

SYMPOSIUM: PANDEMICS AND THE CONSTITUTION

**FEDERALISM AND CONTAGION:
REEVALUATING THE ROLE OF THE CDC**

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I. INTRODUCTION

The emergence of a novel coronavirus (SARS-CoV-2) and its associated illness COVID-19 has reignited questions of public health federalism. That debate centers on the optimal distribution of power between the federal and state governments during a pandemic. Governments have contended with contagious disease throughout human history. Varied responses include ancient Rome's development of sanitary engineering¹ and the Venetian government's quarantine of ships returning from the Crusades.² Contagious disease has also played an active role in shaping United States history.³ Beyond most living American's memories, but embedded in the national experience includes numerous waves of yellow fever, smallpox, cholera, and the infamous 1918 Spanish flu.⁴ In response to these epidemics, localities and states have applied various methods of control. These state and local control measures have often been inconsistent, supported by little scientific evidence, and adversely influenced by local politics.

This essay argues for a rebalancing of public health federalism to increase federal leadership during public health crises by empowering the

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1. Edward P. Richards, *The Jurisprudence of Prevention: The Right of Societal Self-Defense against Dangerous Individuals*, 16 *Hastings Const. L.Q.* 329, 332 (1989).

2. *Id.* at 333.

3. *Top 10 Terrible Epidemics*, TIME MAGAZINE ONLINE, <http://content.time.com/time/specials/packages/completelist/0,29569,2027479,00.html> [<https://perma.cc/DL5W-BGKK>].

4. *The Most Dangerous Epidemics in U.S. History*, HEALTHLINE (Sept. 29, 2016), <https://www.healthline.com/health/worst-disease-outbreaks-history#1> [<https://perma.cc/VD7K-U4US>].

Centers for Disease Control (CDC). Part I outlines the background authorities operating during a public health crisis for the state and federal governments, respectively. Part II argues that decisions on sanitary ordinances such as the closing of schools, public areas, and individual safety measures should be more heavily influenced by real-time federal policy. History demonstrates that local decision-makers can treat public health crises too casually by failing to implement mitigation measures or, on occasion, institute draconian but ineffective measures. Former FDA Director Scott Gottlieb pointed out recent local inaction hinders a national response.⁵ Instead, more decisions made at the federal level would insulate local officials from the winds of local politics, and enable a more coordinated and effective response. Part III argues for a more aggressive statutory authorization of the federal government's quarantine authority. In the past, local governments have instituted arbitrary and counter-productive quarantines. Additionally, confusion remains as to the federal government's authority over the subject today. Part IV briefly explores the constitutional authorities for the aforementioned recommendations. Our success in the past 100 years in the control and eradication of many contagious diseases leaves case law in public health federalism largely underdeveloped. This ambiguity is compounded by the evolution of law in the past two hundred years, as the scope of the federal government's power has grown. In all, the changes advocated for represent a significant shift in public health federalism in the way crises are approached. With the law unchanged, our system of dual sovereignty during a pandemic has the potential to dangerously blur the lines of authority, leading to an ill-coordinated response.

II. BACKGROUND AUTHORITY DURING A PUBLIC HEALTH CRISIS

In the U.S., states possess police power, guaranteed by the Constitution, which includes power over public health.⁶ State police power, an expression of civil authority, comes from the 10th Amendment, which reserves states the rights and powers "not delegated to the United States."⁷ States thus have power to promulgate and enforce laws in the furtherance of public health. Public health is defined as the promotion of the health of people and communities, which includes responding to

5. Scott Gottlieb (@ScottGottliebMD), Twitter (Mar. 5, 2020, 9:11 AM), <https://twitter.com/ScottGottliebMD/status/1235568500774768640?s=20> [<https://perma.cc/J675-6T6X>].

6. See *Barnes v. Glen Theatre*, 501 U.S. 560 (1991) (noting that "the traditional police power of the States is . . . to provide for the public health, safety and morals).

7. U.S. Const. amend. X.

contagious disease threats.⁸ In addition, medical practice licensure and many hospital regulations are also within the province of the states.⁹ Local health departments have traditionally been on the front lines of responding to public health crises. These entities are responsible for maintaining health in communities and responding to contagious disease outbreaks within their jurisdictions. Local health departments, in conjunction with mayors and state legislatures, have also traditionally exercised authority over sanitary regulations, which include social distancing regulations in response to an outbreak.

Federal authority in public health crises comes from the Commerce Clause and the Tax and Spending Clause.¹⁰ At the beginning of a potential outbreak, the Secretary of Health and Human Services (HHS) is authorized to provide substantial support for states at the request of the state's health official.¹¹ The CDC can also provide technical and financial support for disease investigation and control.¹² The CDC, while located primarily in Atlanta, is still an agency under HHS, so their actions are authorized under the general authority of the HHS Secretary.¹³ If the outbreak rises to the level of a "public health emergency," the Secretary is authorized to respond beyond just supporting state and local governments. The main authority is Section 319 of the Public Health Service Act.¹⁴ This authorization allows the Secretary to draw from an emergency fund, authorize under the Food Drug and Cosmetic Act for the use of unapproved tests and treatments, and finally, waive a variety of administrative requirements for health care providers.¹⁵ A "public health emergency" was recently declared by the acting HHS Secretary in response to the H1N1 influenza outbreak in April of 2009.¹⁶ In even more extreme circumstances, an emergency could be declared under the Stafford Act. Emergency declarations under the Stafford Act occur upon

8. *What is Public Health?*, AMERICAN PUBLIC HEALTH ASSOCIATION, <https://www.apha.org/what-is-public-health> [<https://perma.cc/ZT5E-3SL8>].

9. *Navigating State Medical Licensure*, AMERICAN MEDICAL ASSOCIATION, <https://www.ama-assn.org/residents-students/career-planning-resource/navigating-state-medical-licensure> [<https://perma.cc/3HEQ-FY39>].

