Legal Tools for Preparedness and Response

Variation in Quarantine Powers Among the 10 Most Populous US States in 2004

Frederic E. Shaw, MD, JD, Karen L. McKie, JD, Clint A. Liveoak, JD, MPA, Richard A. Goodman, MD, JD, MPH, and the State Public Health Counsel Review Team

From April 2004 through December 2004, we reviewed the express legal authorities of the 10 most populous US states to restrict the movement of persons to control communicable diseases. All 10 of the states possessed express legal authority to quarantine and isolate individuals, but the laws varied substantially. In the absence of declared emergencies, only 4 states had express authority to conduct area quarantine, and only 2 states had express authority to conduct group quarantine. During declared emergencies, 7 states had additional authorities for area quarantine. Express authorities are only part of states' legal powers to employ such movement restrictions, but substantial variation in express authorities across states could present potential challenges for the coordination of large national or regional epidemics. (*Am J Public Health.* 2007;97:S38–S43. doi:10.2105/AJPH.2005.083311)

QUARANTINE (THE SEPARATION and restriction of movement of well persons exposed to a communicable disease) and isolation (the separation and restriction of persons ill with such a disease) are among public health's traditional tools for the control of communicable disease.[1,2] In the United States, legal powers to restrict the movement of persons to control communicable diseases trace back to colonial times,[3] but the use of these powers has declined since the introduction of effective antibiotics and vaccines. In recent times, states' powers to restrict the movement of persons (abbreviated here as RMP powers) have been used mainly to detain persons with highly infectious pulmonary tuberculosis who refuse to comply with antibiotic treatment regimens[4] and occasionally for measles[5] or HIV-infected persons who persistently practice unsafe transmission behaviors despite counseling.[6]

Despite waning use, the continuing importance of RMP powers was underscored in 2003 with the advent of severe acute respiratory syndrome (SARS). Although the United States experienced only a small number of SARS cases and did not use RMP to any great extent, RMP was a major tool for controlling the disease in other countries.[7,8] In Ontario, Canada, for example, where an outbreak of SARS occurred, officials put 23 000 persons into voluntary quarantine to interrupt transmission of the virus.[9]

In the United States, the federal government can take measures to prevent the introduction or transmission of communicable diseases from foreign countries into the United States or from one state or possession into another. This includes the power to quarantine and isolate persons with specified communicable diseases who are arriving into the United States from a foreign country, moving from one state or possession into another state or possession, or who are likely to infect others who will then be moving from one state or possession into another.[10–12] However, the legal power to use RMP for communicable disease control within individual states resides in the states' police power, a residual prerogative of sovereignty that the states retained when the US Constitution was ratified and the Tenth Amendment was adopted.[13,14] Thus, in times of serious regional or national epidemics, whether natural or human made, state law, as well as federal law, will govern RMP actions.

In this article, we report the findings of a study of the legal powers for RMP in the 10 most populous US states in 2004, where in over half of the US population resides. This study was prompted by the rising specter of imported communicable diseases, both natural (e.g., pandemic influenza[15]) or human made, which have heightened the need for federal, state, and local agencies to review their legal authorities for public health interventions, including RMP.[16] Exercises designed to test emergency public health procedures and capabilities, such as TOPOFF (Top Officials) and Dark Winter,[17,18] have exposed the need for an improved understanding of public health laws. In addition, some legal commentators and expert panels have suggested the need to modernize these laws.[19,20]

The 10 states chosen for this review have large populations and are likely to be crucial to the control of any large epidemic that affects the United States. In addition, these states have key ports

of entry (by air or sea) and may be among the first to experience and amplify imported epidemics.

