

THE CDC'S COMMUNICABLE DISEASE REGULATIONS: STRIKING THE BALANCE BETWEEN PUBLIC HEALTH & INDIVIDUAL RIGHTS[†]

*James J. Misrahi**

INTRODUCTION

On January 19, 2017, the U.S. Department of Health and Human Services (HHS) published a final rule to update regulations administered by the Centers for Disease Control and Prevention (CDC) relating to the control of communicable diseases at 42 C.F.R part 70 (interstate)¹ and part 71 (foreign).² Individuals, stakeholders, and other interested parties, reflecting a variety of viewpoints, submitted 15,800 public comments in response to the Notice of Proposed Rulemaking (NPRM) published on August 15, 2016.³ The final rule became effective on March 21, 2017.⁴ The final rule significantly enhances the CDC's previous regulations that were largely silent regarding procedures for federal isolation, quarantine, and conditional release, and thus lacked transparency regarding the rights and remedies of individuals subject to these actions. The newly revised communicable disease regulations are consistent with the CDC's governing statutory authority, principles of federalism, and constitutional protections afforded to individuals under the Fourth and Fifth Amendments to the U.S. Constitution. This Article provides an overview of the newly revised regulations and explains how these regulations are designed to protect the public's health while safeguarding the constitutional rights of individuals subject to federal public health actions.

[†] The findings and conclusions in this Article are those of the author and do not necessarily represent the views of the U.S. Department of Health and Human Services or the Centers for Disease Control and Prevention.

* Senior Attorney, HHS Office of the General Counsel, Public Health Division, CDC Branch.

¹ Interstate Quarantine, 42 C.F.R. pt. 70 (2004).

² Foreign Quarantine, 42 C.F.R. pt. 71 (2010).

³ Control of Communicable Diseases, 81 Fed. Reg. 54,230 (Aug. 15, 2016) (to be codified at 42 C.F.R. pts. 70, 71); *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 March 21, 2017).

⁴ See Control of Communicable Diseases; Delay of Effective Date, 82 Fed. Reg. 10,718 (Feb. 15, 2017) (to be codified at 42 C.F.R. pts. 70, 71) (announcing thirty-day delay in effective date).

I. A BRIEF HISTORY OF FEDERAL QUARANTINE

The federal government has a long history of acting to prevent the spread of communicable diseases. In 1796, Congress “enacted the first federal quarantine law in response to a yellow fever epidemic,” which gave the President the authority to direct federal officials to “assist states in enforcing their own quarantine laws.”⁵ In 1799, Congress repealed the 1796 Act and replaced it “with one establishing the first federal inspection system for maritime quarantines.”⁶ In 1878, Congress again amended the Quarantine Act to assign responsibilities to the Marine Hospital Service, which was established in 1798 to provide for the health needs of merchant seamen, and placed it under the authority of the U.S. Department of the Treasury.⁷ The 1878 Quarantine Act, however, was extremely limited and provided that federal quarantine regulations could not conflict with those of state or local authorities.⁸ In 1893, Congress expanded the role of the Marine Hospital Service by enacting “An act granting additional quarantine powers and imposing additional duties upon the marine Hospital Service.”⁹ While the 1893 Act did not preempt the role of the states, it nonetheless granted the Secretary of the Treasury the authority to issue additional rules and regulations to prevent the introduction of diseases, both foreign and interstate, when state and local ordinances were deemed insufficient.¹⁰ The Act also authorized direct federal enforcement of communicable disease regulations when state and municipal authorities refused to act.¹¹

The federal government’s current authority for quarantine and isolation is based on the Public Health Service Act (PHSA), which Congress enacted in 1944.¹² The legislative history indicates, among other things, that the Act was

⁵ See Wendy Parmet, *AIDS and Quarantine: The Revival of an Archaic Doctrine*, 14 HOFSTRA L. REV. 53, 57 (1985) (referring to Act of May 27, 1796, ch. 31, 1 Stat. 474 (repealed 1799)).

⁶ *Id.*

⁷ See David Satcher, *The History of the Public Health Service and the Surgeon General’s Priorities*, 54 FOOD & DRUG L.J. 13, 13–14 (1999).

⁸ *Id.* at 14.

⁹ See *Compagnie Francaise de Navigation a Vapeur v. La. State Bd. of Health*, 186 U.S. 380, 395–96 (1902).

¹⁰ *Id.* at 396–97 n.1.

¹¹ *Id.*

¹² H.R. REP. NO. 1364 (1944), as reprinted in 1944 U.S.C.C.A.N. 1211, 1234. The statute does not directly refer to isolation and quarantine, which are public health terms, but rather refers to “apprehension, detention, and conditional release” in regard to restricting the movement of persons for purposes of preventing the spread of communicable diseases. 42 U.S.C. § 264 (2012). *Isolation* refers to the separation of individuals known to be infected with a communicable disease in such a manner as to prevent the spread of infection, whereas *quarantine* refers to public-health restrictions placed on individuals who appear healthy, but

intended to grant to the Surgeon General¹³ the basic authority to make regulations to prevent the spread of communicable diseases into the United States and between the states, “unencumbered by the confusing limitations found in the [1893] act.”¹⁴ The 1944 Act continued the authority contained in the 1893 Act to “apprehend, detain, and examine persons entering the country from abroad,” but added the authority to allow such persons to be released on condition, “for example, on condition that they report to public-health authorities for subsequent examination.”¹⁵ The 1944 Act also explicitly conferred the authority, which Congress noted may have already existed under the 1893 Act, “to isolate infected persons for the purpose of interstate rather than foreign quarantine.”¹⁶ The legislative history indicates that such authority “would be similar to the familiar quarantine power of State and local health officers.”¹⁷ In regard to interstate quarantine, Congress indicated that the only communicable diseases that it believed merited isolation of infected persons at the time were “venereal diseases, experience having shown that many of those who chiefly spread such diseases move from place to place so rapidly as to make State and local law enforcement measures largely ineffectual.”¹⁸ However, in light of the potential impact of other communicable diseases and the impossibility of foreseeing what preventive measures may become necessary, Congress noted that the statute was drafted broadly enough to encompass any communicable disease designated by the President as quarantinable.¹⁹

While the authority for federal quarantine originally resided with the U.S. Department of the Treasury, this responsibility was transferred to the Federal Security Agency (an independent agency of the U.S. government) in 1939, and

nonetheless have been exposed to an infectious case. *See* AM. PUB. HEALTH ASS'N, CONTROL OF COMMUNICABLE DISEASES MANUAL 573 (James Chin ed., 17th ed. 2000).

¹³ The Office of the Surgeon General was abolished by Section 3 of the 1966 reorganization plan, and its statutory functions were assigned to the Secretary of HHS, which was then the Department of Health, Education, and Welfare (HEW). *See* Reorganization Plan No. 3 of 1966, 31 Fed. Reg. 8855 (June 25, 1966). In carrying out all responsibilities, the Surgeon General now reports to the Assistant Secretary for Health, who is the principal advisor to the HHS Secretary on public health and scientific issues. *See Office of the Assistant Secretary for Health Organizational Chart*, U.S. DEP'T OF HEALTH & HUMAN SERVS., <https://www.hhs.gov/ash/about-ash/organizational-chart/index.html> (last reviewed Nov. 21, 2017). “Accordingly, statutory references to the Surgeon General in § 361 of the Public Health Service Act should be understood as referring to the HHS Secretary.” 70 Fed. Reg. 71,893 n.1 (Nov. 30, 2005).

¹⁴ H.R. REP. NO. 1364 (1944), as reprinted in 1944 U.S.C.C.A.N. 1211, 1234.

¹⁵ *Id.* at 1234–35.

¹⁶ *Id.* at 1235.

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Id.*

subsequently to the Department of Health, Education, and Welfare (HEW) in 1953, later renamed HHS.²⁰ In 1967, responsibility for federal quarantine at ports of entry was transferred to the agency now known as the CDC.²¹ Before 2000, the Food and Drug Administration (FDA) administered interstate federal quarantine regulations.²² On August 16, 2000, the FDA transferred responsibility for interstate quarantine over persons to the CDC, while retaining its authority to control animals and other products that may transmit or spread communicable diseases interstate.²³ Currently, U.S. Quarantine Stations exist at twenty ports of entry and land-border crossings.²⁴ These stations are staffed with quarantine and medical public health officers from the CDC's Division of Global Migration and Quarantine (DGMQ), the organizational component within the CDC responsible for overseeing and implementing the CDC's quarantine regulations.²⁵

II. STATUTORY FRAMEWORK FOR FEDERAL QUARANTINE AUTHORITY

Section 361 of the PHSA authorizes the Surgeon General, with the approval of the HHS Secretary, to make and enforce regulations “to prevent the introduction, transmission, and spread of communicable diseases from foreign countries” into the United States or from one state or possession into another.²⁶ Section 361 is divided into five paragraphs, (a) through (e).²⁷

Paragraph (a) states that to execute the regulations, the Secretary may authorize measures based on his or her judgment, as may be necessary, including “inspection, fumigation, disinfection, sanitation, pest extermination, destruction of animals or articles found to be . . . sources of dangerous infection to human beings, and other measures.”²⁸ This paragraph provides the legal authority for the bulk of the CDC's activities aimed at preventing the spread of communicable disease, including required reporting by airline and

²⁰ See *Quarantine and Isolation: History of Quarantine*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/quarantine/historyquarantine.html> (last updated July 31, 2014).

