



Volume 67

Issue 3 *The 2017 Randolph W. Thorer
Symposium, Minding the Gap: Law and Practice
in Public Health Emergencies*

Article 5

2018

Do State Lines Make Public Health Emergencies Worse? Federal Versus State Control of Quarantine

Polly J. Price

Emory University School of Law

Follow this and additional works at: <https://scholarlycommons.law.emory.edu/elj>

Recommended Citation

Polly J. Price, *Do State Lines Make Public Health Emergencies Worse? Federal Versus State Control of Quarantine*, 67 Emory L. Rev. 491 (2018).

Available at: <https://scholarlycommons.law.emory.edu/elj/vol67/iss3/5>

This Article is brought to you for free and open access by Emory Law Scholarly Commons. It has been accepted for inclusion in Emory Law Journal by an authorized editor of Emory Law Scholarly Commons. For more information, please contact law-scholarly-commons@emory.edu.

DO STATE LINES MAKE PUBLIC HEALTH EMERGENCIES WORSE? FEDERAL VERSUS STATE CONTROL OF QUARANTINE

*Polly J. Price**

ABSTRACT

This Symposium Article explores the origins and limits of the federal government's interstate quarantine power. In the event of a public health emergency, state and local political boundaries may generate self-interested measures that risk substantial harm to neighboring states. To more effectively stem a national epidemic and to better protect the interests of regional populations, should the federal government step in to override a state's protective quarantine? Neither current statutory authority nor how we have thought about it in the past prevents a greater national role. This Article shows how to expand our view of the federal government's interstate quarantine authority as an important tool to respond to public health threats affecting more than one state.

* Asa Griggs Candler Professor of Law and Professor of Global Health, Emory University School of Law; 2017 Andrew Carnegie Fellow. This Article was made possible by a grant from Carnegie Corporation of New York. The statements made and views expressed are solely the responsibility of the author. The author thanks Lucy Gauthier, Executive Managing Editor of the *Emory Law Journal*, for her excellent editorial work and suggestions, and Dr. Ray DuVarney, Professor Emeritus, Emory University.

INTRODUCTION	493
I. FEDERAL QUARANTINE POWER IN THE INTERIOR: “INTERSTATE” AND INTERDEPENDENCE	496
A. <i>Quarantine and Isolation as Public Health Tools</i>	496
B. <i>State Quarantines Harming Neighbors: Two Hypotheticals</i>	500
1. <i>Scenario One: When Returning Travelers “Enter” Both the United States and a State</i>	500
2. <i>Scenario Two: Guarded Quarantine Lines at State Borders</i>	502
C. <i>Why Courts Are an Insufficient Remedy: The Example of State Ebola Quarantines</i>	504
II. FRAMING THE ISSUE: WHAT IS “INTERSTATE” QUARANTINE POWER?	510
A. <i>The Traditional Understanding of Federal Versus State Quarantine Power</i>	514
B. <i>Legislative Authority for Interstate Quarantine</i>	516
C. <i>2017 Federal Quarantine Regulations, “Interstate and Foreign”</i>	519
D. <i>Objections to the Rule: Asking the Wrong Question?</i>	522
III. THE NINETEENTH-CENTURY ORIGIN OF FEDERAL INTERSTATE QUARANTINE POWER	525
A. <i>The First Interstate Quarantine Statute</i>	526
B. <i>Yellow Fever Quarantines: “A Stigma Upon Our Institutions and Civilization”</i>	529
C. <i>Constitutional Debates and Administrative Hurdles</i>	531
D. <i>Congressional Debates in 1906: Rail Traffic Within States</i>	537
E. <i>Summary: What History Teaches About Interstate Quarantine</i>	538
CONCLUSION	539

INTRODUCTION

The 2017 Throter Symposium provided an early opportunity to discuss the federal Centers for Disease Control and Prevention's (CDC) new quarantine regulations.¹ In this Symposium issue, James Misrahi recounts the history of these regulations in his article *The CDC's Communicable Disease Regulations: Striking the Balance Between Public Health & Individual Rights*, and responds to criticisms by some scholars concerning civil rights protections.² Although this Article also addresses the new federal quarantine regulations, the aim is different. This Article considers the concept of *interstate* quarantine, an aspect of the federal government's authority that remains perplexing, and is seldom considered by scholars.³ This is the authority of the federal government to act *within* the United States, not its well-settled authority to quarantine travelers arriving at a U.S. point of entry.

Following Severe Acute Respiratory Syndrome (SARS) and Ebola, scholars have addressed questions surrounding the legal basis for quarantine, including ethical responsibilities and preparedness.⁴ Headlines from the recent

¹ Control of Communicable Diseases, 82 Fed. Reg. 6890 (Jan. 19, 2017) (to be codified at 42 C.F.R. pts. 70–71). Originally intended to become final on February 21, 2017, the effective date was pushed to March 21, 2017, to allow for review by the Trump Administration. Rob Stein, *CDC Seeks Controversial New Quarantine Powers to Stop Outbreaks*, NPR (Feb. 2, 2017, 4:47 AM), <http://www.npr.org/sections/health-shots/2017/02/02/512678115/cdc-seeks-controversial-new-quarantine-powers-to-stop-outbreaks>; see Control of Communicable Diseases; Delay of Effective Date, 82 Fed. Reg. 10,718, 10,719 (Feb. 15, 2017). The notice of delay was published in the Federal Register on February 15, 2017. See Control of Communicable Diseases; Delay of Effective Date, 82 Fed. Reg. at 10,718–19 (“This action is undertaken in accordance with the memorandum of January 20, 2017 from the Assistant to the President and Chief of Staff entitled ‘Regulatory Freeze Pending Review.’”).

² James Misrahi, *The CDC's Communicable Disease Regulations: Striking the Balance Between Public Health & Individual Rights*, 67 EMORY L.J. 463 (2018).

³ An exception is Eang L. Ngov, *Under Containment: Preempting State Ebola Quarantine Regulations*, 88 TEMP. L. REV. 1 (2015), in which Ngov argues in favor of preemption in the context of Ebola. Another recent treatment is Mark A. Rothstein, *From SARS to Ebola: Legal and Ethical Considerations for Modern Quarantine*, 12 IND. HEALTH L. REV. 227 (2015). Rothstein identifies the problem, see *id.* at 256, but his purpose was not to suggest a change of structure, but rather how to make the existing fragmented system work better. I explain how my views differ in Part V.

⁴ See, e.g., Felice Batlan, *Law in the Time of Cholera: Disease, State Power, and Quarantines Past and Future*, 80 TEMP. L. REV. 53 (2007); Christine Coughlin, *Public Health Policy: Revisiting the Need for a Compensation System for Quarantine to Maximize Compliance*, 7 WAKE FOREST J.L. & POL'Y 415 (2017); Roni Adil Elias, *Preventing Contagion and Protecting Civil Liberties: Problems in Quarantine & Isolation Law in the United States & Suggestions for Reform*, 7 CHARLOTTE L. REV. 135 (2016); Rothstein, *supra* note 3; Nazita Gamini, Note, *The Need for Stronger Implementation of Quarantine Laws: How Adopting China's Strategy to Fight SARS Can Help the United States Effectively Utilize Quarantine Powers in the Fight Against Ebola*, 11 J. HEALTH & BIOMEDICAL L. 57 (2015); Anna L. Grilley, Comment, *Arbitrary, Unnecessary Quarantine: Building International and National Infrastructures to Protect Human Rights During Public*

Ebola crisis and the specter of pandemic disease arriving in the United States from elsewhere in the world inevitably have focused public attention on quarantine at U.S. borders, particularly the role of the CDC to interdict contagious disease before it can enter the territorial United States.⁵ But this focus on border control masks concern for epidemic outbreaks within the United States, at least with respect to the federal government's quarantine authority. Unlike the Ebola outbreak, in which the U.S. border was the primary focus, this Article concerns federal government authority when a contagious disease already present in the United States threatens to reach epidemic level. The United States is dangerously handicapped and unprepared to effectively control transmission from state to state, especially when individual states take actions that benefit it but harm their neighbors.

As this Article will explain, state and local governments lack sufficient incentives to cooperate effectively with each other to stem a public health emergency of potentially wide geographic scope. These separate public health authorities, in fact, may face the opposite incentive. State lines demarcating political units present challenges in the face of a potential national epidemic. Much is made of the need for local preparedness, including resource planning, simulations, and drills, but little has been done on a regional or multi-state basis.⁶

Moreover, even if incentives not to cooperate with adjacent governments can be overcome, individual states lack the administrative and enforcement tools necessary to effectively contain the spread of disease from one state to another. This is one aspect of the problem of fragmentation of the public health system in the United States that I have identified elsewhere.⁷

Health Emergencies, 34 WIS. INT'L L.J. 914 (2016); Carrie Lacey, Note, *Abuse of Quarantine Authority: The Case for a Federal Approach to Infectious Disease Containment*, 24 J. LEGAL MED. 199 (2003).

⁵ *Protecting Borders*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/about/ebola/protecting-borders.html> (last updated July 9, 2015).

⁶ An important exception is the Emergency Management Assistance Compact, a state-to-state mutual aid system authorized by Congress to coordinate voluntary assistance from one state to another in the event of a natural disaster or other emergency. See generally *EMAC Legislation*, EMERGENCY MGMT. ASSISTANCE COMPACT, <https://www.emacweb.org/index.php/learn-about-emac/emac-legislation> (last visited Dec. 8, 2017) (describing compact and authorizing legislation). As I discuss further in the Conclusion, however, this Compact does not contemplate the coordination of state and local quarantine policy.

⁷ Polly J. Price, *Sovereignty, Citizenship, and Public Health in the United States*, 17 N.Y.U. J. LEGIS. & PUB. POL'Y 919, 947–51 (2014) [hereinafter Price, *Sovereignty*]; Polly J. Price, Opinion, *If Tuberculosis Spreads . . .*, N.Y. TIMES (July 9, 2014), <https://www.nytimes.com/2014/07/09/opinion/if-tuberculosis-spreads.html> [hereinafter Price, *If Tuberculosis Spreads . . .*].

My purpose is to shift the debate about the federal government's quarantine authority from its focus on international borders to the interior, and to point out the dangers of protectionism when state and local governments attempt to exclude outside threats from local communities. Our longstanding view of a restricted federal interstate quarantine authority reflects an unnecessarily restrained view of what Congress has authorized. The CDC believes it is more constrained by underlying principles of federalism than it in fact is.

I view the new federal quarantine regulations as a missed opportunity to clarify the meaning of "interstate quarantine" both as a matter of jurisdiction and practical application, recognizing that to do so was almost certainly deemed politically inexpedient, and would have hampered the acceptability of these much-needed updates to federal quarantine rules. But such discussion is not foreclosed for the future. Congress has provided ample room for the exercise of interstate quarantine authority, sufficient even to nullify a state-ordered quarantine.

An expanded federal interstate quarantine authority could alleviate harmful and counterproductive parochial interests originating at state and local political levels. State public health departments have extensive legal authority to order quarantine, isolation, disclosure of personal information and contacts, and travel restrictions. But state lines can make a public health emergency worse, and at present there is little that can be done to prevent the modern-day equivalent of the "shotgun quarantine," a chaotic period in U.S. history that devastated lives and commerce in the late nineteenth and early twentieth centuries.⁸ It is instructive to remember this episode and the harm caused by a weak federal authority hamstrung to remedy the situation.

This Article proceeds as follows. Part I begins with brief illustrations to portray the need for clearer lines of quarantine authority, and greater federal authority, in the event of a public health emergency involving multiple states. An epidemic within the nation may require a national quarantine policy to counteract harmful or ineffectual state and local quarantine.

Part II examines the statutory basis for federal interstate quarantine, noting that the new federal quarantine rules neither expand nor contract that statutory authority. Statutory authority already exists for preemption of state quarantine laws, even if the political will to assert it has been lacking.

⁸ See *infra* Section IV.B.

Part III explains the historical background of federal interstate quarantine in the 1890 Epidemic Diseases Act, when Congress provided federal authority to act in the midst of yellow fever epidemics. Congress did so in response to requests from states that they be protected from harmful quarantines imposed by other state and local governments. But practical limitations prevented significant federal intervention. Congress has not re-evaluated the federal government's interstate quarantine authority since the last congressional debate on this subject in 1906.⁹

This Article concludes by drawing these elements together to argue that the federal quarantine statute's language is sufficiently broad to authorize significant federal intervention in matters of state and local quarantine, and that there is no constitutional impediment to do so. We should think hard about how best to use federal interstate quarantine capability to respond more effectively to public health threats. Such authority has not been needed on a large scale in more than a century, but scientists predict a widespread, devastating epidemic is all but certain in the future. We should plan for federal preemption of state and local quarantines in the event such authority is needed to mount an effective national response in the future.

I. FEDERAL QUARANTINE POWER IN THE INTERIOR: "INTERSTATE" AND INTERDEPENDENCE

A. *Quarantine and Isolation as Public Health Tools*

Quarantine and isolation as public health tools have a long history in the United States.¹⁰ Both are used to protect the public by preventing exposure to people who may be infected with a contagious disease. *Isolation* is used to separate ill persons who have a communicable disease from those who are healthy.¹¹ Isolation may involve confinement to a healthcare facility or at home.¹² *Quarantine*, on the other hand, separates and restricts the movement of people who are not sick, but who may have been exposed to a communicable disease.¹³ These people may not know they have been exposed to a disease,

⁹ See *infra* Section IV.D.

¹⁰ See generally Batlan, *supra* note 4 (recounting the history of quarantine in the United States); Alfred J. Sciarrino, *The Grapes of Wrath & the Speckled Monster (Epidemics, Biological Terrorism and the Early Legal History of Two Major Defenses—Quarantine and Vaccination)*, 7 J. MED. & L. 117 (2003) (same).

¹¹ *Quarantine and Isolation*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/quarantine> (last updated Sept. 29, 2017).

¹² *Id.*

¹³ *Id.*

may have the disease but not show symptoms, may develop the disease at a later date, or they may never develop the disease at all.

Quarantine can be imposed on specific individuals or on entire groups. Over the last century, involuntary quarantine has been relatively rare in the United States; it is used today primarily in individual cases of non-compliant tuberculosis (TB) patients.¹⁴ *Voluntary* quarantine and isolation are more common, as patients who are sick willingly comply in order to get better.¹⁵ Many public health officials prefer more modern (and less threatening) terminology such as “preventive monitoring,” “preventive observation,” and “social distancing” measures instead of the term “quarantine.”

Whenever they can, public health professionals seek voluntary compliance with quarantine or isolation orders. Absent voluntary compliance, state authority to impose quarantine is substantial. In some states, the public health department must first apply for a court order.¹⁶ In other states, as is the case for the federal government, a public health quarantine order is self-executing.¹⁷ When an individual or group will not comply voluntarily, public health officers may enlist law enforcement to carry out the order.¹⁸

A quarantine may also cover a geographic area. A prohibition against persons entering or leaving a defined boundary is an example of a geographic or area quarantine. Known as a *cordon sanitaire*, this “zone” quarantine is a barrier implemented to stop the spread of infectious disease, usually by a guarded line.¹⁹ An area quarantine might be used, for example, to separate a

¹⁴ For an overview of federal quarantine authority exercised through a “Do Not Board” list, see *Federal Air Travel Restrictions for Public Health Purposes*, 57 MORBIDITY & MORTALITY WKLY. REP. 1009 (2008). I explain in detail the application of federal quarantine authority in the context of tuberculosis in an article prepared for the U.S.-Mexico Border Health Commission. Polly J. Price, *Tuberculosis Control Laws in the U.S.-Mexico Border Region: Legal Framework in the United States* 7–8 (Emory Univ. Sch. of Law Legal Studies Research Paper, Paper No. 15-371 2015), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2709829; see also Price, *Sovereignty*, *supra* note 7, at 965–73.

