. Only 12 initiates were enacted in 12 states. Thirty-five bills failed, and 77 bills were carried over to the next session. States that introduced and enacted reproductive health legislation are depicted in Figure 7.
The 12 adopted bills are not concentrated in any one particular area. Three initiatives address reproductive programs and services, two relate to infant mortality and health, two instruct state Medicaid offices to apply for federal waivers and two create new health insurance coverage requirements. The remaining three adopted bills deal with substance abuse during pregnancy and reporting requirements for HIV tests of pregnant women.

**Oklahoma** S.B. 983, which passed both the House and Senate unanimously, amends the “Maternal and Infant Care Act.” Among several other minor alterations, new language was inserted to forbid program funds to be used for abortion, abortion referral or abortion counseling.

In **Kansas**, H.B. 2301 establishes a new “pregnancy maintenance program” to provide grants to nonprofits that help women carry pregnancies to term. **Virginia** H.B. 2656 authorizes the creation of new pilot projects to extend access to obstetrical and pediatric care. Eleven additional bills in five states (Illinois, Massachusetts, Minnesota, New York and Tennessee) sought to create new programs related to teen pregnancy and the prevention of sexually transmitted diseases; all were carried over to 2006.

Thirty bills, of which only two were enacted, were introduced to address insurance issues and reproductive health. Adopted **Texas** S.B. 53 expands existing state law that prevents discrimination by insurers based on genetic testing information. **Connecticut** S.B. 508 requires insurance coverage for medically necessary expenses related to the diagnosis and treatment of infertility. Fifteen additional bills in 12 states were introduced to clarify or require coverage for infertility treatments. Seven of these bills failed, and eight others were carried over.
The remaining 13 insurance bills relate to the coverage of other maternity benefits, including various screenings and exams, prenatal care and nutritional supplements. Three of these initiatives failed (New Jersey H.B. 2454, Oregon H.B. 2407 and Oregon S.B. 872), and the rest were carried over. Lawmakers in Montana, Pennsylvania, Utah and West Virginia introduced bills that would mandate the coverage of prescription contraceptive drugs, but none advanced except for two bills in Pennsylvania that were held until 2006.

ORAL HEALTH

At least 54 bills related to oral health were introduced in 19 states. Sixteen initiatives were adopted in 10 states, while 11 bills failed and 27 carried over to 2006. Legislative activity in this area is displayed in Figure 8 below.

Figure 8: Oral Health Legislation

Source: Health Policy Tracking Service, a service of Thomson West, August 2006

Sixteen bills, or roughly one-third of the total number introduced in the subcategory, relate to the licensure of dental professionals. Eight of these initiatives were enacted, and the remaining eight were carried into the 2006 session. In addition to increasing the number of continuing education requirements for dental hygienists, Alaska H.B. 211 adds language to existing licensure statutes related to the criminal backgrounds of potential applicants. The new provision forbids the granting of a license to an individual convicted of a crime that adversely reflects “the applicant’s ability or competency to practice dentistry or that jeopardizes the safety or well-being of a patient.”

Oklahoma H.B. 1337 also amends existing law related to the conduct of dental professionals and outlines a new protocol for complaint investigations. Other adopted licensure bills exempt certain members of the armed forces from existing testing requirements (Connecticut H.B. 6819, Maine S.B. 314 and Nevada S.B. 85).
Access to dental care, including insurance requirements, and Medicaid reimbursement rates for dental services also made up a large percentage of oral health bills introduced. Lawmakers in Mississippi and Rhode Island introduced five bills to increase state payments to professionals who provide care to Medicaid recipients. All of these measures failed. Legislative efforts to reduce Medicaid expenditures, however, were successful in Alaska. House Bill 105 establishes maximum annual dental benefits for Medicaid patients and provides for a yearly review and reduction of these benefits to counter the increasing costs of services.

Eight additional bills were introduced in Massachusetts, Montana, Nevada, Rhode Island, Washington and West Virginia to expand or enhance oral healthcare to more children and adults. Half of these measures were enacted, two failed and two carried over to 2006.
CHAPTER 2. HEALTH DISPARITIES

Lawmakers in at least 19 states addressed the issue of health disparities during their 2005 legislative sessions. Of the 50 bills introduced, 14 initiatives were adopted, 12 failed and 24 were carried over to 2006. Only six of the 19 states that took up the issue in 2005 enacted legislation that same year: Arkansas, California, Colorado, Massachusetts, New Jersey and New Mexico. This legislative activity is depicted in Figure 1.

![Figure 1: Health Disparities Legislation](source)

LEADING STATES

As illustrated by Figure 2 on the following page, New Mexico, New York and North Carolina were the most active states in terms of number of bills introduced. Their combined total of 18 bills made up 36 percent of all new initiatives. Although each of these states introduced six bills related to health disparities, only two proposals in New Mexico gained final approval. The remaining four New Mexico bills failed, and all 12 bills in New York and North Carolina were carried over to the next session. The other 16 states engaged in health disparities legislation averaged only two introduced bills per state. Eighty-five percent of all the enacted measures, however, came from this larger, though less active, pool.
TYPES OF BILLS

2005 health disparities legislation can be classified under the five subcategories depicted in Figure 3. Slightly more than half of all introduced measures involve the creation of offices or commissions to broadly tackle health disparity problems, while a smaller number of bills are more narrowly focused on specific goals.

Lawmakers in 12 states introduced 26 bills in the office or commission subcategory. Eight of these measures were adopted in four states: Arkansas, Massachusetts, New Jersey and New Mexico. Seven other bills failed, and 11 were carried over to 2006. New Jersey H.B. 655 establishes the “Eliminating Health Disparities Initiative” in the state’s Office on Minority and Multicultural Health. The office is charged with formulating and implementing policies to reduce the health disparities between whites and ethnic or racial populations in a number of specific health areas, including incidence of several chronic diseases, infant mortality and childhood immunization rates.
New Mexico adopted H.B. 642, the “Interagency Native American Health Care Disparity Act” to assess healthcare differences among rural and urban Native American populations and other populations in the state. In addition to identifying some of the unique healthcare needs of Native Americans, the initiative aims to better coordinate the delivery of health and social services across several state agencies. Arkansas expanded its Minority Health Commission through three separate appropriations bills, but six bills in North Carolina to increase funding for new health disparities programs were left in committee until 2006.