²¹ *Id.*

²² See Control of Communicable Diseases, 21 C.F.R. pt. 1240 (2012); Interstate Quarantine, 42 C.F.R. pt. 70 (2007) (transferring certain authorities to the CDC).

²³ See *supra* note 22.

²⁴ See *Quarantine and Isolation: Quarantine Stations*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/quarantine/quarantinestations.html> (last updated Sept. 29, 2017).

²⁵ *Id.*

²⁶ 42 U.S.C. § 264(a) (2012).

²⁷ *Id.*

²⁸ *Id.*

vessel operators of ill persons found on board;²⁹ public health measures in regard to infected or contaminated conveyances and animals or articles found on board such conveyances;³⁰ and oversight of certain animal importations, such as nonhuman primates.³¹

Paragraph (b) authorizes the “apprehension, detention, or conditional release of individuals . . . for the purpose of preventing the introduction, transmission, or spread of such communicable diseases as may be specified . . . in Executive orders of the President upon the recommendation of the Secretary, in consultation with the Surgeon General.”³² The communicable diseases currently specified through an Executive Order include cholera, diphtheria, infectious tuberculosis (TB), plague, smallpox, yellow fever, viral hemorrhagic fevers (such as Marburg, Ebola, Lassa fever, and Crimean-Congo),³³ severe acute respiratory syndromes,³⁴ and influenza caused by novel or re-emergent influenza viruses that are causing or have the potential to cause a pandemic.³⁵

Paragraph (c) states that except as provided in paragraph (d), regulations regarding apprehension, detention, examination, or conditional release shall only be applicable to individuals coming into a state or possession from a foreign country or possession.³⁶ Thus, paragraph (c) provides the basis for the isolation, quarantine, or conditional release of foreign arrivals, while paragraph (d) provides the basis for these activities in regard to interstate travelers.

Paragraph (d) imposes two main requirements on the isolation, quarantine, or conditional release of interstate travelers: (1) the qualifying-stage requirement and (2) the requirement for an effect on interstate movement.³⁷ Both requirements must be satisfied. Paragraph (d) states that regulations “may provide for the apprehension and examination of any individual reasonably

²⁹ Control of Communicable Diseases, 42 C.F.R. §§ 71.4, 71.5, 71.20.

³⁰ *Id.* § 71.32(b).

³¹ *Id.* § 71.53.

³² 42 U.S.C. § 264(b) (2012).

³³ Exec. Order 13,295, 3 C.F.R. § 220 (2003).

³⁴ Severe acute respiratory syndromes are defined as “diseases that are associated with fever and signs and symptoms of pneumonia or other respiratory illness, are capable of being transmitted from person to person, and that either are causing, or have the potential to cause, a pandemic, or, upon infection, are highly likely to cause mortality or serious morbidity if not properly controlled. This [definition] does not apply to influenza.” Exec. Order 13,674, 3 C.F.R. § 291 (2014).

³⁵ See Exec. Order 13,295, *amended by* Exec. Order 13,375, 3 C.F.R. § 162 (2005), *and* Exec. Order 13,674.

³⁶ 42 U.S.C. § 264(c).

³⁷ *Id.* § 264(d)(1)–(2).

believed to be infected with a communicable disease in a qualifying stage.”³⁸ As defined by this paragraph, a “qualifying stage” means that the communicable disease is in “a precommunicable stage, if the disease would be likely to cause a public health emergency if transmitted to other individuals” or “a communicable stage.”³⁹ This paragraph also states “that if upon examination any such individual is found to be infected, he [or she] may be detained for such time and in such manner as may be reasonably necessary.”⁴⁰ Additionally, it requires that the individual: (A) “be moving or about to move from a State to another State”; or (B) “be a probable source of infection to individuals who, while infected with such a disease in a qualifying stage, will be moving from a State to another State.”⁴¹

Lastly, paragraph (e) states that nothing in § 361 nor in regulations promulgated under this authority, “may be construed as superseding any provision under State law (including regulations and . . . provisions established by political subdivisions of States), except to the extent that such a provision conflicts with an exercise of Federal authority.”⁴² Accordingly, by its plain language, § 361 does not preempt state or local public health laws or regulations, except in the event of a conflict with federal public health authority.

III. FEDERAL QUARANTINE AUTHORITY RARELY INVOKED

Federal quarantine authority over persons has historically rarely been invoked and, when it has been, only in regard to individual cases of exposed or infected travelers.⁴³ In fact, there is only one published district court case, *United States ex. rel. Siegel v. Shinnick*, that directly relates to the federal government’s placement of an individual into quarantine.⁴⁴ *Siegel* was a habeas

³⁸ *Id.* § 264(d)(1).

³⁹ *Id.* § 264(d)(2).

⁴⁰ *Id.* § 264(d)(1).

⁴¹ *Id.*

⁴² *Id.* § 264(e).

⁴³ While the federal government has never ordered a large-scale quarantine, it has recommended restrictions on public activities as a means of preventing communicable disease spread. On October 5, 1918, Surgeon General Rupert Blue issued an order to state and local health departments to close or suspend all places of public activity. See Gary Gernhart, *A Forgotten Enemy: PHS’s Fight Against the 1918 Influenza Pandemic*, 114 PUB. HEALTH REPS. 559, 560 (1999). State and local health departments, following the Surgeon General’s directive, ordered the closure of schools, churches, saloons, theaters, and other places of public assembly. *Id.* The 1918 Influenza pandemic resulted in the loss of over half a million Americans lives and more than twenty-one million deaths worldwide, exceeding the combined military and civilian deaths from World War I. *Id.*

⁴⁴ 219 F. Supp. 789, 790 (E.D.N.Y. 1963).

corpus proceeding brought on behalf of Ellen Siegel, an arriving passenger whom the U.S. Public Health Service quarantined in a hospital for fourteen days.⁴⁵ Federal public health officials ordered her quarantined because she had been in Stockholm, Sweden, a city that the World Health Organization (WHO) had declared to be a smallpox-infected local area, and could not show proof of vaccination against smallpox.⁴⁶ The court upheld the quarantine, finding that federal public health officials had acted in good faith because an opportunity for exposure had existed while Siegel was in Stockholm.⁴⁷ The court further noted that there was no way of knowing for fourteen days whether Siegel was actually infected with smallpox, and that she was especially susceptible to infection because she had a past history of being unsuccessfully vaccinated against the disease.⁴⁸

More recently, on May 25, 2007, the CDC served a federal isolation order on a returning U.S. citizen who had traveled internationally with suspected extensively drug-resistant tuberculosis, which was later confirmed to be multi-drug resistant.⁴⁹ This was the first federal order issued under the CDC's quarantine authority since *Siegel* in 1963.⁵⁰ While the CDC's regulations in 2007 were silent regarding the rights of individuals subject to federal isolation and quarantine, the CDC nonetheless followed procedures designed to comply with due process. These procedures included the issuance of an initial federal isolation order that was effective for seventy-two hours, followed by an internal reassessment of that order, and subsequent issuances of additional orders authorizing the continued isolation of the individual until rendered non-infectious.⁵¹ As part of the issuance of these additional federal orders, the CDC also offered the isolated individual an opportunity for an administrative hearing to contest his isolation, but the individual did not request such a hearing.⁵² In total, this individual was under federal isolation for approximately nine days from May 25 to June 2, 2007.⁵³ On June 2, the CDC rescinded its

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ *Id.* at 791.

⁴⁸ *Id.*

⁴⁹ See Kevin Sack, *A TB Patient Turns to His Inner Lawyer*, N.Y. TIMES (June 8, 2007), <http://www.nytimes.com/2007/06/08/us/08speaker.html?mcubz=0>.

⁵⁰ *Speaker v. U.S. Dep't of Health & Human Servs.*, 623 F.3d 1371, 1375 (11th Cir. 2010).

⁵¹ Internal documents and records on file with the CDC.