¹⁵ See *Legal Authorities for Isolation and Quarantine*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/quarantine/aboutlawsregulationsquarantineisolation.html> (last updated Oct. 8, 2014) (“Federal [q]uarantine [r]arely used”); *State Quarantine and Isolation Statutes*, NAT’L CONF. STATE LEGISLATURES (Oct. 29, 2014), <http://www.ncsl.org/research/health/state-quarantine-and-isolation-statutes.aspx> (“Public health quarantine and isolation are legal authorities that may be, but rarely are, implemented to prevent the spread of communicable diseases.”).

¹⁶ See *State Quarantine and Isolation Statutes*, *supra* note 15 (listing state laws and describing range of authority).

¹⁷ See *id.* (listing Arizona, Arkansas, and Georgia as examples of states with self-executing quarantine orders).

¹⁸ See *generally id.* (listing state laws and describing range of authority).

¹⁹ Rothstein, *supra* note 3, at 235.

group of persons who may have been exposed to a disease until it can be determined that they are not ill. The *cordon sanitaire* is intended to protect a community from contagion by preventing the entry of anyone or anything. Such quarantines raise serious ethical and human rights issues.²⁰

All U.S. states provide for isolation or quarantine by statute.²¹ Quarantine of persons without symptoms can take a variety of forms, ranging from confinement at home or in a facility, to less onerous travel and social distancing restrictions with self-reported symptoms.²² Individuals have rights to due process of law, and generally, isolation or quarantine must be carried out in the least restrictive setting necessary to maintain public health.²³ On the other hand, societal rights are also significant—namely, a right to be protected from individuals who pose public health threats. Courts weigh these interests when conflicts between individuals and government authority occur. Involuntary quarantine is a drastic curtailment of civil liberties for the benefit of the public at large, and thus its use is generally considered a tool of last recourse.²⁴

For any quarantine, the government must show (1) a public health necessity, (2) an intervention that is both effective and demonstrates a reasonable connection between means and ends, (3) proportionality (i.e., that the intervention is neither too broadly nor too narrowly tailored), and (4) that the quarantine or isolation is in the least restrictive setting while accomplishing its purpose.²⁵ State governments are under no obligation to compensate quarantined persons for lost income, business disruption, or other economic harms.²⁶

²⁰ Rachel Kaplan Hoffmann & Keith Hoffmann, *Ethical Considerations in the Use of Cordons Sanitaires*, CLINICAL CORRELATIONS (Feb. 19, 2015), <http://www.clinicalcorrelations.org/?p=8357>.

²¹ See *Legal Authorities for Isolation and Quarantine*, *supra* note 15; *State Quarantine and Isolation Statutes*, *supra* note 15.

²² A CDC guide to state Ebola protocols provides examples of the range of state responses to quarantine and monitoring of persons who may have been exposed to Ebola but show no symptoms. See *Interim Table of State Ebola Screening and Monitoring Policies for Asymptomatic Individuals*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/php/docs/interim-ebolascreening.pdf> (last visited Nov. 26, 2017).

²³ See Katye M. Jobe, Comment, *The Constitutionality of Quarantine and Isolation Orders in an Ebola Epidemic and Beyond*, 51 WAKE FOREST L. REV. 165, 180 (2016).

²⁴ See Michelle A. Daubert, Comment, *Pandemic Fears and Contemporary Quarantine: Protecting Liberty Through A Continuum of Due Process Rights*, 54 BUFF. L. REV. 1299, 1299 (2007) (“Both isolation and quarantine severely curtail the freedom of individuals to whom they are applied. Thus, they are often tools of last resort because they require the separation of infected and potentially infected persons from the public through confinement to treatment facilities, residences, and other locations.”).

²⁵ *Id.* at 1310.

²⁶ See Mark A. Rothstein & Meghan K. Talbott, *Job Security and Income Replacement for Individuals in Quarantine: The Need for Legislation*, 10 J. HEALTH CARE L. & POL’Y 239, 244 (2007).

Legal recourse to challenge a public health order, when available, comes later in the process, usually after an isolation or quarantine order already has been implemented. Public health officials have extensive legal authority to respond quickly.²⁷ Judges have limited jurisdiction to provide immediate relief, and may be inclined to defer to medical experts on the need for emergency measures.²⁸

But what if public health authorities overreact, and place large numbers of persons who are not a threat into involuntary quarantine? Or enact a *cordon sanitaire* to protect a community from outside intercourse, in the hope that such geographic exclusion will prevent entrance of the disease?

For any use of quarantine on a large scale, the basic problem is this: In the midst of an epidemic, the public will tend to overestimate the degree of risk, leading to poor policy results, including inequitable allocation of medical resources, ineffective and economically harmful prevention measures, and deep suspicion of government's ability to control the spread of disease. Public fear also leads to easy scapegoating of minority groups.²⁹ Inevitably, the initial response to a pandemic threat from abroad is to seal the borders—an unworkable national security strategy that reroutes essential public resources away from domestic prevention and treatment. Borders inevitably are porous, even when travelers are individually screened at a port of entry.

State and local governments reflect this impulse as well, but with greater consequences. States have traditional authority over all issues of public health within their borders.³⁰ Political boundaries are smaller and local politicians are more directly responsive to their electorate. At the same time, state and local jurisdictions have limited medical and scientific resources to understand the

²⁷ See, for example, Georgia's public health emergency legislation, GA. CODE ANN. § 38-3-51 et seq. (West Supp. 2017).

²⁸ See, e.g., STATE OF UTAH JUDICIAL COUNCIL, JUDICIAL REVIEW OF ORDERS OF RESTRICTION 12 (2008) (providing for up to ten days before an order of restriction hearing is required).

²⁹ See, e.g., *Jew Ho v. Williamson*, 103 F. 10 (C.C.N.D. Cal. 1900) (quarantining an entire area of San Francisco where Asians lived; order lifted by a federal court under the equal protection clause). More recently, group scapegoating through fear was evident in the AIDS epidemic. See Wendy E. Parmet, *AIDS and Quarantine: The Revival of an Archaic Doctrine*, 14 HOFSTRA L. REV. 53, 53–54 (1985) (“Public health officials have begun to draft or to consider drafting quarantine regulations applicable to AIDS, and public figures, from conservative religious leaders to members of the medical professions, have called for the isolation of some victims or carriers of the disease.”).

³⁰ See LAWRENCE O. GOSTIN & LINDSAY F. WILEY, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 87 (3d ed. 2016) (“States and localities have had primary responsibility for protecting the public's health since the founding of the republic.”); Price, *If Tuberculosis Spreads . . .*, *supra* note 7 (arguing that the CDC should enter this area of traditional state function to provide better services and funding).

transmission of complex diseases and to form independent judgments about the best means to control them. State governments, then, are especially prone to problems of politically driven reaction to an epidemic threat, including overly restrictive and counterproductive use of quarantine. Such actions have real potential to impose disproportionate harm on neighboring states and regions, in addition to exacerbating problems for that state's own residents.

B. State Quarantines Harming Neighbors: Two Hypotheticals

Two hypothetical situations illustrate when greater federal control of interstate quarantine may be desirable. Both scenarios illustrate opportunities for greater federal control over a state-imposed quarantine when a national quarantine policy might be needed. We assume for both scenarios that the governor has specifically invoked quarantine or public health emergency authority existing by statute.³¹

1. Scenario One: When Returning Travelers "Enter" Both the United States and a State

For the first hypothetical, assume the following. A highly contagious hemorrhagic virus, previously unknown to scientists, strikes three countries in South America, leading the World Health Organization (WHO) to declare an international public health emergency. While U.S. citizens visiting or living in those countries make arrangements to return to the United States, hundreds of volunteer healthcare professionals from the United States arrive in those countries, serving on average for two weeks treating patients.

According to the CDC, returning travelers from these countries can be declared free from the virus after five days, and after that time pose no risk of spreading the disease to others. Accordingly, CDC quarantine officers, working together with Customs and Border Protection (CBP), institute a screening process to identify potential carriers. Likely exposure is determined

³¹ The Model State Emergency Health Powers Act, proposed in 2001, is designed primarily to address public health emergencies such as virus outbreaks or bioterrorism. *Model State Emergency Health Powers Act*, AM. C. L. UNION, <https://www.aclu.org/other/model-state-emergency-health-powers-act> (last visited Nov. 24, 2017). As of 2007, thirty-three states had introduced 133 legislative bills related to the articles or sections of the Act. See Ctr. for Law & the Pub.'s Health, *The Turning Point Model State Public Health Act: State Legislative Update Table* (Aug. 15, 2007), <http://www.publichealthlaw.net/Resources/ResourcesPDFs/MSPHA%20LegisTrack.pdf> [<http://web.archive.org/web/20160623112309/http://www.publichealthlaw.net/Resources/ResourcesPDFs/MSPHA%20LegisTrack.pdf>]. Of these, forty-eight bills or resolutions had passed. See *id.*; see also *Responsibilities in a Public Health Emergency*, NAT'L CONF. STATE LEGISLATURES (Oct. 29, 2014), <http://www.ncsl.org/research/health/public-health-chart.aspx>.

by travel history and occupation: this includes all medical professionals who have worked with patients, but also other returning U.S. citizens who cannot show that they have been in a disease-free area for more than five days. For such persons, the CDC issues a quarantine order requiring them to remain at home for five days, checking temperature twice daily with home visits or video monitoring. Other nations employ similar quarantine practices, and to date, there has been no instance of disease transmission outside of the three affected countries.

The governors of two U.S. states with major international airports, however, have publicly questioned this protocol. They claim, without providing any evidence, that the protocol puts residents of their states at tremendous risk, and that the CDC cannot be trusted to provide competent information. They demand more stringent, drastic measures for travelers returning from these countries.

Specifically, Governor X declares a public health emergency, ordering all returning travelers from affected countries into three weeks of confinement, under guard, in a state-owned building near the airport. Governor Y quickly follows suit, but in addition orders that any healthcare professional who treated patients may not enter that state until he or she has spent thirty days in a non-affected country. Governor Y cites the cost of quarantine for returning health workers as justification for the territorial ban.

As it turns out, both governors are up for re-election soon. Their actions both respond to and exacerbate panic among the population. Although scientists and medical professionals reassure the public that the disease is not easily spread and can be contained effectively by home isolation, schools close and many venues cancel sporting events and concerts.

The governors frankly admit that their orders are designed to dissuade medical professionals from flying into and out of their state airports. Litigation challenging these orders begins, but most experts agree a court is unlikely to invalidate them immediately, if at all, even though courts will consider individual cases via habeas jurisdiction as well as entertain lawsuits for damages after the crisis has passed.

But jurisdictional problems arise at the international airports in both states. The governors insist that CDC quarantine officers change their screening protocol to match the stringent new state standards, and that they identify and hand over to state officials any traveler from these countries for immediate quarantine. In addition, Governor Y demands that all returning healthcare

workers be placed on the federal Do Not Board list, to prevent air travel into the state entirely. No other state governors make such a demand; other states generally follow CDC recommendations.

In the face of the governors' demands, the Surgeon General and the Director of the CDC must decide whether to modify their protocol at the international airports in these two states. Because international arrivals do not officially "enter" the United States or any U.S. state until they have cleared customs and have been given permission to enter by CBP,³² CDC quarantine officers have final authority to screen travelers and issue health orders as appropriate, prior to anyone being admitted to the United States. If the CDC were to change its quarantine protocol to comply with the quarantine orders of these two states, CDC officials would have to issue three-week quarantine orders, and then either transport the quarantined individual directly to the state's confinement facility or remand them to state custody at the airport.

The CDC stands its ground, citing overwhelming scientific evidence that such stringent quarantine practices are unnecessary. CBP refuses to identify to state officials those travelers who have arrived from the affected countries and have cleared the CDC's health screening process. The decision to enforce only the federal quarantine protocol was made partly at the behest of neighboring states, where the services of their returning health professionals are urgently needed.

Because state health officers thus have no way to distinguish travelers from affected countries versus travelers from elsewhere, state officials set up a screening process for all returning passengers, just past the "Welcome to the United States" sign. At this checkpoint, all travelers must produce their arriving flight information. Those from countries where the virus is suspected or is already present are then taken into state custody for quarantine, even if the CDC concluded they posed no risk or could be monitored via self-isolation at home.

2. *Scenario Two: Guarded Quarantine Lines at State Borders*

This time, assume that the viral hemorrhagic disease described in scenario one has spread domestically, with dozens of cases reported in the United States. The disease is not yet present in state X. To prevent the disease from entering state X, the Governor, invoking emergency health powers, shuts down

³² See *Applying for Admission into United States*, U.S. CUSTOMS & BORDER PROTECTION (Mar. 10, 2015), <https://www.cbp.gov/travel/international-visitors/applying-admission-united-states>.

travel and commercial transport from neighboring states where the disease is present.

Two medical supply companies are located in state X. Company A, the primary maker of protective suits for medical workers, has its distribution center for these and other critical medical supplies in this state. Nearby, Company B has a stockpile of vaccines, which although prepared for a different disease are thought to be effective against the new threat. This area quarantine prevents the medical supplies and vaccines from leaving the state, making them exclusively available to that state's residents. The travel restriction also has the effect of disrupting food and water transport throughout the region.

Urgent calls from neighboring governors are unheeded, with the Governor of state X explaining that this is a temporary measure, to be reassessed at a later date. Governor X also exercises public health emergency powers to commandeer for purchase both Company A's and Company B's medical supplies, which are then distributed to state X's residents according to its health department's protocol. Although this aspect of the travel ban benefits the state's residents, they are harmed in other ways, including transport of food from a large distribution center just outside state lines.

In legal terms, one state has declared a quarantine against another state, prohibiting incoming or outgoing travel and transport of goods. This prohibition against persons entering or leaving at a defined boundary is an example of a geographic or area quarantine—a *cordon sanitaire*.

To summarize this second hypothetical:

- (1) One state declares quarantine against another, prohibiting incoming travel and transport of goods to prevent disease from entering the state. This prohibition against persons entering the state would include its own returning citizens, effectively limiting their travel.
- (2) The state quarantine prevents movement out in a way that also hoards food, medicine, vaccine supplies urgently needed elsewhere, and other vital goods previously shared via the normal workings of a free market.

The motivation need not be intentional self-interest. The population's fear of contagion may override a state government's ability to keep travel and commerce open, even in limited fashion.

C. *Why Courts Are an Insufficient Remedy: The Example of State Ebola Quarantines*

The geographic or area quarantines described in scenario two have no modern-day counterpart in the United States.³³ But the United States experienced something very much like this during epidemics of yellow fever around the turn of the twentieth century. This historical precedent, the precursor to the modern federal quarantine statute, is explored in Part IV. For now, it is sufficient to note that the specter of armed guards at state lines or other geographic areas is not only imaginable, but probably “legal” for a period of time, absent direct federal intervention.³⁴ The judiciary—whether state or federal—is unlikely to serve as an effective brake on overreaching state quarantines, at least within the time frame in which such intervention would have practical effect.

While Part III revisits interstate issues arising from a geographic quarantine, this section focuses on scenario one—the quarantine of travelers returning from abroad, when state and federal rules differ. The quarantine of returning travelers in the first scenario is recognizable as a variation of actual events during the 2014 Ebola outbreak. Ebola presented a unique situation because the disease takes up to three weeks to develop after exposure, requiring lengthy quarantine or observation of people who were exposed but not sick.³⁵ This is because usually no symptoms appear between exposure and the onset of illness, the point at which Ebola is known to be contagious to others.³⁶ A key question for public health officials became what to do with these people during the three-week period of potential latency. The options ranged from home self-monitoring, with or without some ability to leave the home under limited circumstances, to confinement in a medical institution or

³³ While not the drastic step of a geographic quarantine, there are other modern examples of local protectionism as a bias in public health federalism. These include disputes over trash and toxic waste disposal from out-of-state sources. As I describe elsewhere, these and other examples reflect the urge to defend one’s state against outside threats. See Polly J. Price, *Epidemics, Outsiders, and Local Protection: Federalism Theater in the Era of the Shotgun Quarantine*, 19 U. PA. J. CONST. L. 369, 425–27 (2016).