Along with the creation of new commissions or offices to study the problem, several states introduced legislation related to health disparities data collection systems. Michigan, Minnesota, New Mexico and New York proposed such measures, but only New Mexico S.B. 786 was enacted. The act calls for the creation of a statewide clearinghouse of health information that includes “social, cultural and economic conditions … including language preference.” The database will be used to better direct state healthcare resources and personnel.

The new grants programs and disease-specific programs subcategories cover a combined 11 introduced bills, four of which were enacted in 2005. Colorado H.B. 1262 creates a health disparities grant program funded by tobacco tax revenue. Legislative fiscal analysts predict the fund will generate approximately $4 million per year through at least FY 2008. Enacted legislation in Illinois, H.B. 615, asserts that “local governments and communities are best equipped” to identify and address problems associated with health disparities. The act establishes a grant program specifically aimed at county-level organizations and stakeholders and encourages more cooperation between state and local health agencies.

Another proposal introduced in Illinois focuses on the impacts of Alzheimer’s disease on minority patients. House Bill 3799 seeks greater advocacy resources for the state’s Center for Minority Health Services to promote awareness of the increased risk of Alzheimer’s disease among minorities. Similarly, California adopted two bills that target specific health threats while acknowledging the effects of health disparities. Senate Bill 650 authorizes funding for a program designed to extend more prostate cancer services to low-income and uninsured men, and H.B. 1142 establishes an initiative “to address the disproportionate impact of HIV/AIDS on the health of African-Americans.”

Finally, several states explored the implementation of cultural competence training for physicians and other healthcare professionals to bridge health disparity gaps. Seven bills were introduced in Indiana, Massachusetts, Michigan, New Jersey, New Mexico and New York. Senate Bill 144 in New Jersey was enacted, bills in Indiana and New Mexico failed and the rest were carried over to 2006. The New Jersey act mandates cultural competence training for physicians as a condition of licensure.
Lawmakers in 44 states introduced at least 186 bills related to adolescent and school health in 2005. By year’s end, 28 of these states had enacted legislation. Figure 1 depicts this legislative activity.

LEADING STATES

With 19 bills introduced in 2005, New York led all other states in terms of bill volume. None of these measures were adopted in 2005, however, and the vast majority of bills were carried over for consideration in the next legislative session. At the same time, all but two of the 17 bills introduced in the second leading state, Texas, died in committee. Furthermore, the two measures that did achieve final passage in that state were symbolic resolutions rather than substantive policy changes. None of the remaining states stand out as being particularly active in this topic area, with an average of four introduced bills per state in 2005. This activity is illustrated in Figure 2.
Figure 2: Number of Adolescent and School Health Bills Introduced in Each State
Source: Health Policy Tracking Service, a service of Thomson West, August 2006

Note: Lawmakers in Florida, Idaho, Mississippi, Nevada and North Dakota did not introduce legislation.

**TYPES OF BILLS**

The majority of bills relating to adolescent and school health can be classified in one of the five subcategories listed in Figure 3, although there is a certain amount of overlap, especially among bills in the Nutrition and Obesity and Physical Activity categories.

Figure 3: Legislative Action by Adolescent and School Health Categories
Source: Health Policy Tracking Service, a service of Thomson West, August 2006

The 63 bills that fall under the safety and violence subcategory comprise approximately 35 percent of all introduced legislation. Only eight of these bills in five states were enacted in 2005, however. Of the remaining initiatives, 15 failed and 40 were held until 2006. The bulk of both introduced and adopted legislation in this category relate to the prevention of harassment, intimidation or bullying. Enacted bills in Arizona (H.B. 2368), Indiana (S.B. 285), Tennessee (H.B. 2114) and Virginia (H.B. 2879) generally direct school boards of education to adopt and implement policies on bullying. Language in the Virginia bill that would have directed the board of education to set guidelines for the use of video monitoring was removed before the bill’s final passage. Arkansas enacted H.B. 1708 to provide procedures for the anonymous reporting of bullying. Other initiatives carried over until 2006 address a variety of other issues including teen dating violence, school safety hot lines, community collaboration and changes to curricula related to violence. Legislation related to nutrition, obesity and physical activity also was an important component of introduced legislation aimed at improving the health of young people. At least 69 such bills were identified in 35 states. An additional 17 bills specifically address physical activity, although many of the nutrition and obesity initiatives also contain language promoting the same types of fitness plans or
studies. Thirty-four bills in these two subcategories were enacted in 19 states. Twenty-two bills failed, and 30 were carried over to 2006.

Enacted legislation focuses on a range of different initiatives including body mass index testing, nutrition education, guidelines for food and beverage sales in school cafeterias and in vending machines and the creation of various task forces or commissions. Lawmakers in Arizona, Kansas, Kentucky, Maine, New Mexico, North Carolina and South Carolina mandated that their state health departments develop minimum nutrition standards for all foods sold in elementary, middle and junior high schools. The Kentucky bill (S.B. 172) is different from other school nutrition bills in that it penalizes schools that violate its requirements. Louisiana, Maryland, North Carolina and West Virginia established statewide nutrition standards through legislation, and Colorado, Illinois, Tennessee and Utah adopted bills or resolutions to encourage local school district to establish nutrition policies.

At least two school nutrition and physical activity bills were vetoed. Connecticut Gov. Jodi Rell (R) vetoed S.B. 1309, citing her strong support for local control of schools and parental participation. The bill would have mandated several nutrition and activity requirements, including 100 minutes of physical activity per week for elementary school students, not counting physical education. Gov. Arnold Schwarzenegger (R) of California returned H.B. 443, which related to food sales. In his veto message, the governor suggested that the bill was unnecessary because it addressed issues that were already under the authority of the State Board of Education.

State lawmakers in Maine adopted some of the original recommendations offered by the Commission to Study Public Health that Concern Schools, Children and Nutrition when they enacted S.B. 263. Although not all of the Commission’s recommendations received final approval from lawmakers, four of the recommendations did pass. These include efforts to expand nutrition education, the installation of milk-only vending machines in schools, implementation of the National Farm to School Program and the posting of caloric information for prepackaged food items sold in cafeterias.

A fourth subcategory of state actions under the broad topic of adolescent and school health issues is K-12 sexual education. At least 20 bills were introduced in 12 states, but only two symbolic initiatives in Texas gained final approval. The enacted House and Senate resolutions recognize “Abstinence Awareness Day” in that state. Nationally, ten additional bills were carried over to 2006, and eight measures failed outright or died in committee. Introduced legislation primarily addresses sex education curricula and ways of keeping parents informed of that curricula.

