PUBLIC HEALTH LAW BENCHBOOK FOR MICHIGAN COURTS – REVISED AND UPDATED

2025

1. Acknowledgements

This 2025 Public Health Law Benchbook for Michigan Courts has been revised and updated from the 2007 and 2016 editions under the leadership of Jim Koval, Bureau of Emergency Preparedness, EMS and Systems of Care (BEPESoC) with the Michigan Department of Health and Human Services (MDHHS).

The members of the project team responsible for this 2025 edition are Phyllis Jeden and Susan Fleurant, with the Network for Public Health Law; and Stacie Kershner, Legal Consultant. Special thanks to Denise Chrysler, Peter Jacobson, and Stephen Murphy for their contributions to the content and helpful review.

This publication was supported by Cooperative Agreement Number 6 NU90TU000003-01-02 funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the Department of Health and Human Services.

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MDHHS-Pub-2198 (6-25).

Michigan Supreme Court 2025

- The Honorable Megan K. Cavanagh, *Chief Justice*
- The Honorable Elizabeth M. Welch, *Justice*
- The Honorable Brian K. Zahra, *Justice*
- The Honorable Kimberly A. Thomas, *Justice*
- The Honorable Richard Bernstein, *Justice*
- The Honorable Kyra H. Bolden, *Justice*
- The Honorable Thomas P. Boyd, *State Court Administrator*
- Elizabeth Rios-Jones, *Deputy State Court Administrator*
- Alicia Moon, *Supreme Court General Counsel*
- Larry S. Royster, *Supreme Court Chief of Staff and Supreme Court Clerk*

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Chapter 1: Introduction

1.1 Benchbook Overview and Scope

A. Overview

Public health is the "science of protecting and improving the health of people and their communities."[1] Public health laws are "any laws that have important consequences for the health of defined populations."[2] Public health law provides a basis for the powers and responsibilities of government at different levels and areas of jurisdiction to protect and improve the health of the public. During the COVID-19 pandemic, public health necessarily focused attention on emergency preparedness and response. However, public health also includes a wide range of laws for the prevention and control of contagious and chronic disease, injury, and environmental harms. This Benchbook will discuss several of these issues.

Public health is often described as a "victim of its own success." When public health is at its best, it is nearly invisible to the public, with illnesses and injuries being prevented. But public health has been under scrutiny since the beginning of the COVID-19 pandemic that laid bare cracks in the system, exacerbated health disparities, and brought with it increased challenges to legal authority for public health.

It is essential for the judiciary to be familiar with the important role that law plays in public health and health equity. The U. S. Supreme Court's landmark *Jacobson v. Massachusetts* ruling in 1905 recognized the judiciary as both an enforcer of governmental public health policies and an arbiter of the conflicts between individual liberties and public interests that arise from governmental public health action.[3] Despite this central role, many members of the judiciary have received little, if any, formal public health law training.

Under the U.S. Constitution, states are primarily responsible for the health, safety, and welfare of people within their state.[4] Thus, public health law is

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[1] CDC Foundation, *What is Public Health?* <https://www.cdcfoundation.org/what-public-health> (accessed April 9, 2025).
[2] Goodman et al., Centers for Disease Control & Prevention, 55 MMWR 29-33, *Law and Public Health at CDC* <https://www.cdc.gov/mmwr/preview/mmwrhtml/su5502a11.htm> (posted December 22, 2006) (accessed April 9, 2025).
[3] *Jacobson v. Massachusetts*, 197 US 11, 29; 25 S Ct 358; 49 L Ed 643 (1905).
[4] US Dep't of Health & Human Servs, *What is the difference between isolation and quarantine?* <https://www.hhs.gov/answers/public-health-and-safety/what-is-the-difference-between-isolation-and-quarantine/index.html> (accessed April 9, 2025).

primarily state law, and its juridical interpretation is affected by several considerations:

First, prior to the COVID-19 pandemic beginning in 2020, most public health cases addressing infectious diseases or other conditions requiring the intervention of local health officials dated back to at least the early 20th century, addressing diseases such as yellow fever, smallpox, and cholera. Cases stemming primarily from COVID-19 have challenged longstanding principles established in these early cases, which may result in unintended public health consequences beyond the immediate cases.

Second, public health experts in court proceedings often use complex scientific terms and methods that must be applied to a public health context. The word “quarantine” is one example. Under Michigan law, the term "quarantine," is used to describe the segregation of plants in MCL 286.201 *et seq.* and animals in MCL 287.121 *et seq*. The term “quarantine grounds” is referenced in MCL 105.1 as a legal reason to appropriate private property, along with highways, parks, sewers, cemeteries, and other spaces needed for public use; however, “quarantine grounds” are not defined. And during the height of the COVID-19 outbreak, common uses for “quarantine” included isolating for a specified duration after a positive test or the onset of symptoms; or “stay-at-home" or “shelter-in-place” orders directed at entire populations. (See reference to “self-quarantine,” added to the Michigan Employment Security Act at MCL 421.29 as an exception to disqualification of unemployment benefits.) Importantly, while these definitions are clearly health-related, none specifically capture the public health usage of the term "quarantine": “separat[ion] and restrict[ion of] the movement of people who were exposed to a contagious disease to see if they become sick.”[5] This last definition is also found in federal law.[6]

Third, many public health laws predate current rules of evidence and procedure.

Fourth, public health orders often impact the liberty, property, and economic rights of individuals, including the rights of individuals who may or may not be ill and those who wish to participate in society without the threat of exposure.

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[5] US Dep’t of Health & Human Servs, *What is the difference between isolation and quarantine?* <https://www.hhs.gov/answers/public-health-and-safety/what-is-the-difference-between-isolation-and-quarantine/index.html> (accessed April 9, 2025).

[6] See *Interstate Quarantine*, 42 CFR 70; see also *Foreign Quarantine*, 42 CFR 71.

Finally, during a public health emergency, the deliberative nature of the judicial process may be strained to keep pace with the rapid response and containment measures sought by members of the public health community. The recent COVID-19 pandemic was served as an example of this.

This updated benchbook is intended to improve understanding of law relevant to routine public health practice and public health emergencies. Courts play an increasingly critical role in protecting the public's health. This benchbook is a reference tool that judges may use as they encounter the broad range of public health issues that come into their courtrooms. In addition, this benchbook may serve as a resource to increase communication between the judiciary and public health agencies at the community, state, and national levels about a variety of public health issues.

B. Scope Note

It would be impracticable to address each and every aspect of the legal system potentially influenced by public health concerns. Indeed, almost every aspect of the legal system is related in some way to public health and health equity. However, benchbooks are not volumes of law; rather, they are readily accessible legal references for judges to use in the courtroom, providing procedural frameworks, statutory texts, relevant case law summaries, and model orders. As such, this benchbook is intended to address the areas of public health practice most likely to reach Michigan courts.

The 2025 updated benchbook includes sections on federalism and jurisdiction, constitutional rights and considerations, public health information, and control and prevention of the following: communicable diseases, environmental health hazards, foodborne illness, and chronic diseases. This benchbook contains neither areas covered by other benchbooks (e.g., Controlled Substances) nor matters fully addressed in other legal resources (e.g., treatises on Fourth Amendment search and seizure). Further, this benchbook is not intended to cover matters traditionally considered to be in the province of health care rather than public health.

This version of the benchbook has been organized for optimal reading in electronic format, with overarching legal issues hyperlinked for less repetition and easier access. The benchbook also contains model court orders to implement key public health powers of the state and localities, and additional resources to offer further clarity on public health law and practice.

1.2 Public Health, Public Health Law, and Health Equity

A. Public Health[7]

The term public health refers both to the health status of the population and to the discipline or field. According to the Centers for Disease Control and Prevention (CDC) Foundation, "Public health is the science of protecting and improving the health of people and their communities. This work is achieved by promoting healthy lifestyles, researching disease and injury prevention, and detecting, preventing and responding to infectious diseases."[8] Public health is primarily a function of government, but necessarily relies on others, including businesses, non-profit organizations, and residents to achieve its goals.

While public health and health care may intersect, the two disciplines are different. In health care, doctors and other medical professionals assess the health of the individual patient in front of them, diagnose illness or injury, and prescribe treatment (e.g., medicine, therapy, surgery). In public health, epidemiologists and other public health professionals assess the health of a population, identify harms causing disease or injury, and implement interventions to improve population health outcomes.

To improve health outcomes, public health focuses efforts on prevention. Prevention can be thought of in levels or phases: primary, secondary, or tertiary.[9] Primary prevention interventions include those initiated to prevent harm from ever occurring. Health promotion of safe sex is primary prevention, as is distribution of condoms to prevent sexually transmitted infections (STIs). Secondary prevention efforts include those taken once exposure is suspected, or when illness or injury is in early stages, to minimize the harmful effects. Routine sexually transmitted infection (STI) testing and contact tracing of sexual partners are examples of secondary prevention. Tertiary prevention strategies focus on reducing or remediating

[7] American Pub Health Ass'n, *What is Public Health?* <https://www.youtube.com/watch?v=ig2cnOLFBR4&t=2s> (posted December 21, 2021) (accessed April 9, 2025).
[8] CDC Foundation, *What is Public Health?* <https://www.cdcfoundation.org/what-public-health> (accessed April 9, 2025).
[9] Beaglehole, Bonita & Kjellström, *Basic Epidemiology* (Geneva, Switzerland: World Health Organization, 2d ed, 2006) <https://iris.who.int/bitstream/handle/10665/43541/9241547073_eng.pdf>.

harm that has already occurred. Medication treatment for infections to prevent more serious illness is an example of tertiary prevention.[10]

Another example in the context of lead poisoning prevention might be as follows: primary prevention – removing lead hazards to prevent childhood exposures; secondary prevention – screening for elevated blood lead levels as part of well-child pediatrician appointments; and tertiary prevention – providing educational supports and accommodations for children affected by lead poisoning.[11]

Public health experts also recognize another level of prevention: primordial.[12] Primordial prevention efforts are focused on addressing the risk factors associated with the underlying social determinants of health. The intention is to create healthy environments and promote healthy conditions and thus reduce the risk of chronic disease and injury. In the example above of lead poisoning prevention, increasing access to safe and affordable housing is primordial prevention, as lead paint is found in older housing stock, and low-income families may be less able to afford to rent or own homes that have been remediated. The social determinants of health are further discussed below.

The Core Functions and Essential Public Health Services, updated in 2020, provide a framework for public health priorities.[13] The three core functions of public health are assessment, policy development, and assurance. The ten essential public health services are the activities each health department should engage in to improve health outcomes. Equity and that should be at the center of all public health efforts. This framework is illustrated by the following:

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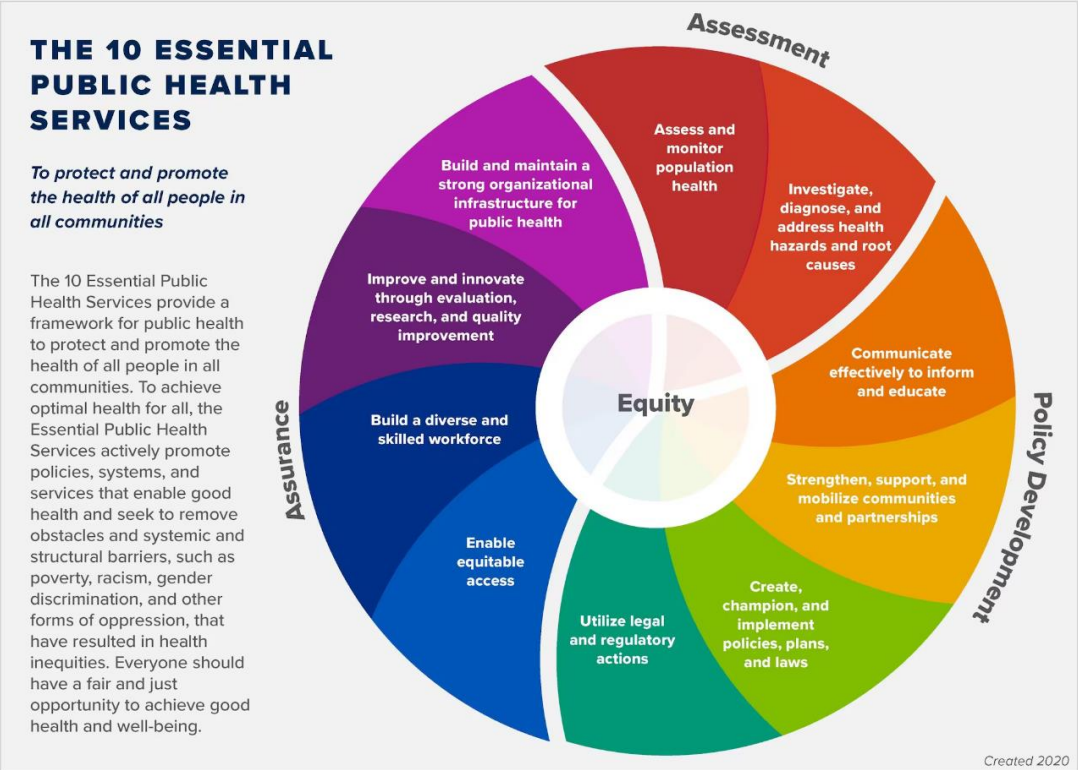
[10] Leavell & Clark, *Preventive medicine for the doctor in his community; an epidemiologic approach (*New York: McGraw-Hill, 1965), pp. 20-28.
[11] Ettinger, Leonard, & Mason, *CDC's Lead Poisoning Prevention Program: A Long-standing Responsibility and Commitment to Protect Children From Lead Exposure*, 25 J Pub Health Mgmt & Prac S5, S5-S12 (2019) <https://pmc.ncbi.nlm.nih.gov/articles/PMC6320665/>.
[12] Strasser, *Reflections on Cardiovascular Diseases*, 3 Interdisc Sci Revs 225-230 (1978). Strasser is credited with first defining the primordial state or level of intervention.
[13] Centers for Disease Control & Prevention, *10 Essential Public Health Services* <https://www.cdc.gov/public-health-gateway/php/about/?CDC_AAref_Val=https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html> (posted May 16, 2024) (accessed April 9, 2025).

Figure 1[14]



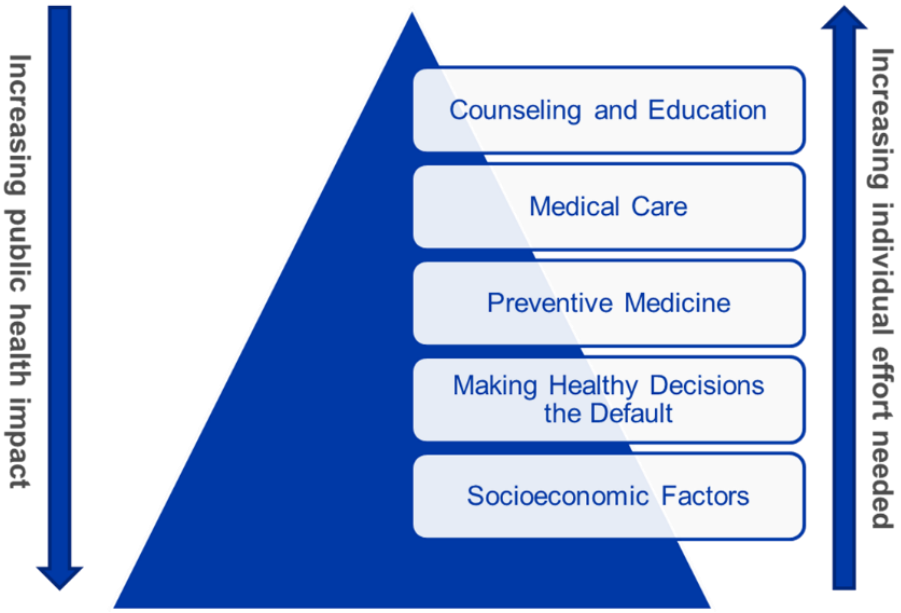
Note that two of the 10 essential services specifically address law: "utilize legal and regulatory actions," and "create, champion and implement policies, plans, and laws."