³⁴ As discussed below, federal courts might void or ameliorate overly aggressive and harmful state quarantines while they are in place, but they face numerous practical hurdles, meaning individuals would have no effective remedy when reasonably needed.

³⁵ See *Ebola (Ebola Virus Disease)*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/vhf/ebola/index.html> (last updated June 13, 2017).

³⁶ See *id.* (describing symptoms and transmission).

other isolation facility. In Georgia, for example, some returning travelers could be confined in a state facility for up to three weeks.³⁷

In 2014, several state governors publicly denounced the CDC quarantine protocol and screenings as inadequate, and imposed their own, more stringent requirements.³⁸ Led by New Jersey Governor Chris Christie, other governors followed suit, criticizing the Obama Administration for allegedly failing to protect the nation.³⁹ The spectacle was political theater, but the state quarantine policies caused harm beyond state borders, including the fact that international airports in these states handled arrivals of people who lived and worked in adjacent states.

These state governors—from both political parties—squabbled publicly with the CDC and other federal government actors about who was in charge, whether to close the borders, and who should be quarantined.⁴⁰ Some political analysts concluded that the governors feared political fallout should their state fail to take an aggressive approach, after New Jersey Governor Chris Christie had done so.⁴¹

In the states with tighter restrictions, CDC quarantine officers cooperated fully with state public health officials, knowing that many of the quarantine measures imposed by state political leaders were not necessary.⁴² The CDC stated that while its guidance “established a baseline standard, states had the authority to apply restrictions that exceeded CDC’s recommendations.”⁴³ That

³⁷ See Greg Bluestein, *Nathan Deal Backs More Aggressive Ebola Quarantine Policy*, ATLANTA J. CONST.: POLITICALLY GA. (Oct. 27, 2014), <http://politics.myajc.com/blog/politics/nathan-deal-backs-more-aggressive-ebola-quarantine-policy/8svkLxeZAzGY8aUsqc5uDK/>.

³⁸ An editorial in *The New England Journal of Medicine* criticized these governors’ actions as harmful and unnecessary, stating, “We should be guided by the science and not the tremendous fear that this virus evokes.” Jeffrey M. Drazen et al., *Ebola and Quarantine*, 371 NEW ENG. J. MED. 2029, 2030 (Nov. 20, 2014).

³⁹ See Laura Stampler, *Chris Christie Defends Controversial Ebola Quarantine*, TIME HEALTH (Oct. 28, 2014), <http://time.com/3543163/christie-ebola-quarantine-kaci-hickox/>; see also Matt Katz, *Governors Defend Decisions on Ebola Quarantines*, NPR (Oct. 26, 2014, 5:01 PM), <https://www.npr.org/2014/10/26/359120784/governors-defend-decisions-on-ebola-quarantines>.

⁴⁰ Jess Bidgood & Kate Xernike, *From Governors, a Mix of Hard-Line Acts and Conciliation Over Ebola*, N.Y. TIMES (Oct. 30, 2014), https://www.nytimes.com/2014/10/31/us/kaci-hickox-nurse-under-ebola-quarantine-takes-bike-ride-defying-maine-officials.html?_r=0.

⁴¹ *Id.* Announcing new restrictions soon after Governor Christie had done so in New Jersey, Georgia Governor Nathan Deal stated: “We intend to be as protective of Georgia citizens as possible . . . I would remind you, however, it’s better to be overly cautious than not cautious at all.” Bluestein, *supra* note 37.

⁴² *Cf.* Denver Nicks, *The CDC Has Less Power than You Think, and Likes It that Way*, TIME (Oct. 27, 2014), <http://time.com/3516827/cdc-constitution-quarantine>.

⁴³ *Notes on the Interim U.S. Guidance for Monitoring and Movement of Persons with Potential Ebola Virus Exposure*, CTNS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/vhf/ebola/exposure/monitoring-and-movement-of-persons-with-exposure.html> (last updated Feb. 19, 2016).

stance, politically, was the path of least resistance. The CDC needed to retain good working relationships with the governors and health departments of those states. Those governors are also each represented in Congress by two U.S. Senators. The CDC is dependent on funding via annual appropriations by Congress,⁴⁴ so it has strong incentives not to rock the boat at the state level.

Lawsuits brought by individuals would be insufficient to remedy the worst effects of an overly aggressive state quarantine while it is in place. An indication of how the judicial system might view excessive state quarantine policies can be gleaned from two recent lawsuits stemming from the 2014 Ebola outbreak. Litigation in New Jersey and Connecticut disputed the necessity for the kind of strict quarantine imposed by those states' health departments with respect to returning health workers and others who potentially had been exposed to the virus but who exhibited no symptoms.⁴⁵ Medical groups argued that automatic three-week quarantines discouraged health-care workers from traveling to Ebola-stricken countries, while New Jersey and other states contended that such restrictions were necessary to protect public health.⁴⁶

Litigation in New Jersey pitted Governor Chris Christie against Kaci Hickox, whose highly publicized experience in quarantine in both New Jersey and Maine can provide a postmortem on state Ebola quarantines.⁴⁷ Hickox

⁴⁴ See Leah S. Fischer et al., *How Is CDC Funded to Respond to Public Health Emergencies? Federal Appropriations and Budget Execution Process for Non-Financial Experts*, 15 HEALTH SECURITY 307 (2017).

⁴⁵ Polly J. Price, *Quarantines and Liability in the Context of Ebola*, 131 PUB. HEALTH REP. 500, 500 (2016).

⁴⁶ *Id.*

⁴⁷ *Hickox v. Christie*, 205 F. Supp. 3d 579 (D.N.J. 2016). When Hickox returned to the United States from Sierra Leone in 2014, where she had worked at an Ebola treatment unit, her immediate quarantine at Newark International Airport became widely publicized. *Id.* at 585–87. By order of the New Jersey Department of Health, Hickox spent nearly four days in isolation, initially at Newark International Airport. *Id.* at 584. By agreement between the New Jersey and Maine health departments, Hickox moved to her residence in Maine, where she remained under a quarantine order for three weeks. Hickox exhibited no symptoms throughout her isolation and never developed Ebola. *Id.* at 586–87.

In technical parlance, Hickox was placed in quarantine, not isolation, given that she did not exhibit symptoms of Ebola, and indeed never contracted the disease. A state judge ruled that public health officials had not proved “by clear and convincing evidence that limiting Respondent’s movements to the degree requested” was needed to protect the public and thus modified the quarantine order. *Mayhew v. Hickox*, No. CV-2014-36, slip op. at 1 (Me. Dist. Ct., Fort Kent, Oct. 31, 2014) (order pending hearing). The modification eased the most stringent aspect of the order—home seclusion for three weeks—while retaining monitoring and social-distancing aspects of the quarantine order consistent with recommendations by the CDC. Jess Bidgood & Dave Phillips, *Judge in Maine Eases Restrictions on Nurse*, N.Y. TIMES (Oct. 31, 2014), http://www.nytimes.com/2014/11/01/us/ebola-maine-nurse-kaci-hickox.html?_r=0; *Maine Ebola Nurse Kaci Hickox, Free of Monitoring, Says We Must “Get Over This Fear,”* NBC NEWS (Nov. 11, 2014, 10:45 AM), <https://www>

sued Governor Christie and New Jersey public health officials for compensatory and punitive damages in the amount of \$250,000, alleging there was no legal or medical basis for the quarantine order in her case.⁴⁸ Hickox claimed there was no adequate individualized assessment of any risk she might have posed to the public.⁴⁹ She also claimed that the duration and terms of the confinement lacked justification, all of which violated her civil rights.⁵⁰

Hickox later settled the lawsuit in favor of reform of New Jersey's quarantine practice.⁵¹ The settlement created a so-called quarantine "Bill of Rights" including procedural protections and a heightened standard of medical necessity.⁵² Notably, the settlement did not include any monetary damages or attorney's fees, likely because official immunity would have been difficult to overcome had the case proceeded in court.⁵³

Another challenge to state quarantine practices during the Ebola outbreak arose in Connecticut. Yale University's Legal Services Organization filed a class action lawsuit against the Governor and state public health officials over the state's treatment of residents affected by Connecticut's Ebola quarantine policies.⁵⁴ The complaint sought damages on behalf of Connecticut residents who were quarantined for up to three weeks with police officers posted outside

nbcnews.com/storyline/ebola-virus-outbreak/maine-ebola-nurse-kaci-hickox-free-monitoring-says-we-must-n246131.

⁴⁸ *Hickox*, 205 F. Supp. 3d. at 592, 597–98. Hickox was placed into quarantine at the New Jersey airport upon her arrival on October 24, 2014, and was later transported to a hospital isolation unit. *Id.* at 585–86. The following day, the New Jersey Department of Health issued an administrative order declaring quarantine and isolation of Hickox. *Id.* at 586–87. Hickox also included a defamation claim specifically against Governor Christie. *Id.* at 605.

⁴⁹ *Id.* at 597.

⁵⁰ See Robert Gatter, *Quarantine Controversy: Kaci Hickox v. Governor Chris Christie*, 46 HASTINGS CTR. REP. 7, 7 (2016).

⁵¹ See Charles Toutant, *Remuneration Rare in Quarantine Suits, Ebola Nurse Settlement Shows*, N.J. L.J. (Aug. 2, 2017), <http://www.njlawjournal.com/id=1202794613880/Remuneration-Rare-in-Quarantine-Suits-Ebola-Nurse-Settlement-Shows>; Mark Santora, *New Jersey Accepts Rights for People in Quarantine to End Ebola Suit*, N.Y. TIMES (July 27, 2017), <https://www.nytimes.com/2017/07/27/nyregion/new-jersey-accepts-rights-for-people-in-quarantine-to-end-ebola-suit.html>.

⁵² See *Kaci Hickox's Settlement with Christie Administration Creates Quarantine "Bill of Rights,"* AM. C. L. UNION N.J. (July 27, 2017), <https://www.aclu-nj.org/news/2017/07/27/victory-detained-nurses-ebola-suit-secures-due-process>.

⁵³ See Toutant, *supra* note 51.

⁵⁴ Sheri Fink, *Connecticut Faces Lawsuit over Ebola Quarantine Policies*, N.Y. TIMES (Feb. 7, 2016), <http://www.nytimes.com/2016/02/08/nyregion/connecticut-faces-lawsuit-over-ebola-quarantine-policies.html>.

their residences.⁵⁵ This lawsuit was dismissed on the grounds of governmental immunity and lack of standing.⁵⁶

With the exception of the litigation in Maine, which demonstrated that courts are willing to modify the conditions of a quarantine, the New Jersey and Connecticut litigation teach that individual lawsuits seeking damages after the fact may not provide a sufficient deterrent to prevent this kind of harm. For one thing, it takes time for any lawsuit to wind through the court system. And these were only two lawsuits; large-scale quarantines could overwhelm the court system.

The threat of paying damages after the fact is unlikely to deter overreaching quarantine policy for two additional reasons. First is the likelihood of official immunity, an important legal protection for public health officials. State public health emergency statutes typically provide immunity explicitly.⁵⁷ And even where there is no specific provision for immunity, government employees are protected from liability for reasonable actions taken in a good-faith belief of public necessity. Qualified immunity, when applicable, shields government officials from liability while performing discretionary functions when their actions did not violate “clearly established law,” even if later found to be unlawful.⁵⁸ A right is not clearly established unless its contours are “sufficiently clear that every reasonable official would have understood that what he is doing violates that right.”⁵⁹

This doctrine of qualified immunity protects public health workers who act in good faith and in a reasonable manner. As evident from the order dismissing the litigation over Connecticut’s Ebola quarantine policy, precedent and policy lean heavily in favor of public health workers unless they violate settled constitutional standards or clear statutory directives. Immunity from liability is particularly relevant in the area of quarantine because courts have yet to establish clear constitutional mandates.

⁵⁵ AM. CIVIL LIBERTIES UNION & YALE GLOBAL HEALTH JUSTICE P’SHIP, FEAR, POLITICS, AND EBOLA: HOW QUARANTINES HURT THE FIGHT AGAINST EBOLA AND VIOLATE THE CONSTITUTION 18 (2015).

⁵⁶ See Associated Press, *Judge Dismisses Lawsuit Against Malloy, State over Ebola Quarantines*, HARTFORD COURANT (Apr. 3, 2017, 3:52 PM), <http://www.courant.com/news/connecticut/hc-malloy-ebola-quarantine-20170403-story.html>.

⁵⁷ See, for example, Georgia’s public health emergency legislation, GA. CODE ANN. § 38-3-51 et seq. (West Supp. 2017). In addition, the Model State Emergency Health Powers Act also provides immunity for public health officials. See The Center for Law & The Public’s Health, *supra* note 31; see also *Responsibilities in a Public Health Emergency*, *supra* note 31.

⁵⁸ *Ashcroft v. al-Kidd*, 563 U.S. 731, 735 (2011).

⁵⁹ *Id.* at 741 (internal quotations marks omitted).

The second reason is that even if a plaintiff were to prevail, monetary damages are likely to be minimal. Individuals subject to quarantine or isolation are not entitled to payment for lost wages.⁶⁰ Back pay is not the state's responsibility. Kacie Hickox, for example, settled her lawsuit in return for change to New Jersey's quarantine rules, but she received no monetary award or attorney's fees.⁶¹ She likely settled the suit in recognition of the substantial hurdles of government immunity and difficult-to-quantify damages in light of the state's lack of obligation to pay for the time she was prevented from working. The settlement did, however, change quarantine practice going forward—at least in New Jersey—a more-than-symbolic victory recognizing that Hickox and other returning health workers had been treated wrongly.

Thus, from a civil liability standpoint, there is little incentive *not* to impose quarantines more stringent than necessary, whether of individuals, groups, or exclusionary zones. This is not to question the ethics and responsibilities of state public health employees, but political control is often held by elected politicians who are not subject to these professional constraints.

While there is reason to believe that some states imposed strict quarantines not out of medical advisability but as a reaction to the clamor of their electorate, local governments also fall prey to this tendency to overreact. In one example, the City of Milford, Connecticut, imposed a twenty-one-day ban on an elementary school student following a family trip to Nigeria.⁶² At the time, Nigeria had no cases of Ebola. The City later settled a lawsuit brought by the child's father for \$30,000.⁶³

Other negative incentives may include the perception that other state and local health departments are unable to contain epidemics within their jurisdictions, with unwanted spillover effects for their neighbors. This is one manifestation of a weak system of public health in the United States, due to its fragmented nature and reliance on political will to support health departments through local taxes.⁶⁴

⁶⁰ See Rothstein & Talbott, *supra* note 26, at 244.

⁶¹ See Toutant, *supra* note 51.

⁶² Associated Press, *Milford Paid \$30K to Settle Ebola Lawsuit*, HARTFORD COURANT (June 13, 2015, 3:15 PM), <http://www.courant.com/breaking-news/hc-milford-ebola-lawsuit-settlement-20150613-story.html>.

⁶³ *Id.*

⁶⁴ As I wrote recently, "Our system of federalism and a fragmented public health infrastructure mean that the cost of health control measures falls on state and local governments, with uneven effectiveness and greatly disproportionate impact in some communities. The problem is thus systemic: the fragmented structure of public health agencies in the United States can prevent an effective response to even wholly local epidemics." Price, *Sovereignty*, *supra* note 7, at 919.

Of course at the federal level as well, government policy may be driven by fear, not science. Before he was elected president, for example, Donald Trump stated during the Ebola outbreak that U.S. “health [care] workers who got sick while treating victims should be prevented from returning to the United States for medical care.”⁶⁵ This stance was contrary to medical and scientific consensus, raising concerns about how Mr. Trump might direct federal quarantine policy were he to be elected president. The desire is to avoid unnecessary and harmful government overreaction at any level of government where that might occur. The federal government is not better at quarantine policy than states simply because it is the federal government (although it directs the superior resources of the CDC). The question instead is whether uniform national policy might in some instances be preferable to a patchwork of state quarantines.