10. Brian Kamoie et. al., *Assessing Laws and Legal Authorities for Public Health Emergency Legal Preparedness*, 36 J.L. MED. & ETHICS 23, 24 (2008).

11. Kathleen S. Swendiman, CONG. RESEARCH SERV., R40560, *The 2009 Influenza (H1N1) Pandemic: Selected Legal Issues*, 1 (2009); 42 U.S.C. §§ 243(c) (1985), 247(b) (2010).

12. 42 U.S.C. §§ 243(c) (1985), 247(b) (2010).

13. U.S. Dept. Health and Human Services, *HHS Organizational Chart* (Jan. 13 2020), <https://www.hhs.gov/about/agencies/orgchart/index.html> [<https://perma.cc/Y96E-9S24>].

14. 42 U.S.C. § 247(a) (2019).

15. Swendiman, *supra* note 12, at 1.

16. *Id.*

the request of a state governor, when “the disaster is of such severity and magnitude that effective response is beyond the capabilities of the State and the affected local governments and that Federal assistance is necessary.”¹⁷ Once an emergency has been declared, additional resources from the federal government are available to assist the state and local efforts.¹⁸ There is some debate over whether a pandemic would qualify as a “major disaster” under the Stafford Act because a “natural catastrophe”¹⁹ is required. However, the George W. Bush administration appears to have considered flu pandemics eligible for major disaster assistance.²⁰ Beyond grants and seldom interventions, the federal government has taken a hands-off approach to public health directives in states.

III. NECESSARY REFORM OF LOCAL ORDINANCE PROCESS

This section argues for Congress to formally empower the CDC to influence local policy, and for the CDC to informally influence state and local governments more directly. Both preemptively and throughout a pandemic, local public health measures are essential to the containment and mitigation of an outbreak. Local ordinances and state laws have historically taken many forms to respond to this invisible threat. The variability in local responses has the potential to lead to a collective action problem, among others. One location may adopt draconian sanitary measures, and another proximate locality may use a rather relaxed approach. The resulting disorganization and increase in cases can exacerbate a pandemic and damage the government’s overall public health credibility. Just as a rational actor might refrain from getting vaccinated if they know everyone else received the vaccine, a locality may refrain from imposing strict regulations if they know areas surrounding them have implemented them. A locality then would gain much of the benefits of disease containment, without incurring much of the costs.

This calls for a more centralized response involving the federal government in order to gain uniformity within local sanitary measures. While sanitary ordinances combating disease have been in use in the United States for hundreds of years, they gained particular prominence within localities during the Spanish flu outbreak of 1918, which killed

17. 42 U.S.C. § 5170(a) (2013).

18. See Kristen DiGirolamo, *Legal Preparedness for Pandemic Influenza: Is Virginia Ready*, 13 RICH. J. L. & PUB. INT. 385 (2010).

19. 42 U.S.C. §5122(2) (2018).

20. Swendiman, *supra* note 12, at 4.

more than an estimated 670,000 Americans.²¹ Types of non-medical sanitary ordinances generally fall into the following categories: travel controls, decreased social mixing, mandatory individual actions (such as mask-wearing), and civil confinement (stay at home orders or centralized quarantine). The purpose of these responses is to slow the rate of new infections by reducing social contacts and decreasing the likelihood of transmission. These ordinances most commonly focus on locations where large numbers of people gather, such as schools, theatres, and other public areas.

One problem with local-level decision making is that some localities inevitably choose to treat a public health crisis too casually. This nonchalance can be attributed to a variety of causes, such as area cultural differences or local political strife. The latter was the case in Philadelphia, widely considered the hardest-hit United States city during the 1918 epidemic. While cases of severe influenza began to rise in the city, the city refused to cancel a scheduled large parade. The mayor was instead distracted, embroiled in a conspiracy and murder scandal.²² The parade continued despite city officials' knowledge that such a gathering was inadvisable.²³ The Liberty Loan parade hosted two hundred thousand celebrants in a patriotic event featuring boy scouts, soldiers, and sailors.²⁴ Within a few days of the parade, "the number of cases of influenza exploded."²⁵ This viral supercharging incident is eerily similar to an event that transpired in Wuhan, China, during the COVID-19 outbreak. On January 19, 2020, the City of Wuhan hosted the "Wanjia Banquet," where more than 40,000 families in the community participated in a potluck.²⁶ Local officials had knowledge of an outbreak of an unknown disease in the city and nevertheless continued with the large gathering.²⁷ Weeks later, Wuhan, was in the throes of an epidemic that tested the limits of the

21. See Donald R. Olson, et al., *Epidemiological evidence of an early wave of 1918 influenza pandemic in New York City*, 102 PROC. NATL. ACAD. SCI. 11059, 11063 (2005).

22. Christina Stetler, *The 1918 Spanish Influenza, Three Months of Horror in Philadelphia*, 84 PENNSYLVANIA HIST.: A J. OF MID-ATLANTIC STUD. 462, 467 (2017).

23. *Id.*

24. *Id.*

25. *Id.* at 468.

26. Phoenix Network, WEIBO (Jan. 20, 2020), <https://m.weibo.cn/status/4462935805605012> [<https://perma.cc/36JM-WM4R>] ("On January 18, it was a traditional small year in southern China, and the Wanjia Banquet of Baitbuting Community in Wuhan, Hubei, was lively. More than 40,000 families in the community presented home-made dishes and ate a group of dinner."); Chris Buckley & Steven Meyers, *As New Coronavirus Spread, China's Old Habits Delayed Fight*, N.Y. TIMES (Feb. 7, 2020), <https://www.nytimes.com/2020/02/01/world/asia/china-coronavirus.html> [<https://perma.cc/DP7Y-M233>].