The final subcategory contains bills related to mental health and substance abuse issues. Of the 15 introduced measures, four were enacted, five failed and six carried over to 2006. Arkansas S.B. 969 creates a youth suicide prevention program, and lawmakers in New Jersey enacted H.B. 3931, which requires suicide prevention instruction for the State Board of Education staff. Two additional symbolic measures were adopted in Delaware and Pennsylvania. Delaware H.C.R. 21 recognizes “Mental Health Awareness Month,” and S.R. 90 in Pennsylvania designates a “Sober Graduation Month.”
CHAPTER 4. HIV/AIDS AND STDs

Lawmakers in 46 states introduced at least 239 bills related to HIV/AIDS and STDs in 2005. Seventy-four of these measures were enacted in 30 states. Of the remaining 165 bills, 57 failed and 108 carried over to the 2006 legislative session. This activity is depicted in Figure 1.

Figure 1: HIV/AIDS and STDs Legislation

LEADING STATES

Lawmakers in New York introduced 38 bills in this topic area, the most among all the states. However, only one measure was signed into law in 2005, S.B. 5722, which amends the “Civil Service Act” to provide HIV testing for first responders. All of the other proposals carried over to 2006. The second most active state, Illinois, adopted a much higher percentage of its 33 introduced bills. Fourteen new initiatives were enacted, and 15 others were held until the next session.

New Jersey and Texas, the only other states to introduce 15 or more bills, acted on a combined 42 pieces of legislation. Excluding Illinois, New Jersey, New York and Texas, the remaining 42 states accounted for at least 127 additional bills, averaging about three new bills introduced per state. Figure 2 illustrates the number of HIV/AIDS and STDs measures introduced in each state.
Lawmakers in at least 14 states introduced 49 bills related to HIV/AIDS and correctional facilities. Thirteen of these measures were enacted in six states: Illinois, Maryland, Missouri, Tennessee, Texas.
and Utah. Eight bills failed, and 28 were carried over to 2006. Almost half of the bills that carried over (13) originated in New York. Most of the legislation in this subcategory provides for the testing of prisoners for HIV/AIDS upon their admission or prior to their discharge from correctional facilities. Enacted Texas H.B. 43 mandates HIV testing for all state prisoners before they are released. Furthermore, the law requires the reporting of positive test results to the Department of State Health Services. Correctional facilities are authorized, but not required, to test incoming inmates as well and may segregate prisoners who test positive for HIV from the rest of the prison population. Illinois H.B. 524 requires individuals convicted of certain crimes to be tested for HIV and STDs before incarceration. Unlike the Texas statute, test results in Illinois are kept strictly confidential unless the courts intervene.

Other adopted legislation allows state governments to test inmates for HIV when correctional officers and certain other state employees come into contact with inmates' bodily fluids. Tennessee S.B. 1731, which passed both the House and Senate unanimously, gives laboratory personnel who are exposed to the fluids of an arrested individual the right to request blood samples for HIV and hepatitis testing. Missouri H.B. 700 and Utah H.B. 98, both enacted, increase the penalties for purposely exposing officers to bodily fluids. In many cases, these types of crimes will now be classified as felonies. Maryland H.B. 944 sets new guidelines for court hearings to determine whether an inmate or individual charged with a crime may be tested for HIV. If certain health or law enforcement personnel are exposed to blood or other fluids, the courts must order testing within a certain amount of time after the incident.

Legislation regarding potential exposure to HIV was not confined to the settings of correctional facilities. Twenty states introduced at least 20 bills related to the criminality of intentional HIV/AIDS exposure by any citizen — incarcerated or not. Five initiatives were enacted in four states: Oregon, South Dakota, Tennessee and Texas. Five bills of this type failed, and 10 were carried over to 2006.

Bills that address health insurance coverage and access to treatment for HIV/AIDS make up the second largest subcategory after measures related to criminal justice. Lawmakers in at least 18 states considered 43 bills in this area. Seven new proposals were enacted, 13 failed and 23 were carried over. Five states — Illinois, Montana, New Hampshire, New Jersey and New York — adopted legislation, but most of this legislation deals only with minor details. More substantive bills failed in Alabama, Arizona, Indiana, Kentucky, Oregon and Texas. Although two initiatives were enacted in New Jersey, seven other bills in that state died in committee.

The introduced bills in this area cover a wide range of different initiatives, but many seek to reclassify HIV/AIDS in such a way that patients would become eligible for increased services or would be able to participate in state disease management plans or high-risk insurance pools. These proposals, however, were not enacted into law. Alabama lawmakers considered but did not adopt H.B. 16, which would have extended the definition of disability to include AIDS for certain state employees seeking workers' compensation benefits. A similar bill in Indiana, H.B. 1538, would have extended such benefits to volunteer first responders in addition to paid employees, but this measure also died.
CHAPTER 5. ENVIRONMENTAL PUBLIC HEALTH

In 2005, at least 249 environmental public health bills were introduced in 38 states and the District of Columbia. Of those bills, 52 were adopted, 83 failed and 114 carried over to the 2006 session. Roughly two-thirds of the states that introduced environmental public health legislation adopted (see Figure 1). The majority of bills aim to control the release of hazardous substances or reduce the levels of such substances already found in the environment.

![Figure 1: Environmental Public Health Legislation](source: Health Policy Tracking Service, a service of Thomson West, August 2006)

LEADING STATES

California, New Jersey and New York had the most environmental public health legislative activity.

The California Legislature adopted 12 bills in areas such as reducing vehicular emissions; monitoring the release and accumulation of toxic chemicals in the environment; and regulating and restricting the use of hazardous substances such as mercury, pesticides and lead. Only three bills — relating to heftier penalties for violations of pesticide regulations, disclosure by chemical manufacturers to the state of purchasers of products containing specific chemicals, and sanitizing public water used for recreational bathing — died. The remaining 10 bills carried over to 2006.

In New Jersey, lawmakers adopted only two bills: H.B. 3182 reduces fine particle diesel emissions, and H.B. 1447 coordinates state and local hazardous materials emergency response programs. New Jersey concluded its biennium session, thus the remaining 21 bills failed. Some of the bills that failed related to safety requirements for retail food establishments; stricter penalties for environmental law violations; restrictions on and removal of toxic substances such as pesticides, electronic waste and toxic mold; lead screening for children; and creating regional lead treatment centers.