METHODS

From April through December 2004, we conducted a detailed qualitative review of the statutes, regulations, and cases pertaining to RMP in the 10 most populous US states. We reviewed RMP laws in the following states, in order of descending population size: California, Texas, New York, Florida, Illinois, Pennsylvania, Ohio, Michigan, New Jersey, and Georgia. In 2000, the combined population of these states accounted for 54.1% of the estimated US population.[21]

We identified all of the state laws containing explicit powers to separate, quarantine, isolate, apprehend, detain, or otherwise achieve RMP. We reviewed only express powers, meaning powers that were specifically mentioned and delineated in statutes, regulations, or cases. We excluded RMP powers that were inherent, implied, or that state officials could claim based on nonspecific, general, or "umbrella" public health powers or broad grants of authority, although we recognize that such RMP powers exist (see "Discussion" section). A typical example of such a broad authority is that given to public health officials in Pennsylvania, who have the authority to "determine the appropriate disease control measure based upon the disease or infection, the patient's circumstances, the type of facility available and any other available information relating to the patient and the disease or infection."[22]

We restricted our study to state-level law and searched statutes and codes, regulations, and published cases. We accessed the law through LexisNexis, state online databases, and printed sources of state statutes, regulations, and cases.

We excluded laws that related only to the testing or examination of persons, the quarantine of common carrier conveyances (unless they also referred to the detention of persons within the conveyances), and maritime quarantine. We characterized and analyzed the laws by their general characteristics, express legal authorities for RMP in the absence of a declared emergency, and express legal authorities for RMP during declared emergencies. We sent our preliminary results to the state public health counsel in all 10 of the states for review and comment.

RESULTS

The state public health counsel in all 10 of the states responded with comments and corrections on our findings. The majority of comments involved legal citation errors; a few pointed out overlooked statutes or gave interpretation to the applicability of specific provisions of law.

General Characteristics

Express state RMP laws existed as statutes (written laws passed by legislatures) and regulations (administrative rules with the force of law promulgated and enforced by government agencies). We found these express state RMP laws listed in state law codes dealing with the general control of communicable disease, tuberculosis, and veneral or sexually transmitted disease, and with the authorities of the governor or other state or local officers during declared emergencies. We located a few older cases on the state's quarantine powers, but these were generally not cited as current authority by state counsel. Although all 10 of the states possessed statutes or regulations giving express authority to conduct RMP, the laws varied greatly among the states by their level of detail, location in the state's legal code, complexity, and specificity.

Express Authority in Absence of a Declared Emergency

In all 10 of the states, the state department of health or another official person or agency possessed express authority to order RMP within the state, or in any local jurisdiction, during times when no emergency had been declared. In all 10 of the states, at least 1 local official entity also had express RMP authority, but the states varied widely on which entity was specified. In Texas, for example, only 2 local entities had express authority to impose quarantine in times when no emergency had been declared: the local "health authority" (a designated physician, usually employed by the locality) and a municipality.[23]

In New Jersey, several different local officials and bodies had express authority to institute RMP, including local boards of health[24]; health officers[25]; persons in charge of jail houses (for sexually transmitted diseases)[26]; persons in charge of migrant camps[27]; and others.[28]

In Pennsylvania, in addition to the state department of health, 10 county and municipal health departments had been approved to provide public health services within their jurisdictions. These departments had authority and responsibilities similar to those of the state department of health, including initiating RMP. Local boards and departments of health also had responsibility for the prevention and control of disease within their jurisdictional borders, but the local boards or departments had to obtain approval from the state department of health before instituting any disease control measure, including RMP.[29]

In New York, although the primary express responsibility for RMP rested with local public health officers and boards of health, the state commissioner of health could annul or modify orders made by local boards of health if, in his or her judgment, the order affected the public health beyond the territory over which such local board had jurisdiction.[30]

Area quarantine (also called *cordon sanitaire*) is the restriction of persons from entering or leaving a certain place or geographical space. In the absence of a declared emergency, 4 states, California,[31] Texas,[32] New York,[33] and probably Ohio, had express legal authority to conduct area quarantine

TABLE 1—Express Legal Authority for Area and Group Quarantine in the 10 Most Populous US States, With Primary Legal Citation: 2004