27. Buckley, *supra* note 27.

available medical infrastructure, a harbinger for cities such as New York of what was to come. Large gatherings in the midst of an outbreak are unquestionably a very bad practice. While a failure to cancel large public gatherings can lead to local epidemics, they can also cause mass exportation of the pathogen as seen out of Hubei province in China during the COVID-19 outbreak, and at a minimum serve as a poor example other localities may emulate.

History also illustrates that local responses often include botched implementation and flawed measures. During the 1918 epidemic, the city of Minneapolis attempted to close movie theatres; ironically, however, when the impending regulations were announced, the downtown theatres became “packed . . . with patrons who took advantage of their last chance to see a performance.”²⁸ The city gave too large a window between when the regulations were announced and the date of implementation, causing their policy to initially encourage the behavior they sought to curtail. New Haven, Connecticut, against the recommendation from the federal health agency, thought it sufficient to show slides about health on movie screens instead of actually closing movie theaters.²⁹ The slides warned patrons to avoid coughing or sneezing during the performance; otherwise, the state health authorities would shutter the theatre.³⁰ Local health officials also tended to promulgate regulations that had little to no effect on disease transmission, or not even heed their own public health advice. The commissioner of the State Board of Health of Minnesota advocated the wearing of masks during the 1918 epidemic, but did not wear one himself stating, “I personally prefer to take my chances.”³¹ Many cities also passed ordinances requiring proper ventilation of streetcars and theatres, giving commuters and patrons a false sense of security.³² In other areas, cutting holes in your masks to smoke cigars and cigarettes was also a common act of civil disobedience.³³ Maladapted local public health actions are not a relic of the early 20th century, either. A recent study found that if the State of Indiana had acted earlier on the CDC’s

28. Miles Ott, et al., *Lessons Learned from the 1918-1919 Influenza Pandemic in Minneapolis and St. Paul, Minnesota*, 122 PUBLIC HEALTH REP. 803, 805 (2007).

29. Julia F. Irwin, *An Epidemic without Enmity: Explaining the Missing Ethnic Tensions in New Haven’s 1918 Influenza Epidemic*, 36 URBAN HIST. REV. 5, 7 (2008).

30. *Id.*

31. Ott, *supra* note 29, at 806 (2007).

32. Irwin, *supra* note 30, at 7; Ott, *supra* note 29, at 806.

33. Richard H. Peterson, *The Spanish Influenza Epidemic in San Diego, 1918-1919*, 71 SOUTHERN CALIFORNIA Q. 89, 98 (1989).

recommendation, an HIV epidemic from 2011–2015 caused by intravenous drug use would have been cut by 90 percent.³⁴

What are the causes of these flawed local decisions? In many cases, it seems local officials do not understand the methods of disease transmission and the delayed impacts of social distancing measures.³⁵ In some cases, it is probably appropriate to blame political expediency. Local officials' decisions to close schools, cancel public gatherings, and substantially alter the private lives of their citizens can be unpopular, especially for extended periods of time. This is evidenced by citizen's willful flouting of regulations and casual dismissal of their purposes, such as packing a theatre the day before it is scheduled to shut down.³⁶ These same political incentives also encourage local officials to hide or dismiss an outbreak until the evidence is overwhelming.

History also points to numerous examples of localities scapegoating minority groups in the midst of an outbreak. In the 1300s, some blamed the bubonic plague on the Jewish community, while in the 1800s, typhoid was pinned on the Irish, and even today, the 2009 H1N1 flu was associated with Mexican Americans.³⁷ A local response to a pandemic allows for opportunities to discriminate against these individuals falsely seen as originators or harbors of the disease. One prominent example occurred in San Francisco's Chinatown. During the late 1800s, the Chinese section of San Francisco was subject to constant ridicule as a harbor for disease, with little supporting evidence.³⁸ In 1900, the City of San Francisco, in a long line of discriminatory actions against Chinese Americans, instituted a mandatory vaccination program for only Chinese residents of Chinatown. The vaccination program was eventually found to have been implemented

34. Miles Parks, *Pence's New Coronavirus Role Raises Questions About His Public Health Record*, NPR (Feb. 27, 2020), <https://www.npr.org/2020/02/27/809930094/pences-new-coronavirus-role-raises-questions-about-his-public-health-record> [https://perma.cc/6FHX-NNPP].

35. See generally Min W. Fong et. al., *Nonpharmaceutical Measures for Pandemic Influenza in Nonhealthcare Settings – Social Distancing Measures*, 26 J. EMERGING INFECTIONS DISEASES 976 (May 2020) https://wwwnc.cdc.gov/eid/article/26/5/19-0995_article [https://perma.cc/B2BR-WB7D].

36. Stetler, *supra* note 23, at 467.

37. Marian Liu, *The coronavirus and the long history of using diseases to justify xenophobia*, THE WASHINGTON POST, Feb. 14, 2020 <https://www.washingtonpost.com/nation/2020/02/14/coronavirus-long-history-blaming-the-other-public-health-crises/> [https://perma.cc/E2GA-ABHY].

38. Charles McClain, *Of Medicine, Race and American Law: The Bubonic Plague Outbreak of 1900*, 13 L. & SOC'Y INQUIRY 447, 463 (1988) (San Francisco officials consistently referred to this area with contemptuous language, and a panel of city supervisors in 1885 even stated, "All great cities have their slums and localities where filth, disease, crime and misery abound," in reference to Chinatown.).

on flimsy evidence of an outbreak of the plague.³⁹ While the actions were eventually struck down as a violation of the Equal Protection Clause,⁴⁰ this situation highlights the potential for regulations promulgated by local officials to reflect an area's discriminatory biases.