To return to my point, we should explore the question whether the federal government may override or veto excessively restrictive state quarantines that harm both national interests and the interests of neighboring states. When might an enforceable, uniform national standard be preferable? When might it *not* be permissible for states to “apply restrictions that exceeded CDC’s recommendations”?⁶⁶ As explained in the following sections, the federal government has this authority but has not exercised it in the modern era because it has not been needed. The United States has not yet experienced an epidemic on the scale of SARS in several Asian countries,⁶⁷ Swine Flu (H1N1) in Mexico,⁶⁸ or Ebola in West Africa.

II. FRAMING THE ISSUE: WHAT IS “INTERSTATE” QUARANTINE POWER?

To understand the concept of “interstate” quarantine in federal law, we must distinguish it from its better-known counterpart, federal health inspection and quarantine authority at U.S. border points of entry. Health inspection at the border is an uncontroversial proposition, at least in the context of federal control over entry into the country. The authority of the U.S. government to impose health inspections on immigrants, interdict arriving travelers, for

⁶⁵ Stein, *supra* note 1.

⁶⁶ *Notes on the Interim U.S. Guidance for Monitoring and Movement of Persons with Potential Ebola Virus Exposure*, *supra* note 43.

⁶⁷ The WHO reported more than 8,000 people worldwide were infected with SARS, and among these, 774 died, during the 2003 outbreak. *SARS Basics Fact Sheet*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/sars/about/fs-sars.html> (last updated July 2, 2012).

⁶⁸ *Outbreak of Swine-Origin Influenza A (H1N1) Virus Infection — Mexico, March–April 2009*, 58 MORBIDITY & MORTALITY WKLY. REP. 467, 468 (2009) (noting nearly 2,000 reported cases, including cases in each of Mexico’s states and Federal District).

example, is long-standing in our history.⁶⁹ Non-citizens having one of a list of diseases may not be issued travel visas nor can they enter the country, while returning American citizens are subject to temporary quarantine for these same diseases.⁷⁰ The federal government, not the states, is the primary guardian of the nation's borders, and this is true for public health defense as well. Congress, in fact, permits the executive branch to suspend entry from entire countries, if epidemic conditions in those countries are believed to pose a public health threat to the United States.⁷¹ Some politicians called for the Obama Administration to invoke this authority against some nations in West Africa during the 2014 Ebola outbreak.⁷²

This Article does not address the ways in which border health defense might be improved. It takes for granted that the border is unavoidably porous to contagious disease. Birds and mosquitoes, for example, are notoriously disrespectful of political boundaries and are responsible for many lethal viruses.⁷³ Nor do I consider whether the present allocation of quarantine stations and the number of U.S. public health service personnel assigned to them are optimal.

The federal government's quarantine authority is not only international ("to prevent the introduction . . . of communicable diseases from foreign countries into the [United] States"), but also an independent authority for preventing the spread of communicable diseases within the United States.⁷⁴ Federal

⁶⁹ See ALAN M. KRAUT, *SILENT TRAVELERS: GENES, GERMS, AND THE "IMMIGRANT MENACE"* (1994) (exploring history of immigrant health inspections in the United States).

⁷⁰ See generally Price, *Sovereignty*, *supra* note 7, at 926–28 (citing immigration laws). For the current list of quarantinable communicable diseases, see *Legal Authorities for Isolation and Quarantine*, *supra* note 15.

⁷¹ The text of 42 U.S.C. § 265 provides: "Whenever the Surgeon General determines that by reason of the existence of any communicable disease in a foreign country there is serious danger of the introduction of such disease into the United States, and that this danger is so increased by the introduction of persons or property from such country that a suspension of the right to introduce such persons and property is required in the interest of the public health, the Surgeon General, in accordance with regulations approved by the President, shall have the power to prohibit, in whole or in part, the introduction of persons and property from such countries or places as he shall designate in order to avert such danger, and for such period of time as he may deem necessary for such purpose." 42 U.S.C. § 265 (2012).

⁷² See, e.g., Igor Bobic, *Scott Brown Wants to Secure the Border Because of Ebola*, HUFFINGTON POST (Oct. 9, 2014, 11:42 AM), http://www.huffingtonpost.com/2014/10/09/scott-brown-ebola_n_5959200.html; Steven Nelson, *Congressman: Close Border to Ebola Countries*, U.S. NEWS (July 30, 2014, 11:52 AM), <https://www.usnews.com/news/articles/2014/07/30/congressman-close-border-to-ebola-countries> (identifying Representative Alan Grayson, a Democrat from Florida).

⁷³ *Mosquito-Borne Diseases*, AM. MOSQUITO CONTROL ASS'N, <http://www.mosquito.org/page/diseases> (last visited Nov. 24, 2017).

⁷⁴ 42 U.S.C. § 264.

quarantine authority exists for the interior, but it is rarely used. As a practical matter, within the United States this power is relevant only to air travel.⁷⁵

The common view is that the federal government may interfere with a state's or municipality's choice to impose quarantine restrictions only when a state asks for assistance, or when it fails to take effective measures to prevent an epidemic crossing state lines.⁷⁶ In the hypothetical scenarios discussed above, the states have not failed to act, nor have they requested assistance.⁷⁷ These scenarios instead draw attention to the opposite problem: a state or local government engages in protectionism (economic or political) beyond medical justification, disrupting commerce and the movement of persons to the detriment of neighboring states as well as to the national interest.

This concept of interstate quarantine as a power of the federal government has been in the U.S. Code since 1890, in substantially the same language as the current statutory version.⁷⁸ We would do well to explore the concept as an outer boundary of federal authority, but we also should consider what, practically, the federal government might do to help prevent the spread of epidemic disease in the United States through the use of its quarantine authority.

The topic has received little scholarly attention. A 2003 report commissioned by the CDC raises but does not resolve the issue of whether a state might impose a travel ban, or any type of quarantine with adverse effects on state or local governments outside its borders.⁷⁹ As the report notes,

The authority of the United States government to control foreign and interstate travel is established by the Constitution and federal statute. It is less clear, however, the circumstances under which states may restrict interstate travel to prevent the spread of infection, and this

⁷⁵ As detailed below in Part IV, at the request of a state public health officer the CDC can place a tuberculosis patient on a federal Do Not Board list, which prevents an individual on the list from boarding both domestic and international flights. See *Public Health Interventions Involving Travelers with Tuberculosis — U.S. Ports of Entry, 2007–2012*, 61 MORBIDITY & MORTALITY WKLY. REP. 570, 571 (2012).

⁷⁶ Recent scholarship emphasizes the inability of states, acting alone, to effectively respond to a major epidemic without federal assistance and coordination. See, e.g., Wendy E. Parmet, *After September 11: Rethinking Public Health Federalism*, 30 J.L. MED. & ETHICS 201 (2002) (exploring the Commerce Clause and police power of states); John Thomas Clarkson, Note, *Phase Six Pandemic: A Call to Re-Evaluate Federal Quarantine Authority Before the Next Catastrophic Outbreak*, 44 GA. L. REV. 803 (2010) (describing the ability of the federal government to respond to a public health emergency).

⁷⁷ See *supra* Section II.B.

⁷⁸ Part IV reviews the historical evolution of the federal quarantine statute.

⁷⁹ See MARK A. ROTHSTEIN ET AL., *QUARANTINE AND ISOLATION: LESSONS LEARNED FROM SARS: A REPORT TO THE CENTERS FOR DISEASE CONTROL AND PREVENTION* (2003).

issue should be thoroughly researched and resolved through memoranda of understanding or other means.⁸⁰

This issue has yet to be thoroughly researched and it certainly has not been resolved. Recently, however, Professor Eang Ngov published an important article exploring preemption of state Ebola quarantine regulations.⁸¹ Ngov's preemption argument hinges on the federal government's border quarantine authority, rather than interstate, because it focuses on national re-entry of medical workers during the Ebola crisis.⁸² Ngov argues that excessively restrictive state quarantines ultimately harm a greater federal purpose: it discourages medical professionals from volunteering their services abroad, harming the national interest in global health security.⁸³

My analysis, by contrast, does not rely on plenary authority at the borders for the "dominant federal purpose" of a preemption analysis.⁸⁴ Instead, this Article identifies a dominant federal purpose in the longstanding, independent *interstate* authority provided by Congress. We need not rely on national security or global threats for preemption analysis because there is a purely domestic federal interest drawn from direct statutory authorization. For that reason, this Article explores preemption of state quarantine orders from a different vantage point—one that benefits from the historical analysis provided in Part III.

In addition, this analysis is not limited to the recent context of the 2014 Ebola outbreak. That episode was experienced primarily as a threat from abroad. Instead, this Article examines the issue from an imagined future epidemic wholly internal to the United States. While such an epidemic may in some sense have originated from abroad, the major problems the United States would face would no longer be about what to do at the border. The inquiry here is both different from and broader than Ngov's analysis.

My argument instead is that the federal government's authority to intervene in the event of spread of epidemic disease *within* the United States has been viewed in an unnecessarily restrictive way. The federal government need not wait to act until requested by a State, or until a state fails to act. It possesses statutory authority to act independently if circumstances demand. The

⁸⁰ *Id.* at 8.

⁸¹ Ngov, *supra* note 3, at 6.

⁸² *Id.* at 5–6.

⁸³ *Id.* at 8.

⁸⁴ *See id.* ("The dominant federal purposes are national security and control over foreign affairs, which would be affected by the spread of Ebola in the United States and abroad.").

remaining parts of this Article examine this claim, beginning with the statutory basis for federal quarantine authority.

A. *The Traditional Understanding of Federal Versus State Quarantine Power*

The sections below provide an overview of the interstate quarantine authority held by the federal government, beginning with its current statutory basis through the CDC's 2017 quarantine regulations. Since 2000, the federal government's quarantine authority has been delegated to the CDC.⁸⁵

It is helpful to begin with a broad overview of current practice. First, what do we usually mean when discussing federal versus state quarantine power? As understood today, the federal government's modern actions in the area of public health are based primarily upon the Commerce Clause,⁸⁶ the tax clause (spending to "provide for the common Defence and General Welfare of the United States"),⁸⁷ and the federal government's responsibility to protect the nation from external threats.⁸⁸ State and local governments are responsible for population-based health services, including surveillance and treatment of contagious diseases.⁸⁹

The federal government has both constitutional and statutory authority to independently administer interstate and foreign quarantine. It may also "assist with or take over the management of an intrastate incident if requested by a state or if the federal government determines local efforts are inadequate."⁹⁰

The unique brand of federalism in the United States divides quarantine authority between states and the federal government.⁹¹ If a communicable disease is suspected or identified in a person arriving at the U.S. border or port

⁸⁵ JARED P. COLE, CONG. RESEARCH SERV., RL33201, FEDERAL AND STATE QUARANTINE AND ISOLATION AUTHORITY 2 (2014). Matters of interstate and foreign quarantine are delegated to the CDC's Division of Global Migration and Quarantine. *Id.*

⁸⁶ U.S. CONST. art. I, § 8, cl. 3 ("[The Congress shall have Power] To regulate Commerce with foreign Nations, and among the several States, and with the Indian tribes . . .").

⁸⁷ U.S. CONST. art. I, § 8, cl. 1 ("The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States . . ."). This authority is the modern basis for federal grants to state and local health departments to encourage compliance with public health standards.

⁸⁸ Several provisions of the U.S. Constitution together provide the authority to "provide for the common defense," a phrase contained in the Constitution's preamble. These include separate powers listed in Section Eight of the Article I of the Constitution. See Jim Talent, *A Constitutional Basis for Defense*, HERITAGE FOUND. (June 1, 2010), <http://www.heritage.org/defense/report/constitutional-basis-defense>.

⁸⁹ See LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 47 (2000).

⁹⁰ COLE, *supra* note 85, at 1.

⁹¹ See generally Price, *Sovereignty*, *supra* note 7, at 922.

of entry, the CDC may issue a federal isolation or quarantine order.⁹² Federal regulations also allow the CDC to take measures to limit the spread of communicable diseases from one state into another, including anytime the CDC Director determines that the actions taken by the health authorities of a state are insufficient to prevent the spread of communicable disease.⁹³ The communicable diseases subject to quarantine are listed in an executive order of the President.⁹⁴

In the United States, immigration and border control officers may refuse to admit any non-U.S. citizen infected with a “communicable disease of public health significance.”⁹⁵ U.S. citizens, on the other hand, cannot be refused re-entry into the country, although officials can order immediate isolation at their arrival point, and can prohibit air travel for the period during which a sick patient could spread the disease.⁹⁶

To summarize, the federal government:

- Acts to prevent the entry of communicable diseases into the United States.
- Is authorized to take measures to prevent the spread of communicable diseases between states.
- May assist state and local authorities in preventing the spread of communicable diseases.
- Maintains a Do Not Board list preventing air travel for patients with any infectious disease that is a potential public health threat to passengers, including infectious TB. Persons are added to the Do Not Board list only with reliable medical information provided by a state

⁹² See *Quarantine and Isolation: U.S. Quarantine Stations*, *supra* note 11. U.S. CBP and U.S. Coast Guard officers are authorized to help enforce federal quarantine orders. See Control of Communicable Diseases, 82 Fed. Reg. 6890, 6916 (Jan. 19, 2017) (“[L]aw enforcement support for quarantine or isolation orders will generally be provided by U.S. Customs and Border Protection, U.S. Coast Guard, or other Federal law enforcement programs . . .”).

⁹³ 42 C.F.R. § 70.2 (2016).

⁹⁴ See Exec. Order No. 13,295, 3 C.F.R. § 220 (2003), *as amended by* Exec. Order No. 13,375, 3 C.F.R. § 162 (2005), *and* Exec. Order No. 13,674, 3 C.F.R. § 291 (2014).

⁹⁵ See *Legal Authorities for Medical Examination of Aliens*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/immigrantrefugeehealth/laws-regulations.html> (last updated Jan. 28, 2016).

⁹⁶ See Price, *Sovereignty*, *supra* note 7, at 923. See generally QUARANTINE STATIONS AT PORTS OF ENTRY: PROTECTING THE PUBLIC’S HEALTH 1–8, 36–42 (Laura B. Sivitz et al. eds., 2006).

public health official and following a reviewed approval process by the U.S. Department of Health and Human Services.⁹⁷

State, local, and tribal public health authorities:

- Initiate isolation and quarantine within their borders, relying on local law enforcement officers to enforce public health orders.⁹⁸
- Assume primary responsibility for treatment and for tracing contacts of persons with infectious diseases such as TB.⁹⁹

The nation's primary public health authority is divided among 2,684 state, local, and tribal health departments.¹⁰⁰ These health departments are responsible for the prevention and control of communicable disease. Among other tasks, state and local health departments investigate contagious disease outbreaks, coordinate control efforts, and provide public information. Jurisdictional boundaries are guarded, among other reasons, to preserve limited budgets.¹⁰¹

B. Legislative Authority for Interstate Quarantine

The ability to impose interstate quarantine is established by Congress, and is found in the Public Health Service Act. The relevant section authorizes the apprehension and examination of

[A]ny individual reasonably believed to be infected with a communicable disease in a qualifying stage and (A) To be moving or about to move from a State to another State; or (B) To be a probable source of infection to individuals who, while infected with such disease in a qualifying stage, will be moving from a State to another State.¹⁰²

⁹⁷ *Federal Air Travel Restrictions for Public Health Purposes*, *supra* note 14; *see also Questions and Answers About the Federal Register Notice*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/quarantine/qas-fm-travel-restriction.html> (last updated Mar. 27, 2015).

⁹⁸ *See generally State Quarantine and Isolation Statutes*, *supra* note 15 (listing state laws and describing range of authority).

⁹⁹ CTR. FOR LAW & THE PUB.'S HEALTH, TUBERCULOSIS CONTROL LAWS AND POLICIES: A HANDBOOK FOR PUBLIC HEALTH AND LEGAL PRACTITIONERS 21–22 (2009).