Former CDC director Thomas Frieden portrays the degree of results of different types of health care and public health interventions with his "Health Impact Pyramid."[15] Starting at the top are counseling and education interventions, followed by clinical interventions, next preventive medicine, then making healthy decisions the default, and lastly, positively influencing socioeconomic factors. Moving down the pyramid, the overall public health impact increases and the effort required by an individual decreases. Moving up the pyramid, the overall public health impact decreases, and the effort of an individual increases. Generally, interventions closer to the top of the pyramid also cost more per person impacted, and interventions nearer to the bottom cost less per person. However, interventions closer to the top may be funded, at least in part, by private insurance or other personal

[14] *Id*.
[15] Frieden, *A Framework for Public Health Action: The Health Impact Pyramid*, 100 Am J Pub Health 590, 590-595 (2010) <https://doi.org/10.2105/AJPH.2009.185652>.

sources, whereas interventions nearer the bottom are traditionally funded by the government and taxpayers.

Figure 2[16]



Over the past century, the United States saw significant declines in morbidity and mortality in several key areas due to targeted public health efforts. These include:

- Vaccine-preventable diseases.
- Motor-vehicle safety.
- Safer workplaces.
- Control of infectious diseases.
- Decline in deaths from coronary heart disease and stroke.
- Safer and healthier foods.
- Healthier mothers and babies.

[16] Centers for Disease Control & Prevention, Public Health 101 Series, *Introduction to Public Health* <https://www.cdc.gov/training-publichealth101/php/training/introduction-to-public-health.html> (2025) (accessed April 10, 2025).

- Family planning.
- Fluoridation of drinking water to reduce dental decay; and
- Recognition of tobacco use as a health hazard.[17]

Despite dramatic achievements, some declines in these key areas in morbidity and mortality have stagnated. For example, declining vaccination rates has resulted in outbreaks of measles, pertussis, and other preventable diseases.[18] Further, new challenges are being addressed using public health approaches, including opioid use[19] and gun violence.[20]

B. Public Health Law

Law played an important role in each of the public health achievements mentioned in the previous section. Vaccine requirements for attendance at schools, indoor smoking prohibitions, mandatory seatbelt usage and similar laws contributed to the implementation, enforcement and compliance of interventions intended to improve public health outcomes.[21]

What is public health law? Lawrence Gostin, a public health law expert, defines public health law as the following:

> Public health law is the study of the legal powers and duties of the state, in collaboration with its partners (e.g., health care, business, the community, the media, and academe), to assure the conditions for people to be healthy (to identify, prevent, and ameliorate risks to health in the population) and the limitations on the power of the state to constrain the autonomy, privacy, liberty, proprietary, or other legally protected interests of individuals for the common good… The prime objective of public health law is to pursue the highest

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[17] Centers for Disease Control & Prevention, 48 MMWR 241, 241-243, *Ten Great Public Health Achievements – United States, 1900-1999.* <http://www.cdc.gov/mmwr/preview/mmwrhtml/00056796.htm> (posted April 2, 1999) (accessed April 9, 2025).

[18] Wells, Mich Pub NPR, *More Michigan kids are getting vaccine-preventable diseases* <https://www.michiganpublic.org/health/2024-12-12/more-michigan-kids-are-getting-vaccine-preventable-diseases> (posted December 12, 2024) (accessed April 9, 2025).

[19] Bridge Mich, *Fighting Michigan's opioid crisis with new needles, purer drugs, respect for addicts* <https://www.bridgemi.com/michigan-health-watch/fighting-michigans-opioid-crisis-new-needles-purer-drugs-respect-addicts> (posted March 24, 2024) (accessed April 9, 2025).

[20] Nargiso, Second Wave Mich, *How public health focuses on gun safety and reducing firearm violence* <https://www.secondwavemedia.com/features/102224gunsafety.aspx> (posted October 22, 2024) (accessed April 9, 2025).

[21] Moulton, Goodman & Parmet, *Perspective: Law and Great Public Health Achievements*, in *Law in Public Health Practice* (Goodman et al. eds, 2d ed, 2007).

possible level of physical and mental health in the population, consistent with the values of social justice.[22]

Gostin's definition emphasizes the inherent tension in balancing the government's powers, duties and limitations against individual interests, as well as the need for collaboration with other disciplines and with the community.

Public health laws can be divided into three main categories:

- **Infrastructural** – laws that establish the public health infrastructure, such as authorizing the department responsible for carrying out the majority of public health initiatives and appropriating funds.

- **Interventional** – laws designed to address or improve public health outcomes, whether under the health department's authority or other sectors; and

- **Incidental** – laws that are not targeted at public health but have consequences for public health, whether positive or negative.[23]

Like health care and public health in the previous section, health care law and public health law are also distinct, although complementary, fields. Legal issues common in health care delivery focus on the individual patient and physicians' obligations to their patients; in contrast, public health law emphasizes population health. Health care law addresses things like the doctor-patient relationship, patient privacy, medical malpractice, regulatory structure of health care systems, and fraud and abuse. Public health law focuses on the health of populations, such as disease control, food safety, sanitation, and water and air quality.

Laws intended to protect the public's health must be balanced against individual rights.[24] The figure of the Nuffield Intervention Ladder below illustrates categories of public health interventions becoming increasingly more restrictive moving up the rungs of the ladder.[25] Public health prefers voluntary or less restrictive measures when possible, such as requiring

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[22] Gostin, Lawrence O., *A Theory and Definition of Public Health Law*, 10 J. Health Care L. & Pol'y 1-12 (2007) <https://scholarship.law.georgetown.edu/cgi/viewcontent.cgi?article=1091&context=facpub>.
[23] Burris, *From Health Care Law to the Social Determinants of Heath: A Public Health Research Perspective*, 159 U P L Rev 1649, 1662-1663 (2011).
[24] *Jacobson,* 197 US at 29.
[25] Nuffield Council on Bioethics, *Public health: ethical issues* <https://cdn.nuffieldbioethics.org/wp-content/uploads/Public-health-ethical-issues.pdf> (posted November 2007) (accessed April 9, 2025).

nutritional information on food labels to inform purchasers. However, as the danger to public health increases or when higher rates of compliance are necessary to protect the public's health, more restrictive measures may be necessary.

Figure 3[26]

The field of public health law also has a guiding framework. The Five Essential Public Health Law Services are designed to support the two law-related essential services in the 10 Essential Public Health Services. This model reflects the need for collaboration among lawyers, public health practitioners, subject matter experts, and members of the community. The model uses a transdisciplinary approach, a collaborative strategy that combines public health legal practice with the monitoring, assessment, and enforcement responsibilities typically carried out by public health professionals.[27]

[26] Image generated by authors based on the Nuffield Intervention Ladder.
[27] Burris et al., *Better Health Faster: The 5 Essential Public Health Law Services*, 131 Pub Health Rep 747, 747-653 (2016) <https://pmc.ncbi.nlm.nih.gov/articles/PMC5230841/pdf/10.1177_0033354916667496.pdf>.

Figure 4[28]

C. Health Equity and Health in All Policies

Among other duties, the Michigan Department of Health and Human Services (MDHHS) and local health departments are charged with the "prevention and control of health problems of particularly vulnerable population groups." MCL 333.2221(1) and MCL 333.2433(1).[29] MDHHS is also specifically charged with addressing racial and ethnic health disparities in the state and creating a structure to do so. MCL 333.2227. Within MDHHS, the Office of Transformation, Engagement and Community Health (TEaCH) works to improve service delivery, strengthen state health infrastructure, and support culturally responsive practices to eliminate differences in health outcomes. Some population groups in Michigan experience worse health outcomes relative to others. Social, economic, environmental, and structural disparities are among the factors that lead to worse health outcomes. For example, the average lifespan of someone living in Grosse Pointe, a predominantly White city where the median household income is $136,094, is 82 years old; less than ten miles away in Detroit, a predominately Black city where the median household income is

[28] Network for Pub Health Law, *Five Essential Public Health Law Services* <https://www.networkforphl.org/resources/topics/trainings/five-essential-public-health-law-services/> (accessed April 9, 2025).

[29] MDHHS powers also include the latitude to "[e]ither directly or by interagency contract, develop and deliver health services to vulnerable population groups." MCL 333.2226(f); see also Strichartz, Commentary of the Michigan Public Health Code (ICLE, 1982), p 101 ("Subsection (f) again emphasizes the need to develop programs for vulnerable population groups.").

$38,080, the average lifespan is 13 years shorter.[30] A developing understanding of these issues has led to increasing efforts to consider health equity in all aspects of public health and beyond.

The Robert Wood Johnson Foundation provides the following definition of health equity:

> Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.[31]

Conditions such as employment, education, housing, and health care are part of what make up the social determinants of health. The social determinants of health are defined by the CDC as follows:

> Social determinants of health (SDOH) are the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, worship, and age. These conditions include a wide set of forces and systems that shape daily life such as economic policies and systems, development agendas, social norms, social policies, and political systems.[32]

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[30] Wayne State University School of Medicine, *Wayne State develops novel geocoded map to improve health outcomes throughout Michigan* <https://www.med.wayne.edu/data-mapping> (accessed April 9, 2025); US Census Bureau, *Gross Pointe city, Michigan* <https://data.census.gov/profile/Grosse_Pointe_city,_Michigan?g=160XX00US2635480#race-and-ethnicity> (accessed April 9, 2025); US Census Bureau, *Detroit city, Michigan* <https://data.census.gov/profile/Detroit_city,_Michigan?g=160XX00US2622000> (accessed April 9, 2025). See also, Tulane University, Celia Scott Weatherhead School of Public Health & Tropical Medicine, *Health Inequality: Examining Public Health Disparities by ZIP code,* (2020) <https://publichealth.tulane.edu/blog/health-disparities-by-zip-code/> (accessed April 9, 2025) and *Moving from indifference to reparative action: a public health approach to racial health inequities in life expectancy in cities in the USA.* Morse, Michelle et al. The Lancet, Volume 404, Issue 10469, 2237 – 2239.

[31] Braveman et al., Robert Wood Johnson Foundation, *What is Health Equity? And What Difference Does a Definition Make?* <https://www.rwjf.org/en/insights/our-research/2017/05/what-is-health-equity-.html> (posted May 2017) (accessed April 9, 2025).

[32] Centers for Disease Control and Prevention, *Social Determinants of Health (SDOH)* <https://www.cdc.gov/about/priorities/why-is-addressing-sdoh-important.html> (accessed April 9, 2025) (”CDC has adapted this definition from the World Health Organization”).

Though a factor in health outcomes, health care only accounts for an estimated 10 to 20% of those outcomes. The social determinants of health account for the remaining 80 to 90%.[33]

Acknowledging that systemic, institutional, and other forms of racism have perpetuated disparities, jurisdictions across the country, including many in Michigan and the state itself, have declared racism as a public health crisis.[34] Because laws, such as redlining, have driven racism and continue to propel wide disparities in the social determinants of health, laws are also used to advance health equity.[35]

One way to address health equity is to consider the Health in All Policies (HiAP) approach. HiAP is defined as "a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas."[3637] The HiAP approach acknowledges that most policies that impact the social determinants of health are implemented outside of health departments, so to advance health equity lawmakers must consider the public health consequences of all law and policy, not just law and policy that centers on health. One example of Michigan's approach to incorporating HiAP in decision-making is the Good Housing = Good Health Program where, in 2023, local health departments received funding to improve access to housing resources.

Advancing health equity is a distinct responsibility of state and local health departments under the Public Health Code. But the mandate serves the state in less obvious ways because when conditions are improved for a particular group of people, they inevitably benefit all of society. This

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[33] Hood, et al., American Journal of Preventative Medicine, *County Health Rankings: Relationships Between Determinant Factors and Health Outcomes* <https://pubmed.ncbi.nlm.nih.gov/26526164/> (posted February 2016) (accessed April 9, 2025).
[34] Executive Order No. 2020-9; American Public Health Association, *Racism as a Public Health Crisis: From Declaration to Action* <https://endingracism.apha.org> (accessed April 9, 2025).
[35] Mehdipanah, McVay & Schulz, *Historic Redlining Practices and Contemporary Determinants of Health in the Detroit Metropolitan Area*, 113 Am J Pub Health S49, S49-S57 (January 25, 2023) <https://ajph.aphapublications.org/doi/epdf/10.2105/AJPH.2022.307162> .
[36] Rudolph et al., American Pub Health Ass'n, *Health in All Policies: A Guide for State and Local Governments* <https://www.apha.org/-/media/files/pdf/factsheets/health_inall_policies_guide_169pages.pdf> (posted 2013) (accessed April 9, 2025).
[37] MDHHS, *Michigan's Roadmap to Healthy Communities* <https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Inside-MDHHS/Policy-and-Planning/Social-Determinants-of-Health-Strategy/SDOH-Strategy-Phase-III-FINAL-011724.pdf?rev=563815e5ebdd445394297b8aed433300&hash=2E56E1B40130871D2441B39CA46E632E> (posted January 17, 2024) (accessed April 9, 2025).

phenomenon is often referred to as “universal design”[38] or the “curb cut effect.”[39] Curb cuts are the ramp-like cuts connecting streets and sidewalks. The first curb cuts in the United States appeared in Kalamazoo, Michigan in 1945.[40] The installation of curb cuts across the country was prompted by the needs of those with limited mobility, but the innovation brought benefits to those who use bikes and strollers, those making deliveries, and so on. The curb cut effect shows that by advancing conditions for those who have been historically disenfranchised the entire community also benefits. In this way, public health agencies in Michigan are strengthening the health of the entire state.

[38] The UD Project, *What is Universal Design* <https://universaldesign.org/definition> (Ronald Mace, an architect and product developer coined the term universal design in the late 1970s.) (accessed April 9, 2025).

[39] Blackwell, Stanford Social Innovation Review, *The Curb-Cut Effect,* <https://ssir.org/articles/entry/the_curb_cut_effect#:~:text=Second%2C%20the%20curb%2Dcut%20effect,41%20percent%20of%20Americans%20combined.&text=Policymakers%20tend%20to%20overlook%20the,a%20path%20forward%20for%20everyone.> (posted 2017) (accessed April 9, 2025).

[40] *Id.* See also Kalamazoo Public Library, *Curb Cuts Come to Kalamazoo: Jack H. Fisher and the Push for Accessibility* <*https://www.kpl.gov/local-history/kalamazoo-history/general/curb-cuts-come-to-kalamazoo/*> (posted March 2023) (accessed April 9, 2025).

Chapter 2: Public Health Structure and Authority

2.1 Overview

All three levels of government – federal, state, and local – protect the public's health. Additionally, federally recognized tribes protect the public within their tribal boundaries. It is important that each level of government understands its authority to act, when it must act or refrain from acting, when it has discretion to act, and when it should exercise that discretion. The Network for Public Health Law created a helpful framework for jurisdictions at each level of government to better understand their public health authority.[41] The important questions jurisdictions should consider are:

- **Can I?** Does the jurisdiction have the legal authority to act, and if so, in what way(s)? What authority is granted in statutory or regulatory provisions? How are measures implemented and enforced? Is there overlapping authority within different agencies in the jurisdiction? Is the authority preempted (a higher level of government having superseding authority, such as federal over state or state over local), limiting the jurisdiction's ability to act?

- **Must I?** Is the jurisdiction legally mandated to take specific action? Are there restrictions or limitations dictating how a jurisdiction may not act? What discretion does a jurisdiction have in fulfilling its obligations?

- **Should I?** How should the jurisdiction exercise discretionary authority? What are the potential consequences of this action, alternative actions, or inaction? Does this action further the community's stated goals and values? Are there ethical or policy implications to be considered? Is the action potentially biased, arbitrary, or capricious? Might the action exacerbate existing health disparities of certain communities, and can these burdens be mitigated in some way? Are resources, including funds, equipment and personnel, available or can they be obtained? Is the action in the best interest of other individuals, businesses, and communities? Are social and economic costs of prevention measures greater than the costs of unchecked disease spread on individuals and businesses? Is the action politically feasible? Is this the best timing? What is the risk of liability for action or inaction? How should the action be carried out? What challenges will there be to compliance and enforcement? How will action or inaction be communicated to the public?[42]

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[41] Chrysler, *Public Health Decision-Making Tool,* Network for Public Health Law <https://www.networkforphl.org/resources/public-health-decision-making-tool/> (posted May 13, 2019) (accessed April 10, 2025).

[42] The Network for Public Health Law and The Association of State and Territorial Health Officials, *The Prevention Measures Law Project 3.0: User Guide* <https://www.astho.org/49009b/globalassets/pdf/the-prevention-measures-law-project-3-user-guide.pdf> (posted March 20224) (accessed April 11, 2025).