⁵² *Id.*

⁵³ KATHLEEN S. SWENDIMAN & NANCY LEE JONES, CONG. RESEARCH SERV., RL34144, EXTENSIVELY DRUG-RESISTANT TUBERCULOSIS (XDR-TB): EMERGING PUBLIC HEALTH THREATS AND QUARANTINE AND ISOLATION 3 (2010).

federal isolation order in light of the issuance of a concurrent isolation order by local public health authorities.⁵⁴

Since 2007, the CDC has, on average, issued one isolation order per year, mostly for travelers who are known or suspected of being infected with drug-resistant tuberculosis.⁵⁵ In these cases, the CDC has used its federal authority to transport the infected traveler to a local hospital, take steps to confirm the diagnosis, and offer voluntary medical treatment. Typically, the CDC has rescinded its federal isolation after the first seventy-two hours of detention once a local public health authority has agreed to accept custody of the patient. The CDC has also used its federal authority to facilitate the movement of infected patients into the United States or across state lines as part of a transfer between hospitals or for purposes of allowing such individuals to seek medical treatment in the United States. None of these orders has been the subject of a legal challenge.

More frequently, the CDC has used its relationship with the Department of Homeland Security (DHS) to request that the commercial air travel of individuals who may pose a communicable disease risk to the traveling public be limited.⁵⁶ Since June 2007, domestic and international public health officials have been able to request that individuals who meet certain criteria be placed on a national Public Health Do Not Board list (PHDNB).⁵⁷ The list is administered by the Transportation Security Administration (TSA) under the authority of the Aviation and Transportation Security Act,⁵⁸ which authorizes

⁵⁴ *Id.* The patient in this case also attempted unsuccessfully to pursue a claim for damages against the CDC alleging a violation of the Privacy Act. *See* *Speaker v. U.S. Dep't of Health & Human Servs.*, 489 F. App'x 425 (11th Cir. 2012) (holding that there was no basis for reversing the district court's grant of summary judgment to the defendants).

⁵⁵ *See* Control of Communicable Diseases, 82 Fed. Reg. 6890, 6963 (Jan. 19, 2017) (to be codified at 42 C.F.R. pts. 70, 71) (stating that between January 1, 2005 and May 10, 2016, HHS/CDC issued twelve isolation orders, which would correspond to an average of about one order per year).

⁵⁶ *See Federal Air Travel Restrictions for Public Health Purposes—United States, June 2007–May 2008*, 57 MORBIDITY & MORTALITY WKLY REP. 1009, 1012, (2008).

⁵⁷ To place an individual on the PHDNB, the following criteria are considered: “(1) the individual is known or reasonably believed to be infectious or reasonably believed to have been exposed to a communicable disease and may become infectious with a communicable disease that would be a public health threat should the individual be permitted to board a commercial aircraft or travel in a manner that would expose the public and; (2) the individual is not aware of his or her diagnosis, has been advised regarding the diagnosis and is non-compliant with public health requests or has shown potential for non-compliance, or is unable to be located; or (3) the individual is at risk of traveling on a commercial flight or of traveling internationally by any means; or (4) the individual's placement on the [PH]DNB is necessary to effectively respond to outbreaks of communicable disease or other conditions of public health concern.” *Criteria for Requesting Federal Travel Restrictions for Public Health Purposes, Including for Viral Hemorrhagic Fevers*, 80 Fed. Reg. 16,400, 16,400–01 (Mar. 27, 2015).

⁵⁸ 49 U.S.C. § 114(f), (h)(4) (2012).

TSA to take actions and cooperate with other federal agencies in preventing threats to air travelers.⁵⁹ During the notification process, the CDC “asks the appropriate state or local health department to notify the individual directly, state the reasons for the placement on the [PH]DNC list,” and inform the individual of the medical or public health requirements to be removed from the list.⁶⁰ Individuals who have had their travel temporarily restricted as a result of placement on the PHDNC list are also granted the opportunity to submit a written appeal to the DGMQ Director if they believe that the CDC has erred in its public health request to DHS.⁶¹

During the 2014–2016 outbreak of Ebola, the CDC also established a program of active screening at U.S. airports and issued interim guidance to state and local public health partners for the monitoring and movement of travelers arriving from affected West African countries.⁶² This screening program included temperature checks of arriving travelers, visual inspection for symptoms, and assessment of a traveler’s history of risk exposure for Ebola.⁶³ The CDC’s guidance recommended, among other things, that state and local public health partners immediately transfer symptomatic travelers to a designated hospital, while asymptomatic travelers, based upon their risk exposure, could be actively monitored or placed into quarantine.⁶⁴

While the CDC’s guidance was not the subject of a legal challenge, Kaci Hickox, a nurse who had cared for Ebola patients while in Sierra Leone, brought a civil rights action under 42 U.S.C. § 1983 against New Jersey state officials. She alleged that her quarantine upon returning into the United States violated her Fourth and Fifth Amendment rights under the U.S. Constitution and constituted false imprisonment and false light under New Jersey common law torts.⁶⁵ The district court ultimately dismissed the federal constitutional claims against the defendants on qualified-immunity grounds, but allowed the plaintiff to proceed with her state law tort claims for false imprisonment and false light.⁶⁶ On July 27, 2017, the parties announced a non-monetary

⁵⁹ See Criteria for Requesting Federal Travel Restrictions for Public Health Purposes, Including for Viral Hemorrhagic Fevers, 80 Fed. Reg. at 16,401.

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² See *Hickox v. Christie*, 205 F. Supp. 3d 579, 585 (D.N.J. 2016) (describing the CDC’s advice to the New Jersey Department of Health).

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ *Id.* at 584.

⁶⁶ *Id.* at 603, 605–06 (recognizing that under New Jersey law, plaintiffs can sue for false light when information about them that is false and highly offensive is knowingly or recklessly made public).

settlement that, among other things, established a new “Bill of Rights” for individuals subject to possible quarantine or isolation in New Jersey.⁶⁷ Specifically, the settlement recognized the right of quarantined individuals to retain and consult with legal counsel, challenge their quarantine, have a hearing at which evidence can be presented and witnesses cross-examined, send and receive communications, and have visitors if visitation can be accomplished in a reasonable and medically safe manner.⁶⁸

IV. A GUIDE TO THE CDC’S NEWLY REVISED COMMUNICABLE DISEASE REGULATIONS

On January 19, 2017, HHS issued final regulations to update the CDC’s authorities at 42 C.F.R parts 70 (interstate) and 71 (foreign).⁶⁹ As previously discussed, these regulations are promulgated primarily under the authority of 42 U.S.C. § 264, which authorizes the HHS Secretary to make and enforce regulations to prevent the introduction, transmission, and spread of communicable diseases from foreign countries and from one state or possession into another.⁷⁰ These revised regulations contain a number of clarifications and authorities to assist the CDC in responding to public health emergencies, as well as preventing the spread of communicable disease more generally. Most notable among these revised regulations are provisions designed to better facilitate the identification of ill persons onboard conveyances and at ports of entry, to allow the CDC to issue travel permits for the controlled movement of potentially infected persons across state lines, and various other provisions designed to accord individuals under federal isolation, quarantine, or conditional release, with necessary due process.⁷¹

Sections 70.1 and 71.1 contain key definitions used throughout the regulations. Both sections share certain definitions, including *airline*, *apprehension*, *conditional release*, *contaminated environment*, *electronic- or internet-based monitoring*, *medical examination*, *non-invasive*, and *public health prevention measures*.⁷² These sections also contain definitions that are

⁶⁷ See *Victory: Detained Nurse’s Ebola Suit Secures Due Process*, 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>.

⁶⁸ *Id.* As discussed, *infra*, many of these rights appear to align with the protections afforded to individuals subject to federal isolation and quarantine under the CDC’s newly revised communicable disease regulations.

⁶⁹ Control of Communicable Diseases, 82 Fed. Reg. 6890 (Jan. 19, 2017) (to be codified at 42 C.F.R. pts. 70 and 71).

⁷⁰ *Id.* at 6892.

⁷¹ *Id.* at 6968–78.

⁷² *Id.* at 6969–70, 6974–75.

applicable to how the CDC accords due process to individuals, including how the CDC defines *indigent status*, *medical reviewer*, and *appointed representatives*.⁷³

Because 42 U.S.C. § 264 sets forth a different standard for the apprehension, detention, or conditional release of individuals moving interstate than it does for individuals arriving into the United States from a foreign country, section 70.1 contains additional definitions not found in section 71.1.⁷⁴ These definitions include *precommunicable stage*; *public health emergency*; *qualifying stage*; and *reasonably believed to be infected, as applied to an individual*.⁷⁵ The definition of *public health emergency*, for instance, is particularly relevant because under 42 U.S.C. § 264(d)(2)(B), the CDC is only authorized to apprehend and examine an individual who is in the precommunicable stage of a quarantinable communicable disease, if the “disease would be likely to cause a public health emergency if transmitted to other individuals.”⁷⁶ While not expanding the list of quarantinable communicable diseases, the definition allows the CDC to rely on a variety of factors in assessing whether a disease would likely cause a public health emergency, including assessments of public health events made by the CDC Director with potential for high mortality or serious morbidity, declarations of public health emergencies made by the HHS Secretary, and notifications or determinations of public health emergencies of international concern made by WHO in accordance with the International Health Regulations (IHR).⁷⁷

A new section at 70.11 requires an airline pilot who is in command of a commercial passenger flight in interstate traffic to report to the CDC “the occurrence onboard of any deaths or the presence of ill persons among passengers or crew.”⁷⁸ The CDC may also direct the pilot to take measures to “prevent the potential spread of communicable disease, provided that such measures do not affect the airworthiness of the aircraft or the safety of flight operations.”⁷⁹ This new section complements an existing reporting requirement at section 71.21, requiring that the commander of an aircraft or master of ship arriving into the United States report the occurrence of deaths or ill persons on

⁷³ *Id.*

⁷⁴ *Id.* at 6969–70.