¹⁰⁰ *See* CAROLYN J. LEEP, NAT'L ASS'N OF CTY. & CITY HEALTH OFFICIALS, THE LOCAL HEALTH DEPARTMENT WORKFORCE: FINDINGS FROM THE 2005 NATIONAL PROFILE OF LOCAL HEALTH DEPARTMENTS STUDY 1 (2007).

¹⁰¹ Price, *Sovereignty*, *supra* note 7, at 947–48, 950–51.

¹⁰² 42 U.S.C. § 264(d)(1) (2012).

Federal quarantine and isolation orders are self-executing, meaning that federal authorities need not apply to a court in advance.¹⁰³

The statutory provision for “Regulations to control communicable diseases” further empowers the Surgeon General to make and enforce regulations to prevent introduction of communicable diseases from foreign countries, as well as measures to prevent spread of disease within the United States.¹⁰⁴ The general authority over interstate quarantine appears in subsection (a).¹⁰⁵ The key language is the Surgeon General’s authority to “prevent the introduction, transmission, or spread of communicable diseases . . . from one State or possession into any other State or possession.”¹⁰⁶

Following this general authority, subsection (d) provides for “apprehension and examination of persons reasonably believed to be infected”:

Regulations prescribed under this section may provide for the apprehension and examination of any individual reasonably believed to be infected with a communicable disease in a qualifying stage and (A) to be moving or about to move from a State to another State; or (B) to be a probable source of infection to individuals who, while infected with such disease in a qualifying stage, will be moving from a State to another State. Such regulations may provide that if upon examination any such individual is found to be infected, he may be detained for such time and in such manner as may be reasonably necessary.¹⁰⁷

Again, the key language is “from one State or possession into any other State or possession,” unchanged since the Public Health Service Act of 1944.¹⁰⁸ The penalty prescribed by Congress for any individual who violates a quarantine

¹⁰³ See Control of Communicable Diseases, 82 Fed. Reg. 6890, 6899–6900 (Jan. 19, 2017) (explaining exception to general warrant requirement).

¹⁰⁴ 42 U.S.C. § 264.

¹⁰⁵ See *id.* § 264(a) (“The Surgeon General, with the approval of the Secretary, is authorized to make and enforce such regulations as in his judgment are necessary to prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the States or possessions, *or from one State or possession into any other State or possession.*” (emphasis added)).

¹⁰⁶ *Id.*

¹⁰⁷ *Id.* § 264(d).

¹⁰⁸ As the annotation to 42 U.S.C. § 264 notes, there were several administrative permutations, including the substitution of the Secretary of Health and Human Services. The annotation provides: “Transfer of Functions”: “Functions of Federal Security Administrator transferred to Secretary of Health, Education, and Welfare and all agencies of Federal Security Agency transferred to Department of Health, Education, and Welfare by section 5 of Reorg. Plan No. 1 of 1953, set out as a note under section 3501 of this title. Federal Security Agency and office of Administrator abolished by section 8 of Reorg. Plan No. 1 of 1953. Secretary and Department of Health, Education, and Welfare redesignated Secretary and Department of Health and Human Services by section 509(b) of Pub. L. 96–88 which is classified to section 3508(b) of Title 20.” *Id.*

order or regulation is a “fine of not more than \$1,000 or by imprisonment for not more than one year, or both.”¹⁰⁹

42 U.S.C. § 264 also contains a subsection concerning preemption:

Nothing in this section or section 266 of this title, or the regulations promulgated under such sections, may be construed as superseding any provision under State law (including regulations and including provisions established by political subdivisions of States), except to the extent that such a provision conflicts with an exercise of Federal authority under this section or section 266 of this title.¹¹⁰

This preemption clause was added in 2002 as part of the Public Health Security and Bioterrorism Preparedness and Response Act, legislation passed by Congress in the wake of anthrax attacks and in the shadow of September 11.¹¹¹ The legislation was designed generally to provide more effective response to acts of bioterrorism as well as other public health emergencies.

Substantively, the 2002 Bioterrorism Act enhanced the federal government’s quarantine authority in case of exposure to disease by substituting “in a communicable stage” with “in a qualifying stage.”¹¹² Under this new language, persons potentially exposed to a disease, but not yet (or perhaps ever) showing symptoms, may be subject to a federal quarantine order.¹¹³ This expansion from “communicable stage” to “qualifying stage” would become important in the Ebola outbreak of 2014.

The legislative history of the preemption clause, however, is unclear. The clause appears in a section of the 2002 Bioterrorism Act titled “Streamlining and Clarifying Communicable Disease Quarantine Provisions.”¹¹⁴ This section prohibited the National Advisory Health Council, a holdover from the original 1944 Public Health Service Act, from any role in determining specific diseases subject to individual detentions, instead giving authority that to the President, upon recommendation of the Secretary of Health and Human Services (HHS) and in consultation with the Surgeon General. The section also removed the

¹⁰⁹ *Id.* § 271(a).

¹¹⁰ *Id.* § 264(e). The reference to 42 U.S.C. § 266 is to “Special Quarantine Powers in Time of War,” enacted in 1944 when national emergencies were proclaimed by President Roosevelt during World War II. *Id.* § 266.

¹¹¹ Public Health Security and Bioterrorism Preparedness and Response Act of 2002, Pub. L. No. 107-188, 116 Stat. 594 (June 12, 2002).

¹¹² *Id.* at 116 Stat. 627, § 142 (amending 42 U.S.C. § 264(d)).

¹¹³ *Id.*

¹¹⁴ *Id.*

Council from any role in promulgating regulations providing for apprehension of individuals for quarantine or isolation.¹¹⁵

The legislative history of the 2002 Bioterrorism Act does not reveal where this preemption clause originated or any particular information about why it was included. Although there is no specific legislative history, the introduction of the preemption section was likely a political trade-off for what some perceived to be potential impingement of state authority resulting from other provisions in the 2002 Bioterrorism Act.

In any event, the preemption clause by its terms has no relevance for federal nullification of a state-imposed *cordon sanitaire* or other type of quarantine. Preemption is permissible, if not mandated, anytime “such a [state] provision conflicts with an exercise of Federal authority under this section.”¹¹⁶ So, a federal quarantine imposed to “prevent the introduction, transmission, or spread of communicable diseases . . . from one State or possession into any other State or possession”¹¹⁷ is an “exercise of Federal authority under this section.” To the extent preemption analysis is relevant to my argument, then, it does not come from the preemption clause in the quarantine statute itself.

I will return to the current statutory authority for interstate quarantine to explore its historical antecedents. These antecedents illuminate how the limits to interstate quarantine authority were originally viewed as a matter of constitutional law and congressional intent. First, however, we should consider the relevant implementing regulations—the new federal quarantine regulations discussed at this Symposium.

C. 2017 Federal Quarantine Regulations, “Interstate and Foreign”

The new regulations related to interstate quarantine are found in a rule published January 19, 2017, titled “Control of Communicable Diseases: Interstate and Foreign,” which became effective on March 21, 2017.¹¹⁸ The 2017 Regulations were promulgated pursuant to title 42 of the Code of Federal Regulations, in two parts. Part 70 applies to interstate quarantine, while Part 71 applies to foreign arrivals.¹¹⁹ The new rule encapsulates quarantine both

¹¹⁵ *Id.*

¹¹⁶ 42 U.S.C. § 264(e) (2012).

¹¹⁷ *Id.* § 264(a); see also *infra* note 172 and accompanying text.

¹¹⁸ Control of Communicable Diseases, 82 Fed. Reg. 6890, 6890 (Jan. 19, 2017). The final rule amends 42 C.F.R. pts. 70 and 71. *Id.*

¹¹⁹ See 42 C.F.R. pts. 70–71.

“Interstate and Foreign.”¹²⁰ Procedures for both are now combined in the new regulations.

As stated by the CDC, “This final rule improves CDC’s ability to protect against the introduction, transmission, and spread of communicable diseases while ensuring due process.”¹²¹ According to CDC, the substance of the new rule does not change longstanding CDC procedures: “This Final Rule enhances HHS/CDC’s ability to prevent the introduction, transmission, and spread of communicable diseases into the United States and interstate by clarifying and providing greater transparency regarding its response capabilities and practices.”¹²² The rule, in other words, does not expand the CDC’s jurisdictional authority, whether interstate or at the border, with respect to quarantine.¹²³

Some prior history of the 2017 quarantine regulations is instructive. The CDC first proposed an update to federal quarantine regulations in 2005.¹²⁴ Those proposed regulations were formally withdrawn and replaced with the rules that became final in 2017.¹²⁵ Prompted by the potential spread of avian flu (which, unlike Ebola, can be spread through the air),¹²⁶ in 2005 the CDC proposed regulations that would have granted the federal government a power of “provisional quarantine” to confine airline passengers involuntarily for up to three days if they exhibit symptoms of certain infectious diseases.¹²⁷ Federal officials would also have been able to quarantine passengers exposed to people with those symptoms.

¹²⁰ Control of Communicable Diseases, 82 Fed. Reg. at 6890.

¹²¹ *Final Rule for Control of Communicable Diseases: Interstate and Foreign*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/quarantine/final-rule-communicable-diseases.html> (last updated Mar. 21, 2017).

¹²² *Specific Laws and Regulations Governing the Control of Communicable Diseases*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/quarantine/specificlawsregulations.html> (last updated Mar. 21, 2017).

¹²³ *Questions and Answers About the Final Rule for Control of Communicable Diseases: Interstate (Domestic) and Foreign Quarantine*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/quarantine/qa-final-rule-communicable-diseases.html> (last updated Mar. 21, 2017).

¹²⁴ See Press Release, Ctrs. for Disease Control & Prevention, CDC Proposes Modernizing Control of Communicable Disease Regulations, <https://www.cdc.gov/media/pressrel/r051122.htm> (last updated Nov. 22, 2005). The 2017 rules modified the 2005 proposal by making due process protections more explicit and by requiring a narrower range of information to be collected by airlines.

¹²⁵ See Control of Communicable Diseases, 81 Fed. Reg. 54,230, 54,234 (proposed Aug. 15, 2016) (to be codified at 42 C.F.R. pts. 70–71).

¹²⁶ *Prevention and Treatment of Avian Influenza A Viruses in People*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/flu/avianflu/prevention.htm> (last updated Apr. 17, 2017).

¹²⁷ Alison Young, *Obama Administration Scraps Quarantine Regulations*, USA TODAY (Apr. 1, 2010, 8:53 AM), http://usatoday30.usatoday.com/news/washington/2010-04-01-quarantine_N.htm.

The proposed rules would have expanded obligations of airlines to inform the CDC about sick passengers and to maintain contact information about all fliers in case the CDC and other federal agencies need to investigate a serious disease outbreak. Opposed by the airline industry and civil liberties groups, the regulations were withdrawn in 2010.¹²⁸

Carried over from the 2005 proposed rules, however, are “provisions governing the content of written . . . orders for quarantine, isolation, and conditional release, . . . procedures for administrative hearings to review these written Federal orders, and a specific provision governing the content and compiling of an administrative record.”¹²⁹

While the 2005 proposed regulations were pending, in 2008 Congress asked HHS to take another look at federal quarantine and isolation practices, specifically in the context of TB control.¹³⁰ The request for a review of quarantine regulations followed a TB scare in 2007, when the public learned that a person later determined to be suffering from drug-resistant TB had boarded multiple flights.¹³¹ The resulting legislation, the Comprehensive Tuberculosis Elimination Act of 2008, directed HHS to update federal quarantine regulations: “Not later than 240 days after the date of enactment of this Act [Oct. 13, 2008], the Secretary of Health and Human Services shall promulgate regulations to update the current interstate and foreign quarantine regulations found in parts 70 and 71 of title 42, Code of Federal Regulations.”¹³²

Hardly noticed, and relatively inconsequential, two final rules were published in December 2012 amending the Interstate and Foreign Quarantine Regulations.¹³³ “The updates reorganize[d] the Scope and Definitions [sections of the regulations] to reflect modern terminology and plain language used in practice by industry and public health partners.”¹³⁴ According to the CDC,

¹²⁸ *Id.*

¹²⁹ Control of Communicable Diseases, 81 Fed. Reg. at 54,234.

¹³⁰ Comprehensive Tuberculosis Elimination Act of 2008, Pub. L. No. 110-392, § 121(c), 122 Stat. 4200 (Oct. 13, 2008).

¹³¹ Vikki Valentine, *A Timeline of Andrew Speaker’s Infection*, NPR (June 6, 2007), <http://www.npr.org/news/specials/tb/>.

¹³² Comprehensive Tuberculosis Elimination Act of 2008 § 121(c).

¹³³ *Final Rules for Control of Communicable Diseases: Interstate and Foreign—Scope and Definitions*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/quarantine/final-rules-control-communicable-diseases.html> (last updated Mar. 10, 2014).

¹³⁴ *Id.*

these 2012 updates were “the first step in helping modernize the federal quarantine regulations.”¹³⁵

Thus, the new 2017 regulations culminate a multi-year effort to update quarantine regulations to better reflect how federal quarantine and isolation authority has been exercised in practice, and to detail the due process protections accorded to individuals who may be affected.

D. Objections to the Rule: Asking the Wrong Question?

Some aspects of the new quarantine regulations immediately drew criticism. In an opinion piece published in the *New York Times*, titled “Why the C.D.C.’s Power to Quarantine Should Worry Us,” the authors objected to internal review procedures as insufficient protection for due process rights, though without suggesting a viable alternative for independent medical review outside of the agency before a quarantine decision is made.¹³⁶ Nor do the authors suggest which medical professionals outside of the agency should review the continuing justification for an existing quarantine order. Instead, the authors claim there would be little or no internal agency review before a quarantined individual could petition a federal court for review of the quarantine order.¹³⁷ These objections on civil liberties/due process grounds apply equally to interstate as well as border quarantine authority, without distinguishing the two.

It may be that the authors’ primary concern is with who wields that authority within the executive branch. The editorial contends that, with the new rules, “the administration of Donald J. Trump has even more authority to detain people.”¹³⁸ Oddly, the authors cite the case of Kaci Hickox as an example of why we should fear the new *federal* regulations, even though, as they acknowledge, their objection was to the actions of state governors, in this case Governor Chris Christie, not the federal government.¹³⁹ The writers in fact highlighted why *state* power to quarantine should also worry us.¹⁴⁰ The concern over federal quarantine authority seemed squarely directed at the

¹³⁵ *Id.*

¹³⁶ Kyle Edwards et al., Opinion, *Why the C.D.C.’s Power to Quarantine Should Worry Us*, N.Y. TIMES (Jan. 23, 2017), https://www.nytimes.com/2017/01/23/opinion/why-the-cdcs-power-to-quarantine-should-worry-us.html?_r=0.

¹³⁷ *Id.*

¹³⁸ *Id.*

¹³⁹ *Id.*

¹⁴⁰ *Id.*

Trump Administration, understandable given candidate Trump's comments about closing the border during the Ebola outbreak in West Africa.¹⁴¹

As Professor Wendy Parmet noted, "The concern . . . is that unless these regulations are carried out with care, and by people who [base their actions] on science, they can be used to trammel the civil liberties of Americans."¹⁴² These apprehensions apply equally to state quarantine policies.

Parmet is especially concerned that the CDC's enhanced powers would take effect just as the Trump Administration is assuming control over the agency. As Parmet explained, "A lot of the signals we've received from President Trump suggests he may be inclined to not always listen to the science . . . and to ground policy in what I guess we're now calling 'alternative facts,' instead of scientific facts. That's scary."¹⁴³

Another scholar, Scott Burris, expressed similar concerns: "My worst fear is we have a replay of Ebola and we have, say, President Trump assert the policy he thought we ought to have when he was citizen Trump."¹⁴⁴

The desire, quite rightly, is to avoid government overreaction, at any level of government where that might occur. Professor Lawrence Gostin, for example, stated that "the last thing we want in the face of a public health crisis is overreaction. . . . And I think having rules in place that are modern at least will provide some buffer against the whims of an administration that may overreact."¹⁴⁵

Some media portrayed the 2017 quarantine regulations as expanding the federal government's power within a state. For example, a report on *National Public Radio* stated: "With the new rules, the CDC would be able to detain people anywhere in the country, without getting approval from state and local officials."¹⁴⁶

¹⁴¹ S.A. Miller, *Donald Trump: Fight Ebola at the Border*, WASH. TIMES (Aug. 4, 2014), <http://www.washingtontimes.com/news/2014/aug/4/donald-trump-fight-ebola-border> (noting that Trump would "den[y] . . . all travelers from West Africa entry into the United States").