The vast majority of environmental public health bills introduced in New York did not experience much legislative activity in 2005 and were carried over to 2006. Only three bills were adopted: H.B. 2767
authorizes schools to stock and administer emergency medication for asthma treatment, S.B. 4469 restricts the sale of mercury-added products and S.B. 1771 establishes a toxic mold task force.

Figure 2 provides further information on legislative activity related to environmental public health.

![Figure 2: Number of Environmental Public Health Bills Introduced in Each State](source)

Note: Lawmakers in Arkansas, Delaware, Florida, Idaho, Kansas, Louisiana, North Dakota, Nevada, Oklahoma, South Dakota, Utah and Wisconsin did not introduce legislation.

**TYPES OF BILLS**

Environmental public health bills are divided into the following eight categories: asbestos, asthma and air quality, environmental health tracking and policy, food contamination, mercury, pesticides, toxics (in general) and lead.

Out of 10 asbestos bills introduced, four were adopted, one failed and five carried over. *Hawaii* lawmakers introduced the most asbestos bills and enacted H.B. 1295 to test schools for asbestos before renovations. Lawmakers in *California* adopted H.B. 459 to protect consumers from purchasing real property located in an area with naturally occurring asbestos. House Bill 740 was adopted in *Montana*, creating a special fund to be used for asbestos-related programs in one county. *New Hampshire* S.B 115 also was adopted, transferring the responsibility of asbestos to the Department of Environmental Services.

The states introduced 48 bills related to asthma and air quality. Sixteen were adopted, 11 failed and 21 carried over. The largest subcategory contains 11 bills to reduce greenhouse gases and vehicular emissions, and measures were adopted in *California* (H.B. 1007 and H.B. 1229) and *New Jersey* (H.B. 3182). Nine bills were introduced to reduce smoking in public places; however, only S.B. 90 was adopted in *Georgia*. Seven of the eight bills allowing students to self administer emergency asthma medications were adopted in *Alaska*, *Colorado*, *Maryland*, *New Mexico*, *North Carolina*, *South Carolina* and *Wyoming*, and lawmakers in *New York* adopted H.B. 2767, allowing schools to stock and administer the medications. Bills concerning standards of indoor air quality, particularly in schools, were adopted in *Arizona* (S.B. 1009) and *Washington* (S.B. 5841). House Bill 6713 was adopted in *Connecticut* to collect data on asthma diagnoses, and H.B. 1133 was adopted in *Illinois* to improve Medicaid’s prevention and treatment of pediatric asthma.

Only six bills were adopted out of 26 related to environmental health tracking and policy, while four failed and 16 carried over. Three bills were adopted in *California* on bio-monitoring of toxic chemicals in the environment and in people (S.B. 600), regulating environmental laboratories (H.B. 1317) and authorizing a local agency to investigate businesses that could release hazardous materials (S.B. 471). Lawmakers in *Ohio* adopted H.B. 203 establishing a School Health and Safety Network to inspect schools for potential hazards. In the *District of Columbia*, L.B. 16 was adopted, establishing a single agency to
protect human health and the environment. The Michigan Legislature adopted S.B. 538 to provide small businesses loans to implement pollution prevention projects.

Seven bills were introduced regarding food contamination of which one was adopted, one failed and five carried over. Lawmakers in North Carolina adopted H.B. 1096, permitting the health services commissioner to make changes to the inspection schedule for retail food establishments. New Jersey S.B. 2916, requiring retail food establishments to employ at least one individual certified in food safety, failed upon adjournment. Of the carryover bills, the California Legislature introduced two of interest: H.B. 1291 would create a logo for foods free of toxic substances and S.B. 144 would establish a new retail food code including crimes and enforcement.

State lawmakers introduced 21 bills to control the use of mercury. Four were adopted, nine failed and eight carried over. Most bills under this category would prohibit the sale of mercury-added products such as thermostats, electrical relays, switches, measuring devices, lamps, batteries and medical or scientific instruments. Lawmakers in California and New York adopted H.B. 1415 and S.B. 4469, respectively under this subcategory. House Bill 5911 and S.B. 611 were adopted in Rhode Island specifically limiting mercury-added components in motor vehicles and regulating their removal and recycling.

Twenty pesticide-related bills were introduced, two were adopted, six failed and 12 carried over. This category had the lowest adoption rate, and California was the only state to pass legislation. House Bill 405 prohibits the use of pesticides on school grounds that have conditional registration, interim registration or experimental use permits. House Bill 1011 prohibits the sale of pesticides except by licensed pest control dealers for all uses including nonagricultural uses.

Toxics make up the largest category with 60 bills. Ten were adopted, 23 failed and 27 carried over. Toxics contain measures related to the reduction or disposal of hazardous substances in general. For example, Oregon lawmakers adopted S.B. 43, which aims to lessen hazardous waste and the use of toxics. The Michigan Legislature adopted H.B. 5148 and S.B. 747 to improve landfills and regulate the disposal of toxic substances. Other bills address particular toxic materials not included under other categories. For instance, Michigan H.B. 5427 was adopted to monitor mining areas for hazardous substances. House Bill 1078 and S.B. 536 were adopted in California to clean up properties used for methamphetamine production.

Legislatures in New York and Washington adopted S.B. 1771 and S.B. 5049, respectively, to inspect and remove toxic mold. House Bill 397 adopted in Ohio regulates hazardous construction and demolition debris. New Jersey was the only state that introduced and adopted legislation (H.B. 1447) to coordinate and plan for a hazardous materials emergency response. Of the bills that failed, 17 died in states that did not carry measures over to the 2006 session, including 11 bills in New Jersey.

Lead makes up the second largest category with 57 bills. Eight were adopted, 27 failed and 22 carried over. Bills addressing lead had the highest failure rate among the eight categories. The majority of bills relate to testing and disclosure of lead hazards in residential properties; however, only one such bill was adopted in Maine (H.B. 1077). Most of the bills adopted focus on children who are more susceptible to lead poisoning. Lawmakers in Rhode Island and South Carolina adopted S.B. 1174 and H.B. 3582, respectively, to enforce lead safety standards, particularly in dwellings or childcare facilities with children under the age of six.

Indiana S.B. 538 requires reporting of lead poisoning cases of children under the age of seven and directs Medicaid to improve screening and treatment of children. Senate Bill 95 adopted in Missouri establishes rules for lead abatement projects and directs that fines collected for violations fund child lead testing. Three other bills were adopted: Maryland H.B. 251 lowers the blood lead level that is deemed dangerous and that necessitates corrective measures. California H.B. 121 regulates lead levels in imported candy and Maine H.B. 719 imposes fees on manufacturers and wholesalers of paint to pay for lead hazards educational outreach programs and a media campaign.
See Figure 3 for a visual representation of the number of bills that were adopted, failed, or carried over by category.