A difficult lesson from history may be that local responses, clouded by political and immediate social considerations, are not necessarily the best arbiter during public health crises. While the CDC has traditionally acted in an advisory role to state and local governments, the agency is in the best position to promulgate locality-specific sanitary regulations in response to a pandemic. The CDC is divorced from any local political influences, and is well equipped with expert knowledge that local institutions lack. This is reflected in the CDC's employee makeup, which consists of mostly scientists and public health experts.⁴¹ The current statutory structure instead encourages states to develop their own pandemic response plans, to which the Secretary can then award small grants during a public health emergency.⁴² To maximize influence, the CDC must cultivate relationships with state and local health departments. Those state and local officials then should (but are not required) to effectuate the policy the CDC prescribes. The CDC has previously taken a hands-off approach when dealing with localities. For example, in 1985, during the HIV epidemic, the CDC recommended contact tracing and regulation of houses of prostitution to local health departments but ultimately left those decisions to be made by localities.⁴³ What were the consequences of that hands-off policy? The American approach resulted in a six times higher HIV infection rate compared to other less wealthy neighbors' more organized responses.⁴⁴ Instead of issuing broad recommendations, the CDC should exercise greater authority by promulgating region or locality-specific directives.

In order for the CDC to gain much-needed influence over local policy, Congress should pass formal legislation greatly expanding the

39. *Id.*

40. *Wong Wai v. Williamson*, 103 F. 1, 10 (C.C.N.D. Cal. 1900).

41. Denver Nicks, *The CDC Has Less Power Than You Think and Likes it That Way*, TIME (Oct. 17, 2014) <https://time.com/3516827/cdc-constitution-quarantine/> [<https://perma.cc/CKG5-3UJ7>].

42. *See* Pandemic and All-Hazards Preparedness Act, Pub L. No. 109-417, § 201, 120 Stat. 2831, 2837-45 (2006).

43. Verla S. Neslund, Gene W. Matthews & James W. Curran, *The role of the CDC in the development of AIDS recommendations and guidelines*, 15 L. MED. & HEALTH CARE 73, 77 (1987).

44. Donald G. McNeil Jr., *To Take On the Coronavirus, Go Medieval on It*, N.Y. TIMES (Feb. 28, 2020) <https://www.nytimes.com/2020/02/28/sunday-review/coronavirus-quarantine.html> [<https://perma.cc/W8YH-EDRP>].

CDC's grantmaking programs. In a public health emergency, the CDC should be statutorily empowered to award large grants to localities, on a precondition they adopt the CDC's local recommendations on sanitary measures. Not only would potentially apprehensive localities acquiesce to the recommendations, but they would have significantly more resources to respond. Localities would have great latitude with the grants. For example, upon acceptance of a CDC recommendation to close area schools, the grant funds could be awarded to parents who have to stay home for childcare to supplement their lost income. Grants could also be awarded to businesses who are recommended to close, but stand to lose significant revenue as a result.

The CDC also should exercise its informal (reputational) authority to influence state and local officials more aggressively. The CDC should issue locality-based directives in real-time, in response to a pandemic. The CDC is a highly respected government agency, and the opinion of its scientists and public health professionals is valued by the American public. Therefore, a CDC recommendation to close or re-open a specific area's schools, businesses, or public spaces is likely to significantly influence local decision-makers. This recommendation also serves a dual purpose of lessening any potential blowback local decision-makers may receive. This further enables them to enact potentially unpopular social distancing measures, which are often critical in the control of a spreading disease. A more aggressive CDC on informal recommendations would result in better decision making on a local level in response to a pandemic.

IV. PUBLIC HEALTH CONFINEMENT: TIME TO EXPAND THE CDC'S AUTHORITY

A. *Jurisprudence of Quarantine and Inconsistent Application*

Another important tool in the fight against a pandemic is the use of quarantines and other types of isolations, decisions over which go to the heart of traditional police power, delegated to the states. Public health confinements have been exercised since the beginning of United States history, as infectious disease was a constant threat to public order in colonial America.⁴⁵ The authority over quarantine and isolation represents more power than is obvious during that time. For example, someone suspected of smallpox would be isolated in a pest house, which was more

45. Ed. Richards, *The Coronavirus and the Constitution*, THE VOLOKH CONSPIRACY (Feb. 10, 2020), <https://reason.com/2020/02/10/the-coronavirus-and-the-constitution/> [https://perma.cc/5V3H-86EC].

often than not a death sentence.⁴⁶ Soon after the Constitution's ratification, each state subsequently passed its own quarantine laws.⁴⁷ In the landmark early Commerce Clause case *Gibbons v. Ogden*, Chief Justice Marshall noted a state's plenary power over "everything within the territory of a State, not surrendered to the general government," including "quarantine laws."⁴⁸

Compagnie Francaise de Navigation a Vapeur v. Louisiana State Board of Health demonstrated the Supreme Court's deference to state authorities in matters related to public health, including quarantines.⁴⁹ In 1898, a ship had recently docked in New Orleans with many hundreds of passengers. Although there was no evidence of infected passengers, they were not allowed to disembark upon arrival.⁵⁰ The Supreme Court determined the State Board of Health did have the authority in this instance to prohibit entrance from anyone who may "increase the prevalence of disease."⁵¹ This case remains a touchstone for quarantine law today and was recently cited in a case arising out of the 2014 African Ebola epidemic.⁵² In an earlier Supreme Court case, *Smith v. Turner*, some Justices tacitly endorsed a state-implemented border closure, if it was a direct public health measure.⁵³ However, the case's precedential value is questionable, given the lack of a majority opinion. At issue in this case, however, was not a state border closure, but a head-tax imposed by states on individuals landing at their ports to fund public health duties related to quarantines. This tax was challenged as an impermissible regulation on interstate commerce.⁵⁴ New York argued that this tax was analogous to a state border closure previously allowed during epidemics, citing Governor Mifflin of Pennsylvania's actions in closing the border in 1798. The advocate on behalf of the State of New York used colorful language to describe the situation.