⁷⁵ *Id.* While the definition of what constitutes a reasonable belief only appears in the definitions section under 70.1, the CDC would apply the same standard to foreign arrivals under part 71.

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ *Id.* at 6971.

⁷⁹ *Id.*

board prior to arrival.⁸⁰ In sections 70.11 (applicable to airline operators) and 71.1 (applicable to airline and vessel operators), *ill persons* is defined in terms of the symptoms that may appear in travelers with communicable diseases of public health concern (e.g., persistent fever or high fever accompanied by skin rash).⁸¹ While not expanding the list of quarantinable communicable diseases, this new provision allows the CDC to more easily identify sick travelers who may warrant additional public health investigation and follow-up. This section also relieves airline operators of a pre-existing regulatory burden under section 70.4 that requires reporting to the local health authority as soon as a case or suspected case of a communicable disease occurs on board.⁸²

A new section at 70.10 authorizes the CDC to conduct non-invasive public health prevention measures (e.g., temperature assessments using a no-contact thermometer) to detect the presence of communicable diseases at U.S. airports and other locations where individuals may gather to engage in interstate travel.⁸³ This section complements a similar provision at 71.20 to conduct public health prevention measures regarding foreign travelers arriving at U.S. ports of entry.⁸⁴ These sections also authorize the CDC to collect certain information relating to the traveler's health status, known or possible exposure to communicable disease, and travel history.⁸⁵ Public health prevention measures were used successfully during the 2014–2016 Ebola epidemic when the CDC established an entry risk-assessment program for individuals arriving from affected countries.⁸⁶ The same program may be used in the future in response to a public health emergency with a similar communicable disease risk profile. Again, while not expanding the CDC's authority to isolate or quarantine travelers, these new provisions allow the CDC to more easily identify sick travelers during a public health emergency who may warrant further public health investigation and follow-up.

A new section at 70.5 prohibits individuals who are under a federal order of isolation, quarantine, or conditional release from traveling interstate without

⁸⁰ 42 C.F.R. § 71.21 (2016).

⁸¹ Control of Communicable Diseases, 82 Fed. Reg. at 6969, 6974.

⁸² 42 C.F.R. § 70.4 (2016). Airline operators now have the option of reporting to either the local public health department of jurisdiction or to the CDC, which will then assume responsibility for informing the local health department. Control of Communicable Diseases, 82 Fed. Reg. at 6927.

⁸³ Control of Communicable Diseases, 82 Fed. Reg. at 6971.

⁸⁴ *Id.* at 6975.

⁸⁵ *Id.* at 6971, 6975.

⁸⁶ See Clive M. Brown et al., *Airport Exit and Entry Screening for Ebola – August–November 10, 2014*, 63 MORBIDITY & MORTALITY WKLY REP. 1163, 1163–67 (2014) (describing outcomes of combined exit and entry screening processes).

a travel permit issued by the CDC, or in violation of the terms of a conditional release order.⁸⁷ Similarly, the requirements of this section may be applied to individuals under a state or local public health order if the public health authority of jurisdiction requests federal assistance, or in the event that the CDC Director makes a finding of inadequate local control.⁸⁸ This section further prohibits conveyance operators from knowingly transporting individuals in violation of the terms of a travel permit or conditional release order.⁸⁹ Individuals who have had their request for a travel permit denied or have had their travel permit revoked may administratively appeal those decisions to the CDC Director.⁹⁰ This section replaces a previously existing provision that applied to individuals in the communicable period of cholera, plague, smallpox, typhus, or yellow fever.⁹¹ One of the lessons learned from the 2014–2016 Ebola epidemic was the need for a federal mechanism, in coordination with state and local public health authorities, to allow for the controlled movement of individuals in need of further public health monitoring, particularly regarding healthcare workers desiring to return to their home states of residence from Ebola-affected countries.⁹² Accordingly, this section may be used in the future to respond to a public health emergency with a similar communicable disease risk profile that necessitates the safe monitoring and movement of travelers returning from affected areas.

As previously stated, parts 70 and 71 both contain numerous provisions designed to accord due process to individuals under federal orders of isolation, quarantine, or conditional release.⁹³ These due process protections are accorded to individuals regardless of their national origin or citizenship status.⁹⁴ A revised provision at section 70.6 provides the regulatory authority for the CDC to apprehend, medically examine, quarantine, isolate, or conditionally release individuals if the Director reasonably believes that such individuals are infected with a quarantinable communicable disease in its qualifying stage and such individuals are moving or about to move between

⁸⁷ Control of Communicable Diseases, 82 Fed. Reg. at 6970–71.

⁸⁸ *Id.*

⁸⁹ *Id.* at 6970.

⁹⁰ *Id.*

⁹¹ *Id.*; 42 C.F.R. § 70.5 (2016).

⁹² See Alex Park, *Court Rules Maine Can't Quarantine Ebola Nurse*, MOTHER JONES (Oct. 31, 2014, 6:13 PM), <http://www.motherjones.com/politics/2014/10/maine-ebola-kaci-hickox-paul-lepage>.

⁹³ See Control of Communicable Diseases, 82 Fed. Reg. at 6969–70, 6974–75.

⁹⁴ See *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) (stating that the regulations apply to all persons regardless of citizenship or nationality).

states, or if such individuals constitute a probable source of infection to other individuals who may then move between states.⁹⁵ *Reasonably believed to be infected, as applied to an individual* is defined under section 70.1 as the existence of specific, articulable facts that would lead a public health officer to conclude that such an individual has been exposed to the infectious agent that causes a quarantinable communicable disease and, as a consequence of the exposure, is or may be harboring in the body the infectious agent of that quarantinable communicable disease.⁹⁶ A previously existing provision at 42 C.F.R. § 71.32(a) provides the CDC with similar authority to isolate, quarantine, or conditionally release individuals arriving into the United States whenever the Director has reason to believe that such individuals are infected with or have been exposed to a quarantinable communicable disease.⁹⁷ Individuals who are conditionally released may be required to submit to temporary public health supervision, including supervision through electronic- or internet-based means.⁹⁸ During the period of apprehension or while individuals are held in quarantine or isolation, the CDC must also arrange for “adequate food and water, appropriate accommodation, appropriate medical treatment, and means of necessary communication.”⁹⁹

A new provision at section 70.12 authorizes the CDC to require “an individual to undergo a medical examination as part of a Federal order for quarantine, isolation, or conditional release.”¹⁰⁰ While the authority to medically examine an individual was previously implicit in the CDC’s interstate authority to determine whom to place into quarantine or isolation, this new provision sets forth explicit obligations in regard to such examinations. Specifically, the CDC must now advise an individual that such an examination will be conducted by an authorized, licensed health worker, and only with the patient’s prior informed consent.¹⁰¹ In practice, CDC staff members do not perform medical examinations, but rather defer to hospital clinicians who conduct such tasks based on infection-control guidance and other input from the CDC. Sections 70.13 and 71.30 provide authorization for

⁹⁵ Control of Communicable Diseases, 82 Fed. Reg. at 6971.

⁹⁶ *Id.* at 6970.

⁹⁷ 42 C.F.R. § 71.32(a) (2016).

⁹⁸ *Electronic- or internet-based monitoring* is defined to include communication through e-mail, SMS texts, video or audio conference, webcam technologies, integrated voice response systems, entry of information into web based forums, wearable tracking technologies, or other mechanisms or technologies as determined by the CDC Director or the supervising health authority. Control of Communicable Diseases, 82 Fed. Reg. at 6969, 6974.

⁹⁹ *Id.* at 6971, 6976.

¹⁰⁰ *Id.* at 6971.