Figure 3: Legislative Action by Environmental Public Health Categories
Source: Health Policy Tracking Service, a service of Thomson West, August 2006
CHAPTER 6. IMMUNIZATIONS

In 2005, 45 states and the District of Columbia introduced at least 267 bills pertaining to immunizations. Fifty-one were adopted, 96 failed and 120 carried over to the 2006 session. Thirty-one states enacted legislation (see Figure 1). Most bills aim to raise immunization levels, particularly among children and first responders, and remove dangerous amounts of mercury from vaccinations.

Figure 1: Immunization Legislation

LEADING STATES

In New York, Pennsylvania and Texas lawmakers introduced more than 15 immunization-related bills.

New York led the states in immunization legislation. Twenty-seven bills were introduced, three were enacted and 24 carried over. No bills were killed. Nine of the bills introduced would have expanded parents’ right to exempt their children from vaccine requirements for religious or personal objections or authorize nurse practitioners to determine if a child should be exempt from immunizations for medical reasons. However, none of the bills passed their chambers of origin. Lawmakers did adopt legislation pertaining to mercury in vaccines for pregnant women and children, school immunization requirements and extending a study on statewide immunization rates.

Sixteen bills were introduced in Pennsylvania. Two were adopted, and 14 carried over. House Resolution 308 urges the Department of Health to require tetanus and diphtheria boosters for children who are entering the seventh grade or are 12 years old. House Resolution 418 established “Meningitis Awareness and Prevention Week” in November 2005.

Lawmakers in Texas introduced 17 bills — five were adopted and 12 failed. Texas does not hold a 2006 session so no bills carried over. Twelve of the bills introduced would expand vaccine requirements to include inoculation against additional diseases for particular population groups or people in certain public facilities. Four such bills were adopted: H.B. 1316 adds pneumococcal disease and hepatitis A to the list of childhood immunization requirements; H.B. 1575 and S.B. 6 relate to maintaining and sharing...
immunization records of juvenile delinquents and foster children, respectively; and S.B. 1330 requires hospitals to offer pneumococcal and influenza vaccines to elderly patients if they are available. The Texas Legislature also adopted S.B. 310 to protect firefighters and emergency medical technicians from adverse reactions to smallpox vaccinations even though inoculation is voluntary.

Figure 2 provides further information on immunization legislative activity by state.

Figure 2 provides further information on immunization legislative activity by state.
Source: Health Policy Tracking Service, a service of Thomson West, August 2006

Note: Lawmakers in Idaho, Louisiana, North Dakota, New Mexico and Wyoming did not introduce legislation.

**TYPES OF BILLS**

Immunization legislation is broken down into 14 categories: expansion of vaccine requirements, mercury-containing vaccines, first responders, exemptions, immunizations systems, cervical cancer prevention, public health disasters, pharmacists/non-physicians administering vaccines, vaccine benefit coverage, fee systems and funding, education and follow-up, disparities, infant mortality and research.

The largest category, expansion of vaccine requirements, also had the highest adoption rate of 27.5 percent (excluding disparities in which one out of two bills was adopted). Of the 82 introduced bills, 22 were adopted, 23 failed and 37 carried over. Legislation passed in Illinois, Indiana, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New York, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas and Washington. Most bills relate to vaccine requirements for public facilities such as hospitals, correction institutions and schools. Others refer to specific population groups including foster children, juvenile delinquents, homeless persons and home-schooled children. They often expand the list of necessary immunizations to include vaccines against diseases like hepatitis A, chicken pox and tetanus. Bills in another large subcategory focus on meningitis education and prevention — 18 were introduced and six passed.

The second largest category prohibits or restricts vaccines containing mercury. Of the categories with more than four introduced bills, mercury-containing vaccines had one of the lowest adoption rates (about 10 percent). Out of 39 bills introduced, four were adopted, 15 failed and 20 carried over. Lawmakers in Delaware adopted H.B. 108, banning mercury in vaccines administered to pregnant women and children under the age of eight. Illinois H.B. 511 allows trace amounts of mercury in vaccines for all citizens until 2008, at which time all vaccines administered in the state must be mercury-free (except during an outbreak). Legislatures in Missouri and New York adopted S.B. 74 and S.B. 2707, respectively, permitting only trace amounts of mercury in vaccines for pregnant women and children under the age of three (except during an outbreak). The Missouri bill also requires comparable insurance coverage of mercury-free vaccines.

Thirty bills were introduced relating to vaccinations for first responders. Four passed, 17 failed and nine carried over. This category had an adoption rate of about 13 percent. The West Virginia Legislature adopted H.B. 2619 to pay the cost of immunizations for volunteer firefighters against hepatitis B and other bloodborne pathogens. Lawmakers in Arkansas and Texas adopted H.B. 1011 and S.B. 310, respectively, which qualify first responders who have an adverse reaction to a smallpox vaccination for disability compensation. Iowa H.B. 789 was adopted, permitting priority designation for recipients of
vaccines in the event of a shortage and providing first responders immunity from civil liability for failure or refusal to administer vaccines to persons not on priority lists.

Twenty-one bills were introduced allowing parents to exempt their children from vaccine requirements for medical reasons or religious beliefs. Two bills were adopted, eight failed and 11 carried over, giving this category the lowest adoption rate of about 9.5 percent. South Dakota S.B. 39 allows parents to exempt their children from school vaccine requirements. Illinois H.B. 3628 permits parents to exempt their children from vaccine requirements in welfare agencies.

One quarter of the bills introduced under immunizations systems were adopted. Out of 24 bills, six were adopted, nine failed and nine carried over. The Maryland Legislature adopted H.B. 267, establishing a commission to study the availability and affordability of vaccines and recommend strategies for increasing immunization levels among children and adults. Lawmakers in Nebraska adopted L.B. 301, which creates the Women's Health Initiative to coordinate public women's health services including immunization programs. New York H.B. 6620 was adopted to extend the sunset dates for a law requiring an advisory council to study and report on immunization rates and for certain demonstration programs connected to child immunizations. Virginia H.B. 2519 and S.B. 1132 were adopted to initiate a statewide immunization registry. Senate Bill 2 was adopted in Tennessee to prohibit price gouging of vaccines during a public health emergency.