¹⁴² Stein, *supra* note 1 (alteration in original).

¹⁴³ *Id.*

¹⁴⁴ *Id.*

¹⁴⁵ *Id.*

¹⁴⁶ *Id.*

But as noted above, the regulations on their face do not purport to expand federal quarantine jurisdiction as it is already exercised within the United States. And the CDC explicitly disclaimed this aim as well.¹⁴⁷

Furthermore, as a practical matter, the CDC must still rely on state and local health authorities to notify it of persons for whom quarantine is believed necessary or advisable.¹⁴⁸ It has no police force to execute orders. Its limited interstate power has been exercised only through leverage over airlines via Do Not Board orders.¹⁴⁹ Federal isolation orders are quite rare: only twelve isolation orders were issued between 2005 and 2016, an average of about one order per year.¹⁵⁰ CDC's interstate quarantine power reaches only the relatively affluent who travel within the United States by air. And even then, CDC is reliant on notification by state or local health authorities to know about the person at all, since interstate quarantine orders originate with a request from a state public health official.

While the federal government possesses substantial statutory authority to exercise its quarantine powers within the United States, both historically and today the federal government defers to states on matters of quarantine and isolation. The CDC states:

In general, HHS defers to the state and local health authorities in the primary use of their separate quarantine powers. Based on long experience and collaborative working relationships with our state and local partners, CDC anticipates the need to use this federal authority to actually quarantine a person will occur only in rare situations, such as events at ports of entry or other time-sensitive settings.¹⁵¹

With this recent regulatory history in mind, the next Part describes the motivation of Congress in providing for federal interstate quarantine authority

¹⁴⁷ See *Final Rule for Control of Communicable Diseases: Interstate and Foreign*, *supra* note 121 (noting that the rule “[d]oes not expand CDC’s authority beyond what is granted by Congress, nor does it alter the list of diseases subject to federal isolation or quarantine, which is established by an Executive Order of the President”).

¹⁴⁸ See *Control of Communicable Diseases*, 82 Fed. Reg. 6890, 6906 (Jan. 19, 2017) (“HHS/CDC further notes that it typically conducts the public health risk assessment in coordination with the State or local health department of jurisdiction before issuing a Federal public health order Furthermore, decisions regarding the issuance of Federal public health orders or medical examination for a suspected quarantinable communicable disease would typically be made in coordination with a State or local health department of jurisdiction.”).

¹⁴⁹ See *infra* Part IV.

¹⁵⁰ *Control of Communicable Diseases*, 82 Fed. Reg. at 6963.

¹⁵¹ *Questions and Answers on Legal Authorities for Isolation and Quarantine*, CTRS. FOR DISEASE & CONTROL PREVENTION 1–2 (Jan. 20, 2004), <https://www.cdc.gov/sars/quarantine/qa-isolation.pdf>.

in the interior. Congress authorized broad federal power at the behest of states suffering the most from an epidemic the rest of the nation seemed willing to ignore.

III. THE NINETEENTH-CENTURY ORIGIN OF FEDERAL INTERSTATE QUARANTINE POWER

Part I imagined a scenario in which one state declares quarantine against another, prohibiting incoming or outgoing travel and transport of goods. Although there is no recent example, a little more than a century ago state and local governments throughout the southern United States faced just that during frightening and deadly outbreaks of yellow fever.

This historical episode allows us to examine how and why the federal government gained interstate quarantine authority in the first place. Debates in Congress over control of state and local quarantine tested Commerce Clause and federalism principles that held state lines to be the limiting point of action for the federal government. The outcome of these debates, I suggest, constituted in many respects a “constitutional moment”¹⁵²—a turning point in relations between states and the national government over responsibility for quarantine and the control of epidemic disease. Congress fully expected the federal government to assume some control when the nation was faced with a fast-moving, contagious disease.

This history also reveals that federal control of quarantine within a state—displacing an overly restrictive, parochial area quarantine with a uniform national policy—is consistent with the original intent and understanding of the federal quarantine statute.

¹⁵² The “constitutional moment” concept is associated most famously with Professor Bruce Ackerman. See BRUCE ACKERMAN, *WE THE PEOPLE: TRANSFORMATIONS* (1998) (arguing that major shifts in constitutional law can occur when there is sustained popular attention to questions of constitutional significance). Similarly, there are constitutional principles in the background of the events I describe below. The upshot being that all three branches of the federal government—Congress, the Supreme Court, and the Executive—at various points during the period I describe all agreed that the national government had a significant role to play in fighting epidemics threatening more than one state. Moreover, as noted below, many state governors agreed that the federal government needed interstate quarantine authority, with southern states taking the lead in asking Congress to authorize and appropriate money for effective federal intervention in their region.

A. *The First Interstate Quarantine Statute*

Congressional authorization for federal intervention to prevent the spread of disease from state to state dates back to the closing decades of the nineteenth century. Before considering the historical circumstances that prompted Congress to act, it is instructive to look at the authorizing language for federal intervention and trace its evolution to the present. The key language for this interstate link—when disease threatens to spread “from one State to another”—has been on the books since 1890.¹⁵³

The federal government’s interstate quarantine authority has always been linked to its historical authority over U.S. entry points.¹⁵⁴ Outbreaks of yellow fever, small pox, and cholera in the nineteenth century had been connected to ports and recently arrived ships.¹⁵⁵ Experience proved that disease could be introduced from abroad, and the federal government had an obligation to assist states if they failed to stop disease at the borders.¹⁵⁶

Initially, medical officers from the Marine Hospital Service were employed at quarantine inspection stations owned by the national government.¹⁵⁷ An 1878 Act clarifying their responsibilities at certain ports contained the proviso “That there shall be no interference in any manner with any quarantine laws or regulations as they now exist or may hereafter be adopted under State laws.”¹⁵⁸ This Act did not address interstate transmission of disease at all, except, perhaps, by implication—failure to properly quarantine at seaports permitted introduction and spread of disease inland.

In 1879, proponents of a national quarantine measure, known as the “Yellow Fever Bill,” justified the federal government’s inland intervention under its constitutional right to regulate commerce and to protect the country

¹⁵³ Act of March 27, 1890, ch. 51, 26 Stat. 31, 31 (1890). I discuss this and other acts of Congress below, in section IV.C.

¹⁵⁴ See generally Laura K. Donohue, *Biodefense and Constitutional Constraints*, 4 NAT’L SECURITY & ARMED CONFLICT L. REV. 82, 90–91 (2014) (“During the late nineteenth century, however, the balance of power subtly shifted. The federal government avoided a direct Commerce Clause assertion and, instead, began to use the power of the purse to buy up local and state ports, transferring their operation to federal control.”); Price, *supra* note 33, at 399 (“The question of national control over seaport inspection dominated congressional debate . . .”).

¹⁵⁵ See Batlan, *supra* note 4 (describing history of epidemics in the United States).

¹⁵⁶ See *id.* at 62–64 (explaining early federal quarantine laws to prevent infectious disease from entering port cities).

¹⁵⁷ For a general history of the Marine Hospital Service and its evolution into the U.S. Public Health Service, see *Commissioned Corps of the U.S. Public Health Service: History*, U.S. DEP’T OF HEALTH & HUMAN SERVS., <https://www.usphs.gov/aboutus/history.aspx> (last updated Sept. 5, 2014).

¹⁵⁸ Act of April 29, 1878, ch. 66, 20 Stat. 37, 38.

from foreign “invader.”¹⁵⁹ Opponents of the bill argued that it was unconstitutional and a violation of state rights.¹⁶⁰

Ultimately a much weaker bill emerged. In the wake of the devastating yellow fever epidemic of 1878, Congress tentatively provided some federal power to intervene when failure of a state-run port quarantine threatened to spread disease from state to state. For the first time, Congress distinguished between “maritime” and “inland” quarantine,¹⁶¹ and this terminology is significant for later grants of authority. In an Act of Congress creating a National Board of Health, the Board was to give “special attention . . . to the subject of quarantine, both maritime and inland, and especially as to regulations which should be established between State or local systems of quarantine and a national quarantine system.”¹⁶²

Later that same year, Congress recognized the need for quarantine rules to prevent transmission “into one State from another,” laying an interstate commerce basis for federal authority over inland quarantine.¹⁶³ This Act, though, emphasized cooperation with states, rather than any preemptive federal authority:

That the National Board of Health shall co-operate with and, so far as it lawfully may, aid State and municipal boards of health in the execution and enforcement of the rules and regulations of such boards to prevent the introduction of contagious or infectious diseases into the United States from foreign countries, *and into one State from another . . .*¹⁶⁴

Although the National Board of Health was short-lived, it did set a precedent for future public health efforts by the federal government. Congress had given the Board authority to provide money to state and local health boards “and to assume quarantine powers when states did not appear competent or willing to do so.”¹⁶⁵ As a condition of receipt of federal funds,

¹⁵⁹ See Margaret Warner, *Local Control Versus National Interest: The Debate over Southern Public Health, 1878–1884*, 50 J. S. HIST. 407, 412 (1984).

¹⁶⁰ *Id.*

¹⁶¹ Act of March 3, 1879, ch. 202, 20 Stat. 484, 485 (“An act to prevent the introduction of infections or contagious diseases into the United States, and to establish a National Board of Health”).

¹⁶² *Id.*

¹⁶³ Act of June 2, 1879, 21 Stat. 5 (“An act to prevent the introduction of contagious or infectious diseases into the United States”).

¹⁶⁴ *Id.* (emphasis added).

¹⁶⁵ Warner, *supra* note 159, at 413.

state and local agencies were required to adopt national standards for quarantine.¹⁶⁶

Following the demise of the National Board of Health, in 1890 Congress enacted the precursor of the modern federal quarantine statute. This statute was popularly known as the “Epidemic Diseases Act,” with the full title “An act to prevent the introduction of contagious diseases from one State to another and for the punishment of certain offenses.”¹⁶⁷ In relevant part, the Act stated:

That whenever it shall be made to appear to the satisfaction of the President that cholera, yellow-fever, small-pox, or plague exists in any State or Territory, or in the District of Columbia, *and that there is danger of the spread of such diseases into other States, Territories, or the District of Columbia*, he is hereby authorized to cause the Secretary of the Treasury to promulgate such rules and regulations as in his judgment may be necessary to prevent the spread of such disease . . . and to employ such inspectors and other persons as may be necessary to execute such regulations to prevent the spread of such disease.¹⁶⁸

The Epidemic Diseases Act also provided criminal penalties for any officer or agent of the United States, or any common carrier, who should “willfully violate any of the quarantine laws of the United States or any of the rules and regulations made and promulgated by the Secretary of the Treasury.”¹⁶⁹

The 1890 Epidemic Diseases Act was unchanged through 1944,¹⁷⁰ when the Public Health Service Act modernized the U.S. Public Health Service and coordinated its various functions. The key language from the Epidemic Diseases Act, however, was retained—the Public Health Service Act continued to authorize federal intervention whenever specified contagious diseases threatened to spread “from one state . . . into any other State.”¹⁷¹

Sec. 361. (a) The Surgeon General . . . is authorized to make and enforce such regulations as in his judgment are necessary to prevent

¹⁶⁶ *Id.*

¹⁶⁷ Act of March 27, 1890, ch. 51, 26 Stat. 31. Preceding this was an Act of Aug. 1, 1888, which concerned only the establishment of federally operated port quarantine stations, but not displacing those already operated by some states. Act of Aug. 1, 1888, ch. 727, 25 Stat. 355 (“An Act to Perfect the Quarantine System of the United States”).

¹⁶⁸ Act of March 27, 1890, ch. 51, 26 Stat. at 31 (emphasis added).

¹⁶⁹ *Id.*

¹⁷⁰ *See, e.g.*, 42 U.S.C. § 95 (1934) (quoting Act of March 27, 1890, ch. 51, 26 Stat. 31, with annotated heading “Regulations to prevent the spread of contagious diseases from one State, etc., to another, etc., authorized”); 58 U.S.C.A. § 9176 (Mallory 1916) (same).

¹⁷¹ Public Health Service Act, Pub. L. No. 410, 58 Stat. 703 (July 1, 1944).

the introduction, transmission, or spread of communicable diseases from foreign countries into the States or possessions, or from one State or possession into any other State or possession. For purposes of carrying out and enforcing such regulations, the Surgeon General may provide for such inspection, fumigation, disinfection, sanitation, pest extermination, destruction of animals or articles found to be so infected or contaminated as to be sources of dangerous infection to human beings, and other measures, as in his judgment may be necessary.¹⁷²

Thus, there is today longstanding congressional authority for some form of interstate quarantine by the federal government, as the Public Health Service Act 1944 is the direct predecessor of the current statute, 42 U.S.C. § 264.

*B. Yellow Fever Quarantines: “A Stigma Upon Our Institutions and Civilization”*¹⁷³

What conditions compelled Congress to extend quarantine power inland in the 1890 Epidemic Diseases Act? The border/inland division of authority we have today was created at a time when it was believed that epidemics within the United States could be avoided by securing ports and perfecting a system of ship quarantine.¹⁷⁴ It is true that the main focus of dispute over federal quarantine authority initially had to do with state control over local seaports.¹⁷⁵ In the meantime, before the last states finally ceded control of port quarantine to the federal government, it was evident that no system of port quarantine was perfect: Yellow fever inevitably appeared on an annual basis, and with it the

¹⁷² *Id.* The 1944 Public Health Service Act was enacted against the backdrop of World War II, providing perhaps a wartime justification for interstate quarantine. In other ways, wartime necessity expanded federal authority in health matters generally. See Polly J. Price, *Federalization of the Mosquito: Structural Innovation in the New Deal Administrative State*, 60 EMORY L.J. 325 (2010) (explaining origins of the CDC in war-time anti-malaria effort).

¹⁷³ This quote is from a Senate Committee Report reprinted in Annual Report of the Supervising Surgeon-General of the Marine-Hospital Service of the United States for the Fiscal Year 1898, quoted in full below. U.S. TREASURY DEP’T, BUREAU OF PUB. HEALTH & MARINE-HOSP. SERV., ANNUAL REPORT OF THE SUPERVISING SURGEON-GENERAL OF THE MARINE HOSPITAL SERVICE OF THE UNITED STATES FOR THE FISCAL YEAR 1898 754 (1899) [hereinafter ANNUAL REPORT 1898].

¹⁷⁴ See *Federal Quarantine Control*, ATLANTA J. CONST., June 26, 1906, at 6 (characterizing a Congressional debate, the article reported “the majority being of the opinion that if the marine hospital service were given full control of port stations the entrance of disease would be rendered next to impossible”).