¹⁰¹ *Id.*

the CDC to pay hospitals and other facilities for the medical care and treatment of individuals in federal quarantine and isolation.¹⁰² Section 70.12 further states, “Individuals reasonably believed to be infected based on the results of a medical examination may be isolated, or if such results are inconclusive or unavailable, individuals may be quarantined or conditionally released”¹⁰³ A new provision at section 71.36 imposes similar obligations when a medical examination is ordered for individuals arriving into the United States.¹⁰⁴

New sections 70.14 and 71.37 describe the requirements relating to the issuance of a written federal order for quarantine, isolation, or conditional release, including the specific language and description of the processes and rights that must be included in such orders.¹⁰⁵ This includes an explanation that an automatic reassessment of the order will occur no later than seventy-two hours after it has been served and that, if further detention is warranted, the individual will be afforded an opportunity to request an administrative medical review of his or her isolation, quarantine, or conditional release.¹⁰⁶ Federal orders for isolation, quarantine, or conditional release must be served no later than seventy-two hours after the individual is apprehended.¹⁰⁷ These sections also provide that they do not interfere with the rights of individuals to obtain judicial review of their federal detention as may occur,¹⁰⁸ for instance, through a petition for a writ of habeas corpus under 28 U.S.C. § 2241. In practice, the CDC accompanies its federal orders for isolation, quarantine, or conditional release with a medical declaration signed by a quarantine medical officer under penalty of perjury under 28 U.S.C. § 1746. These medical declarations set forth the factual and scientific basis for the federal government’s actions, as well as the quarantine medical officer’s professional opinion that based on the available evidence, federal isolation, quarantine, or conditional release, is appropriate and necessary to protect the public’s health.

New sections 70.15 and 71.38 require that the CDC conduct an automatic, mandatory reassessment of the federal order for quarantine, isolation, or conditional release no later than seventy-two hours after serving the federal order.¹⁰⁹ Such a reassessment must be conducted by a different CDC official

¹⁰² *Id.* at 6971, 6976.

¹⁰³ *Id.*

¹⁰⁴ *Id.* at 6976.

¹⁰⁵ *Id.* at 6972, 6976–77.

¹⁰⁶ *Id.* at 6972, 6976.

¹⁰⁷ *Id.*

¹⁰⁸ *Id.* at 6972, 6977.

¹⁰⁹ *Id.*

from the one who issued the initial order,¹¹⁰ and typically will be conducted by a more senior-level management official within DGMQ. While these reassessments previously occurred as matters of standard operating procedures, they must now be conducted as a regulatory requirement. The reassessment includes a review of any records relied upon in issuing the federal order, and must also include a determination of whether less restrictive means are available to protect the public's health.¹¹¹ This determination includes assessing the individual's ability and willingness to comply with public health recommendations on a voluntary basis, as well as other factors such as the appropriateness of home confinement if the individual is confined to a facility.¹¹² In the event that the CDC determines that the public's health requires that the isolation, quarantine, or conditional release continue, the CDC will serve a second federal order on the individual that explains the process for requesting an administrative medical review.¹¹³ Typically, a medical review may be requested by calling the CDC's Emergency Operations Center and speaking to an official in DGMQ's Quarantine and Border Health Services Branch.

New sections 70.16 and 71.39 provide for a medical review of a federal order for quarantine, isolation, or conditional release, upon the request of the individual subject to the order.¹¹⁴ A medical review may be requested after the CDC has had an opportunity to reassess the federal order under sections 70.15 or 71.38.¹¹⁵ The purpose of the medical review is to determine whether the CDC "has a reasonable belief that the individual is infected with a quarantinable communicable disease"; the purpose is not to determine the constitutionality or legality of statutes or regulations.¹¹⁶ The CDC-appointed medical reviewer must be a physician, nurse practitioner, or similar medical professional qualified in the diagnosis and treatment of infectious diseases.¹¹⁷ In the past, the medical reviewer has been appointed from within the CDC, but the regulations do not preclude appointing the individual from outside the agency or outside of the federal government.¹¹⁸ The regulations do, however,

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² Control of Communicable Diseases, 81 Fed. Reg. 54,320, 54,247 (Aug. 15, 2016) (to be codified at 42 CFR pts. 70, 71).

¹¹³ Control of Communicable Diseases, 82 Fed. Reg. at 6972, 6977.

¹¹⁴ *Id.* at 6972–73, 6977–78.

¹¹⁵ *Id.* at 6972, 6977.

¹¹⁶ Control of Communicable Diseases, 81 Fed. Reg. at 54,247.

¹¹⁷ Control of Communicable Diseases, 82 Fed. Reg. at 6969, 6972, 6977.

¹¹⁸ *Id.* at 6915 ("We note further that the definition of both 'representatives' and 'medical reviewer' would in fact allow for the appointment of non-HHS/CDC employees in these capacities because both terms

require that the medical reviewer at a minimum not be the same individual who issued the federal order for quarantine, isolation, or conditional release.¹¹⁹

The individual may choose to be represented at the medical review by an advocate—such as an attorney, family member, or physician—at his or her own expense (except when the individual qualifies as an indigent as described below), submit medical or other evidence, and present witnesses.¹²⁰ Prior to the medical review, the CDC must also give the individual a reasonable opportunity to examine the available evidence used to justify the isolation, quarantine, or conditional release.¹²¹ The CDC may conduct the medical review by telephone, audio or video conference, or through other methods designed to allow the individual an opportunity to participate in the medical review.¹²² As a matter of agency practice, a court reporter will transcribe the medical review, and all witnesses will be sworn. Furthermore, while the CDC lacks the legal authority to compel witness testimony through compulsory processes such as a subpoena, it will use reasonable efforts to make any witnesses available as necessary to conduct a full and fair hearing.¹²³

In the event that the individual qualifies as an indigent,¹²⁴ the CDC must appoint representatives at the government's expense to act on behalf of the individual.¹²⁵ *Representatives* are defined as a “physician, nurse practitioner, or similar medical professional qualified in the diagnosis and treatment of infectious diseases, and an attorney who is knowledgeable of public health practices.”¹²⁶ The final rule indicates that an attorney may become “knowledgeable of public health practices” in several ways, including prior advocacy, continuing legal education programs, law school courses, or independent study.¹²⁷ While the regulations permit the CDC to appoint representatives from within the department or agency, the rule suggests that for

are broadly defined in terms of the professional qualifications and not employment status of these individuals.”).

¹¹⁹ *Id.* at 6972, 6977.

¹²⁰ *Id.*

¹²¹ *Id.* at 6972–73, 6977.

¹²² *Id.* at 6973, 6977.

¹²³ *Id.* at 6915.

¹²⁴ *Indigent* status is defined as annual family income falling below 200% of the current poverty guidelines published in the Federal Register under the authority of 42 U.S.C. § 9902(2) “or, if no income is earned, liquid assets totaling less than 15% of the applicable poverty guidelines.” Control of Communicable Diseases, 82 Fed. Reg. at 6969, 6974. The final rule, however, states that the CDC does not intend to require access to financial records, but rather may rely on individuals to self-report their indigent status. *Id.* at 6915.

¹²⁵ *Id.* at 6972–73, 6977–78.

¹²⁶ *Id.* at 6970, 6974.

¹²⁷ *Id.* at 6890, 6914.

indigent individuals, the agency generally plans to appoint legal counsel from outside the CDC, such as through memorandums of understanding with law school legal clinics, bar associations, and advocacy groups.¹²⁸

Upon conclusion of the medical review, the reviewer will issue a written report to the Director detailing his or her findings of fact and recommendations, including a determination as to whether less restrictive means are available to protect the public's health.¹²⁹ The written report must also be served on the individual and on any representatives.¹³⁰ Based on the Director's review of the report, he or she will issue a written order continuing, modifying, or rescinding the federal quarantine, isolation, or conditional release.¹³¹ Once issued, this order will serve as final agency action.¹³² Under the Administrative Procedure Act, final agency action for which there is no other adequate remedy in a court of law is generally subject to judicial review.¹³³ Even though the Director's order constitutes final agency action, the regulations still permit the individual to request that the isolation, quarantine, or conditional release be rescinded, but based only upon the existence of "significant, new or changed facts or medical evidence that raise[s] a genuine issue as to whether the individual should continue to be subject to Federal quarantine."¹³⁴

V. CONSISTENCY WITH FEDERALISM AND U.S. CONSTITUTIONAL STANDARDS

The CDC's newly revised regulations are in accordance with principles of federalism. Under the current federal statute relating to the control of communicable diseases, federal regulations cannot preempt state or local public health regulations, except in the event of a conflict with federal authority.¹³⁵ Similarly, the newly revised regulations do not alter the relationship between the federal and state or local governments as embodied in the statute.¹³⁶ However, under the authority found in 42 U.S.C. § 264(a) to

¹²⁸ *Id.* at 6914.

¹²⁹ *Id.* at 6972–73, 6977–78.

¹³⁰ *Id.*

¹³¹ *Id.*

¹³² *Id.* at 6973, 6978.