2.2 Federal Public Health Authority

A. General Authority

Public health is traditionally a state function derived from the police powers reserved under the Tenth Amendment of the U.S. Constitution. The U.S. Constitution, including its amendments, provides no specific authority for public health. The silence of the U.S. Constitution, viewed in conjunction with the Tenth Amendment's reservation of undelegated powers to the states, indicates that the federal government's public health powers extend only to the following enumerated powers:

- Areas under federal control (e.g., military bases, national parks and monuments);[43]
- Defense (e.g., war or terrorism);[44]
- Interstate Commerce (e.g., food safety, disease spread);[45]
- Taxing and Spending (e.g., highway funds tied to raising the minimum drinking age).[46]

The federal government is also able to exercise its implied powers under the Necessary and Proper Clause[47] for actions not stated explicitly but required to carry out the express powers.

On occasion, the federal government and states may have concurrent authority for the same activity. When both the federal government and states (or localities or tribes), work together, this is referred to as cooperative federalism.[48] Prevention of head injuries or fatalities from motorcycle crashes is a public health example of cooperative federalism:

> The National Highway Traffic Safety Administration does not regulate whether motorcycle helmets must be worn anywhere in the United States; it leaves that decision to the discretion of the states. However, it has issued regulations detailing the minimum performance requirements for any motorcycle helmet allowed to be sold in the United States. So, while the

[43] US Const, art IV, § 3, cl 2.
[44] US Const, art I, § 8.
[45] US Const, art I, § 8, cl 3.
[46] US Const, art I, § 8, cl 1.
[47] US Const, art I, § 8, cl 18.
[48] Tulane Univ Law Sch, *The Evolution of Cooperative Federalism* <https://online.law.tulane.edu/blog/the-evolution-of-cooperative-federalism> (posted April 15, 2021) (accessed March 28, 2025).

federal government does not regulate whether a motorcycle helmet must be worn, if a state law requires helmets to be worn, those helmets must meet the federal safety standards.[49]

B. Preemption

1. Generally

The federal government is also able to use its power to preempt state and local authority under the U.S. Constitution's Supremacy Clause.[50] Preemption is a legal doctrine that enables a higher level of government to "limit or eliminate the power of a lower level of government to regulate a specific issue."[51]

2. Types of Preemption

- "Floor preemption" is when the higher level of government sets the minimum standard, but lower levels of government are allowed to impose stricter, more protective laws.

- "Ceiling preemption" is when the higher-level sets maximum standards, but the lower level of government can establish weaker, less protective laws.

- "Null" or "vacuum preemption" is when the higher level of government sets no standard but precludes action of any lower level of government.

- "Punitive preemption" is a severe form of null preemption in which the higher level of government precludes and penalizes action by the lower level of government.

- "Savings Clause" — If the higher level of government law does not intend to prevent the lower level of government from enacting its own laws, adding a savings clause outlining what is not preempted can be critical to avoiding confusion or litigation.

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[49] Ashe & Khan, *Constitutional Foundations in Public Health Practice*, in Public Health Law: Concepts and Case Studies (Ransom & Valladeres eds, 2021), (p30).
[50] US Const, art IV, cl 2.
[51] ChangeLab Solutions, *Fundamentals of Preemption* <https://www.changelabsolutions.org/product/understanding-preemption> (posted June 2019) (accessed March 28, 2025).

3. How Preemption Works

Preemption works in several ways. For example, federal law may expressly preempt state or local authority. Federal law may also impliedly preempt state or local authority. Field preemption occurs when the federal law is comprehensive and demonstrates Congress's intention to occupy the whole field. Airline health and safety, as mentioned above, is an example of field preemption. Conflict preemption occurs when the federal law and state or local law cannot both be carried out. Obstacle preemption occurs when the state or local law would pose an obstacle to fulfilling the objective of the federal law.

4. Impact on Equity

Preemption is not inherently positive or negative but may result in circumstances that either advance or inhibit public health and health equity.[52] Preemption can lead to uniform standards and efficiency, as well as equal treatment. While a higher level of government might not set the strongest possible standard, preemption can ensure a set minimum standard.

The federal airline safety standard that prohibits smoking on flights, protecting passengers and employees, is one example of federal preemption. States may not have their own smoking regulations for airplanes. The standards do not change midflight when flying into the country or crossing state lines. Although some flights may be between airports in the same state, it would be too complicated to enforce regulations for intrastate flights if different than interstate or international flights.

On the other hand, preemption may inhibit innovation at the state or local level, removing decision-making from lawmakers who are closer to their constituents, and stalling responsiveness to problems. And, despite equal treatment that has resulted from preemption, preemption has also been used to thwart public health efforts that could have resulted in greater health equity.

[52] Carr et al., *Equity First: Conceptualizing a Normative Framework to Assess the Role of Preemption in Public Health*, 98 Milbank Q 131, 131-149 (2020).

One example of this is the menu labeling requirement included in the federal Patient Protection and Affordable Care Act (ACA) in 2010.[53] The ACA requires that retail food establishments with 20 or more locations provide calorie counts for each item on their menu. The federal law preempts state and local laws that are different than the federal law, meaning that many state and local laws that required disclosure of ingredients, such as sodium, are now not permitted. While the federal law extended to state and local jurisdictions that may never have enacted similar laws on their own, the federal law also prevented state and local jurisdictions from having disclosure requirements of calories along with other information.[54]

When higher levels of government enact laws that include preemption of lower levels of government, analysis of whether the implications of preemption are more or less protective of the public's health and whether the law has the potential to reduce or increase health disparities is warranted. If challenged in court, there is a presumption against preemption, especially when state or local police powers of health, safety, or welfare may be infringed.[55] Preemption, which can apply to the exercise of authority at all levels of government, is discussed in more detail below.

Federal preemption of state or local law is considered here. See Section 2.3, State, Local, and Tribal Public Health Authority, (C), Local Health Departments, below further discusses preemption in the context of state preemption of local law.

C. Structure and Scope of Agency Authority

The Public Health Service (PHS), led by the Assistant Secretary for Health, is comprised of most of the agencies within the U.S. Department of Health and Human Services (HHS). The lead federal public health agency is the U.S. Centers for Disease Control and Prevention (CDC). The PHS also

[53] 21 USC 343(q).
[54] Pertschuk et al., *Assessing the Impact of Federal and State Preemption in Public Health: A Framework for Decision Makers,* 19 J Pub Health Mgmt & Prac 213–219, 215 (2013) <https://pubmed.ncbi.nlm.nih.gov/22759986/>.
[55] Adkins, Pepper & Sykes, Cong Rsch Serv, R45825.3, *Federal Preemption: A Legal Primer* <https://www.congress.gov/crs-product/R45825> (posted May 18, 2023) (March 25, 2025).

includes the U. S. Public Health Service Commissioned Corps, one of the eight U. S. uniformed services.[56]

HHS and each agency in the Public Health Service is charged by Congress, directly or by delegation from the Assistant Secretary for Health, to carry out a specific responsibility for public health. Beginning in 1984, under the *Chevron*[57] doctrine, courts deferred to reasonable federal administrative agency interpretation of ambiguous statutory authority. However, federal executive authority has since been limited by the U.S. Supreme Court decisions in *Relentless, Inc v.. Department of Commerce* and *Loper Bright Enterprises v. Raimondo,* which overturned the longstanding doctrine of *Chevron* deference. Without this deference to agencies regarding interpretations of statutes that are "silent or ambiguous with respect to the specific issue,"[58] courts are to rely on their independent judgments interpreting agency authority in such cases. The U.S. Supreme Court clarified that overturning *Chevron* did not automatically overturn the many cases decided relying on this doctrine. Rather, challenges to past interpretations would have to be raised again individually. This change in doctrine may result in increased litigation and judicial uncertainty and may cause agency action to slow.[59]

At the time of writing this benchbook, other recent cases have also restrained federal agency action relating to doctrines such as the Non-Delegation Doctrine[60] and the Major Questions Doctrine.[61] Relying on the latter in *West Virginia v. EPA*, the U.S. Supreme Court struck down regulations related to the Clean Air Act, requiring Congress to provide a "clear delegation" of authority, rather than a broad delegation of power,

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[56] In 2025, several executive orders impacted the structure, organization, and existence of many federal agencies. This description was accurate as of the writing of this Benchbook.
[57] *Chevron, USA, Inc v. Nat'l Resources Defense Council, Inc*, 467 US 837; 104 S Ct 2778; 81 L Ed 2d 694 (1984), overruled by *Loper Bright Enterprises v Raimondo*, 603 US 369; 144 S Ct 2244; 219 L Ed 2d 832 (2024).
[58] *Relentless, Inc v. Dept of Commerce,* 144 S Ct 325; 217 L Ed 2d 154 (2023); *Loper Bright Enterprises,* 603 US at 369; *Chevron, USA, Inc,* 467 US at 843.
[59] Sachs, *Supreme Power — The Loss of Judicial Deference to Health Agencies*, 391 New Eng J Med 777, 777-779 (July 17, 2024) <https://www.nejm.org/doi/full/10.1056/NEJMp2408197>; Nelson, Milbank Memorial Fund, *Impact of Supreme Court Chevron Decision on Health Policy* <https://www.milbank.org/2024/07/impact-of-supreme-court-chevron-decision-on-health-policy/> (posted July 17, 2024) (accessed March 28, 2025).
[60] Cong Rsch Serv, Constitution Annotated, *ArtI.S1.5.1 Overview of Nondelegation Doctrine* <https://constitution.congress.gov/browse/essay/artI-S1-5-1/ALDE_00000014/> (March 28, 2025).
[61] Constitution Annotated, *S1.C1.7 Major Questions Doctrine and Administrative Agencies* <https://constitution.congress.gov/browse/essay/artII-S1-C1-7/ALDE_00013796/> (accessed March 25, 2025).

when the issue is “of such magnitude and consequence.”[62] Proponents argue that delegation must be narrowly interpreted under either of these doctrines or run afoul of the U.S. Constitution principle of separation of powers.

2.3 State, Local, and Tribal Public Health Authority

The state bears the primary responsibility for preventing and responding to threats to the public’s health within its jurisdiction.[63] Moreover, even with a federal government response, states are required to provide significant assistance and resources during public health emergencies.

The power of a state to protect the public's health is derived from two sources of authority — police power and *parens patriae* power. Police power is the power to make laws to preserve public safety, order, health, and morals by restraining and regulating the use of liberty and property.[64] The *parens patriae* power refers to the state's capacity to act “as provider of protection to those unable to care for themselves.”[65] This power is generally invoked when the state seeks legal standing

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[62] *West Virginia v. EPA,* 597 US 697, 735; 142 S Ct 2587; 213 L Ed 2d 896 (2022).

[63] *Jacobson v. Massachusetts*, 197 US 11, 38; 25 S Ct 358; 49 L Ed 643 (1905) ("The safety and health of the people of Massachusetts are, in the first instance, for that commonwealth to guard and protect. They are matters that do not ordinarily concern the national government."); *Compagnie Francaise de Navigation a Vapeur v Louisiana State Bd of Health*, 186 US 380, 387; 22 S Ct 811; 46 L Ed 1209 (1902). The Court stated:

> That from an early day the power of the states to enact and enforce quarantine laws for the safety and the protection of the health of their inhabitants has been recognized by Congress is beyond the question. That until Congress has exercised its power on the subject, such state quarantine laws and state laws for the purpose of preventing, eradicating, or controlling the spread of contagious or infectious diseases, are not repugnant to the Constitution of the United States, although their operation affects interstate or foreign commerce, is not an open question.

[64] *Medtronic, Inc v. Lohr*, 518 US 470, 475; 116 S Ct 2240; 135 L Ed 2d 700 (1996). The Court stated:

> Throughout our history the several States have exercised their police powers to protect the health and safety of their citizens. Because these are “primarily, and historically…matters of local concern,” the States traditionally have had great latitude under their police powers to legislate as to the protection of lives, limbs, health, comfort, and quiet of all persons. (Citations omitted.).

Black's Law Dictionary (12th ed, 2024); Freund, *The Police Power: Public Policy & Constitutional Rights* (Chicago: Callaghan & Company, 1976).

[65] *Black's Law Dictionary* (12th ed, 2024). See also *Heller v Doe*, 509 US 312, 332; 113 S Ct 2637; 125 L Ed 2d 257 (1993) ("[T]he state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable…to care for themselves ….") (citations omitted.); *Alfred L Snapp & Son, Inc v. Puerto Rico,* 458 US 592, 607; 102 S Ct 3260; 73 L Ed 2d 995 (1982). The Court stated:

> In order to maintain [a *parens patriae*] action, the State must articulate an interest apart from the interests of particular private parties, i.e., the State must be more than a nominal party. The State must express a quasi-sovereign interest…. [A] State has a quasi-sovereign interest in the health and well-being—both physical and economic—of its residents in general.

to protect the community's well-being or to act in the interest of an individual who lacks the capacity to do so themselves, for example, when the state serves as a guardian for a minor or for an incapacitated individual.[66]

This section focuses on the role and authority of the MDHHS and the state's local health departments.

A. Sources of State and Local Public Health Authority

The Michigan Constitution requires that the state legislature "pass suitable laws for the protection and promotion of the public health." Const 1963, art 4, §51. The Michigan Public Health Code became effective in 1978, and it is the source of authority for Michigan's state and local health departments. 1978 PA 368, MCL 333.1101 *et seq.* The code defines the powers and responsibilities of state and local health departments, including the authority to take actions to protect the public. Both state and local health departments are granted broad authority and general power to protect the public's health as it is not possible to address, or even to conceive of, every possible public health threat.

MDHHS is empowered with the general authority to "promulgate rules necessary or appropriate to implement and carry out the duties or functions vested by law in the department." MCL 333.2233. Note that parts of the Public Health Code specifically enable or prohibit aspects of rulemaking, which may affect the scope of MDHHS's general rulemaking authority.

Administrative rules are another important source of public health authority for MDHHS.[67] Administrative rules define minimum standards as well as inform businesses and the public on how an agency will exert authority. The process for rulemaking is laid out in the Administrative Procedures Act of 1969 (APA), MCL 24.201 *et seq.* Pursuant to MCL 24.259(2), the version of the Michigan Administrative Code published online is the official version. An example of administrative rules relevant to public health include those concerning communicable diseases.

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[66] Gostin, *Public Health Law: Power, Duty, Restraint* (Berkeley: University of California Press, 2008), pp 95-96. An incapacitated individual is defined by the Estates and Protected Individuals Code as "an individual who is impaired by reason of mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication, or other cause, not including minority, to the extent of lacking sufficient understanding or capacity to make or communicate informed decisions." MCL 700.1105(a).

[67] Instead of making rules under the APA, like MDHHS, local health departments adopt regulations. The process that governs the adoption of regulations by local health departments is laid out in the Public Health Code. See MCL 333.2441-2442.

While federal administrative agencies have recently—at the time of writing this benchbook—faced legal challenges limiting deference to agency interpretation of regulations by the federal courts with *Loper Bright Enterprises v. Raimondo* overturning *Chevron USA Inc v. Natural Resources Defense Council, Inc*, Michigan never adopted a *Chevron*-like test for state courts. Rather, as stated in *In re Complaint of Rovas Against SBC Michigan*:

> [T]he agency's interpretation is entitled to respectful consideration and, if persuasive, should not be overruled without cogent reasons. Furthermore, the agency's interpretation can be particularly helpful for "doubtful or obscure" provisions. But, in the end, the agency's interpretation cannot conflict with the plain meaning of the statute. [68]

There have also been non-delegation doctrine challenges to administrative authority in Michigan. In 2020, in *In re Certified Questions from the US District Court, Western District of Michigan, Southern Division*, the Michigan Supreme Court found the Emergency Powers of the Governor Act (EPGA), MCL 10.31, *et seq.* violated separation of powers and/or the non-delegation doctrine,[69] stating:

> Simply put, as the scope of the powers conferred upon the governor by the Legislature becomes increasingly broad, in regard to both the subject matter and their duration, the standards imposed upon the governor's discretion by the Legislature must correspondingly become more detailed and precise.[70]

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[68] *In re Rovas Complaint*, 482 Mich 90, 108 (2008) citing *Boyer-Campbell Co v Fry*, 271 Mich 282, 296 (1935). See also Neena Menon, Yale Journal on Regulation, Non-Deferential Deference: Michigan's "Respectful Consideration" and Clues for the Future After Loper Bright <https://www.yalejreg.com/nc/non-deferential-deference-michigans-respectful-consideration-and-clues-for-the-future-after-loper-bright-by-neena-menon/> (posted July 23, 2024) (accessed April 10, 2025).