¹⁷⁵ See Batlan, *supra* note 4, at 66–67 (“In the wake of additional epidemics, in 1888 Congress provided half a million dollars to the Marine Hospital Service to build seven federal quarantine stations, which now competed with state quarantine facilities. . . . Such federal power was soon increased by an act that provided authority to the Marine Hospital Service to approve state and local quarantine facilities and bring them up to federal standards. The Service was also charged with enforcing federal quarantine rules. This 1893 law provided compensation to states that transferred their quarantine facilities to the federal government.”).

frequent appearance of state and local area quarantines.¹⁷⁶ As a result, the subject of inland quarantine became increasingly urgent. The federal government was called upon to quell the “shotgun quarantine,” infamous during frequent epidemics of yellow fever in the late 19th and early 20th century South.¹⁷⁷

In severe yellow fever outbreaks from the 1870s through 1905, the “shotgun quarantine” became the term used for a state or local government’s declaration of a quarantine against entry from places thought to be experiencing an outbreak of yellow fever, to prevent the entry of persons from anywhere yellow fever might be present.¹⁷⁸

A shotgun quarantine consisted of a geographic barrier against “all persons, whether sick or well,” and any commerce or U.S. Mail that might attempt to pass through.¹⁷⁹ Shotgun quarantines were formal declarations ordered by governors, mayors, town councils, and other political bodies.¹⁸⁰ Armed law-enforcement officers and local volunteers blocked roadways, and “[t]rains attempting to pass through the cordon would either be stopped before entering, or not permitted to discharge passengers or cargo” within the state.¹⁸¹

An 1898 article in the *Washington Post* characterized the problem this way:

Seriously, this shotgun quarantine system has reached such a stage in some Southern States that it will surely ruin them unless it is reformed. In some places it is no longer a justifiable precaution against possible infection, but a matter of retaliation between county and parish, city and town. It is a case of “you quarantine us, we’ll quarantine you,” and some bumptious Board of Health or self-constituted authority on contagious diseases may be relied upon to carry out the threat to the letter.¹⁸²

¹⁷⁶ See Price, *supra* note 33, at 376.

¹⁷⁷ See *id.* at 371. For another description of state and local quarantines in response to epidemics of yellow fever, see Batlan, *supra* note 4, at 65 (“Many residents fleeing infected cities were denied shelter and some died of starvation and exposure. Hastily erected quarantines at state borders proved ineffective at curtailing the epidemic but halted commerce throughout the South.”).

¹⁷⁸ Price, *supra* note 33, at 382.

¹⁷⁹ See *id.* at 381.

¹⁸⁰ *Id.*

¹⁸¹ *Id.*

¹⁸² *Southern Shotgun Quarantine*, WASH. POST, Sept. 30, 1898, at 6.

But as state and regional efforts to control shotgun quarantines failed, southern politicians turned to Congress for help.¹⁸³ For over four decades, the shotgun quarantine challenged the capacity and will of the federal government to manage epidemics.¹⁸⁴ Congress explored the constitutional question of its authority to override state quarantines, but never came to a definitive resolution about how, practically, the federal government could help.¹⁸⁵

Southern states insisted there should be a federal role to preempt unnecessary or retaliatory state and local quarantines because they caused economic harm and suffering to populations elsewhere.¹⁸⁶ Regional solutions had not worked.¹⁸⁷ Business leaders as well as politicians petitioned Congress for a solution.¹⁸⁸ States could not control local health boards, let alone the actions of neighboring localities, adding to the chaos.¹⁸⁹

C. *Constitutional Debates and Administrative Hurdles*

During the four-decade period of congressional action on matters of quarantine, the U.S. Supreme Court weighed in twice. It first addressed state and local quarantine in a case involving a yellow fever epidemic in New Orleans in the 1880s.¹⁹⁰ In *Morgan's Steamship v. Board of Health*, the Supreme Court stated:

[W]henver Congress shall undertake to provide for the commercial cities of the United States a general system of quarantine, or shall confide the execution of the details of such a system to a National Board of Health, or to local boards, as may be found expedient, all State laws on the subject will be abrogated, at least so far as the two are inconsistent.¹⁹¹

¹⁸³ Price, *supra* note 33, at 371.

¹⁸⁴ *Id.*

¹⁸⁵ *Id.*

¹⁸⁶ *Id.* at 397–98.

¹⁸⁷ *Id.* at 394.

¹⁸⁸ *Id.* at 394–98.

¹⁸⁹ See Batlan, *supra* note 4, at 73 (“By the late nineteenth century, many city and county health boards functioned with extraordinary power to pass a multitude of regulations that might or might not conflict with state laws. . . . This uneasy and unstable patchwork of local, state, and federal jurisdiction, often entailing inconsistent laws, produced multiple and repeated conflicts.”).

¹⁹⁰ See *Morgan's S.S. Co. v. La. Bd. of Health*, 118 U.S. 455 (1886).

¹⁹¹ *Id.* at 464.

The Court's opinion indicated that the federal government had authority to establish "a general system of quarantine" under the Commerce Clause.¹⁹²

Four years later, Congress undertook this displacement of state law with the 1890 Epidemic Diseases Act. The Act's language was broad enough to permit the federal government to intervene inland, including the abrogation of state quarantines, if it chose to do so.¹⁹³ The question would become *if* and *when*, not whether the federal government had the authority to abrogate "all state laws on the subject."¹⁹⁴

Yet any federal response to epidemics after the 1890 Act depended on a fledgling administrative apparatus with very little funding, staffing, or political direction. The Marine Hospital Service was still uncertain how to promulgate enforceable regulations to prevent the local shotgun quarantine. One problem was how to react swiftly enough, given limited personnel and resources. Even with a successful federally run quarantine in the Brownsville, Texas area in 1882,¹⁹⁵ both the Marine Hospital Service and Congress remained stymied about how it might improve the situation elsewhere. Handling the yellow fever situation in south Texas required intensive manpower along with political savvy to deal with local politicians.¹⁹⁶ Replicating that feat throughout the South proved impossible as state and local quarantines continued to pop up with regularity whenever yellow fever made its annual appearance.

In annual reports to Congress, the Surgeon General of the Marine Hospital Service frequently described practical hurdles to lifting state and local shotgun

¹⁹² *Id.* This Article does not evaluate other Commerce Clause jurisprudence arguably relevant to geographic quarantine of people. For example, in *R.R. Co. v. Husen*, 95 U.S. 465, 468–69 (1877), the State of Missouri by statute prevented cattle from Texas to be driven into the state ostensibly to avoid introduction of bovine disease into cattle already present in Missouri. Although acknowledging the right of a state to inspect and quarantine diseased cattle, the Missouri legislation was nonetheless invalid: "While we unhesitatingly admit that a state may pass sanitary laws, and laws for the protection of life, liberty, health, or property within its borders; . . . while for the purpose of self-protection it may establish quarantine, and reasonable inspection laws, it may not interfere with transportation into or through the State, beyond what is absolutely necessary for its self-protection. It may not, under the cover of exerting its police powers, substantially prohibit or burden either foreign or inter-state commerce." *Id.* at 472. The Missouri statute at issue, however, forbade all cattle from Texas for an eight-month period *every year*. *Id.* at 469. By contrast, shotgun quarantines were temporary, intermittent measures, discretionary by health officials based on their determination of public necessity at the time. *See supra* notes 178–82 and accompanying text.

¹⁹³ *See supra* note 174 and accompanying text.

¹⁹⁴ Act of March 27, 1890, ch. 51, 26 Stat. 31.

¹⁹⁵ *See* JOHN MCKIERNAN-GONZÁLEZ, *FEVERED MEASURES: PUBLIC HEALTH AND RACE AT THE TEXAS-MEXICO BORDER, 1848–1942* 39–49 (2012) (describing a 190-mile-long yellow fever quarantine between Laredo and Corpus Christi, Texas, set up by the Marine Hospital Service after quarantines were declared against Brownsville).

¹⁹⁶ *Id.* at 40–41, 43.

quarantines. For example, the 1898 Surgeon General's Report contained several articles detailing the practical impediments to keeping inland travel and communication open.¹⁹⁷ Representative titles included:

Measures to Be Adopted in a District Threatened by Yellow Fever;
Measures to Be Adopted in Infected and Noninfected Towns;
Regulation of Traffic to, from, and Through Infected Towns;
Detention Camps and Camps of Observation;
Train Inspection Service.¹⁹⁸

The 1898 Surgeon General's Report also reprinted, in full, a report of the Senate Committee on Public Health and National Quarantine from that year.¹⁹⁹ The Committee favored legislation bolstering federal regulatory authority during an epidemic, because "[t]he evils of the present system have become intolerable".²⁰⁰

During the season just ended hundreds of lives were lost by reason of defects in existing law. The commerce of the entire South was paralyzed, and the rights of citizens disregarded by lawless methods. Cities and towns were quarantined against rival communities, producing bitter controversy, and railway trains passing from one State to another were prohibited from proceeding, the passengers in many cases being forcibly taken from the cars and carried to improvised fever camps, where they were exposed to hardship and contagion.²⁰¹

The report stated in no uncertain terms the need for federal action to quell the shotgun quarantine: "The amount of damage inflicted upon the country by the shotgun quarantine can never be accurately stated, but it certainly amounted to many millions, and the possibility of its existence is a stigma upon our institutions and civilization."²⁰²

¹⁹⁷ ANNUAL REPORT 1898, *supra* note 173.

¹⁹⁸ *Id.* at 9.

¹⁹⁹ *Id.* at 752 (reprinting S. REP. NO. 521 (1897)). A Senate committee to address yellow fever was first formed in 1878, following the devastating epidemic of that year in New Orleans and the Mississippi valley. See *Chairmen of Senate Standing Committees, 1789–present*, U.S. SENATE, <https://www.senate.gov/artandhistory/history/resources/pdf/CommitteeChairs.pdf>. The Select Committee on Epidemic Diseases established December 4, 1878, was made a standing committee in 1887. *Id.* The standing Committee on Epidemic was created in 1887 and lasted until 1896, when it became the Committee on Public Health and National Quarantine (terminated in 1921). *Id.*

²⁰⁰ ANNUAL REPORT 1898, *supra* note 173, at 753–54.

²⁰¹ *Id.* at 754.

²⁰² *Id.*

The proposed legislation detailed in the Committee's report would have permitted federal regulations "to prohibit or permit the movement of vessels, railway trains, and vehicles, or transportation of persons."²⁰³ Specifically, the bill provided:

Whenever yellow fever, cholera, plague, or typhus fever has passed the quarantines of the United States, or in any manner any one of these diseases has gained entrance or has appeared within the limits of any State, Territory, or the District of Columbia, the quarantine regulations of the United States, prepared under the direction of the Secretary of the Treasury, for the purpose of preventing the spread of such diseases from one State, Territory, or the District of Columbia into another State, Territory, or the District of Columbia, shall be supreme and have precedence of State or municipal laws, rules, or regulations, and the President is authorized to enforce the same and to control the movements of vessels, railway trains, vehicles, or persons so as to prevent these diseases from spreading from one State, Territory, or the District of Columbia to another State, Territory, or the District of Columbia, and to prevent unnecessary restrictions upon interstate commerce.²⁰⁴

The proposed bill never received a floor vote, despite the Surgeon General's plea for more explicit statutory authority to keep transportation channels open. Facing intransigence by state and local governments, officers of the Marine Hospital Service frequently were forced to back down in their efforts to keep open chains of interstate travel and transport.²⁰⁵ With explicit presidential authority, the Surgeon General and his officers believed they could be more effective. The Senate Committee on Public Health and National Quarantine, having studied this very question, believed so as well.²⁰⁶

Earlier bills had also attempted to supplement the federal interstate quarantine statute with more specific authorization to countermand quarantine orders of state and local health officials. For example, a bill introduced in the Senate in 1892 "granting additional quarantine powers" to the Marine Hospital Service would have permitted the president to "detail an officer or appoint a proper person" when state or municipal authorities failed or refused to enforce federal quarantine regulations.²⁰⁷ The bill would have amended the 1890

²⁰³ *Id.*

²⁰⁴ *Id.*

²⁰⁵ *See id.* at 375.

²⁰⁶ *See supra* notes 199–200 and accompanying text.

²⁰⁷ A Bill Granting Additional Quarantine Powers and Imposing Additional Duties upon the Marine Hospital Service, S. 2707, 52d Cong. § 3 (as introduced Mar. 24, 1892).

Epidemic Diseases Act, which set forth criminal penalties for state and local officials who “willfully violate[d] any of the quarantine laws of the United States,” but did not by its terms allow the president to send federal officers to directly enforce federal quarantine policy over the objection of states.²⁰⁸

Thus, in the years following the Supreme Court’s 1886 decision in *Morgan’s Steamship*, the Marine Hospital Service struggled to form an administrative apparatus that would permit effective displacement of state quarantines. Then, in 1902 the Supreme Court once again hinted that Congress had more authority to nullify state and local quarantines than it had yet to exercise.

In *Louisiana v. Texas*,²⁰⁹ the state of Louisiana complained that Texas routinely closed its borders for its own economic benefit on the pretext of yellow fever, effectively placing “an embargo on all interstate commerce between the city of New Orleans and the State of Texas.”²¹⁰ Rather than a legitimate public health purpose, it was claimed, Texas acted “to benefit the commerce of Galveston and of other Texas cities at the expense of the commerce of New Orleans.”²¹¹ Louisiana claimed these quarantines violated the Commerce Clause.²¹²

The case was dismissed on jurisdictional grounds.²¹³ In a concurring opinion, however, Justice John Harlan suggested the federal government might intervene in these circumstances:

[I]f the allegations of the bill be true, the Texas authorities have gone beyond the necessities of the situation and established a quarantine system that is absolutely subversive of all commerce between Texas and Louisiana, particularly commerce between Texas and New Orleans. This Court has often declared that the States have the power to protect the health of their people by police regulations directed to that end, and that regulations of that character are not to be disregarded because they may indirectly or incidentally affect interstate commerce. But when that principle has been announced it has always been said that the police power of a State cannot be so exerted as to obstruct foreign or interstate commerce beyond the

²⁰⁸ Act of March 27, 1890, ch. 51, 26 Stat. 31, 31 (1890).

²⁰⁹ 176 U.S.1 (1900).

²¹⁰ *Texas’ Quarantine Rights*, WASH. POST, Jan. 16, 1900, at 10.

²¹¹ *Id.*

²¹² *Louisiana*, 176 U.S. at 19.

²¹³ *Id.* at 16, 22.

necessity for its exercise, and that the courts must guard vigilantly against needless intrusion upon the field committed to Congress.²¹⁴

Justice Harlan's plea extended forcefully for the federal government to act. The courts would "guard vigilantly"²¹⁵ to enforce a dormant federal power, but by the time a court case wound its way through the system it would often be too late to prevent human suffering and economic harm. The Executive Branch, by contrast, could act immediately.

Legal scholars also weighed in on the interstate quarantine question. In an 1889 article in the *Harvard Law Review*, Blewett Harrison Lee opined that state inland quarantines more often than not ran afoul of the Commerce Clause.²¹⁶ He wrote: "The doctrine of the case seems to be that a State police law which obstructs interstate commerce to a greater extent than is strictly necessary for the accomplishment of the purpose of the law, is an unconstitutional regulation of commerce."²¹⁷

The question continued to be explored in the coming years. In 1891, a writer in the *American Law Review* explained the established understanding of a state's police power to protect the health of its residents:

It is well settled, upon the authorities, that the power to establish quarantine regulations rests with the States and has not been surrendered to the Federal government. The source of this power lies in the general right of a State to provide for the health of its people, and although the power when exercised may, in a greater or less degree, affect commerce, yet quarantine laws are not enacted for that purpose, but solely for preserving the public health.²¹⁸

Other scholars were concerned with increased federal authority over state quarantine.²¹⁹ But recognizing that the extent of that authority was not free from doubt, in 1891 one member of Congress asked:

²¹⁴ *Id.* at 23–24 (Harlan, J., concurring).

²¹⁵ *Id.* at 24.

²¹⁶ Blewett Harrison Lee, *Limitations Imposed by the Federal Constitution on the Right of the States to Enact Quarantine Laws*, 2 HARV. L. REV. 293 (1889).

²¹⁷ *Id.* at 306.

²¹⁸ H. Campbell Black, *The Police Power and the Public Health*, 25 AM. L. REV. 170, 181 (1891).

²¹⁹ See William Hamilton Cowles, *State Quarantine Laws and the Federal Constitution*, 25 AM. L. REV. 45 (1891); John H. Girdner et al., *The National Government and the Public Health*, 165 N. AM. REV. 733 (1897); James H. McCall, *The Quarantine Laws and National Control of Quarantine*, 72 MED. NEWS 483 (1898); D.H. Pingrey, *Valid State Laws Incidentally Affecting Foreign and Interstate Commerce*, 28 CENT. L.J. 336 (1889); U.O.B. Wingate, *National Public Health Legislation*, 504 N. AM. REV. 527 (1898).