State (in Descending Order of Population)	Express Authority in Absence of a Declared Emergency		Additional Express Authority During Declared Emergency	
	Area Quarantine	Group Quarantine	Area Quarantine	Group Quarantine
California	Yes; Calif Health & Safety Code §120145 (2006)	No	No	No
Texas	Yes; Tex Health & Safety Code § 81.085 (2006)	No	Yes; Tex Gov Code § 418.018 (2006)	No
New York	Yes; NY Pub. Health Law § 2100 (2006)	No	Yes, NY Exec Law § 24 (2006)	No
Florida	No	No	No	No
Illinois	No	Yes; 20 Ill Comp Stat § 2305/2 (2007)	Yes; 20 Ill Comp Stat 3305/7 (2006)	No
Pennsylvania	No[a]	Yes; 35 PS § 2140.301 (2006)	Yes; 35 PaCS § 7301 (2006)	No
Ohio	Yes; Ohio Rev Code Ann § 3707.05 and § 3707.08 (2006), see text	No	No	No
Michigan	No	No	Yes; Mich Comp Laws Serv § 333.2251 (2006)	No
Georgia	No	No	Yes; Ga Code Ann § 38-3-51	No
New Jersey	No	No	Yes; NJ Stat § App A:9–49 (2006)	No

Note: Express legal authority means a power that was specifically mentioned and delineated in written law, excluding area and group quarantine powers that could be claimed by states on the basis of general or "umbrella" public health powers or broad grants of authority, and excluding implied or inherent authority (although such authority may exist). "Additional authority" during declared emergencies means additional legal authority beyond that available in the absence of a declared emergency. Years in parentheses refer to current codes; all cited laws were in force in 2004. The characterization and definition of declared emergencies varied by state.
[a]28 Pa Code § 27.67 (2006) could be interpreted to authorize area quarantine.

(Table 1; in Pennsylvania, an administrative regulation, 28 Pa. Code § 27.67, could be interpreted to give express area quarantine authority). The state counsel in Ohio believed that this express authority probably existed, because the relevant statute referred to a requirement that local boards of health obtain the approval of the Ohio Department of Health before closing a highway or imposing quarantine on another municipal corporation or township.[34] The state counsel reasoned that the closing of a highway would constitute area quarantine, as would the imposing of quarantine on a municipality or township. In addition, Ohio law allowed boards of health to prohibit entrance and exit to an area where a quarantined individual was being held.[35]

Group quarantine is the restriction of movement of more than 1 person without naming or specifying the individuals. For example, a public health official might wish to quarantine all persons who attended a certain event, even when their individual identities are not known. Using group quarantine, the official can serve notice on the group as a whole and identify them only by their group characteristics.

In the absence of a declared emergency, only Illinois[36] and Pennsylvania law expressly authorized group quarantine (Table 1). In Pennsylvania, under the Counterterrorism Planning Preparedness and Response Act,[37] the governor, in consultation with the secretary of the department of health, could order temporary group quarantine in the absence of a declared emergency "in the case of an actual or suspected outbreak of a contagious disease or epidemic because of an actual or suspected bioterrorist or biohazardous event."[38] The state's disease prevention and control regulations could also be interpreted to authorize group quarantine.[39]

Express Authorities During Declared Emergencies

In all 10 of the states, an official, usually the governor, could declare an emergency for epidemics or other communicable disease threats, although the terminology varied among states. In 7 states, the formal declaration of an emergency triggered additional express authorities for area quarantine beyond those ordinarily authorized (Table 1). Typically, these were characterized as the governor's authority to control "ingress and egress" of persons to and from affected geographical areas. In New York, for example, in the event of a public emergency within localities, the chief executive could designate specific zones in which the ingress and egress of vehicles and persons were prohibited.[40] In New Jersey, the governor had the authority to order a "prohibited area" during emergencies, the equivalent of area quarantine authority.[41]

Additional express authority for group quarantine during declared emergencies was not mentioned in the laws of any of the 10 states. The express group quarantine authority during nonemergencies in Illinois and Pennsylvania was presumed to apply during declared emergencies also.