[69] *In re Certified Questions from the United States Dist Court, W Dist of Michigan*, 506 Mich 332; 958 NW2d 1 (2020). (The Court was also asked whether the Emergency Management Act (EMA), MCL 30.401, *et seq.*, violated separation of powers and/or the non-delegation doctrine, the Court found the governor lacked authority by statute after 28 days to renew or issue the COVID-19 executive order, and the Court declined to answer the question of constitutionality of the EMA. This question was revisited in *T & V Assocs, Inc v. Dir of Dep't of Health & Human Servs*, 12 NW3d 594 (Mich 2024), in which the Supreme Court overturned a finding that the EMA was similarly an unconstitutional violation of non-delegation doctrine by finding the case to be moot. *Moore Murphy Hosp, LLC v. Health Dept of NW Michigan,* 11 NW3d 505 (Mich, 2024)).

[70] *Id.* at 363.

The court found that the EPGA's delegation of power to the governor was so expansive as to be against Michigan's Constitution.

B. Michigan Department of Health and Human Services

Michigan, whose public health system started in 1873 as a State Board of Public Health,[71] now vests its core public health functions and its general public health powers in MDHHS, whose director is appointed by the governor. MCL 333.2202(1).

1. Role

Under Michigan's public health structure, local health departments share coequal authority with MDHHS. But it is local health departments that have the prime responsibility of carrying out activities under the Public Health Code and that retain authority over most key decisions. Accordingly, the Public Health Code grants almost identical powers and responsibilities to both the state and local health departments. However, MDHHS is still responsible for ensuring that the state's public health is protected and so may step in where a local health department is not able or willing to perform its duties and where a particular threat may warrant a statewide response.

Pursuant to the code, MDHHS must "promote an adequate and appropriate system of local health services throughout the state and shall endeavor to develop and establish arrangements and procedures for the effective coordination and integration of all public health services including effective cooperation between public and nonpublic entities to provide a unified system of statewide health care."[72] MCL 333.2224.

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[71] MDHHS, Michigan Local Public Health Accreditation Program, *Michigan's Guide to Public Health for Local Governing Entities* <https://accreditation.localhealth.net/wp-content/uploads/2023/06/Public_Health_Guide_Final-Digital-Accessible-6.23.pdf> (posted September 2022) (April 10, 2025).

[72] Strichartz, Commentary of the Michigan Public Health Code (ICLE, 1982), p 100. The Michigan Public Health Code, effective in 1978, marks "the first time the department is charged with looking at the total health care system and also creating a unified system of statewide health care at the local level. A cooperative enterprise is envisioned through which public health reaches out to all the components affecting its operation at the state and local levels."

2. General Duties and Authority

MCL 333.2221(2) sets forth some of the general duties of MDHHS:

> (2) The department shall:
> (a) Have general supervision of the interests of the health and life of the people of this state.
> (b) Implement and enforce laws for which responsibility is vested in the department.
> (c) Collect and utilize vital and health statistics and provide for epidemiological and other research studies for the purpose of protecting the public health.
> (d) Make investigations and inquiries as to:
> (i) The causes of disease and especially of epidemics.
> (ii) The causes of morbidity and mortality.
> (iii) The causes, prevention, and control of environmental health hazards, nuisances, and sources of illness.
> (e) Plan, implement, and evaluate health education by the provision of expert technical assistance and financial support.
> (f) Take appropriate affirmative action to promote equal employment opportunity within the department and local health departments and to promote equal access to governmental financed health services to all individuals in the state in need of service.
> (g) Have powers necessary or appropriate to perform the duties and exercise the powers given by law to the department and which are not otherwise prohibited by law.
> (h) Plan, implement, and evaluate nutrition services by the provision of expert technical assistance and financial support.

MDHHS is also authorized under MCL 333.2226 to (a) both engage in research programs and to staff professional training programs; (b) advise governmental entities or others on the location, drainage, water supply, disposal of solid waste, heating, and ventilation of buildings; (c) enter into agreements, contracts, or arrangements with entities of government and others to help carry out duties and functions; (d) exercise authority and promulgate rules in order to safeguard public health, prevent spread of diseases and sources of contamination, and “to implement and carry out the powers and

duties vested by law" in MDHHS; (e) accept donations; and (f) "develop and deliver health services to vulnerable population groups."

MDHHS is tasked with periodic reporting to the governor and legislature (MCL 333.2231), has authority to "[e]xercise overall leadership in recognizing the importance of public health education objectives" (MCL 333.2237), and is required to annually identify priority health problems for the state (MCL 333.2301).

3. Specific Additional Authority

a. Imminent Danger

Under MCL 333.2251(1):

> Upon a determination that an imminent danger to the health or lives of individuals exists in this state, the [MDHHS] director immediately shall inform the individuals affected by the imminent danger and issue an order that shall be delivered to a person authorized to avoid, correct, or remove the imminent danger.

MCL 2251(5)(b) defines "imminent danger" as:

> [A] condition or practice that exists which could reasonably be expected to cause death, disease, or serious physical harm immediately or before the imminence of the danger can be eliminated through enforcement procedures otherwise provided.

Under subsection (2), upon failure of a person to comply promptly with a department order issued under this section, MDHHS "may petition the circuit court having jurisdiction to restrain a condition or practice which the director determines causes the imminent danger or to require action to avoid, correct, or remove the imminent danger." Nearly identical authority to that provided to MDHHS by the preceding sections is also afforded to local health departments under MCL 333.2451 to address imminent danger.

In addition, if the MDHHS director determines that conditions anywhere in Michigan constitute a menace to the public health, the director may take full charge of the administration of state and local health laws, rules, regulations, and ordinances in addressing the threat pursuant to MCL 333.2251(3).

One example of imminent danger is found under the statute regulating body art (MCL 333.13104), where practice without a license is enough on its own to constitute imminent danger.

b. Epidemics

MCL 333.2253(1), amended in March 2023, states that:

> [I]f the director determines that control of an epidemic is necessary to protect the public health, the director by emergency order may make a declaration of that determination and may within that emergency order prohibit the gathering of people for any purpose and establish procedures to be followed during the epidemic to ensure continuation of essential public health services and enforcement of health laws.

See Chapter 8, Public Health Emergency Preparedness and Response, for further discussion on MCL 333.2253.

c. Inspections and Investigations

MDHHS is authorized to perform inspections and investigations, or to authorize the same. MCL 333.2241.

d. Enforcement Mechanisms

Under MCL 333.2255, MDHHS:

> [W]ithout posting bond, may maintain injunctive action in the name of the people of this state to restrain, prevent, or correct a violation of law, rule, or order which the department has the duty to enforce or to restrain, prevent, or correct an

> activity or condition which the department believes adversely affects the public health.

MCL 333.1299 also provides an enforcement mechanism:

> (1) A person who violates a provision of this code for which a penalty is not otherwise provided is guilty of a misdemeanor.
>
> (2) A prosecuting attorney having jurisdiction and the attorney general knowing of a violation of this code, a rule promulgated under this code, or a local health department regulation the violation of which is punishable by a criminal penalty may prosecute the violator.

MCL 333.2261 states that, "[e]xcept as otherwise provided by this code, a person who violates a rule or order of the department is guilty of a misdemeanor punishable by imprisonment of not more than 6 months, or a fine of not more than $200.00, or both."[73] A corresponding section relating to local regulations and orders is under MCL 333.2443.

Pursuant to MCL 333.2262(1), MDHHS "may promulgate rules to adopt a schedule of monetary civil penalties, not to exceed $1,000.00 for each violation or day that a violation continues…" Subsection (2) states, in part, that if a representative of MDHHS:

> believes that a person has violated this code or a rule promulgated or an order issued under this code which the department has the authority and duty to enforce, the representative may issue a citation at that time or not later than 90-days after discovery of the alleged violation.

[73] Strichartz, Commentary of the Michigan Public Health Code (ICLE, 1982), p 110. Strichartz commented:

> Punishment for violation of a rule or order of the department provides additional enforcement powers to the department. When taken together with § 2262 it provides a powerful tool to ensure that there will be a speedy response to department orders and citations. The section also supplements § 1299 (misdemeanor for violation of code unless otherwise provided.

That section further details the form of the citation and how it is to be delivered or sent.

MCL 333.2263 details the manner in and time by which an alleged violator may petition for an administrative hearing and provides further information regarding such hearings and appeals as well as where the applicable penalty should be paid.

4. Relationship with Other State Departments

When the Public Health Code was first enacted, the state health department was tasked with managing regulatory programs that are now implemented by other state agencies. For example, the state health department regulated food establishments, but that power now rests with the Michigan Department of Agriculture and Rural Development (MDARD) under Michigan's Food Law. MCL 289.1101 *et seq.*[74] However, MDARD delegates enforcement authority and responsibility for food service establishments to local health departments (MCL 289.3105). Similarly, the state health department was once tasked with implementing the Safe Drinking Water Act (MCL 325.1016), but this power was later moved to the Michigan Department of Environment, Great Lakes, and Energy (EGLE), which is permitted to enter into agreements, contracts, or cooperative arrangements with local health departments, among others, to administer the Act.

Several other Michigan laws enacted to protect the public's health are implemented by agencies other than the state's health department. However, it is still MDHHS that is empowered to carry out core public health functions and is the state department that retains general public health powers.

The evolving public health law landscape in Michigan may cause confusion when reviewing laws that have not been updated and refer to departments that no longer exist or that do not assign clear responsibility to a particular state agency or agencies. In addition, there are areas of overlapping authority. For example, Article 12 of the Public Health Code grants EGLE the authority to serve as Michigan's environmental health agency, but there are separate laws

[74] *See Chapter 6, Food Safety.*

for environmental health and public health with environmental health functions divided among state agencies. MCL 333.12103(1).

Though confusing at times, the fact that state agencies outside of MDHHS are responsible for implementing and considering laws that protect the public's health embodies the concept of "Health in All Policies." As discussed in chapter 1, because the social determinants of health are the greatest driver of health outcomes and because most policies that impact these determinants are implemented outside of public health, to effectively and efficiently protect the public's health requires the cooperation of all state departments working together. In this way, most policies are health policy, and other departments outside of state and local health departments are also working in public health.

C. Local Health Departments

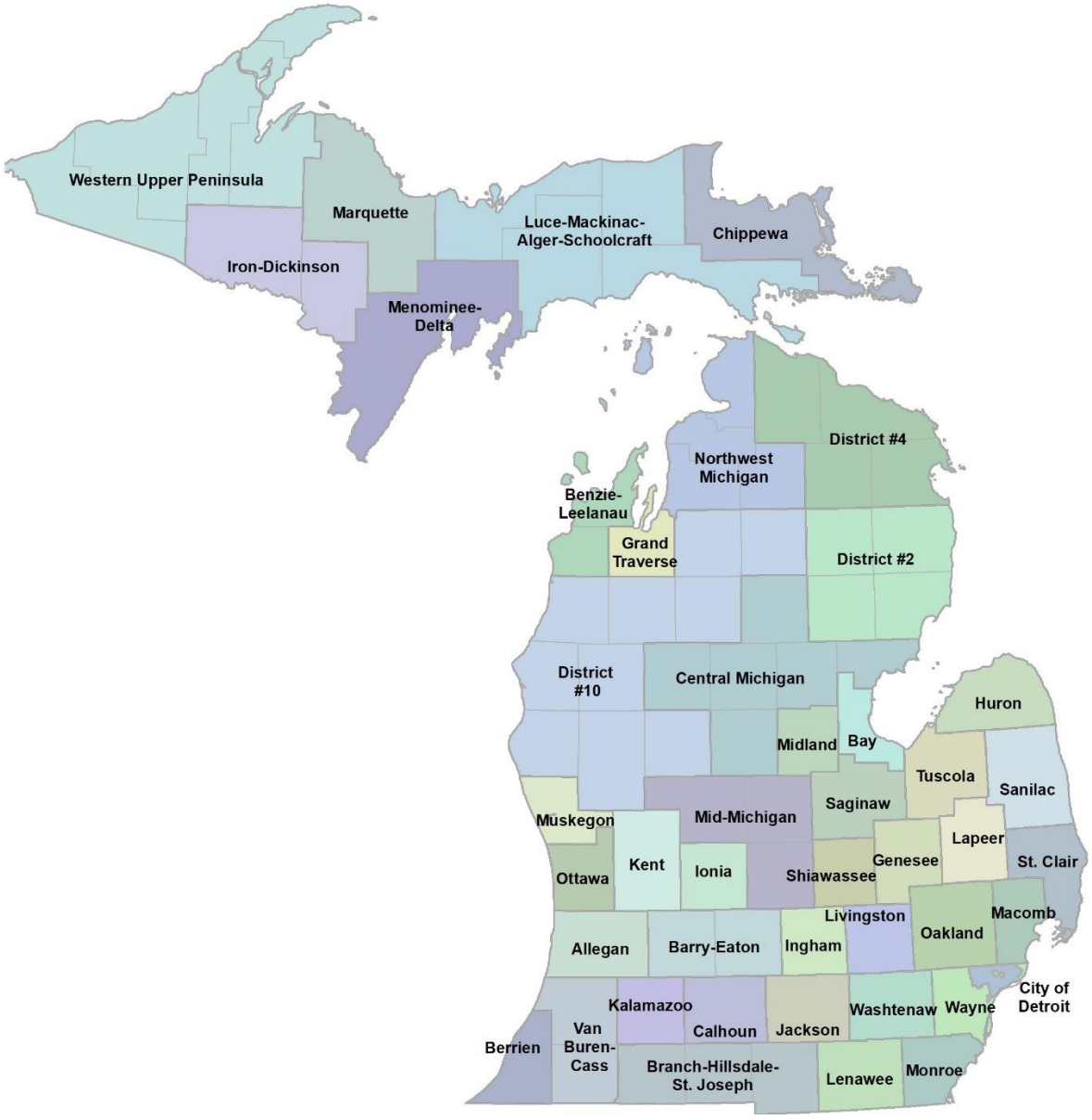
1. Role and Structure

Michigan's local health departments have a vital role to play in protecting the public against health threats as the state's primary responders. Local health departments are integrated into their local communities and are in the best position to respond to the needs of those communities. MDHHS provides local health departments with technical assistance, training, funding and other support. MDHHS must also enter into an agreement with local health departments to require the implementation of standards established by MDHHS. See MCL 333.2495 and MCL 333.2484.

The state's 83 counties are served by 45 health departments. Under MCL 333.2413, the local governing entity of a county provides for a county health department unless a district health department is created pursuant to MCL 333.2415. These district health departments cover multiple counties. Only Detroit has a city health department due to population size. MCL 333.2421. See the image below for a map of Michigan health departments. Each local health department is a part of its local government and is separate from MDHHS. They are governed by a local entity made up of county board(s) of commissioners and/or the county executive, the city council, and/or the city mayor. See MCL 333.2406 and MCL 333.2411.

Figure 5[75]

Local Health Departments State of Michigan



[75] MDHHS, *Division of Local Health Services* <https://www.michigan.gov/mdhhs/keep-mi-healthy/local-health-services/what-is-local-public-health> (accessed April 10, 2025).

2. General Duties and Authority

Just as the Public Health Code defines the powers and responsibilities of the state health department, it also defines the same for local health departments.

Under MCL 333.2431, local health departments are responsible for the following general duties:

> (1) A local health department shall:
>
> (a) Have a plan of organization approved by the department.[76]
>
> (b) Demonstrate ability to provide required services.
>
> (c) Demonstrate ability to defend and indemnify employees for civil liability sustained in the performance of official duties except for wanton and willful misconduct.
>
> (d) Meet the other requirements of this part.
>
> (2) Each local health department shall report to the department at least annually on its activities, including information required by the department.
>
> (3) In reviewing a plan for organization of a local health department, the department shall consider the fiscal capacity and public health effort of the applicant and shall encourage boundaries consistent with those of planning agencies established pursuant to federal law.
>
> (4) The department may waive a requirement of this section during the option period specified in section 2422 based on acceptable plan development during the planning period described in section 2424 and thereafter based on acceptable progress toward implementation of the plan as determined by the department.