¹³³ 5 U.S.C. § 704 (2012); *see* Control of Communicable Diseases, 82 Fed. Reg. at 6916. In the final rule, the CDC notes that it takes no position as to whether judicial review of a federal order for isolation, quarantine, or conditional release should occur through a petition for a writ of habeas corpus, or under the Administrative Procedures Act. Control of Communicable Diseases, 82 Fed. Reg. at 6916.

¹³⁴ *Id.* at 6972–73, 6977–78.

¹³⁵ 42 U.S.C. § 264(e) (2012).

¹³⁶ Control of Communicable Diseases, 82 Fed. Reg. at 6925, 6968.

prevent the interstate spread of communicable disease, the CDC may regulate activities that occur entirely within a state or locality if those activities present a risk of interstate disease spread.¹³⁷ For instance, a long-standing provision at 42 C.F.R. § 70.2 authorizes the CDC to take public health measures based on a finding of inadequate local control.¹³⁸ The newly revised regulations also contain new provisions that are designed to assist in preventing interstate spread of communicable disease, particularly in the event of a public health emergency. For instance, under new section 70.5, the travel permit requirement may be applied to “individuals traveling entirely intrastate and to conveyances that transport such individuals upon the request of a State or local health authority of jurisdiction” or in the event of “inadequate local control.”¹³⁹ Under new section 70.10, the CDC may also implement public health prevention measures at locations where individuals may gather to engage in interstate travel, even if such locations are traditionally only associated with intrastate activities.¹⁴⁰ While it is expected that these authorities will be rarely invoked, they are nonetheless consistent with how courts have interpreted the scope of the federal government’s authority under the Commerce Clause.¹⁴¹

The CDC’s newly revised communicable disease control regulations are also in accordance with the Fourth and Fifth Amendments.¹⁴² The Fourth

¹³⁷ 42 U.S.C. § 264(a) (2012).

¹³⁸ Interstate Quarantine, 42 C.F.R. § 70.2 (2011).

¹³⁹ Control of Communicable Diseases, 82 Fed. Reg. at 6970–71.

¹⁴⁰ *Id.* at 6971. For instance, informal bus companies have been known to operate out of storefronts in New York City and in other cities. See Alex Lockie, *I Took an 18-Hour Bus Ride from New York City to Atlanta for \$40, and I Liked It Better than Flying*, BUS. INSIDER (Dec. 24, 2015, 10:49 AM), <http://www.businessinsider.com/what-its-like-to-take-the-chinatown-bus-from-new-york-to-atlanta-2015-12>.

¹⁴¹ See *United States v. Lopez*, 514 U.S. 549, 558–59 (1995) (noting that the Commerce Clause authorizes the regulation of “the instrumentalities of interstate commerce, or persons or things in interstate commerce, even though the threat [to interstate commerce] may come only from intrastate activities”).

¹⁴² It can be argued that the CDC’s communicable disease regulations also implicate other constitutionally protected rights such as the right to travel, right to freedom of movement, and right to free association, but these arguments do not merit extended discussion in the context of public health. The U.S. Supreme Court has recognized a “freedom of association” in only two distinct areas: (1) “choices to enter into and maintain certain intimate human relationships” (as an element of personal liberty) and (2) “a right to associate for the purpose of engaging in those activities protected by the First Amendment,” including “speech, assembly, petition for redress of grievances, and the exercise of religion.” *City of Dallas v. Stanglin*, 490 U.S. 19, 23–24 (1989) (quoting *Roberts v. United States Jaycees*, 468 U.S. 609, 617–18 (1984)). The CDC’s regulations do not implicate any of these areas. Furthermore, while courts have recognized a right to travel, as a privilege of national citizenship protected by the Privileges and Immunities Clause and as an aspect of liberty protected by the Due Process Clause, see *Jones v. Helms*, 452 U.S. 412, 418–19 (1981) (recognizing rights of U.S. citizens to travel from one state to another and take up residency), such rights are not unqualified and may be restricted through the valid exercise of quarantine laws and regulations. See *Zemel v. Rusk*, 381 U.S. 1, 15–16 (1965) (stating, in dicta, “The right to travel *within* the United States is of course also constitutionally protected, . . . [b]ut that freedom does not mean that areas ravaged by flood, fire or pestilence cannot be

Amendment protects the rights of persons to be free in their persons, houses, papers, and effects, against unreasonable searches and seizures.¹⁴³ The ultimate measure of the constitutionality of a government search or seizure is reasonableness.¹⁴⁴ The Fifth Amendment provides that the federal government shall deprive no person of life, liberty, or property without due process of law.¹⁴⁵ The U.S. Supreme Court has interpreted the Fifth Amendment's Due Process Clause to "contain[] a substantive component that bars certain arbitrary, wrongful government actions 'regardless of the fairness of the procedures used to implement them.'"¹⁴⁶ The Due Process Clause, of course, also encompasses a guarantee of fair procedures.¹⁴⁷

The CDC's newly revised communicable disease regulations authorize a variety of activities that are routine and non-invasive regarding travelers, and thus do not raise Fourth Amendment concerns. Under the authority of sections 70.10 and 71.20, the CDC may, at airports and other locations, conduct non-invasive public health prevention measures to detect the presence of communicable diseases among travelers arriving in the United States or engaging in interstate travel.¹⁴⁸ The Supreme Court has recognized that Congress has granted the Executive Branch with plenary authority to conduct routine searches and seizures at the border without probable cause, a warrant, or even reasonable suspicion.¹⁴⁹ The border-search exception is based on longstanding concern regarding the protection and integrity of the border.¹⁵⁰ Thus, the CDC's potential application of non-invasive public health prevention measures to foreign arrivals is in accordance with Fourth Amendment standards.

The CDC's application of non-invasive public health prevention measures to interstate travelers would also be permissible under the Fourth Amendment.

quarantined when it can be demonstrated that unlimited travel to the area would directly and materially interfere with the safety and welfare of the area or the Nation as a whole."'). Thus, it follows that an individual's right to travel may be restricted through valid communicable disease regulations.

¹⁴³ U.S. CONST. amend. IV.

¹⁴⁴ *Vernonia Sch. Dist. 47J v. Acton*, 515 U.S. 646, 652 (1995).

¹⁴⁵ U.S. CONST. amend. V.

¹⁴⁶ *Zinermon v. Burch*, 494 U.S. 113, 125 (1990) (quoting *Daniels v. Williams*, 474 U.S. 327, 331 (1986)).

¹⁴⁷ *Id.* at 125.

¹⁴⁸ These measures include observation, questioning, review of travel documents, and non-invasive procedures such as temperature assessments that do not puncture the skin or involve the insertion of a foreign instrument into the body or a body cavity, other than the ear, nose, and mouth. *See Control of Communicable Diseases*, 82 Fed. Reg. 6890, 6969–71, 6975.

¹⁴⁹ *See United States v. Gonzalez-Rincon*, 36 F.3d 859, 864 (9th Cir. 1994).

¹⁵⁰ *See United States v. Montoya de Hernandez*, 473 U.S. 531, 538 (1985).

Under the special-needs doctrine articulated by the Supreme Court in *Skinner v. Railway Labor Executives' Ass'n*, certain categories of searches and seizures of persons are permissible without probable cause or a warrant.¹⁵¹ In *Skinner*, the Court upheld drug and alcohol testing of railroad employees as a safety measure, which justified invasions of Fourth Amendment protections.¹⁵² Indeed, under the special-needs doctrine, a court examines whether a “special need” beyond the normal need for law enforcement makes the warrant and probable cause requirement impracticable.¹⁵³ After the government identifies a special need, the court conducts a balancing test to weigh the government’s interest in requiring the search against the interference with the individual’s liberty.¹⁵⁴ These searches are justified because, as articulated in *Skinner*, “[i]n limited circumstances, where the privacy interests implicated by the search are minimal, and where an important governmental interest furthered by the intrusion would be placed in jeopardy by a requirement of individualized suspicion, a search may be reasonable despite the absence of such suspicion.”¹⁵⁵

In regard to preventing communicable disease spread, the public interest in allowing non-invasive searches at airports and other locations outweighs the minimal intrusion on the interstate traveler. Furthermore, requiring individualized suspicion, for instance, before performing non-invasive temperature assessments on all inbound travelers from a disease-affected area would be impractical and frustrate the government’s legitimate interests in protecting the public’s health. Thus, it is unlikely that such measures would be viewed as running afoul of Fourth Amendment standards.

Courts have also established different standards for searches and seizures that may involve more than a minimal intrusion upon the individual. While the border-search exception applies at arriving ports of entry, courts have required that extended detentions of travelers or intrusive medical examinations be premised upon reasonable suspicion.¹⁵⁶ Similarly, outside the border and in the context of mental health detentions, courts have generally required a showing of probable cause to justify the seizure of an individual with a potentially

¹⁵¹ 489 U.S. 602, 619 (1989).