The rising hopes of the metropolis began to fade . . . But the leading spirits of that day were unwilling to give up the city without a final desperate effort. The havoc in the summer of 1798 is represented as terrific. The whole country was roused. A *cordon sanitaire* was thrown

46. *Id.*

47. Edward P. Richards, *The Jurisprudence of Prevention: The Right of Societal Self-Defense against Dangerous Individuals*, 16 HASTINGS CONST. L. Q. 329, 333 n.18 (1989).

48. 22 U.S. (9 Wheat.) 186, 203 (1824).

49. 186 U.S. 380 (1902).

50. *Id.* at 382.

51. *Id.* at 385.

52. *Hickox v. Christie*, 205 F. Supp. 3d 579, 591 (D.N.J. 2016).

53. *See* 48 U.S. 283, 340-41 (1849).

54. *See id.*

around the city. Governor Mifflin of Pennsylvania proclaimed a non-intercourse between New York and Philadelphia.⁵⁵

While the Court struck down the New York-imposed head tax per passenger⁵⁶, Senior Justice McLean indicated he might rule otherwise, if the action more closely resembled a public health measure. McLean wrote, “In giving the commercial power to Congress the States did not part with that power of self-preservation which must be inherent in every organized community. They may guard against the introduction of any thing which may . . . endanger the health . . . of their citizens.”⁵⁷ Thus, McLean viewed a state’s power to exclude potentially infectious individuals inherent in a state’s police power, and not an impermissible impediment of interstate commerce.

As previously mentioned, the power to quarantine and isolate has often been viewed as entirely subsumed in a state’s police power. However, this power has been used by localities in ways that endanger civil liberties and do not further public health. For example, from the 1870s through 1910, governments in the South implemented what were known as “shotgun quarantines.”⁵⁸ These quarantines purported to defend areas against the scourge of yellow fever. Quarantines, however, did little to stop the spread because mosquitoes are the viral vector. To enforce these town-by-town quarantines, local governments posted armed individuals (hence the shotgun title) to prevent entry from places in which yellow fever was believed to be present.⁵⁹ Decisions on the imposition of local quarantines were usually made arbitrarily by ill-informed local politicians and often at a moment’s notice when a case of yellow fever appeared elsewhere.⁶⁰ During this time period, states even lobbied the federal government to step in and rein in the destructive use of these quarantines.⁶¹ Predictably, these quarantines devastated commerce by halting the movement of trains and people exacting a significant human cost.⁶² They pitted town against town and halted the movement of commerce. Even today, during the COVID-19 outbreak, there is an example of these shotgun (lite) style quarantines. Dare County in North

55. *See id* at syllabus.

56. *Id.* at 572.

57. *Id.* at 400.

58. Polly J. Price, *Epidemics, Outsiders, and Local Protection: Federalism Theatre in the Era of Shotgun Quarantine* 19 J. Const. L. 369, 371 (2016).

59. *Id.*

60. *Id.* at 377.

61. *Id.* at 382.

62. *Id.* at 371.

Carolina recently decided to restrict access to the county.⁶³ The county established checkpoints at all entry points in order to prevent the introduction of COVID-19 in the county. If more local governments decide to enact similar measures, this patchwork of laws would hinder economic activity, and work against an effective national pandemic response.

B. *Current Authorities*

The federal government has played a role in quarantine and isolation since the beginning of United States history. The first federal quarantine act was signed in 1796 in response to a yellow fever epidemic.⁶⁴ This law only permitted assistance to localities with quarantines upon request, and did not allow unilateral imposition by the federal government.⁶⁵ Subsequent outbreaks of cholera from arriving passenger ships resulted in the federal government gaining more authority over quarantine.⁶⁶ In 1893, Congress passed a law that clarified the role of the federal government, and gradually international border quarantine stations were turned over to the federal government.⁶⁷ Finally, in 1944, Congress clearly established the federal government's authority for quarantine at the international border level.⁶⁸ Pursuant to Section 361 of the Public Health Service Act, the Surgeon General is authorized to take measures to prevent the entry of communicable diseases into the United States,⁶⁹ the authority over which is delegated to the CDC.⁷⁰ The CDC is authorized to detain, medically examine, and release individuals arriving into the United States

63. *COVID-19 Bulletin #2*, DARE COUNTY EMERGENCY MANAGEMENT JOINT INFORMATION CENTER (Mar. 17, 2020) <https://www.darenc.com/Home/Components/News/News/5970/17> [<https://perma.cc/Y3PB-U3VH>].

64. Christopher Ogolla, *Non-Criminal Habeas Corpus for Quarantine and Isolation Detainees: Serving the Private Right or Violating Public Policy*, 14 DEPAUL J. HEALTH CARE L. 135, 154 (2011).

65. Arjun K. Jaikumar, *Red Flags in Federal Quarantine: The Questionable Constitutionality of Federal Quarantine after NFIB v. Sebelius*, 114 COLUM. L. REV. 677, 686 (2014).

66. *History of Quarantine*, CENTERS FOR DISEASE CONTROL (Jan. 10, 2012) <https://www.cdc.gov/quarantine/historyquarantine.html> [<https://perma.cc/84MW-FNB6>].

67. *Id.*

68. Joseph P. Topinka, *Yaw, Pitch and Roll: Quarantine and Isolation at United States Airports*, 30 J.L. Med. 51, 58 (2009).

69. 42 U.S.C. § 264(a) (2002).