Cervical cancer prevention also had a 25 percent adoption rate. Twenty bills were introduced, five were adopted, six failed and nine carried over. Most bills aim to establish a commission or task force to study cervical cancer prevention strategies including vaccines. Such measures were adopted in Minnesota (H.B. 139), Montana (S.B. 328), New Hampshire (H.B. 111) and New Jersey (H.B. 4071). Lawmakers in Illinois adopted H.B. 3564 to expand a breast and cervical cancer research program to include ovarian cancer.

Of the nine public health disaster bills introduced, one was adopted, two failed and six carried over. Most legislation outlines a strategy for vaccination in the case of an outbreak. Many measures also authorize quarantines of infected persons and persons who refuse vaccination. Lawmakers in Hawaii passed H.B. 516, creating an emergency response stockpile of vaccines and other medical supplies to treat the population in a public health emergency.

Eleven bills were introduced in the category of pharmacists and non-physicians administering vaccines. Two were adopted, two failed and seven carried over. Most bills allow pharmacists to administer certain vaccines and provide training requirements. Connecticut H.B. 6791 permits pharmacists to administer influenza vaccines to adults, and Oregon S.B. 490 authorizes pharmacists to administer influenza vaccines to persons as young as 15 years of age.

Most vaccine benefit coverage legislation directs insurance providers or public healthcare programs to cover certain vaccines. Nineteen bills were introduced, three were adopted, eight failed and eight carried over. California S.B. 375 was adopted to require Medicare supplemental coverage of influenza vaccines. Lawmakers in Illinois adopted H.B. 806 to establish a state healthcare program for children that will cover childhood vaccinations. New Jersey H.B. 4543 was adopted to require insurance providers to cover childhood vaccines.

Bills in the category of fee systems and funding aim to support immunization programs by either assessing a fee on insurers and pharmaceutical manufacturers or increasing cigarette taxes. Only four bills were introduced, none were adopted, three failed and one carried over.

The education and follow-up category also includes only four bills — one was adopted, one failed and two carried over. Colorado S.B. 87 allows the state to contact parents or legal guardians if their children’s immunizations are overdue. The other three bills would educate grandparents acting as foster parents on childhood vaccines.
Little legislative attention was paid to racial and ethnic disparities or funding programs to increase immunization levels among minorities. Two bills were introduced, one failed and Illinois H.B. 615 was adopted to direct the Department of Public Health to administer a program of grants for community-based healthcare projects for minorities.

Only one bill was introduced under infant mortality. Arizona H.B. 2639 died, but it would have created a committee to devise a strategy for reducing infant mortality levels.

One bill involved vaccine research, and it carried over to 2006. California S.B. 492 would fund valley fever research and vaccine development.

See Figure 3 for a visual representation of the number of bills that were adopted, failed or carried over by category.
CHAPTER 7. BIRTH DEFECTS AND DISABILITIES

In 2005 at least 28 states introduced legislation related to birth defects and disabilities. Of the 94 bills introduced, 29 were adopted, 22 failed and 43 carried over to the 2006 legislative session. Seventeen states enacted legislation (see Figure 1). Most bills address the need for improved newborn and early childhood screening requirements and public programs that provide services for people with disabilities or monitor the occurrence of birth defects and disabilities.

Figure 1: Birth Defects and Disabilities Legislation

LEADING STATES

California and New York introduced the greatest number of bills, and California adopted the most bills.

California legislators introduced 13 bills — seven were adopted, one failed and five carried over. Most legislative activity relates to special education services for disabled persons and protecting the public from harmful substances that can cause birth defects such as toxins in cosmetics, chemicals in public drinking water and lead in firearms. The bill that failed, H.B. 927, would have established full-day preschool and childcare programs giving priority to children with exceptional needs (including disabled children). However, the bill was vetoed because Gov. Arnold Schwarzenegger (R) believes that sufficient funding for full-day programs already exists in contractual agreements through the California Department of Education.

Lawmakers in New York introduced 17 bills — two were adopted, four failed and 11 carried over. Senate Bill 2952 was adopted to establish an autism research program at Stony Brook University, and H.B. 6146 instructs school buses to carry certain information on passengers with disabilities in case of an emergency. Of the bills that failed, S.B. 3765 and H.B. 5616 would have revised laws to use terminology that “puts the person before the disability.” Examples of respectful language would be “individuals with disabilities” or “individuals with mental illness” rather than “the handicapped” or “the mentally ill.” The other bills that failed were companions to the bills that were adopted.
Figure 2 provides further information on birth defects and disabilities legislative activity by state.

Types of Bills

Legislation related to birth defects and disabilities is divided into the following 11 categories: newborn and early childhood screening, public programs, disability discrimination and awareness, education, substances that cause birth defects, terminology modification, transportation services and safety, funding, affordable housing, wards of the state and retirement benefits for disabled. Of the categories with at least eight bills, newborn and early childhood screening legislation had the highest adoption rate (about 43 percent). All other categories had adoption rates between 21 and 25 percent except for disability discrimination and awareness, which had an adoption rate of about 15 percent.

Twenty-one bills were introduced regarding newborn and early childhood screening — nine were adopted, three failed and nine carried over. Most bills would establish screening requirements such as vision and hearing tests for newborns or development tests (including testing for autism) for children. Many also regulate fees for screening and require reporting the outcomes to state health departments. Legislatures in Arizona, Delaware, Kentucky, New Hampshire, New Jersey, New Mexico, Rhode Island and Virginia adopted measures.

In the public programs category, 23 bills were introduced, five were adopted, five failed and 13 carried over. Measures were adopted in Illinois, Maryland, New Hampshire, New York and Pennsylvania. Most notably, Illinois S.B. 1698 and Maryland H.B. 1315 each create a registry and require hospitals or healthcare professionals to report all incidences of certain birth defects to the state health department for monitoring purposes. In addition, Pennsylvania S.R. 76 directs the Legislative Budget and Finance Committee to conduct a comprehensive evaluation of all state services for people with hearing disabilities.

Of the 13 bills introduced regarding disability discrimination and awareness, two were adopted, three failed and eight carried over. The Michigan Legislature adopted H.B. 4887, reinforcing antidiscrimination laws in schools. Lawmakers in North Carolina adopted H.B. 85, authorizing the Division of Motor Vehicles to issue an Autism Society special license plate.