DISCUSSION

Our study found that, in 2004, all 10 of the most populous US states had express legal authority for RMP both during declared emergencies and during times of nonemergency. These laws, however, varied profoundly among the 10 states, both in form and content. In form, the laws diverged by their location in code and their structure. In content, they diverged by their specificity, level of detail, and scope of application. Our findings are consistent with, and extend, those of previous researchers of state public health laws.[19]

This variation in express authorities is relevant because the states have traditionally been the primary actors in multistate epidemics. Under the US system of federalism, legal authority for RMP during interstate epidemics is shared between the state and federal governments, and RMP in such epidemics can be based on either state or federal law. However, because states and localities have the primary operational responsibility for community containment measures during large outbreaks (e.g., of SARS, smallpox, or communicable diseases yet unknown),[42] the earliest RMP measures are likely to be ordered by state or local officials relying on state law.

What are the implications of this profound variation in state RMP laws? For routine public health purposes, such as the occasional isolation of recalcitrant patients with highly infectious tuberculosis, the consequences are certainly small. However, in large, fast-moving national or regional epidemics involving highly communicable diseases, the federal government will be responsible for coordinating response activities with the states and making recommendations about community containment measures, including RMP. Large variations in how states respond to such recommendations could make this coordinated response more complex, and at least in theory, large variations in law could lead to variations in response.[43,44]

Group quarantine is 1 example. Group quarantine could be an important tool during some large, fast-moving epidemics, because public health officials may not have time to individually identify every person who should be quarantined. In certain dangerous and widespread epidemics, federal officials might recommend large-scale group quarantine to control the spread of communicable diseases. We found only 2 states, Illinois and Pennsylvania, in which group quarantine was expressly authorized in law.

A jurisdiction's lack of express legal authority for group quarantine, or any other variation of RMP, does not mean that the jurisdiction lacks that power or that a court would invalidate an order for group quarantine by public health officials. Courts could hold group quarantine valid based on broad statutory public health powers or inherent authority emanating from the police power.

Likewise, area quarantine (*cordon sanitaire*) can be a useful way of restricting personal movement and slowing down the transmission of highly infectious agents. Our analysis found that only 4 of the states had express statewide authority for area quarantine in the absence of a declared emergency. For declared emergencies, the number of states with this express authority increased to 7. During severe emergencies, governors would probably declare emergencies and, therefore, trigger area quarantine authority. In lesser emergencies, however, governors might not declare emergencies, and state officials would have to rely on nonemergency powers. As with group quarantine, judges could hold area quarantine valid under implicit or inherent powers.

The large variation that we found in state RMP laws is not particularly surprising, given the huge differences found in many other areas of state law. Legal scholars and practitioners have long recognized the difficulties presented by such variations. One solution to this problem is the adoption of uniform state laws—i.e., model standardized laws that if adopted by a sufficient number of state legislatures can reduce the effects of variation. For example, it was the variation and conflict among state laws governing commercial transactions that led to the creation of the most celebrated and elaborate of US uniform state laws, the Uniform Commercial Code.[45] The main writer of the uniform state laws in the United States, the National Conference of Commissioners on Uniform State Laws, has promulgated other uniform model state laws pertaining to health, such as laws on health care decisions and information, and the determination of death. Although the National Conference of Commissioners on Uniform State Laws has not drafted a model law on RMP, it has considered model laws for other issues related to public health emergencies. Other organizations have also drafted model laws as a way to overcome variation among the states. A recent study found 107 model public health laws available in full text on the Internet (Centers for Disease Control and Prevention, unpublished data, 2005).

In 2001, after the attacks of September 11, the Centers for Disease Control and Prevention sponsored the drafting of a model law for state emergency health powers, the Draft Model State Emergency Health Powers Act (DMSEHPA).[46] The DMSEHPA was created in part because of the recognition of the great variation among state laws pertaining to public health emergencies, including RMP. Sections of the act cover aspects of RMP (e.g., group quarantine is specifically authorized): the degree of restriction to be used, due process, procedure, and standards for instituting RMP. Although provisions of the DMSEHPA apply only during officially declared public health emergencies, much of it has been incorporated into another model act that applies to both emergency and nonemergency situations, the Turning Point Model State Public Health Act. The authors of the DMSEHPA have

reported that, as of July 15, 2006, parts of the act had been adopted in 38 states and the District of Columbia.[47] Through these adoptions, the DMSEHPA has probably contributed to making state RMP laws more uniform.