Local health departments also have powers and duties listed under MCL 333.2433:

> (1) A local health department shall continually and diligently endeavor to prevent disease, prolong life, and promote the public health through organized programs, including prevention and control of environmental health hazards; prevention and control of diseases; prevention and control of health problems of particularly vulnerable population groups; development of health care facilities and health services delivery systems; and regulation of

[76] The word "department" as used here refers to MDHHS. See MCL 333.1104(5).

health care facilities and health services delivery systems to the extent provided by law.

(2) A local health department shall:

(a) Implement and enforce laws for which responsibility is vested in the local health department.

(b) Utilize vital and health statistics and provide for epidemiological and other research studies for the purpose of protecting the public health.

(c) Make investigations and inquiries as to:

(i) The causes of disease and especially of epidemics.

(ii) The causes of morbidity and mortality.

(iii) The causes, prevention, and control of environmental health hazards, nuisances, and sources of illness.

(d) Plan, implement, and evaluate health education through the provision of expert technical assistance, or financial support, or both.

(e) Provide or demonstrate the provision of required services as set forth in section 2473(2).

(f) Have powers necessary or appropriate to perform the duties and exercise the powers given by law to the local health officer and which are not otherwise prohibited by law.

(g) Plan, implement, and evaluate nutrition services by provision of expert technical assistance or financial support, or both.

(3) This section does not limit the powers or duties of a local health officer otherwise vested by law.

Under MCL 333.2435, local health departments may also:

(a) Engage in research programs as well as staff training programs.

(b) Advise local agencies and others “as to the location, drainage, water supply, disposal of solid waste, heating, and ventilation of buildings”.

(c) Enter into agreements, contracts, or arrangements with others to carry out duties and functions (unless otherwise prohibited).

(d) "[A]dopt regulations to properly safeguard the public health and to prevent the spread of diseases and sources of contamination";

(e) accept donations to use to perform its functions.

(f) sell and convey real estate it owns.

(g) "Provide services not inconsistent with this code".

(h) "Participate in the cost reimbursement program set forth in sections 2471 to 2498".

(i) "Perform a delegated function unless otherwise prohibited by law."

Local health departments are required to provide services, including those directed at the prevention and control of environmental health hazards, diseases, and health problems of particularly vulnerable population groups, as well as the development of health care facilities, agencies, and health service delivery systems and regulate the same as provided by state law. MCL 333.2473.

3. Specific Additional Authority

Local health departments are granted specific authority to inspect or investigate concerns and for enforcement.

a. Inspections and Investigations

Local health departments are authorized to perform inspections and investigations, or to authorize the same. MCL 333.2446.

b. Enforcement Mechanisms

Under MCL 333.2443, local health departments are provided with enforcement authority that states that:

> Except as otherwise provided in this act, a person who violates a regulation of a local health department or order of a local health officer under this act is guilty of a misdemeanor punishable by imprisonment for not more than 6

> months or a fine of not more than $200.00, or both.

Pursuant to MCL 333.2461(1), a local health department "may adopt a schedule of monetary civil penalties of not more than $1,000.00 for each violation or day that the violation continues…" Subsection (2) states, in part, that:

> If a local health department believes that a person has violated this code or a rule promulgated, regulation adopted, or order issued under this code which the local health department has the authority and duty to enforce, the representative may issue a citation at that time or not later than 90-days after discovery of the alleged violation.

That subsection further details the form of the citation and how it is to be delivered or sent.

MCL 333.2465 allows local health officers to take injunctive action and provides for protection against personal liability "for damages sustained in the performance of local health department functions, except for wanton and willful misconduct."

MCL 333.1299 also provides an enforcement mechanism.

See parallel Section 2.3, State, Local, and Tribal Public Health Authority, (A), Michigan Department of Health and Human Services.

4. Relationship Between State and Local Health Departments

As stated previously, the Public Health Code provides almost identical powers and responsibilities to both MDHHS and local health departments. The code even allows MDHHS to authorize a local health department to exercise functions on its behalf unless otherwise prohibited as local health departments are primarily responsible for health services and programs in their respective areas. Moreover, when a branch of MDHHS delivers services directly to a local health department area, a summary report of the services must be provided to the relevant local health department upon

request by a local health officer. MCL 333.2235. However, MDHHS is also empowered to "exercise any power vested in a local health department in an area where the local health department does not meet the requirements of this part." MCL 333.2437.

a. Home Rule

The Michigan Constitution 1963, art 7, §§ 1, 2, 22 and 34 grants "home rule" to its political subdivisions. Home rule is when local units of government are permitted, whether through state constitutions or in statute, some degree of self-determination and may have responsibility for managing their own affairs without interference from the state.[77] In Michigan, home rule authority includes the power of a city or village to "adopt and amend its charter" and to "adopt resolutions and ordinances relating to its municipal concerns, property and government, subject to the constitution and law." Const 1963, art 7, § 22.[78] Cities and villages "enjoy not only those powers specifically granted, but they may also exercise all powers not expressly denied."[79] Counties and townships possess the powers expressly granted or "fairly implied" by the state constitution or general law. Const 1963, art 7, § 34. Charter counties have greater regulatory authority than non-charter counties. MCL 45.501 *et seq.* The authority of local jurisdictions "shall be liberally construed in their favor. Const 1963, art 7, § 34.

b. Preemption

i. Generally

As described above in Section 2.2, preemption is a legal doctrine that enables a higher level of

[77] Citizens Research Council of Michigan, *Counties in Michigan: An Exercise in Regional Government* <https://crcmich.org/wp-content/uploads/rpt395_counties_exercise_regional_government-2017-1.pdf> (posted March, 2017) (accessed April 11, 2025). See p. 4 for a brief description of Home Rule, Dillon's Rule, and Cooley Doctrine in Michigan.

[78] Statutory authority further details powers and responsibilities of cities and villages. Michigan's Home Rule City Act provides for the incorporation of cities and for revising and amending city charters as well as other powers and duties. MCL 117.1 *et seq*. Similarly, the Home Rule Village Act provides for the incorporation of villages and for revising and amending village charters, among other powers and duties. MCL 78.1 *et seq*.

[79] *City of Detroit v. Walker*, 445 Mich 682, 690; 520 NW2d 135 (1994).

government to "limit or eliminate the power of a lower level of government to regulate a specific issue."[80]

ii. Preemption and Public Health Authority

As noted elsewhere, the Public Health Code grants broad authority to state and local health departments to protect the public's health. Under MCL 333.1115, "A state statute, a rule of the department, or an applicable local health department regulation shall control over a less stringent or inconsistent provision enacted by a local governmental entity for the protection of public health." Likewise MCL 333.2441, local health departments can enact regulations so long as the regulations are "at least as stringent as the standard established by state law applicable to the same or similar subject matter." Also, "[r]egulations of a local health department supersede inconsistent or conflicting local ordinances."

iii. Express Preemption

State preemption of local laws can be expressly stated in statute. State laws that expressly preempt local laws do not always use the term "preempt." Other terms that may signal preemption include, but are not limited to, "exclusive," "sole authority," "supersede," "matter of statewide concern," "occupy the field," "uniform," "may not exceed" or "may not be more restrictive."

iv. Implied Preemption

Michigan also recognizes two types of implied preemption: 1) "conflict preemption" — "when a local regulation directly conflicts with state law," and 2) "field preemption" — "when the state has occupied the entire field of regulation in a certain area."[81] To determine if preemption is implied, examination of the language of the law, along with the legislative history and potentially

[80] ChangeLab Solutions, *Fundamentals of Preemption* <https://www.changelabsolutions.org/product/understanding-preemption> (posted June 2019) (accessed April 10, 2025).
[81] *DeRuiter v. Twp of Byron,* 505 Mich 130, 140; 949 NW2d 91 (2020).

other context may be required. A local law is not necessarily preempted solely because a state law also focuses on the same subject. Rather, preemption may be found when "the ordinance permits what the statute prohibits, or the ordinance prohibits what the statute permits."[82] The local law may survive a preemption challenge if it merely adds to the state law.[83]

v. Preemption Example

At issue in *People of the City of Sterling Heights v. Bahnke* is a Michigan local ordinance.[84] The city issued a citation to Robert Bahnke, manager of Pro Fireworks, for not handing out a flyer, as required under the Sterling Heights Code § 20-115. He appeared before the magistrate, was found to have violated the ordinance, and was fined $150. He argued that the Michigan Fireworks Safety Act (MFSA), MCL 28.457, impliedly preempted the city ordinance, through conflict preemption — the ordinance directly conflicting with the state law, and through field preemption — the state intended to exclusively occupy the field of fireworks sales.

The MFSA states, "Except as provided in this act, a local unit of government shall not enact or enforce an ordinance, code, or regulation pertaining to or in any manner regulating the sale, display, storage, transportation, or distribution of fireworks regulated under this act." A savings clause of the MFSA allows for local governments to regulate "ignition, discharge, or use of consumer fireworks," except as to specific days. The Sterling Heights ordinance required that fireworks vendors display a flyer and hand one out to each purchaser. The text of the flyer was to list the specific days the MFSA allows for, as well as details about when, where, and how the fireworks may or may

[82] *People v. Llewellyn*, 401 Mich 314, 322 n 4 (1977).
[83] *USA Cash #1, Inc v. City of Saginaw*, 285 Mich App 262, 267; 776 NW2d 346 (2009).
[84] *People of the City of Sterling Heights v. Bahnke*, opinion of the Court of Appeals, issued February 15, 2024 (Docket No. 364264).

not be discharged. The circuit court found that requiring the flyer directly conflicted with the state law and was thus preempted by the state statute. As the circuit court found conflict preemption, it did not address the argument of field preemption.

D. Tribal Public Health

In Michigan, there are 12 federally recognized tribes, which operate as sovereign entities. These tribes protect the health of their communities with the help of the Great Lakes Inter-Tribal Epidemiology Center, whose mission is to "support tribal communities in their efforts to improve health by assisting with data needs through partnership development, community based research, education and technical assistance." The tribes are further supported through the Inter-Tribal Council of Michigan which acts as a forum for member tribes, offers technical assistance, and advocates for programs and policies to benefit tribal communities.

A 2019 Executive Directive issued by the governor led to the implementation of a 2020 Tribal Consultation Policy. The policy formalizes the MDHHS policy to seek consultation and participation of tribes for the development of policies and program activities that impact tribes, as well as establishing requirements for MDHHS engagement of and consultation with tribes, among other objectives. To be clear, state and local health departments do not have jurisdiction over tribal lands, but they may coordinate and cooperate with tribes to protect the health of people within their respective jurisdictions.

E. Rural Public Health

The Public Health Code also established the Michigan Center for Rural Health (MCL 333.2612), which is directed to "prepare a biennial plan for rural health" with MDHHS and "professional associations representing health facilities and health professions…" MCL 333.2223. "Established in 1991, the Michigan Center for Rural Health (MCRH) is one of only three non-profit State Offices of Rural Health (SORH) in the country."[85]

[85] Mich State Univ, Michigan Center for Rural Health, *About MCRH* <https://mcrh.msu.edu/aboutus> (accessed April 10, 2025).

2.4 Public Health Officials

A. Immunity and Liability

1. Generally

Pursuant to MCL 333.2228(2), neither the MDHHS director nor MDHHS employees are personally liable for the damages that are sustained while they are performing departmental functions, unless they are found to have committed “wanton and willful misconduct.” Likewise, neither a local health officer nor an employee or representative of a local health department is personally liable for the damages sustained while they are performing local health department functions unless they violate the same “wanton and willful misconduct” standard. MCL 333.2465(2).

2. Additional Protections During a Disaster or Emergency

Though the general protections listed above also apply during a disaster or an emergency, the following additional general authority is provided under MCL 30.412(2).

See Chapter 8, Public Health Emergency Preparedness and Response.

All emergency management functions and activities are governmental functions. Personnel of "disaster relief forces" engaged in "disaster relief activities" are immune from liability for death or injury to any person or for damage to property as a result of any activity taken to comply or reasonably attempt to comply with Michigan's emergency management laws. MCL 30.411. Such immunity is provided for in the General Governmental Immunity Act, under MCL 691.1407, which excludes acts of gross negligence, among other acts.

"Disaster relief activity" may include “training for or responding to an actual, impending, mock, or practice disaster or emergency.” MCL 30.411(3). "Disaster relief forces" include “all agencies of state, county, and municipal government, private and volunteer personnel, public officers and employees, and all other persons or groups of persons having duties or responsibilities under this act or pursuant to a lawful order or directive authorized by this act.” MCL 30.402(f).

A "person" eligible for immunity includes “an individual, partnership, corporation, association, government entity, or any other entity.” MCL 40.402(m). A property owner who, without compensation, voluntarily allows the use of property during an actual or mock emergency also is immune. MCL 40.411(7). Such property owners are required to disclose any hidden safety hazards or dangers. MCL 40.411 (8).

The Interstate Emergency Management Assistance Compact Act has provisions providing immunity for officers and employees of a party state rendering aid in another state, willful misconduct, gross negligence, or recklessness excepted. MCL 3.1001 (Article VI).

The Federal Volunteer Protection Act of 1977, 42 USC 14503(4) provides protection for a volunteer of any nonprofit or governmental agency. If the work is within the volunteer's scope of duties, the volunteer is properly licensed, and the conduct is not the result of criminal or willful misconduct.

Intermittent disaster response personnel assisting pursuant to the National Disaster Medical System (NDMS), 42 USC 300hh-11(d)(1) are provided a federal license to practice a medical profession, immunity, and reemployment protection.

Other laws providing immunity for emergency workers include the Good Samaritan Act, MCL 691.1501; the Emergency Medical Care Act, MCL 691.1502; MCL 333.20965; and the Fire Code, MCL 29.7c.

B. Threats to Public Health Officials

Michigan law protects public health officials from obstruction of their duties and responsibilities. Under MCL 333.1291, “[a] person shall not willfully oppose or obstruct a department representative, health officer, or any other person charged with enforcement of a health law in the performance of that person’s legal duty to enforce the law.” A person who violates this law, other provisions of the Public Health Code, or a rule promulgated under the code is guilty of a misdemeanor and may face up to 90 days of imprisonment and/or up to a $500.00 fine. See MCL 333.1299 and MCL 750.504.

See Section 2.5, Select Violations of the Public Health Code, for reference to the rule of lenity.

2.5 Select Violations of the Public Health Code

A. Criminal

1. Misdemeanor

Pursuant to MCL 333.1299, a person who violates a provision of the Public Health Code is guilty of a misdemeanor, unless otherwise specified. A prosecuting attorney with jurisdiction or an attorney general can prosecute the violation, a rule promulgated under the code, or a local health department regulation.

Further, violation of a state health department rule or order under MCL 333.2261, or a local regulation or order under MCL 333.2443, is punishable as a misdemeanor, specifically "imprisonment for not more than 6 months, or a fine of not more than $200.00, or both."

Under MCL 333.2247, a person who falsely causes a warrant to be issued for a public health investigation or inspection is also guilty of a misdemeanor if done "maliciously and without cause."

A person who violates immunization statutes or rules is also guilty of a misdemeanor under MCL 333.9229.

2. Note on the Rule of Lenity

The Michigan Court of Appeals provides a succinct and helpful summary of the "rule of lenity" and why it is inapplicable in matters brought forth under the Public Health Code:

> The "rule of lenity" provides that courts should mitigate punishment when the punishment in a criminal statute is unclear. The rule of lenity applies only if the statute is ambiguous or in absence of any firm indication of legislative intent. However, the rule of lenity does not apply when construing the Public Health Code because the Legislature mandated in MCL 333.1111(2) that the code's provisions are to be liberally construed for the protection of the health, safety, and welfare of the people of this state.[86]

[86] *People v. Johnson,* 302 Mich App 450, 462; 838 NW2d 889 (2013) (quotation marks and citation omitted).

When considering the violations of the Public Health Code enumerated above, as well as those not included in this section, the rule of lenity may not be applied even where statutes are unclear.

B. Civil

MCL 333.2262 also authorizes the state health department to adopt a schedule of civil monetary penalties, up to $1,000 per violation per day for violation of the Public Health Code, rule or order of the department.