Eight bills were introduced related to education and substances that cause birth defects. In both categories, two bills were adopted, two failed and four carried over. The California Legislature adopted two bills related to education: H.B. 1662 conforms state laws regarding public education services for students with exceptional needs to federal requirements, and S.B. 512 is an omnibus education bill that includes an appropriation to provide community mental health services to students with mental illnesses and amends laws regarding educational programs for adults and children with disabilities. Lawmakers in California also adopted two bills to protect consumers from products that can cause birth defects: S.B.
484 requires labels on cosmetics containing toxins that can cause birth defects, and S.B. 1060 requires warning signs near firearm vendors that exposure to lead can cause birth defects.

A moderate amount of legislative activity focused on terminology modification, transportation services and safety, and funding. Of the five terminology modification bills (which would require the use of more respectful language when referring to persons with disabilities in legislation or other official documentation) introduced in Arkansas, Mississippi, New York and North Carolina — only North Carolina H.B. 686 was adopted, changing the term “handicapped person” to “person with disability.”

Five bills were introduced regarding transportation services and safety in Hawaii, California and New York — two passed, one failed and two carried over. California H.B. 462 was adopted to require construction plans for public transportation facilities to include accessibility for persons with disabilities. New York H.B. 6146 was adopted to direct school buses that transport children with disabilities to maintain certain medical and emergency contact information. Five bills were introduced under the funding category. Two carried over and the following three were adopted: Wisconsin S.B. 167 provides an income tax checkoff for contributions for multiple sclerosis, Illinois H.B. 18 creates the Autism Research Fund and Massachusetts H.B. 4177 directs the secretary of Health and Human Services to apply for additional federal funding to support special education services for children with autism.

Few bills dealing with affordable housing, wards of the state or retirement benefits for disabled persons were introduced. The two bills introduced in the affordable housing category were companion bills in New Jersey. Senate Bill 2696 was adopted to require newly constructed affordable housing units to be adaptable for use by elderly and disabled persons. Two bills were introduced regarding wards of the state in Arizona and California. The California Legislature adopted S.B. 570 to standardize statewide procedures for the evaluation and treatment of minors who are wards of the juvenile court with mental, emotional or developmental disabilities. Lawmakers in New York and California introduced bills regarding retirement benefits for disabled. California H.B. 1166 was adopted to exclude state prosecutors and state public defendants from retirement for disability benefits.

Figure 3 shows the number of bills that were adopted, failed or carried over by category.
CHAPTER 8. EMERGENCY PREPAREDNESS AND RESPONSE

In 2005, 36 states introduced legislation pertaining to emergency preparedness and response. At least 117 bills were introduced, 38 were adopted, 38 failed and 41 carried over (see Figure 1). Most bills relate to state and local emergency preparedness plans and provide exemptions to certain laws in the event of a disaster.

Figure 1: Emergency Preparedness and Response Legislation

![Map of the United States showing states with emergency preparedness and response legislation](image)

**LEADING STATES**

Lawmakers in **New York** and **Pennsylvania** introduced the most bills, and the **Virginia** Legislature adopted the greatest number.

**New York** legislators introduced 10 emergency preparedness and response bills; however, none were adopted and all carried over. Senate Bill 182 — to make “agri-terrorism” a class B felony — was the only measure to pass its chamber of origin. The two bills with the largest reach create the “State Emergency Powers Act,” which defines public health emergencies and the state’s plan for how to react. The largest grouping of bills creates exemptions during public health emergencies for laws pertaining to medical records or pesticides.

Ten bills also were introduced in **Pennsylvania**. One was enacted, one failed and eight carried over. Like in New York, lawmakers introduced three far-reaching measures that identify public health emergencies, delegate emergency powers and provide grants to county health departments. Five of the introduced bills were resolutions urging public health departments to review the potential impact of a disaster and improve the state’s emergency preparedness and to develop greater public awareness. Of these measures, H.R. 468 was adopted.

The **Virginia** Legislature adopted all five bills that were introduced. Two of the bills allow local directors of emergency management to share resources with other states or localities. One measure establishes a
statewide immunization registry to facilitate tracking of vaccine administration. Lawmakers also enacted legislation to address sports-related emergencies and animal health emergencies.

Figure 2 provides further information on emergency preparedness and response legislative activity by state.

![Figure 2: Number of Emergency Preparedness and Response Bills Introduced in Each State](image)

Source: Health Policy Tracking Service, a service of Thomson West, August 2006

Note: Lawmakers in Arizona, Arkansas, Delaware, Idaho, Kansas, Maryland, Mississippi, Montana, Nebraska, New Hampshire, Rhode Island, Tennessee, Vermont and Wyoming did not introduce legislation.

**TYPES OF BILLS**

Emergency preparedness and response is divided into six categories: public health emergencies, exemptions during public health emergencies, interstate cooperation, funding for emergency preparedness projects, resolutions and other.

Public health emergencies is the largest category with 54 introduced bills. Twenty were adopted, 16 failed and 18 carried over, resulting in about a 37 percent adoption rate. Thirty-five of the bills are grouped together under a subcategory of measures that define public health emergencies and stipulate when they should be declared and what departments have emergency powers. Fourteen of the bills were adopted in Alaska, California, Florida, Hawaii, Illinois, Indiana, Iowa, Michigan, Minnesota, New Jersey, New Mexico, Oregon, Texas and Utah. In addition, six other bills were adopted in this category: Illinois H.B. 3819, Virginia H.B. 1607 and Utah S.B. 74 establish a registry of healthcare professionals or maintain a medical reserve corps that can be called upon during a public health emergency (veterinarians are included in the Virginia bill); North Dakota S.B. 2248 requires criminal background checks on healthcare professionals and Department of Health employees that work on bioterrorism and homeland security issues; Ohio S.B. 9 provides certified volunteers immunity from liability during a public health emergency; and Minnesota H.B. 11507 authorizes peace officers to isolate or quarantine persons by force during a public health disaster and protects those isolated or quarantined from being discharged or penalized by their employers.