Another way to mitigate the variation among state laws is to ensure optimal coordination among the states during public health emergencies. One way that states have done this is by forming mutual aid agreements under the Emergency Management Assistance Compact. Much progress has been made, but more legal and legislative work must be done before most forms of mutual aid can be implemented (D. Stier, Centers for Disease Control and Prevention, unpublished data, 2006).

Limitations

Our analysis should be interpreted with 5 caveats, 1 major and 4 minor. The major caveat is the recognition that public health law is not represented only by what is explicitly stated in "black letter" statutes and regulations. Judges also make law through court decisions, and they give great deference to the views of public health officials.[48] This would be especially true during emergencies, when judges could find legal powers for RMP in the broad grants of authority given to state and local public health officials, or in the extremely broad authorities given to governors during emergencies, all firmly rooted in the police power itself.[49]

Second, although we made every attempt to find and describe all of the existing RMP laws of the 10 states, our review may not fully portray the law in each state as would be depicted by advocates in court. Law lives through the interpretation of state officers, lawyers, and ultimately, judges. In most of the 10 states, very few legal cases exist to guide interpretation of the statutes. To acknowledge the crucial importance of the interpreted law, we submitted our findings to state counsel in each of the 10 states.

Third, our review did not encompass separate statutes governing administrative procedures. Most states have state-level administrative procedure acts that impose requirements on rule making and other administrative actions by state officials. No state counsel told us that his or her state's state-level administrative procedure act would affect rule making around RMP, but this remains a theoretical concern. Fourth, because we studied only 10 of the 50 US states, we cannot claim that our findings are representative of all state laws in the United States. Finally, our study was a snapshot of laws in 2004; some of the states have revised their laws since then.[50]

Conclusions

Although some observers have argued for profound revisions and even whole-cloth replacement of "antique" public health laws in the United States,[43] others have urged instead an assessment of the flexibility and value of traditional laws.[51,52] The laws of the 10 states that we studied illustrate that previous researchers have been correct in their assessment that many state communicable disease laws exhibit "profound variation."[19] In theory, these variations could lead to variations in state responses to national disease control recommendations during a large regional or national epidemic. Carefully drawn revisions could lead to more uniform state RMP laws, which might allow more uniform interstate and state–federal responses. Also, in some states, greater specificity in RMP laws could clarify lines of authority among government actors and reduce the potential for conflict. However, revisions in RMP laws should be done cautiously to avoid creating procedural or substantive requirements that could hamper the flexibility (tempered by ethical concerns[53]) needed by public health officials during epidemic responses and to avoid unnecessarily limiting existing powers. ■

About the Authors

At the time of the study, F.E. Shaw, K.L. McKie, and R.A. Goodman were with the Office of the Chief of Public Health Practice, Centers for Disease Control and Prevention, Atlanta, Ga. C.A. Liveoak was with the Office of the Director, Centers for Disease Control and Prevention, Atlanta.

Requests for reprints should be sent to Frederic E. Shaw, Public Health Law Program, Office of the Chief of Public Health Practice, Centers for Disease Control and Prevention, 1600 Clifton Rd NE, MS D-30, Atlanta, GA 30333 (e-mail: fshaw@cdc.gov).

This analytic essay was accepted May 26, 2006.

Note. *The findings and conclusions in this report are those of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention or any state agency. The article is not intended to provide a legal interpretation or opinion about federal or state law, nor does it constitute legal advice.*

Contributors

F.E. Shaw originated the study, supervised the research, and wrote the article. K.L. McKie assisted with the study design and conducted part of the research. C.A. Liveoak conducted part of the research. R.A. Goodman helped to conceptualize the study, interpret the findings, and review drafts of the article. The State Public Health Counsel Review Team reviewed and commented on the research findings for their own states and reviewed drafts of the article.

Acknowledgments

This research was funded by the Centers for Disease Control and Prevention.