If a department representative reasonably believes that an individual has violated or is violating the code, rule, or order, the representative can issue a citation up to 90 days after discovering the violation.

Procedural due process requires the citation to be written and to include the following:

- Details of the violation.
- Reference to the code section, rule or order allegedly violated.
- Reference to the civil penalty code section.
- The civil penalty established for the violation.
- The right to appeal, pursuant to MCL 333.2263.
- The citation must be delivered directly or sent by registered mail to the individual who has allegedly committed a violation.

Chapter 3: Constitutional Rights and Public Health

3.1 Overview

The U.S. Constitution provides protections for individuals and groups that may limit not only federal but also state and local government action. Many of these protections are provided through the amendments to the U.S. Constitution. Starting with the first ten, known as the Bill of Rights, there are 27 amendments in total.[87] Therefore, when a state or local governmental entity is evaluating whether and how to enact a public health measure, they must also examine whether the action conflicts with rights afforded by the U.S. Constitution. At times, there may be tension between the need to protect the public's health and the need to safeguard constitutional rights. This tension was at the center of a foundational public health case from 1905, *Jacobson v. Massachusetts.*[88]

In *Jacobson*, a law enacted by the Commonwealth of Massachusetts empowered local boards of health to require and enforce vaccination, and this law was used by the town of Cambridge to issue a vaccination requirement during a smallpox outbreak. Anyone who could not show proof of vaccination from the past five years had to be vaccinated or be fined $5 (approximately $150 in 2025). The Reverend Henning Jacobson refused either, was jailed and convicted. Jacobson appealed his conviction, which was then upheld by the Massachusetts Supreme Judicial Court. He argued the law at issue was unconstitutional and violated his 14th Amendment rights. Despite the argument that "a compulsory vaccination law is unreasonable, arbitrary and oppressive, and, therefore hostile to the inherent right of every freeman to care for his own body and health in such a way as to him seems best," the conviction was upheld by the U. S. Supreme Court.[89]

The U. S. Supreme Court balanced individual rights against the health and safety of the public. In the opinion, Justice Harlan made the following declaration that weighs heavily in favor of government action in the name of public health:

> The liberty secured by the Constitution of the United States to every person within its jurisdiction does not import an absolute right to each person to be, at all times and in all circumstances, wholly freed from

[87] Originally, the Bill of Rights only applied to the federal government. With the 14th Amendment, the Court has found that the due process clause incorporates many, but not all, in full or in part, of the amendments in the Bill of Rights to the states. This is referred to as the "Incorporation Doctrine." Constitution Annotated, *Amdt14.S1.4.1 Overview of Incorporation of Bill of Rights* <https://constitution.congress.gov/browse/essay/amdt14-S1-4-1/ALDE_00013744/> (accessed April 12, 2025). For a list of amendments and portions of amendments that have been incorporated, see Connotation Annotated, *Amdt14.S1.4.3 Modern Doctrine on Selective Incorporation of Bill of Rights* <https://constitution.congress.gov/browse/essay/amdt14-S1-4-3/ALDE_00013746/> (accessed April 12, 2025).

[88] *Jacobson v. Massachusetts,* 197 US 11; 25 S Ct 358; 49 L Ed 643 (1905).

[89] *Id.* at 26.

> restraint. There are manifold restraints to which every person is necessarily subject for the common good.[90]

In addition to articulating the balancing test for limiting individual liberty to protect the public's health, the decision in *Jacobson* also reiterated the state's authority to use its police powers for public health, the ability of the state to delegate certain authorities to local governments and to health agencies, and the court's deference to public health officials for their expertise. However, the court also cautioned that "[t]he police power of a State…may be exerted in such circumstances or by regulations so arbitrary and oppressive in particular cases as to justify the interference of the courts to prevent wrong and oppression."[91]

Lawrence Gostin, an oft-cited American law professor and public health law expert, stated in 2005, "If the Court today were to decide *Jacobson* once again, the analysis would likely differ — to account for developments in constitutional law — but the outcome would certainly reaffirm the basic power of government to safeguard the public's health."[92] The following sections provide a brief snapshot of the intersection of constitutional law and public health and the tensions that sometimes arise in seeking to strike a balance between individual rights and protecting the public's health.[93]

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[90] *Id.* at 11.

[91] *Id.* at 38. See also *Jew Ho v. Williamson*, 103 F 10 (CCND Cal, 1900), a contemporary case to *Jacobson* that demonstrates when individual rights may be so infringed as to weigh against government actions in the name of public health. The San Francisco Board of Health implemented a 'cordon sanitaire,' a quarantine of 12 city blocks encompassing the Chinese district, allegedly to prevent the spread of bubonic plague. However, the quarantine was enforced only against persons of Chinese race and not against others, there had been no cases in the district for the 30-days prior to the lawsuit, and there were other parts of the city that did have possible cases but were not under quarantine. The court quoted another contemporary case, stating that the quarantine had been applied "with an evil eye and unequal hand." The quarantine was discriminatory and not rooted in science and was thus determined to be unconstitutional.

[92] Gostin, *Police Power and Civil Liberties in Tension,* 95 Am J Pub Health 576, 576-81 (2005). Although 14th Amendment jurisprudence has evolved, until recently, vaccination mandates have generally been found to only require the rational basis test (where the government must demonstrate that the public health activity bears a rational relationship to a legitimate state interest), which is easily met. And dicta has supported that freedom to practice one's religion would not trump a vaccination mandate and thus would also pass strict scrutiny (where the government must demonstrate that the public health activity is necessary to achieve a compelling state interest). See *Prince v. Massachusetts*, 321 US 158, 166 (1944), citing *Jacobson v Massachusetts*, 197 US 11, and *Workman v. Mingo Cty Bd of Educ*, 419 Fed Appx 348, 353 (CA 4, 2011); 132 S Ct 590 (2011) cert denied.

[93] The balancing test between individual rights and protecting the public's health is also applied to federal laws. See *US v. Shinnick,* 219 F Supp 789 (EDNY, 1963), where the court applied this balancing test to uphold a quarantine of an individual returning from a country known to have had a recent smallpox outbreak. The individual could not provide proof of vaccination but argued that the outbreak was too long before her travel for her to have been exposed, and thus her quarantine was not justified. The court

3.2 First Amendment – Free Speech, Expression, Assembly, and Religious Freedom

> Congress shall make no law respecting an establishment of religion or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances.[94]
>
> - ***First Amendment, U.S. Constitution***

As with other constitutional rights, at times, public health practice and interventions may come up against protections otherwise afforded under the First Amendment, particularly the rights to free speech and expression, assembly, and religious freedom.

A. Free Speech and Expression

Free speech and expression rights under the First Amendment are not absolute and may be curbed by the government. This is particularly true regarding commercial speech, which is sometimes at issue when considering public health interventions.[95]

When commercial speech is restricted, it is often analyzed under the *Central Hudson* test, which requires a court to determine the following:

- Whether the commercial speech at issue concerns unlawful activity or is misleading.
- Whether the governmental interest is substantial.
- Whether the challenged regulation directly advances the government's asserted interest; and

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denied her petition for habeas corpus and upheld the quarantine, stating, "The words cautioning against light use of isolation are indeed strong but the three medical men who testified manifestly shared a concern that was evident and real and reasoned."

[94] US Const, Am I.

[95] Public Health Law Center, *A "Commercial Speech" Flowchart for Public Health Regulation and Types of Laws Regulating Public Health Marketing and the "Commercial Speech" Tests Applied* <https://www.publichealthlawcenter.org/sites/default/files/resources/Public-Health-Commercial-Speech-Chart-2018.pdf> (2018) (accessed April 8, 2025).

- Whether the regulation is no more extensive than necessary to further the government's interest.[96]

As was made clear by the court in the *Central Hudson* case, "The Constitution therefore accords a lessor protection to commercial speech than to other constitutionally guaranteed expression."[97]

The government may require information to accompany a product, like nutritional information or other labeling requirements. This is considered compelled speech. In such cases, the relevant standard that courts apply is the *Zauderer* test. The court in *Zauderer v. Off of Disciplinary Couns of Supreme Ct of Ohio* held that compelled speech that is "purely factual and uncontroversial information" is constitutional as long as the disclosure requirements are "reasonably related to the State's interest in preventing the deception of consumers."[98]

Content-neutral speech, whether commercial or non-commercial, may be subject to time, place, and manner restrictions. Such restrictions could include those setting forth parameters for the size or height of signage, for example. Time, place, and manner restrictions must be content neutral (i.e., not dependent on the subject of the speech), narrowly tailored to serve a significant governmental interest, and must leave open ample alternative channels of communication.[99]

The regulation of expressive conduct is analyzed under a test provided by the U. S. Supreme Court in the case of *United States v. O'Brien*. A court analyzing conduct under the *O'Brien* test must determine:

- Whether the government has authority to pass the law in question.
- Whether the restriction furthers an important or substantial governmental interest.
- Whether the governmental interest is unrelated to the suppression of free expression; and

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[96] *1-800-411-Pain Referral Serv, LLC v. Otto,* 744 F3d 1045, 1055 (CA 8, 2014), citing *Central Hudson Gas & Electric Corp v. Pub Serv Comm of New York,* 447 US 557, 566; 100 S Ct 2343; 65 L Ed 2d 341 (1980).
[97] *Central Hudson*, 447 US at 563.
[98] *Zauderer v. Off of Disciplinary Couns of Supreme Ct of Ohio*, 471 US 626, 651; 105 S Ct 2265; 85 L Ed 2d 652 (1985).
[99] *Ward v. Rock Against Racism*, 491 US 781, 791; 109 S Ct 2746;105 L Ed 2d 661 (1989).

- Whether the incidental restriction on First Amendment freedoms is not greater than what is essential to further the government's interest.[100]

B. Freedom of Assembly

Though the First Amendment guarantees the right of individuals to gather for lawful purposes, that right may be restricted where the public's health is concerned. Like restrictions on speech discussed above, the government may impose such restrictions on the time, place, and manner of otherwise protected activity, provided the restrictions are content-neutral, narrowly tailored to serve a compelling governmental interest, and they leave open "ample alternative channels for communication" or for individuals to associate.[101]

Examples of these restrictions arose during the COVID-19 pandemic. The Public Health Code authorizes MDHHS to restrict gatherings to protect the public's health under MCL 333.2253 (1), which states, in part:

> [I]f the director determines that control of an epidemic is necessary to protect the public health, the director by emergency order may make a declaration of that determination and may within that emergency order prohibit the gathering of people for any purpose and establish procedures to be followed during the epidemic to ensure continuation of essential public health services and enforcement of health laws.

See Chapter 8, Public Health Emergency Preparedness and Response, for further discussion on MCL 333.2253 gathering restrictions.

C. Religious Freedom

Vaccinations are a frequent example of how tensions between religious freedom and public health interventions may arise. In the case of mandatory vaccination for children, opponents have argued that religious exemptions are required by the First Amendment of the U.S. Constitution, and analogous state religion protections, such as Article 1, Section 4 of the

[100] *United States v. O'Brien*, 391 US 367, 376-77; 88 S Ct 1673; 20 L Ed 2d 672 (1968). See also *Lorillard Tobacco Co v. Reilly*, 533 US 525; 121 S Ct 2404; 150 L Ed 2d 532 (2001).
[101] *Clark v. Community for Creative Non-Violence,* 468 US 288, 295; 104 S Ct 3065; 82 L Ed 2d 221 (1984).

Michigan Constitution. However, as quoted in the case of *Workman v. Mingo*:

> [I]t has been settled law for many years that claims of religious freedoms must give way in the face of compelling interest of society in fighting the spread of contagious disease through mandatory inoculation programs. [102]

Regardless, Michigan's legislature has provided for religious exemptions from mandatory vaccines for children. MCL 333.9215.

Protection of religious freedom is furthered by state and federal laws, such as Title VII of the Civil Rights Act of 1964 (Title VII), 42 USC §§2000e *et seq.*, which prohibits discrimination in employment based on religion, among other factors, and Michigan's Elliott-Larsen Civil Rights Act, MCL 37.2101 *et seq.*, which provides protection in employment as well as other contexts. Both laws provide some protection for employees, seeking religious exemptions from vaccination requirements.

A 2023 case raising claims under Title VII, *Groff v. DeJoy,* was brought by a U. S. Postal Service employee who requested a reasonable accommodation for his religious beliefs that Sundays are to be devoted to rest and worship instead of work.[103] The employee alleged that he was refused accommodation and instead disciplined for failing to work on Sundays.[104] Title VII requires that employers provide accommodations for religious beliefs and practices unless doing so would amount to an "undue hardship," which was previously interpreted to mean that the burden to be borne by the employer would be insignificant or "de minimis."[105] In a departure from this standard, the U. S. Supreme Court in *Groff* held that:

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[102] *Workman v. Mingo Cnty, Bd of Ed,* 419 Fed Appx 348, 354 (CA 4, 2011), quoting *Sherr v. Northport-East Northport Union Free Sch Dist,* 672 F Supp 81, 88 (EDNY, 1987) (here a parent sought an exemption from a vaccination requirement for a child arguing that the requirement violated the First Amendment right to religious freedom. The Fourth Circuit found against the request for an exemption and the United States Supreme Court later denied certiorari.)

[103] *Groff v. DeJoy,* 600 US 447; 143 S Ct 2279; 216 L Ed 2d 1041 (2023).

[104] *Id.* at 455.

[105] See Mello & Parmet, Journal of the American Medical Association, *Accommodating Religious Objection to Vaccination Mandates - Implications of Groff v. DeJoy for Health Care Employers* <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2809476> (September 7, 2023) (accessed March 31, 2025).

> [A]n employer must show that the burden of granting an accommodation would result in substantial increased costs in relation to the conduct of its particular business.[106]

This case raises new questions regarding the ability of private employers to enforce vaccination requirements over employees' religious objections. In 2024 and 2025, federal juries have even found in favor of Michigan workers in employment-related cases focused on vaccination exemptions.[107]

See Section 4.12, Immunization/Vaccination, (B), Immunization Mandates, for further discussion.

In the 1990 case of *Employment Division v. Smith*, the U. S. Supreme Court considered whether the free exercise of religion was infringed upon by a facially neutral law denying unemployment benefits for use of illegal substances when being used as part of a religious ritual.[108] The court applied the rational basis test, which requires that the law be rationally related to a legitimate state interest, and found that the government can regulate religious practice as long as the regulation is not religiously motivated and is generally applicable, even if the outcome burdens a particular religion.

In response to the decision in *Employment Division,* Congress enacted the Religious Freedom Restoration Act (RFRA), 42 USC § 2000bb *et seq.* providing further protection for religion and requiring a heightened scrutiny standard whenever laws burden religion, even if facially neutral. RFRA was, however, found to be unconstitutional as applied to the states.[109] While several states have adopted RFRA-like statutes, Michigan does not have one at the time of writing this benchbook.

Following the onset of the COVID-19 pandemic, the U. S. Supreme Court has expressed willingness to weigh the balance in favor of religion, rather than give broad deference to public health authorities, as it may have in the past. This is sometimes referred to as the "most favored nation" doctrine, a theory that finds the refusal of a religious-based exemption to be

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[106] *Groff,* 600 US at 470.
[107] See *Domski v. Blue Cross Blue Shield of Mich,* opinion of the United States District Court for the Eastern District of Michigan, issued November 8, 2024 (Case No. 2:23-cv-12023) and *Brown v MGM Grand Casino,* opinion of the United States District Court for the Eastern District of Michigan, issued January 16, 2025 (Case No. 2:22-cv-12978).
[108] *Employment Division v. Smith,* 494 US 872 (1990).
[109] *City of Boerne v. Flores,* 521 US 507, 535-536; 117 S Ct 2157; 138 L Ed 2d 624 (1997). Several states have passed state RFRA Acts in response to the finding in *City of Boerne v. Flores*.

presumptively unconstitutional if the state in question "treats some comparable secular activities more favorably."[110] In this First Amendment context, the U. S. Supreme Court has at times, demonstrated a greater willingness to scrutinize public health judgment.[111]

See Chapter 4, Communicable Disease Prevention and Control, and Chapter 8, Public Health Emergency Preparedness and Response, for further discussion.