If the gentleman will read all the decisions, and then undertake to write down in words exactly where the national power ends and where the State power begins on this subject of quarantine, he will accomplish what in my judgment nobody else has yet accomplished.²²⁰

D. Congressional Debates in 1906: Rail Traffic Within States

The last sustained debate in Congress over federal authority for interstate quarantine occurred in 1906.²²¹ These debates reveal no disagreement with the federal government's interstate authority to prevent the spread of disease "from one state to another."²²² Instead, the debate turned on how best to accomplish this administratively, in light of the nation's recent experience with a severe yellow fever epidemic in 1905.²²³

In a narrow defeat, a conference committee of Congress rejected a provision that would have imposed greater federal control over rail travel within states.²²⁴ The rejected provision provided a clearer administrative path to promulgate and enforce regulations that would lift shotgun quarantines, at least as it affected rail travel and other common carriers. The section provided:

That every common carrier, engaged in interstate commerce, shall, under such regulations, restrictions, and safeguards as may be promulgated by the Secretary of the Treasury, receive, carry, and transport through any State or Territory necessary to complete the journey or carriage into a State wherein delivery or debarkation may be lawful, all passengers, freight, or baggage which may have been discharged and properly certified in accordance with the regulations of the Public Health and Marine-Hospital Service; and every person interfering with or obstructing such carrier or any passenger or any instrumentality of commerce in any such carriage or journey shall be guilty of a misdemeanor and on conviction thereof be punished by a fine not exceeding \$300 or be imprisoned for a period not exceeding one year, or both, in the discretion of the court²²⁵

This rejected provision would not have expanded existing statutory authority for interstate quarantine. Instead, it provided explicit backing for regulatory power over the movement of rail traffic, a practical problem in need

²²⁰ Cowles, *supra* note 219, at 45 (quoting an unnamed member of the U.S. House of Representatives).

²²¹ See Price, *supra* note 33, 414–18 (describing legislative debates over interstate quarantine).

²²² *Id.* at 417.

²²³ *Id.* at 414–18.

²²⁴ H.R. REP. NO. 59-4290, at 1 (1906) (Conf. Rep.).

²²⁵ 59 CONG. REC. 5387, 5389 (1906).

of an administrative solution. That federal officers were hesitant to enforce such regulations absent explicit congressional sanction reflected a nascent administrative agency with little precedent for independent agency action.²²⁶

We know that federal inspectors with the Marine Hospital Service already had substantial experience with monitoring inland rail traffic and negotiating with state authorities to ameliorate local quarantines. Details in the 1898 Surgeon General's Report portray an elaborate railroad inspection system operating at state lines.²²⁷ Their aim was to keep trains and the U.S. Mail moving. The provision rejected in 1906 would have imposed additional penalties on "every person interfering with or obstructing such carrier or any passenger or any instrumentality of commerce," raising the stakes from liability imposed on the common carrier alone.²²⁸ Yet statutory authority already provided criminal penalties for "any person who shall willfully violate any rule or regulation" promulgated by the Secretary of the Treasury deemed "necessary to prevent the spread of such disease from one State or Territory into another."²²⁹ Federal authority already existed to accomplish these aims. The rejected provision merely made more explicit the federal government's pre-existing power to keep rail lines open despite a state or local quarantine.

E. Summary: What History Teaches About Interstate Quarantine

To summarize, the legislative history of the current interstate quarantine statute makes clear that Congress (and the Supreme Court) envisioned a far greater role for federal intervention in matters of state quarantine than we assume today. This history explains the origins of federal interstate quarantine as a measure to intervene when states imposed geographic quarantines to protect themselves from disease outside their borders. I have illustrated instances in which only the federal government could provide for an effective regional quarantine. There is thus precedent for inland quarantine consistent with the original understanding of the interstate quarantine statute, sufficient to lift or nullify a state or local quarantine when needed.

²²⁶ The complexity of railway transportation in this period, with numerous lines and companies crisscrossing the region, is portrayed in JAMES W. ELY, JR., *RAILROADS AND AMERICAN LAW* (2001).

²²⁷ ANNUAL REPORT 1898, *supra* note 173, at 389–411 ("Train-Inspection Service").

²²⁸ 59 CONG. REC. at 5389 (1906). The 1890 Epidemic Diseases Act imposed penalties only on "any common carrier or officer, agent, or employee of any common carrier," while the rejected provision would have imposed those penalties on anyone interfering with a common carrier as well. *See* Epidemic Diseases Act of 1890, ch. 51, 26 Stat. 31, § 3 (1890).

²²⁹ Epidemic Diseases Act of 1890, 26 Stat. 31 at § 1.

What else can we conclude from the legislative history? It is clear that power over quarantine as provided in the 1890 Epidemic Diseases Act meant much more than merely detaining persons at risk of spreading disease. It encompassed the whole apparatus of disease prevention as it was understood and practiced then—fumigation, inspection, and abatement, in addition to physical barriers excluding persons within or outside a particular area. Congress provided the Marine Hospital Service with substantial authority to nullify state and local shotgun quarantines, but not the administrative ability to do so effectively. There was widespread agreement that the Commerce Clause authorized such actions, even with the more limited view of federalism at the time.

Compared to today, of course, it was also a time of simpler transportation, before automobiles and airplanes. But interstate travel then was nonetheless sufficiently complicated that federal public health officers were frustrated by an inability to lift quarantines imposed by municipalities within a state. What was needed was not more statutory authority, but a more robust federal agency capacity.

Yet the statutory authority was clear. There was widespread agreement that only the federal government could evaluate whether state or local quarantines were a pretext for commercial advantage or reflected unwarranted panic, or whether such quarantines were legitimately needed to stem spread of the disease. Only the federal government had the financial and administrative resources to work regionally to govern parochial local interests. Only the federal government could prevent chaos and suffering when “[m]ob law seem[ed] likely to rule” in any given state.²³⁰ In short, yellow fever epidemics in the South provided the backdrop for Congress to establish federal authority to preempt or nullify a state quarantine in these extreme situations.²³¹ That the United States has not experienced such situations since the era of yellow fever does not lessen the federal government’s authority today.

CONCLUSION

Can we imagine a modern-day scenario equivalent to the yellow fever shotgun quarantine? Yellow fever was our closest experience to the kind of chaos that a fast-moving, lethal epidemic might cause today. The 1918

²³⁰ U.S. TREASURY DEP’T, BUREAU OF PUB. HEALTH & MARINE-HOSP. SERV., DOCUMENT NO. 2456, ANNUAL REPORT OF THE SURGEON-GENERAL OF THE PUBLIC HEALTH AND MARINE-HOSPITAL SERVICE OF THE UNITED STATES FOR THE FISCAL YEAR 1883 284 (1883) (describing effects of local shotgun quarantines).

²³¹ *Id.* at 285, 305.

pandemic flu, by contrast, saw no massive relocation of people as “refugees” from the disease, no closing of state borders, or quarantine of entire towns.

Since interstate quarantine authority was first established by Congress in 1890, advances in medical science provide many more tools to combat infectious disease. There have also been enormous changes in state and federal capacity to respond to public health emergencies.²³² Both factors make it less likely that such scenes might be repeated or that federal intervention might be needed.

An important part of state capacity is the Emergency Management Assistance Compact (EMAC), a framework for mutual aid among states in the event of a natural disaster or other emergency.²³³ The need for such a framework arose in the aftermath of Hurricanes Andrew (1992) and Katrina (2005).²³⁴ EMAC, ratified by Congress in 1996, now includes all fifty states and U.S. territories.²³⁵ It is based on voluntary undertakings by one state at the request of another. The EMAC framework does not, however, contemplate the coordination of state and local quarantine policy in the event of a multi-state epidemic, or mandate what is otherwise voluntary cooperation in the event states impose conflicting quarantine policies.

Nonetheless, while most states have made great strides in preparation and readiness for public health emergencies, weaknesses remain, including insufficient incentives for cooperation and inadequate regional planning. Clearly, it would be preferable for any exercise of federal interstate quarantine authority to be with the cooperation of state and local governments. But with current CDC resources and capabilities, population density, and modern speed of transportation and communication, broader authority for the CDC could better serve state interests (recognizing that some federalism trade-off is inevitable).

²³² For an overview of preparedness resources at both the state and national level, see *Public Health Emergency*, U.S. DEP'T HEALTH & HUMAN SERVS., <http://www.phe.gov/preparedness/Pages/default.aspx> (last reviewed Oct. 6, 2017); *Public Health Law Program: Emergency Preparedness*, CTNS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/php/publications/topic/emergency.html> (last updated Aug. 1, 2017); *Public Health Preparedness*, NAT'L ASS'N CTY. & CITY HEALTH OFFICIALS, <http://archived.naccho.org/topics/emergency> (last visited Sept. 16, 2017).

²³³ See *What Is EMAC?*, EMERGENCY MGMT. ASSISTANCE COMPACT, <https://www.emacweb.org/index.php/learn-about-emac/what-is-emac> (last visited Dec. 8, 2017) (describing EMAC operations and history).

²³⁴ *History*, EMERGENCY MGMT. ASSISTANCE COMPACT, <https://www.emacweb.org/index.php/learn-about-emac/emac-history> (last visited Dec. 8, 2017).

²³⁵ *What Is EMAC?*, *supra* note 234.

The emphasis on quarantine to stem a future epidemic is sometimes said to be overblown. In any public health emergency, the goal is to avoid the use of area or group quarantine as much as possible. To do so, preparedness and resources at all levels of government will be key. For example, the WHO recommends ongoing public health strategies for the prevention and control of communicable diseases, including immunization, mass drug distribution, food safety, safe water and sanitation, and vector control.²³⁶ Similarly, the CDC's "Framework for Preventing Infectious Diseases" emphasizes infectious disease surveillance and epidemiologic investigation, together with identification and implementation of high-impact public health interventions and policies to prevent, detect, and control infectious diseases.²³⁷ Fears of a widespread epidemic may be overblown as well, based on the relative strength of U.S. healthcare and scientific research as well as confidence in the nation's ability to produce vaccines.

If the nation were better prepared regionally, the necessity for federal intervention might never arise. Dedicated funds set aside for national emergencies, for example, could be distributed regionally to ease the jurisdictional clashes that might arise between states. However, the most significant federal preparedness legislation, passed in 2002, does not by its terms support grants to "regions," just state and local health departments.²³⁸ This is one reason we should be concerned about how the CDC is funded to respond to public health emergencies. In a recent article addressing this, the authors explain the appropriation process, identifying challenges in funding presented by the political process in both Congress and the Executive.²³⁹

There are other ways the CDC can intervene in state public health matters short of nullifying state health orders. One example is to provide trustworthy epidemiology reports when a local government might have an incentive to underreport the existence of contagious disease. In the recent Zika outbreak, the government of Puerto Rico allegedly underreported the number of Zika

²³⁶ World Health Organization [WHO], *WHO Recommended Strategies for the Prevention and Control of Communicable Diseases*, at 17, WHO/CDS/CPE/SMT/2001.13 (2012), apps.who.int/iris/bitstream/10665/67088/1/WHO_CDS_CPE_SMT_2001.13.pdf.

²³⁷ CTRS. FOR DISEASE CONTROL & PREVENTION, A CDC FRAMEWORK FOR PREVENTING INFECTIOUS DISEASES: SUSTAINING THE ESSENTIALS AND INNOVATING FOR THE FUTURE iii (2011).

²³⁸ "The [National Preparedness for Bioterrorism and Other Public Health Emergencies Act] authorizes grants to state and local health departments and hospitals to improve planning and preparedness activities, enhance laboratory capacity, and educate and train health care personnel." C. STEPHEN REDHEAD ET AL., CONG. RESEARCH SERV., RL31263, PUBLIC HEALTH SECURITY AND BIOTERRORISM PREPAREDNESS AND RESPONSE ACT: PROVISIONS AND CHANGES TO PREEXISTING LAW 3 (2002).

²³⁹ Fischer et al., *supra* note 44.

cases, ostensibly to avoid discouraging travel to the island.²⁴⁰ The CDC issued a travel alert that remained in place even after the government of Puerto Rico declared the outbreak over.²⁴¹ Travel alerts, warnings, and other public information activities by the CDC can alleviate local government shortcomings. Zika is our most recent epidemic concern, but the nature of the disease means traditional tools of quarantine and isolation are not relevant or helpful.²⁴² Travel warnings are probably the preferred mechanism anyway, so long as data is reliable and the public trusts the information it receives.

Any intervention by the federal government over the objections of a state or territory can be highly politically charged. Environmental, scientific, and medical recommendations can be hijacked for political purposes at any level of government. Perhaps the most pressing problem is a crisis of trust in governmental institutions. The political conflict we saw over Ebola does not bode well for “the big one” that scientists widely expect to strike eventually—a fast-spreading, airborne virus such as SARS or swine flu.²⁴³

To restate the questions I am concerned with: What are the limits of the federal government’s interstate quarantine power? In what circumstances, if ever, might the federal government step in to lift a state’s protective quarantine that has no medical justification? When might it be helpful for the CDC to be the final authority on a national quarantine policy, especially when that might entail overriding a quarantine that a state governor has imposed?

While I have provided some examples, some reaching back in history and others more recent, my goal is to encourage further inquiry rather than to propose specific models—to illustrate fault lines in the limitation of interstate quarantine authority as it is currently understood. Neither the current statutory or regulatory authorities, nor how we have thought about it in the past, prevent us from envisioning a different future for national quarantine policy. While statutory and regulatory authorities already exist, more explicit authorization and guidelines could be helpful not only to encourage structured thinking about the issue, but also to encourage regional cooperation to cabin the need for federal intervention in the first place.

²⁴⁰ See Helen Branswell, *Feud Erupted Between CDC, Puerto Rico over Reporting of Zika Cases, Document Shows*, STAT (May 1, 2017), <https://www.statnews.com/2017/05/01/zika-virus-puerto-rico-cdc/>.

²⁴¹ Julie Steenhuisen, *Puerto Rico Declares Zika Outbreak Over, CDC Maintains Travel Warning*, REUTERS, June 5, 2017, <https://www.reuters.com/article/us-health-zika-puertorico/puerto-rico-declares-zika-outbreak-over-cdc-maintains-travel-warning-idUSKBN18W2SU>.

²⁴² See *supra* note 73 and accompanying text.

²⁴³ Sanjay Gupta, *The Big One Is Coming, and It’s Going to Be a Flu Pandemic*, CNN (Sept. 14, 2017, 12:00 PM), <http://www.cnn.com/2017/04/07/health/flu-pandemic-sanjay-gupta/index.html>.

In *Jacobson v. Massachusetts*, the U.S. Supreme Court stated that a “well-ordered society” must be able to enforce “reasonable regulations” in responding to “an epidemic of disease which threatens the safety of its members.”²⁴⁴ The primary responsibility, as it should be, is with states as the first line of defense. The Supreme Court has consistently recognized that “the power of the States to enact and enforce quarantine laws for the safety and the protection of the health of their inhabitants . . . is beyond question.”²⁴⁵

The strength of our response to a public health threat depends on the existence of high-quality institutions with substantial ability to coordinate. These need more insulation from political control. One improvement would be an expansion of the federal government’s quarantine authority within the United States, under the direction of the CDC. Even though the CDC and the U.S. Public Health Service are among the best health agencies in the world, federal law retains much of the same disease-prevention architecture it had more than a century ago. There are a number of ways this could change, but an important step would be to expand our understanding of interstate quarantine authority so that, when necessary, the federal government could referee state and local conflicts over quarantine. These conflicts can occur when uninformed or excessive panic drives political decisions in a manner detrimental to effective control of a national epidemic.

²⁴⁴ 197 U.S. 11, 27, 29 (1905).

²⁴⁵ *Compagnie Francaise De Navigation a Vapeur v. La. State Bd. of Health*, 186 U.S. 380, 387 (1902).