¹⁵² *Id.* at 634.

¹⁵³ *United States v. Ward*, 131 F.3d 335, 342 (3d Cir. 1997).

¹⁵⁴ *Id.*

¹⁵⁵ *Skinner*, 489 U.S. at 624.

¹⁵⁶ *See United States v. Bravo*, 295 F.3d 1002, 1006 (9th Cir. 2002).

dangerous mental health condition.¹⁵⁷ Probable cause is understood to mean a probability or substantial chance of dangerous behavior, although the individual being seized may, in fact, not be dangerous.¹⁵⁸ Some courts, however, have found probable cause to exist based only on “reasonable grounds for believing that the person seized is subject to seizure under the governing legal standard.”¹⁵⁹ Furthermore, courts do not require a warrant to effectuate a mental health seizure.¹⁶⁰

The CDC’s regulations governing the apprehension, examination, detention, and conditional release of individuals are consistent with the governing legal standard for such actions under 42 U.S.C. § 264. Under 42 U.S.C. § 264(d)(2), for instance, regulations may provide for the apprehension and examination of any individual “reasonably believed to be infected with a communicable disease” in its qualifying stage.¹⁶¹ This same standard is found under section 70.6.¹⁶² The CDC, moreover, defines reasonable belief as the existence of specific, articulable facts that would lead a public health officer to conclude that an individual has been exposed and, that as a consequence of the exposure, is or may be harboring in the body, the infectious agent of a quarantinable communicable disease.¹⁶³ Thus, the CDC regulations are in line with court decisions that have defined probable cause as the existence of “reasonable grounds for believing that the person seized is subject to seizure under the governing legal standard.”¹⁶⁴ Furthermore, based on the government’s compelling interest in protecting the public’s health and the exigent circumstances presented by individuals traveling while potentially infected with a dangerous communicable disease, courts may consider quarantine and isolation as justifiable under the previously discussed special-

¹⁵⁷ See *Monday v. Oullette*, 118 F.3d 1099, 1102 (6th Cir. 1997) (“The Fourth Amendment requires an official seizing and detaining a person for a psychiatric evaluation to have probable cause to believe that the person is dangerous to himself or others.”).

¹⁵⁸ *Id.*

¹⁵⁹ See *Villanova v. Abrams*, 972 F.2d 792, 795 (7th Cir. 1992) (recognizing that probable cause for emergency civil commitment exists where “there are reasonable grounds for believing that the person seized is subject to seizure under the governing legal standard”).

¹⁶⁰ See *id.* (holding that there is no requirement for a judicial warrant in mental health cases).

¹⁶¹ 42 U.S.C. § 264(d)(2) (2012). Regarding an individual arriving into the United States from a foreign country, 42 U.S.C. § 264(b) requires only that the apprehension, detention, or conditional release be “for the purpose of preventing the introduction, transmission, or spread of . . . quarantinable communicable diseases.”

¹⁶² Control of Communicable Diseases, 82 Fed. Reg. at 6970 (Jan. 19, 2017) (to be codified at 42 C.F.R. pts. 70, 71). Under 42 C.F.R. § 71.32(a), which is applicable to international arrivals, the CDC must have “reason to believe” that an individual has been exposed to or is infected with a quarantinable communicable disease. Interstate Quarantine, 42 C.F.R. § 71.32(a) (2011).

¹⁶³ Control of Communicable Diseases, 82 Fed. Reg. at 6970.

¹⁶⁴ *Villanova*, 972 F.2d at 795.

needs doctrine, which would allow for such actions based on a standard less stringent than probable cause.¹⁶⁵

The Fifth Amendment's Due Process Clause "bars certain arbitrary, wrongful government actions 'regardless of the fairness of the procedures used to implement them.'"¹⁶⁶ The U.S. Supreme Court has held, with respect to long-term detentions of the mentally ill, that substantive due process requires that such detentions be premised only upon evidence of illness and the risk that the illness may pose a danger to themselves or to the public.¹⁶⁷ Before authorizing the civil commitment of tuberculosis patients, courts have also required a finding that the danger is likely to occur within the foreseeable future.¹⁶⁸ A legitimate government action that infringes upon a fundamental personal liberty must also be pursued through the least restrictive means that accomplishes the government's objectives.¹⁶⁹ In addition, due process requires that the nature and duration of the confinement bear a rational relationship to the purposes of the confinement.¹⁷⁰

The CDC's newly revised regulations are consistent with the standards for substantive due process required by the Fifth Amendment. The CDC's isolation and quarantine authority is currently limited to nine communicable diseases that are specified through an Executive Order of the President.¹⁷¹ For purposes of interstate isolation and quarantine, it must be reasonably believed that the an individual is in the communicable stage of the disease or, if the

¹⁶⁵ See *New Jersey v. T.L.O.*, 469 U.S. 325, 341 (1985) ("Where a careful balancing of governmental and private interests suggests that the public interest is best served by a Fourth Amendment standard of reasonableness that stops short of probable cause, we have not hesitated to adopt such a standard."); *Fisher v. Harden*, 398 F.3d 837, 847 n.5 (6th Cir. 2005) ("We note the possibility that under certain emergency or exigent circumstances, where officers have reasonable suspicion (but not probable cause) to believe that it is imminent that an individual may commit suicide unless the officers intervene, a seizure may be constitutionally permissible."); *KIA P. v. McIntyre*, 235 F.3d 749, 749, 762 (2d Cir. 2000) (holding that a hospital's short-term custody of a newborn for ten days awaiting further test results for methadone addiction and medical clearance by a child welfare agency was reasonable under the Fourth Amendment, but explicitly declining to decide whether the seizure was justified pursuant to "probable cause," "exigent circumstances," or under the "special needs" doctrine).

¹⁶⁶ *Zinermon v. Burch*, 494 U.S. 113, 125 (1990) (quoting *Daniels v. Williams*, 474 U.S. 327, 331 (1986)).

¹⁶⁷ See *O'Connor v. Donaldson*, 422 U.S. 563, 575–76 (1975) (holding that mental illness alone is insufficient to justify indefinite custodial detention).

¹⁶⁸ E.g., *City of Newark v. J.S.*, 652 A.2d 265, 271 (N.J. Super. Ct. Law Div. 1993).

¹⁶⁹ See *Lynch v. Baxley*, 744 F.2d 1452, 1459 (11th Cir. 1984) (recognizing that the U.S. Supreme Court has formally established the less-restrictive-means analysis in substantive due process cases; however, the Court has not addressed this issue regarding involuntary civil commitment).

¹⁷⁰ *Id.* at 1460.

¹⁷¹ See Exec. Order 13,295, 3 C.F.R. § 220 (2003), amended by Exec. Order 13,375, 3 C.F.R. § 162 (2005), and Exec. Order 13,674, 3 C.F.R. § 291 (2014).

individual is in a precommunicable stage, that the disease be likely to cause a public health emergency if transmitted to others.¹⁷² Furthermore, the periods of incubation and communicability for these quarantinable communicable diseases are not arbitrarily set, but rather are well-known and established in scientific literature.¹⁷³ Thus, federal quarantine and isolation do not raise the substantive due process concern that individuals will be confined based solely on mere speculation that they may pose a danger to the public in the distant future.¹⁷⁴

The CDC's newly revised regulations also contain sufficient safeguards to ensure that isolation and quarantine will occur consistent with principles of using the least restrictive means. Under sections 70.15 and 71.38, the CDC must conduct an automatic reassessment of the federal quarantine or isolation order no later than seventy-two hours after service of the federal order to ensure that detention is still warranted and that it is being accomplished through the least restrictive means.¹⁷⁵ Under sections 70.16 and 71.39, the CDC, upon request, must also conduct a medical review that requires the medical reviewer to make a formal determination regarding the agency's use of the least restrictive means and allows the individual to call witnesses and submit evidence.¹⁷⁶ An analysis of the least restrictive means will typically include an assessment of the individual's ability and willingness to comply with public health recommendations. It will also include a determination regarding the appropriateness of less restrictive alternatives, such as home confinement, in light of the risk and dangers posed by the specific quarantinable communicable disease.¹⁷⁷ Furthermore, because the CDC operates in time-sensitive, exigent circumstances, there is no constitutional requirement that it use the least restrictive means at the moment of apprehension, provided that it comply with the Fourth Amendment's standard of reasonableness.¹⁷⁸

¹⁷² 42 U.S.C. § 264(d) (2012).

¹⁷³ For example, "[s]ymptoms may appear anywhere from 2 to 21 days after exposure to Ebola, but the average is 8 to 10 days." See *Ebola (Ebola Virus Disease) Sign, and Symptoms*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/vhf/ebola/symptoms/index.html> (last updated Nov. 2, 2014).

¹⁷⁴ See *Kansas v. Crane*, 534 U.S. 407, 412 (2002) (expressing concern that civil commitment not become a mechanism for retribution or general deterrence).