3.3 Fourth Amendment – Search and Seizure

> The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated, and no Warrants shall issue, but upon probable cause, supported by Oath or affirmation, and particularly describing the place to be searched, and the persons or things to be seized.[112]
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> - ***Fourth Amendment, U.S. Constitution***

A. Generally

The Fourth Amendment of the U.S. Constitution guarantees the right of the people to be free from unreasonable searches and seizures by the government. Searches and seizures may invoke not only the Fourth Amendment but also the Fifth Amendment's due process concerns. The protections afforded by the Fourth Amendment apply to federal, state, and local public health officials through the 14th Amendment. State and local governments are also subject to the Michigan Constitution and its analogous provisions.[113]

B. Definitions

1. Search

A search may be defined as a government intrusion that infringes upon otherwise reasonable expectations of privacy (e.g., privacy in

[110] *Tandon v. Newsom*, 593 US 61, 63; 141 S Ct 1294; 209 L Ed 2d 355 (2021).
[111] *See Roman Cath Diocese of Brooklyn v. Cuomo*, 592 US 14, 18; 141 S Ct 63; 208 L Ed 2d 206 (2020). ("Not only is there no evidence that the applicants have contributed to the spread of COVID–19 but there are many other less restrictive rules that could be adopted to minimize the risk to those attending religious services.").
[112] US Const, Am IV.
[113] Const 1963, art 1, § 11.

one's home, business, vehicle, or person).[114] A search can include the collection and analysis of biological samples.[115]

2. Seizure of Property

The seizure of property is a government action that meaningfully interferes with an individual's possessory interest in property.[116] Also protected by the Fourth Amendment is the curtilage of one's home.[117] Case law extensively defines and clarifies the applicability of the Fourth Amendment in various scenarios.

3. Seizure of an Individual

The seizure of an individual occurs with governmental interference with freedom of movement (e.g., a checkpoint stop).[118]

C. Probable Cause

To obtain a warrant to carry out a search and seizure, there needs to be probable cause.

> For administrative searches conducted to enforce local building, health, or fire codes, "'probable cause' to issue a warrant to inspect…exist[s] if reasonable legislative or administrative standards for conducting an area inspection are satisfied with respect to a particular dwelling. Such standards, which will vary with the municipal program being enforced, may be based upon the passage of time, the nature of the building (*e. g.,* a multi-family apartment house), or the condition of the entire area, but they will not necessarily depend upon specific knowledge of the condition of the particular dwelling."[119]

Though, generally, a valid search warrant is required to search private property to inspect or to investigate a violation of the Public Health Code or

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[114] *United States v. Jacobsen*, 466 US 109, 113; 104 S Ct 1652; 80 L Ed 2d 85 (1984).
[115] *Skinner v. R Labor Executives' Ass'n,* 489 US 602, 614; 109 S Ct 1402; 103 L Ed 2d 639 (1989).
[116] *Jacobson v. Massachusetts,* 197 US 11; 25 S Ct 358; 49 L Ed 643 (1905).
[117] *Florida v. Jardines,* 569 US 1, 6; 133 S Ct 1409; 185 L Ed 2d 495 (2013) ("We therefore regard the area 'immediately surrounding and associated with the home' -- what our cases call the curtilage – as 'part of the home itself for Fourth Amendment purposes.'") (citations omitted). See also *People v Taylor,* 2 Mich 250 (1851); *Pond v People,* 8 Mich 150 (1850).
[118] *Skinner*, 489 US at 613.
[119] *Michigan v. Tyler,* 436 US 499, 506, n 5 (1978) quoting *Camara v Municipal Court,* 387 US 523, 538 (1967).

the regulations adopted under the code, there are several exceptions.[120] These exceptions to the warrant requirement are permitted under specific circumstances, which are listed and discussed in the Michigan Judicial Institute's Criminal Proceedings Benchbook, Vol. 1. One common exception to the requirement of a search warrant is consent. Most administrative searches are conducted with consent, and the standard of consent for an administrative search is lesser than the standard for criminal searches.[121] Consent to searches at reasonable times may also be a condition of obtaining a license to conduct business that may affect the public's health or safety.

The tension between public safety and individual liberty is also reflected in the context of criminal procedure. To the extent that public health law surrounding these issues remains underdeveloped, it is tempting to turn to criminal law analogies for guidance. However, the application of criminal procedure principles to public health action is often complicated by numerous factors, including the differing philosophies underlying the two bodies of law. The Michigan Legislature mandated that the Public Health Code's provisions are to "be liberally construed for the protection of the health, safety, and welfare of the people of this state." MCL 333.1111(2). Thus, while this benchbook identifies criminal law analogies that are potentially relevant to a court's public health-related legal analysis, it does so with the caution that serious consideration should be given to the nuances of cited state and federal criminal jurisprudence as well as the philosophy underlying the Public Health Code before applying those decisions in a public health context.

D. Searches for Administrative Purposes

Decisions by the U. S. Supreme Court have firmly established that the protections of the Fourth Amendment extend beyond entry into one's private dwelling by a police officer.[122]

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[120] *Clemente v. Vaslo*, 679 F3d 482, 489 (CA 6, 2012), quoting *Schneckloth v Bustamonte,* 412 US 218, 227 (1973) ("[A] search conducted without a warrant issued upon probable cause is 'per se unreasonable…subject only to a few specifically established and well-delineated exceptions.'").

[121] *Ross v. Hinton*, 740 F Supp 451 (SD Ohio, 1990) ("The Supreme Court's often stated understanding is that most administrative searches are unobjectionable because they are conducted with consent, and that the standards for consent to an administrative search are less stringent than the standards for consent to a criminal search.").

[122] *Camara*, 387 US at 528 ("The basic purpose of this Amendment…is to safeguard the privacy and security of individuals against arbitrary invasions by government officials.").

> Searches for administrative purposes, like searches for evidence of crime, are encompassed by the Fourth Amendment. And under that Amendment, "one governing principle, justified by history and by current experience, has consistently been followed: except in certain carefully defined classes of cases, a search of private property with property consent is 'unreasonable' unless it has been authorized by a valid search warrant."[123]

Therefore, searches for administrative purposes carried out by a health official, fire official, or building inspector fall within the protection of the Fourth Amendment.

E. Relevant Authority under the Public Health Code

Because local health departments are duty-bound to promote public health and to prevent and control disease and environmental health hazards (MCL 333.2433), they are authorized by the Public Health Code to carry out inspections. To assure compliance with laws enacted to achieve these goals, a local health department is permitted under MCL 333.2446 to, "inspect, investigate, or authorize an inspection or investigation to be made of, any matter, thing, premise, place, person, record, vehicle, incident, or event." Though, notably, the authority provided by this section is general in terms and does not place limits on the time, place, and scope of a search nor does it limit the discretion of the inspection officer.

An analogous provision also exists for MDHHS authority. MCL 333.2241. The subsequent sections recite the need for an affidavit to issue a warrant (MCL 333.2242), the grounds for issuance of a warrant (MCL 333.2243), that a cause based on facts is stated in an affidavit (MCL 333.2244), the contents of a warrant (MCL 333.2245), and execution of a warrant (MCL 333.2246). In addition, where a warrant was executed and procured maliciously and without cause, the responsible party may be guilty of a misdemeanor. MCL 333.2247.

Local health departments may deploy this authorization when determining whether there is imminent danger to the health or lives of those in the area in which they serve (MCL 333.2451(1)), whether the control of an epidemic is necessary (MCL 333.2453), whether a building or a condition is a

[123] *Michigan v. Tyler,* 436 US 499, 506 (1978)(quoting *Camara*, 387 US at 529).

nuisance, unsanitary condition, or cause of illness (MCL 333.2455), or whether an individual is a "health threat to others" (MCL 333.5203).

See Chapter 4, Communicable Disease Prevention and Control, and Chapter 8, Public Health Emergency Preparedness and Response, for further discussion.

Pursuant to MCL 324.20117(3), the directors of either MDHHS; EGLE; or MDARD "or their authorized representatives, have the right to enter at all reasonable times any public or private property" to identify a facility or to investigate a release or threatened release, to inspect, test, take photos, video, or samples of soil, air, surface and groundwater, suspected hazardous substances or containers or labels of suspected hazardous substances, or to determine the need for or to take or monitor any response activity.

Under subsection (7), if the directors or their authorized representatives are refused entry or information, the attorney general may petition the appropriate court for a warrant to access the property or information at issue or commence a civil action to compel compliance with the request as well as to authorize the information gathering and entry into the property at issue as well as enjoin interference with this exercise.

See Section 4.7, Medical Testing, Examination, and Treatment; Section 5.5, Built Environment, (B), Nuisance; and Section 6.3, Food Establishment Licensure and Inspections.

3.4 Fifth and 14th Amendments – Due Process and Equal Protection

> No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offence to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.[124]

[124] US Const, Am V.

- ***Fifth Amendment, U.S. Constitution***

> All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.[125]

- ***14th Amendment, U.S. Constitution, Sec. 1***

The Fifth Amendment of the U.S. Constitution contains a due process clause that limits the federal government's actions with respect to liberty and property rights. The due process clause of the 14th Amendment applies those limits to state actions. Because local jurisdictions derive their power from the state, those limitations also apply to actions of local government. Generally, due process requirements adhered to assure that search and seizure protections under the Fourth Amendment are also respected.

Due process protections are categorized into two types, procedural and substantive. For the government to deprive someone of their life, liberty, or property, they must afford individuals with adequate procedural due process rights dependent on the situation, for example, the right to notice of an impending action.**[126]** Due process is a flexible concept and the extent of procedural due process that is appropriate can vary from an informal and non-adversarial review with a decision from an administrative official to a full-blown hearing with written notice as well as access to counsel.**[127]** When public health officials take action that necessitates a consideration of these safeguards, they consider the nature of the private interest at issue, the risk of an erroneous decision, as well as the fiscal and administrative burdens that will accompany these procedural safeguards.**[128]**

The government must also be justified in seeking such deprivations.

> As opposed to procedural due process, "[s]ubstantive due process is '[t]he doctrine that governmental deprivations of life, liberty or property are subject to limitations regardless of the adequacy of the procedures employed.'" Substantive due process prohibits behavior from state actors that "shock[s] the conscience" and protects those

[125] US Const, Am XIV, §1.
[126] *Mares v. Miami Valley Hosp*, 96 F4th 945, 953 (CA 6, 2024).
[127] *Morrissey v. Brewer,* 408 US 471, 481; 92 S Ct 2593; 33 L Ed 2d 484 (1972).
[128] *Mathews v. Eldridge,* 424 US 319, 335; 96 S Ct 893; 47 L Ed 2d 18 (1976).

> "interests that the U. S. Supreme Court has found so rooted in the traditions and conscience of our people as to be fundamental." It also protects individuals against deprivations based on "arbitrary and capricious" action, "another formulation" of the "shocks the conscience" standard.[129]

Substantive due process in public health reflects a modern assessment of the balancing test between the public's health and individual rights described in *Jacobson.*[130]

Both the Fifth and 14th Amendments also require federal and state governments to uphold principles of equal protection, or fairness. The explicit language of the 14th Amendment applies to state, and therefore local, governments. Though the Fifth Amendment does not include an equal protection clause, like that of the Fourth, it still provides protection from unequal treatment in relation to actions by the federal government.[131]

3.5 Fifth, Tenth, and 14th Amendments – Takings

> Nor shall private property be taken for public use, without just compensation.[132]
>
> - ***Takings Clause, Fifth Amendment, U.S. Constitution***
>
> The powers not delegated to the United States by the U.S. Constitution, nor prohibited by it to the states, are reserved to the states respectively, or to the people.[133]
>
> - ***Tenth Amendment, U.S. Constitution***
>
> All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the

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[129] *Kerchen v. Univ of Mich,* 100 F4th 751, 763 (CA 6, 2024) (citations omitted).

[130] *Jacobson,* 197 US at 11.

[131] *Bolling v. Sharpe*, 347 US 497, 499; 74 S Ct 693; 98 L Ed 884 (1954). The Court stated:

> The Fifth Amendment, which is applicable in the District of Columbia, does not contain an equal protection clause as does the 14th Amendment, which applies only to the states. But the concepts of equal protection and due process, both stemming from our American ideal of fairness, are not mutually exclusive. The "equal protection of the laws" is a more explicit safeguard of prohibited unfairness than "due process of law," and, therefore, we do not imply that the two are always interchangeable phrases. But, as this Court has recognized, discrimination may be so unjustifiable as to be violative of due process.

[132] US Const, Am V.

[133] US Const, Am X.

> United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.[134]
>
> - ***14th Amendment, U.S. Constitution, Sec. 1***

The protection of public health depends, in part, on the ability of government authorities to maintain safety standards and to prohibit actions that endanger the public or the environment. A state's public health powers derive, in large part, from those sovereign powers that are reserved through the Tenth Amendment. Those powers are then extended to local governments through a state's delegation of authority. The government's responsibility to protect the public health, safety and welfare relies on the exercise of "*parens patriae*"[135] and "police powers"[136] to ensure that such protections exist and are enforced.

See Chapter 2, Public Health Structure and Authority, State, Local, and Tribal Public Health Authority for further discussion on a state's police and parens patriae *powers.*

Pursuant to this authority, the government may properly regulate or limit the use of property to protect the public from nuisance or illegal activity.[137] The government may also lawfully implement land use planning, zoning ordinances, building codes, safety and sanitary codes, environmental laws, and other regulations to protect the health and quality of life for those within its jurisdiction. However, the government's authority over the private use of property has constitutional limits that bar the government from taking property except for public purposes within its constitutional authority, and only upon payment of just compensation.

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[134] US Const, Am XIV, §1 .

[135] The "parens patriae power" refers to the state's capacity to act "as provider of protection to those unable to care for themselves." Black's Law Dictionary (12th ed 2024).

[136] The "police power" is the power to make laws to preserve public safety, order, health, and morals by restraining and regulating the use of liberty and property.

Medtronic, Inc v. Lohr, 518 US 470, 475; 116 S Ct 2240; 135 L Ed 2d 700 (1996). The Court stated:

> Throughout our history the several States have exercised their police powers to protect the health and safety of their citizens. Because these are "primarily, and historically…matters of local concern," the States traditionally have had great latitude under their police powers to legislate as to the protection of lives, limbs, health, comfort, and quiet of all persons. (Citations omitted.).
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> *Black's Law Dictionary* (12th ed, 2024); Freund, *The Police Power: Public Policy & Constitutional Rights* (Chicago: Callaghan & Company, 1976).

[137] *Pennsylvania Coal Co v. Mahon,* 260 US 393, 413; 43 S Ct 158; 67 L Ed 322 (1922) ("Government hardly could go on if to some extent values incident to property could not be diminished without paying for every such change in the general law. As long recognized some values are enjoyed under an implied limitation and must yield to the police power.").

Both the Fifth Amendment of the U.S. Constitution and the Michigan Constitution[138] have provisions that govern the taking of private property and the due process clause of the 14th Amendment extends these Fifth Amendment provisions to state actions. As a general rule, when exercising the power of eminent domain, the government must pay compensation for private property taken for public use without consent. In addition, regulatory restrictions, depending on their severity, may constitute a "taking" of property that also requires just compensation.[139]

The section below outlines actions that may rise to the level of a taking that requires compensation and are compared to examples of lawful exercise of government police powers for which no compensation is required. The last section provides an overview of procedures that must be followed for the exercise of eminent domain in Michigan.

See Chapter 8, Public Health Emergency Preparedness and Response for a discussion on regulation and closure of business during an epidemic, and Section 8.4, Constitutional Challenges to Emergency Measures, (B), Takings.

A. Taking, Defined

As stated above, the Fifth Amendment provides for the taking of private property for public use pursuant to government powers of eminent domain. This is to be contrasted with the condemnation of a property, such as in cases of the government exercising its power to abate a public health nuisance, where compensation to owners is not required. But what does constitute a legitimate use of the powers of eminent domain for a taking can be difficult to ascertain.