70. 42 C.F.R. § 70 (2000).

who are suspected of carrying certain types of communicable disease,⁷¹ which are outlined in executive orders.⁷² The CDC maintains quarantine stations at ports of entry and land-border crossings throughout the United States.⁷³

While the federal government has vast quarantine powers at the borders, the policy and implementation beyond the port of entry is left to local and state health departments. The current view in regard to intrastate quarantine authority is that the federal government may not interfere with a state's choice unless the state asks for assistance, or until the epidemic crosses state lines.⁷⁴ While Congress intensely debated taking full control over local quarantine law in 1898 and 1906, they chose not to act.⁷⁵ Congress instead passed the "Interstate Quarantine Law," which gave the federal government some interstate quarantine authority, but did not explicitly authorize the preemption of local quarantines and was never enforced.⁷⁶ Today, states exercise the right to quarantine and isolate individuals in response to their own laws and policy under their police powers.⁷⁷ The CDC elaborates on its authority as follows:

In general, CDC defers to the state and local health authorities in their primary use of their own separate quarantine powers. Based upon long experience and collaborative working relationships with our state and local partners, CDC continues to anticipate the need to use this federal authority to quarantine an exposed person only in rare situations, such as events at ports of entry or in similar time sensitive settings.⁷⁸

Regarding interstate quarantine and isolation authority, the CDC is authorized under 42 C.F.R. 70 to detain, isolate, and quarantine individuals for the purpose of preventing the interstate spread of communicable diseases. Similar to ports of entry quarantines, the CDC has rarely, if ever, moved to exercise their interstate isolation and quarantine authority, leaving the extent of this power untested. However, the CDC stipulates they reserve the right to use this provision within the United States, "where measures taken by [local] authorities are inadequate

71. *Isolation and Quarantine*, CENTERS FOR DISEASE CONTROL (Feb. 24, 2020), <https://www.cdc.gov/quarantine/aboutlawsregulationsquarantineisolation.html> [<https://perma.cc/52HF-3FJU>].

72. Exec. Order No. 13,295, 3 C.F.R. § 13295 (2003).

73. *A Comprehensive Quarantine System*, CENTERS FOR DISEASE CONTROL (Sept. 29, 2017), <https://www.cdc.gov/quarantine/quarantinestations.html> [<https://perma.cc/D3QJ-ZDXC>].

74. Price, *supra* note 59, at 369.

75. *Id.* at 398.

76. *Id.* at 405.

77. Swendiman, *supra* note 12, at 7.

78. Swendiman, *supra* note 12, at 7–8.

to prevent communicable disease spread.”⁷⁹ This statement comes without the teeth of likely federal enforcement, as the CDC has very few ground personnel. There are over 2,684 state and local health departments who are tasked with the monitoring and management of their own jurisdictions.⁸⁰

C. *Resolving the CDC’s Quarantine Power*

The CDC’s power over quarantines within the United States is ambiguous and has rarely been tested. At the same time, the agency, with its vast institutional knowledge, is in the best position to dictate national quarantine action in the face of a pandemic. Where the CDC’s authority is clear (international border quarantines), the agency has been highly effective at containing disease outbreaks. During the 2002–2003 SARS epidemic, the CDC met approximately 12,000 flights with passengers arriving from affected areas.⁸¹ Upon the report of an ill passenger, the CDC quarantine staff met each arriving passenger immediately for a personal risk assessment. The CDC’s effort to combat SARS ended successfully, with only 27 confirmed cases in the United States and zero fatalities.⁸²

Today, without the CDC’s involvement, inconsistent local quarantines have the potential to further the spread of disease and do significant harm during an outbreak. During the 2014 Ebola outbreak, four state governors enforced much different quarantines than what was recommended by the CDC.⁸³ This led to charges of attempts to score political points in the midst of public fear.⁸⁴ The rise of populism and reactionary politicians make a scenario where states attempt to exercise their police power over quarantine in ways contrary to the federal government’s policy more likely. A central decisionmaker like the CDC

79. *Q & As about the Final Rule for Control of Communicable Diseases: Interstate (Domestic) and Foreign Quarantine*, CENTERS FOR DISEASE CONTROL (Mar. 21, 2017), <https://www.cdc.gov/quarantine/qa-final-rule-communicable-diseases.html> [https://perma.cc/9X5U-VQB7].

80. Polly J. Price, *A Coronavirus Quarantine in America Could Be a Giant Legal Mess*, THE ATLANTIC (Feb 16, 2020) <https://www.theatlantic.com/ideas/archive/2020/02/coronavirus-quarantine-america-could-be-giant-legal-mess/606595/> [https://perma.cc/B7UK-YRX5].

81. Martin Cetron et. al., *Isolation and Quarantine: Containment Strategies for SARS 2003, Workshop Summary*, <https://www.ncbi.nlm.nih.gov/books/NBK92450/> [https://perma.cc/A3XP-V7RW].

82. Chris Woolston, *SARS, The Epidemic That Was Halted*, HEALTH DAY (Jan. 1, 2020) <https://consumer.healthday.com/encyclopedia/diseases-and-conditions-15/misc-diseases-and-conditions-news-203/sars-648365.html> [https://perma.cc/Q2TB-77FE].

83. Price, *supra* note 59, at 371.

84. *Id.*

is essential to organize this chaos. The implementation of real-time quarantine directives from the CDC (instead of direction from local public health departments) would ameliorate this possible collective action problem between localities, analogous to the social distancing ordinances previously noted. The CDC also retains a much larger knowledge base than state and local governments and employs some of the nation's top scientists and public health experts. These experts are necessary to weigh the costs and benefits of confinement actions, as a balance must be struck between sometimes draconian measures and the social, economic, and personal costs they exact.

In order to implement the above recommendations, Congress must statutorily enable the CDC to preempt local quarantine laws as well as fully fund local enforcement capabilities. The constitutionality of such laws is addressed below. If Congress does not issue a clear directive, an effort by the CDC to control quarantines will inevitably lead to confusion about who is leading the effort. Even recent history suggests if a significant outbreak of a disease were to occur, the allocation of power between the states and federal government (CDC) will be a subject of significant controversy. Congress must act and clarify the federal government's role in quarantines within the United States.