Twenty-seven bills were introduced regarding exemptions during public health emergencies. Eight failed, 11 carried over and eight were adopted in Illinois, Maine, Missouri, New Mexico, South Dakota and Virginia. Most bills waive laws and regulations in the event of an outbreak or epidemic related to prescriptions, medical records, vaccinations or pesticides. For example, Maine S.B. 494 establishes rules for dispensing drugs during an emergency and limits physician-patient privileges to permit reporting to the Bureau of Health a disease or a condition caused by an environmental hazard that could indicate a public health threat. Similarly, New Mexico S.B. 413 permits the Board of Pharmacy to adopt rules for emergency prescription dispensing. House Bill 2526, adopted in Virginia, authorizes licensed athletic trainers to possess and administer certain drugs during emergencies. Illinois H.B. 511 and Missouri S.B. 74 provide exemptions to laws restricting mercury in vaccinations (for further information on vaccine exemptions see the chapter on Immunizations). New York lawmakers introduced four bills that would waive pesticide laws and regulations during a public health emergency that requires the eradication of plants or animals; all four carried over.
Six bills related to interstate cooperation were introduced. One bill failed, and five were adopted in California, Colorado, Nevada and Virginia, giving this category the highest adoption rate (about 83 percent). All of the adopted bills approve or modify rules for sharing emergency response resources with other states, usually under the Emergency Management Assistance Compact.

Seven out of eight bills to fund emergency preparedness projects failed. Five of them were introduced in North Carolina to finance construction of either a state public health lab or public health incubators for use by local public health departments in underserved regions. Alaska H.B. 100 — to finance the construction and equipping of a state virology lab — was the only bill that carried over.

Resolutions had a very low adoption rate of about 36 percent. Out of 11 bills, four were adopted, three failed and four carried over. Lawmakers in New Jersey adopted H.J.R. 66, directing the commissioner of health to contract out a study of the state’s emergency medical services system. The Louisiana Legislature adopted two bills in a special session to address the Katrina and Rita hurricane disaster, S.C.R. 14 asks emergency agencies such as the Federal Emergency Management Agency, the American Red Cross and the Salvation Army to realign their districts and conform to each other to provide a better and faster disaster response; and S.C.R. 21 urges the Department of Health and Hospitals, the Department of Social Services and the Office of Homeland Security to include the Louisiana Emergency Response Network in making decisions. Pennsylvania H.R. 468 asks the state’s Emergency Management Agency and the state’s Office of Homeland Security to review and improve the state emergency preparedness plan.

The “other” category contains 11 bills, only one of which was adopted. Three failed, and seven carried over. Five of the bills protect first responders and other emergency volunteers from loosing their jobs or being penalized for being absent during a disaster. Maine S.B. 494 was the only bill adopted. Other bills in this category include the following measures: two bills in Connecticut and New Jersey to improve local emergency response plans, a Minnesota bill authorizing a health insurance premium increase in the event of a public health disaster and two bills in New York that make “agri-terrorism” a crime and one to protect air and water circulation systems from unauthorized access in buildings with 50 or more people.

Figure 3 provides a visual representation of the number of bills that were adopted, failed or carried over by category.
CHAPTER 9. PUBLIC HEALTH INFRASTRUCTURE

In 2005 lawmakers in at least 16 states introduced legislation related to public health infrastructure. Of the 40 bills introduced, seven were adopted, 15 failed and 18 carried over. Seven states enacted legislation (see Figure 1). The majority of the bills aim to improve state and local health departments and provide funding to them to meet higher performance standards.

Figure 1: Public Health Infrastructure Legislation

LEADING STATES

Legislators in Massachusetts and Washington introduced the greatest number of bills.

All six bills introduced in the Massachusetts Legislature concern state health department infrastructure. Senate Bill 724, H.B. 4463 and H.B. 4479 would create a council to address several goals related to healthcare cost and quality, including improving the public health system. The final bill carried over to the 2006 session. House Bill 4000, H.B. 4001 and H.B. 4200 would have directed a new commission to analyze the preparedness of the state and local public health infrastructure to respond to a terrorist attack; however, the measure was excluded from the final version of the bill, which was adopted.

Similarly, all six bills introduced in the Washington Legislature relate to public health funding — one was adopted, and five carried over. House Bill 1737, S.B. 5715, H.B. 1818, H.B. 2326 and S.B. 5073 would help fund the public health performance standards adopted in the 1993 Public Health Services Improvement Plan by creating a task force to recommend potential funding sources, appropriating $10 million in general funds or using tobacco settlement funds. The only bill enacted was H.C.R. 4410, to establish a committee to recommend potential funding sources.
Figure 2 provides further information on public health infrastructure legislative activity by state.

![Figure 2: Number of Public Health Infrastructure Bills Introduced in Each State](image)

Source: Health Policy Tracking Service, a service of Thomson West, August 2006


**Types of Bills**

Public health infrastructure legislation is divided into the following five categories: state health department infrastructure, local health department infrastructure, public health funding, performance standards and improvement and expanded scope.

State health department infrastructure had the most legislative activity and the highest adoption rate (about 23 percent). Of the 13 bills introduced, three were adopted, six failed and four carried over. Lawmakers in **Alaska** adopted H.B. 95 to outline the duties of the Department of Health and Social Services including implementing public health policies, monitoring health threats and planning for public health emergencies. **Iowa** H.B. 789 was adopted, establishing a task force to study the current and future capacity of the public health workforce to respond to public health emergencies including disease outbreaks and bioterrorism. **North Carolina** S.B. 804 creates the Local Health Department Accreditation Board to improve the public health infrastructure.

Five bills were introduced related to local health department infrastructure; however, none were adopted, four failed and one carried over. Three of the bills that died were introduced in **North Carolina**. They would have financed the construction of public health incubators to develop epidemiologic monitoring, assessing and replication capabilities. **Pennsylvania** H.B. 596 carried over and would award counties without local health departments one-time grants to create a department, develop a public health emergency preparedness plan and establish a monitoring system.

States introduced 13 bills to increase public health funding — two passed, three failed and eight carried over. **Michigan** H.B. 4831 was adopted to authorize district health departments to assess local health departments a penalty equal to 5 percent of their budgets for trying to secede from the district health arrangement. Lawmakers in **Washington** adopted H.C.R. 4410, which establishes the Joint Select Committee on Public Health Finance to recommend potential sources of future funding for public health services.

Of the nine bills introduced regarding performance standards and improvement, two were adopted, two failed and five carried over. House Bill 95, adopted by the **Alaska** Legislature, includes a provision that authorizes the Department of Health and Social Services to establish public health performance standards. **Missouri** S.B. 74 was adopted to create a commission to evaluate state services for seniors.
The only bill introduced to expand the scope of public health infrastructure was Montana S.B. 137. The measure was adopted to allow the Department of Public Health and Human Services and local boards of health to regulate tattoo and body piercing facilities.

Figure 3 shows the number of bills that were adopted, failed or carried over by category.