The authors wish to acknowledge assistance in legal research and interpretation from the following state public health legal counsel: Peter A. Baldridge, California Department of Health Services, and Donald P. Berens, Jr, and Barbara Asheld, New York State Department of Health. The authors also wish to acknowledge the research assistance of the following fellows and students at the Centers for Disease Control and Prevention (CDC) Public Health Law Program: Margaret Clemens, Stephen K. Trynosky, and Michael A. Woods. Finally, the authors wish to thank Anthony D. Moulton, Co-Director of the CDC Public Health Law Program, James J. Misrahi, of the Department of Health and Human Services Office of General Counsel, CDC and Agency for Toxic Substances and Disease Registry Branch, and Richard E. Hoffman of the University of the Colorado Health Sciences Center, for helpful comments.

Members of the State Public Health Counsel Review Team were: Richard McNelis, Florida Department of Health; Sandy Keating, Georgia Department of Human Resources; Lee Ann Schoeffel, Illinois Department of Health; Karen Krzanowski and Denise Chrysler, Michigan Department of Community Health; Ronald J. Styka, Michigan Department of Attorney General; Ruth Charbonneau and Genevieve Raganelli, New Jersey Department of Health and Senior Services; Socrates H. Tuch, Ohio Department of Health; Grace R. Schuyler, Pennsylvania Department of Health; and Mike Greenberg, Texas Department of State Health Services.

Human Participant Protection

No human subjects were involved in this study.

References

1. Clemow FG. The origin of "quarantine." *BMJ.* 1929;1:122–123.

2. *The Bible.* Leviticus 13:46.

3. Parmet WE. Health care and the Constitution: Public health and the role of the state in the framing era. *Hastings Constitut Law Q.* 1993;20:267–335.

4. Grad FP. Communicable disease and mental health: restrictions of the person. *Am J Law Med.* 1986;12: 381–403.

5. Centers for Disease Control and Prevention. Quarantine and other measures to control an import-associated measles outbreak—Iowa, 2004. *MMWR Morb Mortal Wkly Rep.* 2004;53: 969–971.

6. Hoffman RE. Quarantine in the United States in the 1990s. *Curr Issues Public Health* 1995;1:16–19.

7. Hsieh YH, King CC, Chen CW, et al. Quarantine for SARS, Taiwan. *Emerg Infect Dis.* 2005;11:278–82.

8. Rothstein MA, Alcalde MG, Elster NR, et al. Quarantine and isolation: Lessons learned from SARS: A report to the Centers for Disease Control and Prevention. Institute for Bioethics, Health Policy and Law, University of Louisville School of Medicine, November 2003. Available at: http://www.louisville.edu/medschool/ibhpl/images/pdf/SARS%20REPORT.pdf. Accessed August 22, 2005.

9. Svoboda T, Henry B, Shulman L, et al. Public health measures to control the spread of the severe acute respiratory syndrome during the outbreak in Toronto. *N Engl J Med.* 2004;350: 2352–2361.

10. 42 U.S.C. § 264 (2006).

11. Control of Communicable Diseases, 70 *Federal Register* 71,892 (Proposed rule Nov. 30, 2005).

12. Misrahi JJ, Foster JA, Shaw FE, Cetron MS. HHS/CDC legal response to SARS outbreak. *Emerg Infect Dis.* 2004; 10:353–355.

13. Gostin LO, Koplan JP, Grad FP. The law and the public's health: The foundations. In: Goodman RA, Rothstein MA, Hoffman RE, Lopez W, Matthews GW, eds. *Law in Public Health Practice.* Oxford, England: Oxford University Press; 2003:3–22.

14. Fried C. *Saying What the Law Is: The Constitution in the Supreme Court.* Cambridge, Mass: Harvard University Press; 2004:13–48.

15. Altman LK, Bradsher K. A successful vaccine alone is not enough to prevent avian flu epidemic. *New York Times.* August 8, 2005:A7.

16. Department of Health and Human Services. DHHS pandemic influenza plan. Suppl 8;2005:S8–1–S8–33. Available at: http://www.hhs.gov/pandemicflu/plan/pdf/S08.pdf. Accessed March 28, 2006.