¹⁷⁵ Control of Communicable Diseases, 82 Fed. Reg. 6890, 6972, 6977 (Jan. 19, 2017) (to be codified at 42 C.F.R. pts. 70, 71).

¹⁷⁶ *Id.* at 6972–73, 6977–78.

¹⁷⁷ Control of Communicable Diseases, 81 Fed. Reg. 54,320, 54,247 (Aug. 15, 2016) (to be codified at 42 C.F.R. pts. 70, 71).

¹⁷⁸ See *Yin v. California*, 95 F.3d 864, 870 (9th Cir. 1996) (recognizing that in searches and seizures justified by special needs, the government does not have to use the least restrictive means to further its interests); *Stockton v. City of Freeport*, 147 F. Supp. 2d 642, 647 (S.D. Tex. 2001) (recognizing that the

The U.S. Supreme Court has interpreted the Due Process Clause to guarantee a certain level of procedural fairness.¹⁷⁹ To be sure, due process “is a flexible concept that varies with the particular situation.”¹⁸⁰ To identify constitutional procedural protections, courts weigh the factors first articulated by the Supreme Court in *Mathews v. Eldridge*.¹⁸¹ These factors include (1) the private interest affected by the government’s actions; (2) the “risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards”; and (3) the “Government’s interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.”¹⁸²

The Supreme Court case of *Vitek v. Jones* is instructive regarding the procedural safeguards that may be constitutionally required in cases involving potential deprivations of physical liberty.¹⁸³ In *Vitek*, the Court reviewed the constitutionality of a Nebraska statute that authorized the involuntary transfer of a prison inmate to a mental hospital if a designated physician or psychologist determined that the inmate suffered from a mental disease or defect and could not be properly treated in a correctional facility.¹⁸⁴ After concluding that such transfers implicated a protected liberty interest, the Court expressed its approval of the district court’s articulation of the minimum procedures that Nebraska was required to observe before transferring a prisoner to a mental hospital.¹⁸⁵ These safeguards included: (1) written notice; (2) a hearing, held after sufficient time for the prisoner to prepare, that disclosed the evidence the government relied upon and provided an opportunity for the prisoner to be heard in person and present documentary evidence; (3) an opportunity for the prisoner to present witnesses at the hearing and confront and cross-examine any adverse witnesses, except upon a finding of good cause; (4) an independent decision maker; (5) a written statement by the factfinder of the evidence underlying the decision to transfer the prisoner to a mental hospital; (6) the availability of legal counsel; and (7) timely notice of the preceding safeguards.¹⁸⁶

“Fourth Amendment does not require that a search or seizure be conducted in the least restrictive means,” but “[r]ather, the alleged personal invasion . . . be reasonable under all the circumstances”).

¹⁷⁹ *Zinemon v. Burch*, 494 U.S. 113, 125 (1990).

¹⁸⁰ *Id.* at 127.

¹⁸¹ 424 U.S. 319, 335 (1976); *see Zinemon*, 494 U.S. at 127 (quoting *Mathews*, 424 U.S. at 335).

¹⁸² *Mathews*, 424 U.S. at 335.

¹⁸³ 445 U.S. 480, 494 (1980).

¹⁸⁴ *Id.* at 483.

¹⁸⁵ *Id.* at 492–95.

¹⁸⁶ *Id.* at 494–95.

The CDC's newly revised regulations contain robust review procedures that are in accordance with constitutional requirements of procedural due process. As an initial matter, while individuals have a strong liberty interest in freedom from physical confinement, avoidance of harm to others should also be considered a part of the private interest at stake.¹⁸⁷ The federal government's interest, moreover, is significant because it is not simply guarding the welfare of a single individual or even a small group of individuals, but rather protecting the public at large against the spread of dangerous communicable diseases.¹⁸⁸ Furthermore, the CDC has chosen procedures that are designed to guard against the risk of an erroneous deprivation.¹⁸⁹ These procedures include (1) written notice of quarantine, isolation, or conditional release, including translation or interpretation of federal orders as needed;¹⁹⁰ (2) mandatory review of the federal order no later than seventy-two hours after it is served to ensure that an error has not been committed;¹⁹¹ (3) an opportunity for a medical review where, after having had an opportunity to review the administrative record, the detained individual may be heard, present witnesses, testify, and cross-examine any adverse witnesses;¹⁹² (4) a qualified medical reviewer who is independent from the authorizing official who issued the federal order under review;¹⁹³ (5) a written

¹⁸⁷ See *Goetz v. Crosson*, 967 F.2d 29, 33 (2d Cir. 1992) (recognizing that a mental health patient possesses not only a liberty interest in avoiding erroneous confinement, but also an interest in receiving treatment and avoiding harm to himself or others).

¹⁸⁸ See *Villanova v. Abrams*, 972 F.2d 792, 796 (7th Cir. 1992) ("A person who might poison a city's water supply if left at large is more dangerous than one who with the same probability would merely slash his own wrists; so the case for committing the former is stronger.")

¹⁸⁹ As discussed throughout this Article, much of the relevant legal precedent arises from cases adjudicating the rights of the mentally ill in civil-commitment cases. Arguably, however, isolation and quarantine decisions are less prone to error than civil-commitment cases because the former are based on objective criteria (e.g., laboratory tests, travel history, etc.), and decisions to commit a mentally ill individual are based in part on subjective determinations of a patient's behavior. *Cf. Shaw v. Delo*, 762 F. Supp. 853, 862 (E.D. Mo. 1991) ("The Court is mindful that the science of psychiatry in terms of evaluating mental status requires a certain degree of subjective judgment and is a discipline fraught with 'subtleties and nuances.'" (quoting *Ford v. Wainwright*, 477 U.S. 399, 426 (1986)).

¹⁹⁰ Control of Communicable Diseases, 82 Fed. Reg. 6890, 6972, 6976 (Jan. 19, 2017) (to be codified at 42 C.F.R. pts. 70, 71).

¹⁹¹ *Id.* at 6972, 6977.

¹⁹² *Id.* at 6972-73, 6977-78.

¹⁹³ The CDC's regulations permit, but do not require, that the CDC use HHS or CDC employees to serve as medical reviewers and, in the case of an indigent individual, as appointed representatives. In the mental health context, courts have held that institutions and hospitals may use internal decision makers as part of the civil commitment process. See *Vitek v. Jones*, 445 U.S. 480, 496 (1980) (holding that an "independent decisionmaker conducting the transfer hearing [of a prison inmate to a mental institution] need not come from outside the prison or hospital administration"); *Parham v. J.R.*, 442 U.S. 584, 606 (1979) (holding, in the context of a parent's voluntary mental health commitment of a minor child, that using a staff physician as the

report and recommendation that sets forth the medical reviewer's findings and recommendations, including a determination regarding the CDC's use of the least restrictive means;¹⁹⁴ (6) the right to be represented by an advocate at one's own expense or, if indigent, to have both a medical professional and an attorney appointed at the government's expense;¹⁹⁵ and (7) timely notice of these rights through language in the federal order.¹⁹⁶ Accordingly, the CDC's newly revised regulations do not raise procedural due process concerns.

CONCLUSION

The CDC's newly revised communicable disease regulations represent a significant achievement in protecting the public's health while safeguarding the constitutional rights of affected individuals. While not expanding the list of quarantinable communicable diseases subject to federal isolation and quarantine, new provisions—such as those requiring the reporting of ill travelers onboard interstate flights and authorizing public health prevention measures at U.S. airports and other locations—allow the CDC to more easily identify sick travelers who may warrant further public health investigation and follow-up, particularly during a public health emergency. Similarly, the new provision authorizing interstate travel permits creates a federal mechanism, in coordination with state and local public health authorities, to allow for the safe and controlled movement of exposed travelers in need of further public health monitoring during a public health emergency. Under previous regulations, due process protections for individuals subject to federal isolation, quarantine, and conditional release existed only as a matter of agency practice. With the implementation of the new rule, explicit due process protections are now guaranteed through notice, administrative reviews, and appointment of counsel for indigents. These regulations improve the CDC's ability to respond to public health emergencies and build public trust through increased transparency and assurances that federal public health authorities will only be carried out in accordance with U.S. constitutional standards.

trier-of-fact is sufficient to satisfy due process, provided that the physician can "evaluate independently the child's mental and emotional condition and need for treatment"). Thus, the CDC's potential reliance on internal decision makers does not raise due process concerns.

¹⁹⁴ Control of Communicable Diseases, 82 Fed. Reg. at 6972–73, 6977–78.

¹⁹⁵ *Id.*

¹⁹⁶ See generally *Questions and Answers About the Final Rule for Control of Communicable Diseases: Interstate (Domestic) and Foreign Quarantine*, *supra* note 94.