V. CONSTITUTIONAL AUTHORIZATION FOR RECOMMENDATIONS

A. *General Authority*

The CDC's authority is remarkably broad in regard to communicable disease. The authorizing statute, the Public Health Service Act (PHSA), provides:

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 spread of communicable diseases . . . from one State or possession into any other State or possession.⁸⁵

The authority of the Surgeon General is shared with the CDC.⁸⁶ According to the statute, the CDC has some authority over the interstate spread of communicable diseases. The Supreme Court has not ruled on whether this portion of the PHSA is within the limits of the Commerce Clause.

If the statute were challenged, it would likely be upheld on Commerce Clause grounds. Under its Commerce Clause power, Congress

85. 42 U.S.C. § 264 (2012).

86. See *Isolation and Quarantine*, *supra* note 72.

has the authority to regulate any activity that “substantially affects interstate commerce.”⁸⁷ Implicit in this test are two additional requirements: that the regulatory subject be economic in nature⁸⁸, and that Congress not compel inactive citizens to enter a market in which they were not already participating.⁸⁹ Authority to quarantine during a nationwide pandemic satisfies all these elements.

First, large communicable disease events such as a pandemic dramatically affect interstate commerce. Consequently, regulations curtailing certain activities that promote disease spread should also fall within Congress’s commerce power. A pandemic can drive up demand for healthcare services significantly, thus affecting prices throughout the country. The economic impact of a substantial pandemic in the United States was estimated by some researchers to amount to 166 billion dollars,⁹⁰ which now looks like a significant underestimate after COVID-19. During oral arguments for *United States v. Comstock*⁹¹, Justice Scalia stated that “if anything relates to interstate commerce, it’s communicable disease, it seems to me.”⁹² Communicable diseases do not respect state borders and are inherently an interstate problem that “substantially affects commerce.”⁹³ In that same vein of reasoning, Congress could also conceivably grant the CDC more latitude to influence local sanitary/disease regulations under their Commerce Clause power.

Next, the regulated activity must be economic in nature.⁹⁴ This question is an easy one when the activity involves regulating schools, stores, restaurants, or sporting events. No one would argue that those activities, commonly ordered closed during “stay at home orders” are not economic in nature. The cessation of economic activity must also have an interstate effect. In *Gonzales v. Raich*, the Court upheld the Controlled Substances Act, noting, “Prohibiting the intrastate possession or

87. *United States v. Morrison*, 529 U.S. 598, 610 (2000).

88. *Gonzales v. Raich*, 545 U.S. 1, 17 (2005).

89. *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 588 (2012).

90. See Martin Meltzer et. al., *The Economic Impact of Pandemic Influenza in the United States: Priorities for Intervention*, 5 J. EMERGING INFECTIONS DISEASES 659, 659 (1999) https://wwwnc.cdc.gov/eid/article/5/5/99-0507_article [<https://perma.cc/Z2E3-NKGK>] (this impact is certainly a very low estimate considering the trillions of dollars lost to the COVID-19 pandemic).

91. 560 U.S. 126 (2010).

92. Transcript of Oral Argument at 30, *United States v. Comstock*, 560 U.S. 126 (2010) (No. 08-1224).

93. *United States v. Morrison*, 529 U.S. 598, 613. (“While we need not adopt a categorical rule against aggregating the effects of any noneconomic activity in order to decide these cases, thus far in our Nation’s history our cases have upheld Commerce Clause regulation of intrastate activity only where that activity is economic in nature.”).

94. *Id.*

manufacture of an article of commerce is a rational (and commonly utilized) means of regulating commerce.”⁹⁵ Many activities banned during quarantine are analogous to *Raich*, because they may exclusively take place intrastate, but in the aggregate have significant interstate commerce effects. A prohibition on people going to work, stores, schools, and entertainment venues results in a dramatic reduction in nationwide economic activity.

The more difficult question are activities that facially appear less economic in nature (but often regulated under “stay at home orders”) such as visiting friends or going to the park. While those activities may not be immediately economic in nature, choosing to partake in them during a pandemic, nonetheless, can have significant interstate commerce effects. In *Morrison*, the court found that the federally regulated activity (violence against women) was sufficiently non-economic enough that it could not be regulated under the Commerce Clause.⁹⁶ Ostensibly non-economic activities listed above, which undoubtedly fall under *Morrison* during normal times, have the potential to cause far-reaching negative economic effects during a pandemic. For example, meatpacking plants have dealt with large outbreaks of COVID-19, causing meat prices to increase and shortages throughout the country.⁹⁷ It takes only one person, after visiting friends, to seed an outbreak that potentially shuts down the entire processing plant affecting supply chains across the country. Generally, people congregating anywhere during a pandemic has the potential to dramatically affect interstate commerce, because people becoming ill has a dramatic effect on economic activity.

Finally, post *NFIB v. Sebelius*, the government may not compel inactive citizens to enter a market. However, curtailing public activities is materially different from the individual mandate to buy health insurance in *NFIB v. Sebelius*.⁹⁸ In *NFIB*, the federal government was compelling non-participants to enter the health insurance market. In the case of an intrastate quarantine, market participants are ordered to leave temporarily, distinguishing it from *NFIB*.

95. *Gonzalez v. Raich*, 545 U.S. 1, 26 (2005).

96. See *United States v. Morrison*, 529 U.S. 598, 613 (2000).

97. Taylor Telford and Kimberly Kindy, *As they rushed to maintain U.S. meat supply, big processors saw plants become covid-19 hot spots, worker illnesses spike*, WASH. POST (April 25, 2020), <https://www.washingtonpost.com/business/2020/04/25/meat-workers-safety-jbs-smithfield-tyson/> [https://perma.cc/JP9P-4QL2].