17. Hoffman RE, Norton JE. Lessons learned from a full-scale bioterrorism exercise. *Emerg Infect Dis.* 2000;6: 652–653.

18. O'Toole T, Mair M, Inglesby TV. Shining light on "Dark Winter." *Clin Infect Dis.* 2002;34:972–983.

19. Gostin LO, Burris S, Lazzarini Z. The law and the public's health: A study of infectious disease law in the United States. *Columbia Law J.* 1999; 99:59–128.

20. Annas GJ. Bioterrorism, public health, and civil liberties. *N Engl J Med.* 2002;346:1337–1342.

21. US Census Bureau. Available at: http://quickfacts.census.gov/qfd. Accessed August 18, 2005.

22. 28 Pa. Code § 27.60 (2006).

23. Tex. Health & Safety Code § 81.083, § 122.005, and § 122.006 (2006).

24. N.J. Stat. Ann. §26:4–2 (2006).

25. N.J. Stat. Ann. §26:4–35 (2006).

26. N.J. Stat. Ann. §26:4–49.8 (2006).

27. N.J. Stat. Ann. §34:9A-13 (2006).

28. N.J. Admin. Code §8:57–1.9 (2007).

29. 35 P.S. § 521.7 and § 521.11 (2006), 28 Pa. Code §§ 27.60–27.68 (2007), 16 P.S. §§ 12001–12028 (2006).

30. N.Y Pub. Health Law § 310 (2006).

31. Cal. Health & Safety Code § 120145 and § 120205 (2006).

32. Tex. Health & Safety Code § 81.085 (2006).

33. N.Y. Pub. Health Law § 2100 (2006).

34. Ohio Rev. Code Ann. § 3707.05 (2006).

35. Ohio Rev. Code Ann. § 3707.08 (2006).

36. 20 Ill Comp. Stat. 2305/2 (2007).

37. 35 P.S. §§ 2140.101–2140.303 (2006).

38. 35 P.S. § 2140.301(a) (2006).

39. 28 Pa. Code §27.65 (2006).

40. N.Y. Exec. Law § 24 (2006).

41. N.J. Stat. § App. A:9–49 (2006).

42. Department of Health and Human Services. DHHS Pandemic influenza plan. 2005;Suppl 8:S8–S3. Available at: http://www.hhs.gov/pandemicflu/plan/pdf/S08.pdf. Accessed March 28, 2006.

43. Gostin LO, Sapsin JW, Teret SP, et al. The model state emergency health powers act: Planning for and response to bioterrorism and naturally occurring infectious diseases. *JAMA* 2002;288: 622–628.

44. Brown ME. Reconsidering the Model State Emergency Health Powers Act: Toward state regionalization in bioterrorism response. *Ann Health Law.* 2005;14:95–124.

45. American Law Institute, National Conference of Commissioners on Uniform State Laws. Uniform Commercial Code. Available at: http://www.law.cornell.edu/ucc/ucc.table.html. Accessed March 23, 2007.

46. The Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities. The model state emergency health powers act, Dec. 21, 2001. Available at: http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf. Accessed January 19, 2007.

47. The Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities. Model state public health laws. Available at http://www.publichealthlaw.net/Resources/Modellaws.htm#MSEHPA. Accessed January 31, 2007.

48. Richards EP, Rathbun KC. Public health law. In: Wallace RB, ed. *Public Health & Preventive Medicine, 14th Edition.* Stamford, CT: Appleton & Lange; 1998.

49. *State v. Racskowski*, 86 Conn 677 (Supreme Court of Errors of Connecticut 1913).

50. 2005 N.J. Laws C 222.

51. Richards EP, Rathbun KC. Legislative alternatives to the Model State Emergency Health Powers Act (MSEHPA): LSU Program in Law, Science, and Public Health White Paper #2, April 21, 2003. Available at: http://biotech.law.lsu.edu/blaw/bt/MSEHPA_review.htm. Accessed January 19, 2007.

52. Parmet WE, Mariner WK. A health act that jeopardizes public health. *The Boston Globe.* December 1, 2001:A15.

53. Cetron M, Landwirth J. Public health and ethical considerations in planning for quarantine. *Yale J Biol Med* 2005;78:1–6.