98. 567 U.S. 519 (2012).

B. *Local Directive*

A dramatic expansion of the CDC grant program to influence state and local government policy would be an important tool in managing a pandemic. However, using federal funds to strongly influence state policy raises 10th Amendment questions under the anti-commandeering doctrine. This doctrine is based on the conception of dual sovereignty, where the “separation of the two spheres [state and federal] is one of the Constitution’s structural protections of liberty.”⁹⁹ Thus, the CDC (being an agency of the federal government) is not legally able to order state or local public health officials into action.¹⁰⁰ The most modern test is from *NFIB*, which talks about the level of coercion. In *NFIB*, the Court considered it too coercive to condition *all* Medicaid funding on acceptance of the expansion. That is, states who refused to comply risked losing both new and existing Medicaid funds.¹⁰¹

These grants would not be so coercive as to contravene the 10th Amendment under Congressional tax and spending authority. This is consistent with *NFIB* because, in this proposal, there is no threat to lose all existing federal funding directed at public health crises. In *NFIB*, states did not have “a genuine choice whether to accept the offer” because they risked losing their current Medicaid funding entirely.¹⁰² However, the proposed specialized CDC grant program comes with no risk of losing existing federal funds. This prescribed system of awarding grants for compliance with CDC’s concurrent directives retains a state’s police power while bringing in federal expertise in decision making.

C. *CDC Authority Over Confinements Within the United States*

The Supremacy Clause establishes the Constitution and federal laws as the supreme law of the land, thus it invalidates state laws that interfere or are contrary to federal law. Under the Supremacy Clause, Congressional action may directly preempt state law. There is a general consensus that even state laws related to health and safety are not exempt from invalidation under the Supremacy Clause.¹⁰³

The federal government’s ability to preempt state public health confinements such as quarantines and isolations is within the bounds of

99. *Printz v. United States*, 521 U.S. 898, 921 (1997).

100. *See Printz* 521 U.S. at 935 (“Congress cannot compel the states to enact or enforce a federal regulatory program”). *See also* *New York v. United States*, 505 U.S. 144 (1992) (take title provision).

101. *See NFIB v. Sebelius*, 567 U.S. 519 (2012).

102. *Id.* at 588.

103. LAWRENCE O. GOSTIN, *PUBLIC HEALTH: POWER, DUTY, RESTRAINT* 80 (3rd ed. 2016).

the Constitution. The Supreme Court has suggested Congress would have power over the states in this respect if it chose to legislate on the subject. In *Morgan's Steamship Co. v. Louisiana Board of Health*, the Supreme Court upheld quarantine rules employed by Louisiana.¹⁰⁴ Importantly, the Court noted that if Congress were to implement a general system of quarantine or “confide the execution of the details of such a system to a National Board of Health . . . all State laws on the subject will be abrogated, at least so far as the two are inconsistent.”¹⁰⁵ This direct invitation for Congress to legislate and preempt state quarantines never came to fruition.¹⁰⁶ In *Louisiana v. Texas*, a concurrence suggested that Congress may intervene in local public health confinements.¹⁰⁷ At issue in this case was an objection to the state of Texas’ border closure to Louisiana, which resulted from a case of yellow fever that appeared in New Orleans.¹⁰⁸ The plaintiff Louisiana argued the border closure was an impediment to interstate commerce, thus violating the Commerce Clause.¹⁰⁹ The Court dismissed the case without addressing the Commerce Clause issue for lack of standing.¹¹⁰ In a concurrence, Justice Harlan wrote: “The police power of a State cannot be so exerted as to obstruct foreign or interstate commerce beyond the necessity of its exercise, and that that the courts must guard vigilantly against needless intrusion upon the field committed to Congress.”¹¹¹ In both of these cases, the Supreme Court considered it within the right of Congress to preempt state and local quarantine regulations.

If Congress chooses to grant the CDC with more power to control local quarantines and influence local health policy with an expanded discretionary grant program, it would likely be constitutional. The power to set these policies is within the bounds of the Commerce Clause because the underlying economic activity has a substantial impact on interstate commerce. The grant program would not violate the Tenth Amendment because it conditions only *new* funding on participation, not existing funds. Additionally, the Supreme Court has previously acknowledged the right of Congress to preempt state and local regulation in this area, despite a background principle of state police power.

104. 118 U.S. 455 (1886).

105. *Id.* at 464.

106. Price, *supra* note 59, at 418.

107. 176 U.S. 1 (1900).

108. Price, *supra* note 59, at 401.

109. Louisiana, 176 U.S. at 22.

110. *Id.*

111. *Id.* at 24 (Harlan, J., concurring).

VI. CONCLUSION

Government officials are tasked with the challenging job of responding to public health crises, notwithstanding the difficulties current public health federalism poses. During public health crises, areas of conflict between states and the federal government include local ordinances and quarantine decisions. To organize the chaos, there must be increased leadership from the federal government, particularly the CDC.

The suggested changes include large grant programs administered by the CDC, more aggressive informal influence from the CDC, and Congressional preemption of state quarantine measures. It should not be forgotten that methods of coercion to control the spread of disease have costs as well. Travel bans, decreased social mixing, quarantines, and isolations may slow the progression of a disease, but these measures exact personal, social, and economic costs. Further, strong governmental intervention may cause fear amongst the population and a general distrust in government. These reactions may undermine the efforts of the public health response in the first place. The federal government is more insulated from local political pressures, and thus better suited to absorb this type of criticism without deleterious effects on policy. It is imperative the U.S. gain control over the current and future epidemics. Countries and areas that do will reap large economic and social rewards. Rebalancing the law to favor federal leadership will take pressure off of local decision-makers and create a more effective response to future pandemics.