1. Categorical Takings or Takings "Per Se"

If a "per se" taking is established, then a property owner is entitled to compensation without a case-specific inquiry.

a. Permanent Physical Occupation

If a government caused or allowed the permanent occupation or destruction of private property, even without seeking to acquire the property, a physical taking will be found, no matter

[138] Const 1963, art 10, § 2 ("Private property shall not be taken for public use without just compensation therefore being first made or secured in a manner prescribed by law . . .Compensation shall be determined in proceedings in a court of record.")
[139] *Mahon*, 260 US at 415 ("The general rule at least is, that while property may be regulated to a certain extent, if regulation goes too far it will be recognized as a taking.").

how small the encroachment and no matter whether the public interest is involved. “A permanent physical occupation authorized by government is a 'taking' without regard to the public interest that it may serve.”[140] This principle recognizes that the physical occupation of a person’s property, however small, interferes with one of the most important rights of a property owner — the right to exclude others. For a taking to be deemed as such without further analysis, physical occupation must be permanent. A temporary physical invasion through government action may be evaluated through the *Penn Central* balancing test, as discussed in the next section.

b. Permanent Denial of All Economically Beneficial or Productive Use

Regulations that permanently deny all economically beneficial or productive use of property are often referred to as “total taking” or “confiscatory regulation.”[141]

2. Case Specific Takings

In cases where government regulation denies some, but not all, economically beneficial or productive uses of private property, a taking may nonetheless exist if the impact of the regulation on the property is sufficiently severe, determined by application of a balancing test.[142]

a. Relevant Factors in the “Ad Hoc Balancing Test”

The *Penn Central* balancing test strives to balance the interests of the public with the interests of the property owner, recognizing that such determinations are highly fact-specific and necessitate consideration of a variety of factors, including:

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[140] *Loretto v. Teleprompter Manhattan CATV Corp,* 458 US 419, 425; 102 S Ct 3164; 73 L Ed 2d 868 (1982) (holding that a regulation requiring apartment building owners to allow small cables and equipment to be affixed to the outside walls of the building constitutes a taking).
[141] *Lucas v. South Carolina Coastal Council,* 505 US 1003, 1029-1030; 112 S Ct 2886; 120 L Ed 2d 798 (1992).
[142] *Penn Central Transp Co v. City of New York*, 438 US 104, 136; 98 S Ct 2646; 57 L Ed 2d 631 (1978).

- The economic impact of regulation on the property owner.

- The extent to which the regulation has interfered with reasonable investment-backed expectations; and

- The character of the governmental action.[143]

The Michigan Supreme Court has incorporated the *Penn Central* test into the required evaluation of government actions in Michigan to determine if a taking requiring compensation has occurred.[144]

b. Diminution in Value Alone is Not Necessarily a Taking

The fact that a regulation forces a property owner to suffer some diminution in property value is not sufficient on its own to render a regulation a taking.[145]

c. Denial of the Most Profitable Use of Property Alone is Not Necessarily a Taking

The fact that a regulation denies a property owner the most profitable use of his or her property is not sufficient on its own to render the regulation a taking.[146]

d. "Dedications" or "Exactions" May Amount to Regulatory Takings

Where a government demands that a property owner convey either a property interest (dedication) or payments (exaction) in exchange for a land use permit or approval (e.g., an easement), the courts will evaluate the following:

- Whether there is an "essential nexus" between the dedication or exaction and the legitimate interest sought by the government; and

[143] *Id.* at 124.
[144] *K&K Constr, Inc v. Dep't of Natural Resources,* 456 Mich 570, 577 (1998).
[145] *Paragon Properties Co v. City of Novi,* 452 Mich 568, 579 n 13 (1996).
[146] *Carabell v. Dep't of Natural Resources*, 191 Mich App 610, 613; 478 NW2d 675 (1991).

- Whether there is a "rough proportionality" between the harm being addressed by the dedication and the cost of that dedication to the owner.[147]

B. Relationship with the State's Police Powers

- **The government is not obligated to compensate a property owner for abatement or destruction of property pursuant to police power in cases of emergency.** Pursuant to its police powers, the state or local government may abate or destroy private property as necessary in an emergency to prevent public harm or destruction. These emergency exercises of the government's police powers do not entitle property owners to compensation.[148]

- **The government must compensate a property owner for *per se* takings pursuant to police power unless proscribed conduct or use was restriction inherent in owner's original title.** State or local government may, pursuant to its police powers, physically invade private property or enact regulations that deprive the property owner of all economically beneficial uses of his or her property. However, such *per se* takings must be accompanied by compensation for the property owner *unless* the taking merely enforces a use restriction inherent in the owner's original title.[149]

- **The government must compensate a harmed property owner for improper exercise of police power.** While a government may abate or destroy private property without compensation in order to enforce use restrictions inherent in the owner's original title (i.e., to abate a nuisance), compensation must be paid to the property owners whose property was not injurious to the public health but was harmed or destroyed only through an improper exercise of police power.[150]

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[147] *Nollan v. California Coastal Comm,* 483 US 825, 836-837; 107 S Ct 3141; 97 L Ed 2d 677 (1994).
[148] *Lucas,* 505 US at 1029.
[149] *Id.* at 1026-1027. The Court stated:

> *A fortiori* the legislature's recitation of a noxious-use justification cannot be the basis for departing from our categorical rule that total regulatory takings must be compensated. Where the State seeks to sustain regulation that deprives land of all economically beneficial use, we think it may resist compensation only if the logically antecedent inquiry into the nature of the owner's estate shows that the proscribed use interests were not part of his title to begin with.

[150] *Bd of Ed of Sch Dist of City of Detroit v. Michigan Bell Tel Co,* 51 Mich App 488, 502-503; 215 NW2d 704 (1975).

C. Procedures for Exercising Eminent Domain Powers

Michigan law, through the Uniform Condemnation Procedures Act, provides detailed procedures that a state or local government must follow when exercising its power of eminent domain. MCL 213.51 *et seq.* Section 213.55, in particular, outlines the following:

- The offer to purchase that is required prior to court action (MCL 213.55(1);
- The acting agency's rights (MCL 213.55(2));
- Claims that may be made by an owner (MCL 213.55(3)(a)).
- What must be included with the complaint (MCL 213.55(4)(a)-(e)); and
- The amount of the deposit to be made (MCL 213.55(5)).

3.6 Right to Interstate Travel

Though the U.S. Constitution does not enumerate the right to travel, it is a fundamental right protected by the Privileges and Immunities Clause of the 14th Amendment which states, in part, that "[n]o state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States."[151] The U. S. Supreme Court has recognized the right to interstate travel in many decisions and has held that this right "protects interstate travelers against two sets of burdens: the erection of actual barriers to interstate movement and being treated differently from intrastate travelers."[152]

The right to interstate travel may be implicated in the context of communicable disease prevention and control, especially in the instance of isolation and quarantine. However, without sufficient reason to justify an action, even in the interest of protecting the public's health, governmental entities may not prevent individuals from leaving a state or traveling to another state, must treat those who choose to live in another state like other citizens of that state, and must treat state guests as "a welcome visitor rather than an unfriendly alien…"[153]

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[151] US Const, Am XIV, §1 .
[152] *Bray v. Alexandria Women's Health Clinic*, 506 US 263, 277; 113 S Ct 743; 112 L Ed 2d 34 (1993) (quotation marks and citations omitted).
[153] *Saenz v. Roe,* 526 US 489, 500; 119 S Ct 1518; 143 L Ed 2d 689 (1999).

3.7 Right to Privacy

The U.S. Constitution, particularly the Fourth Amendment, protects an individual's right to privacy. The right to privacy includes the right to bodily autonomy and decision-making. That generally means, for example, being free from forced medical treatment or screening by the government (barring sufficient justification) and being free to make one's own medical choices. Several statutes and regulations protect the privacy of personal health information.

See Chapter 7, Public Health Information, for further discussion on health data privacy.

There are, however, limits to the protections of the Fourth Amendment. As the U. S. Supreme Court noted, these protections must be rooted in reasonable societal expectations:

> [T]he touchstone of Amendment analysis has been the question of whether a person has a "constitutionally protected reasonable expectation of privacy…. The Amendment does not protect the merely subjective expectation of privacy, but only those "[expectations] that society is prepared to recognize as reasonable."[154]

At times, the protection of the public's health necessitates government intrusion upon individual liberties, such as privacy and bodily integrity.[155] Public health agencies and officials must sometimes conduct searches and seizures of persons and property to control disease and other public health threats. Similarly, public health agencies and officials may require access to and dissemination of personal information. In all such cases, both public and private interests are balanced to determine the appropriate scope of state or local action justified by public health and safety concerns.

[154] *Oliver v. United States,* 466 US 170, 171; 104 S Ct 1735; 80 L Ed 2d 214 (1984) (citations omitted).
[155] *Jacobson*, 197 US at 11.

Chapter 4: Communicable Disease Prevention and Control

4.1 Overview

Protecting the public from the spread of communicable diseases has always been the primary responsibility of public health agencies in the United States, even after public health agencies have expanded to also address other important areas, such as chronic disease and injury prevention.

This chapter primarily focuses on prevention and control of communicable diseases that are spread from person-to-person.

See Chapter 5, Environmental Health Hazards Prevention and Control, for discussion of prevention and control of diseases spread by animals or insects. See Chapter 6, Food Safety, for foodborne illnesses.

This chapter also focuses specifically on the measures that are authorized before or without a declared emergency under the federal Stafford Act or National Emergencies Act pursuant to the Michigan Emergency Management Act. During a declared emergency, authority may be expanded or initiated through executive orders.

See Chapter 8, Public Health Emergency Preparedness and Response.

4.2 Communicable Diseases, Defined

MCL 333.5101(1)(B) defines "communicable disease" as:

> an illness due to a specific infectious agent or its toxic products that results from the transmission of that infectious agent or its products from a reservoir to a susceptible host, directly as from an infected individual or animal or indirectly through the agency of an intermediate plant or animal host, vector, or the inanimate environment.

MCL 333.5101(1)(G) further defines "serious communicable disease or infection" as "a communicable disease or infection that is designated as serious by MDHHS under this part," including, but not limited to, "HIV infection, acquired immunodeficiency syndrome, sexually transmitted infection, and tuberculosis."

Generally, the terms "infectious" and "transmissible" can be used interchangeably with "communicable." The National Library of Medicine defines "infectious disease"

simply as a disease that is caused by germs, the most common of which are bacteria, viruses, fungi, or parasites.[156]

Communicable diseases may be transmitted person-to-person or through insect bites (e.g., Lyme disease), other animal bites (e.g., rabies), soil (e.g., tetanus), food (e.g., salmonella), or water (e.g., E. coli).

Contagious diseases, however, generally refer only to those communicable diseases that can be spread person-to-person. These diseases may be transmitted directly through contact with a person who is infected, such as through breathing, coughing, and sneezing (e.g., influenza, COVID-19, tuberculosis), casual physical contact, through contact with bodily fluids (e.g., sexually transmitted infection), or from mother to baby during gestation or birth (e.g., Zika). These diseases may also be transmitted indirectly through contact with a surface contaminated by a person who is infected (e.g., measles, pink eye, chickenpox).

4.3 General Authority

Prevention and control of communicable diseases is a responsibility of federal, state, and local governments. While the federal government generally derives its authority from the Commerce Clause, state authority is derived from the police powers of health, safety, and welfare reserved by the Tenth Amendment. The federal government and states have concurrent authority in some instances. Similarly, in Michigan, MDHHS and local health departments have concurrent statutory authority in some instances.

A. Federal

The Public Health Service Act (PHSA), Section 361 (42 USC §264(a)) is the authorizing act for federal prevention and control of communicable diseases:

> The Surgeon General, with the approval of the secretary, is authorized to make and enforce such regulations as in his judgment are necessary to prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the States or possessions, or from one State or possession into any other State or possession. For purposes of carrying out and enforcing such regulations, the Surgeon General may provide for such inspection, fumigation, disinfection, sanitation, pest extermination, destruction of

[156] Natl Library of Med, Medline Plus, *Infectious Diseases* <https://medlineplus.gov/infectiousdiseases.html> (accessed April 4, 2025).

> animals or articles found to be so infected or contaminated as to be sources of dangerous infection to human beings, and other measures, as in his judgment may be necessary.

Much of the work under the Public Health Service Act (PHSA) is delegated to the Centers for Disease Control and Prevention (CDC). During the COVID-19 pandemic, the limits of the PHSA were tested when the CDC implemented an eviction ban. The Supreme Court stated that the language of 42 USC § 264(a) is not intended to encompass something as tenuous to disease control as an eviction ban, and that if Congress intended an administrative agency be able to do this, Congress must specifically grant that authority.[157] Lower courts applied this to a CDC cruise line ban as well.[158]

Authority for the PHSA is under the United States Constitution, article I, section 8, clause 3, the Commerce Clause, and thus is limited to prevention and control of communicable diseases being spread into the United States from other countries or between states. Regulations for control of quarantinable diseases are found at 42 CFR Parts 70 (interstate) and 71 (into the United States). Quarantinable diseases are limited to those listed by executive order. The following diseases are included in Executive Orders 13295 (2003), 13375 (2005), 13674 (2014), 14047 (2021):

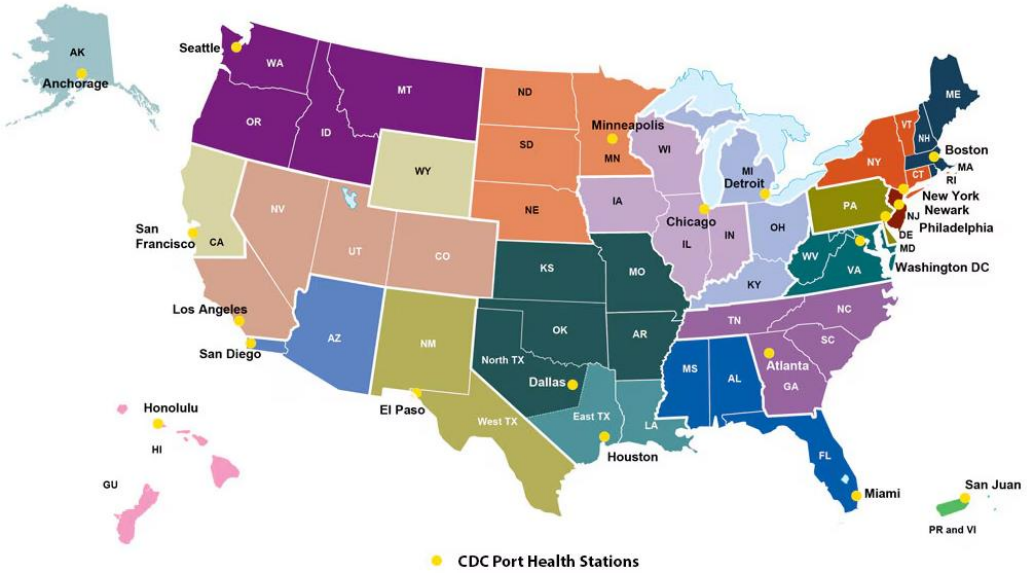
- Cholera.
- Diphtheria.
- Infectious tuberculosis.
- Plague.
- Smallpox.
- Yellow fever.
- Viral hemorrhagic fevers.
- Severe acute respiratory syndromes.

[157] *Alabama Ass'n of Realtors, et al. v. Dep't of Health and Hum Servs, et al.,* 594 US 758, 141 S Ct 2485, 210 L Ed 2d 856 (2021).
[158] *Florida v. Becerra*, opinion of the United States District Court for the Middle District of Florida, issued July 7, 2021 (Case No. 8:21-CV-839-T-23AAS).

- Flu that can cause a pandemic.
- Measles.

CDC Port Health Stations, previously termed Quarantine Stations, are located at 20 land and water ports where international travelers arrive in the United States. These stations have responsibility for limiting the introduction and spread of disease into the United States in collaboration with other government agencies and the private travel sector. Michigan is host to a Port Station at the Detroit Metropolitan Airport in Wayne County, which serves all ports in Michigan, Kentucky, and Ohio.[159]

Figure 6[160]



At the border, public health intersects with immigration and border security. Customs and Border Protection (CBP), Immigration and Customs Enforcement (ICE), and the U. S. Coast Guard are mandated to assist the HHS in enforcing quarantine regulations under 42 USC §268(b).

Non-citizens are subject to more control than U. S. citizens and lawfully admitted permanent residents. CBP monitors the borders to identify persons with "communicable diseases of public health significance," including the diseases in the Executive Orders listed above, plus cancroid, gonorrhea, granuloma inguinale, leprosy, syphilis, and active tuberculosis

[159] Centers for Disease Control & Prevention, *Port Health Stations* <https://www.cdc.gov/port-health/stations/?CDC_AAref_Val=https://www.cdc.gov/quarantine/quarantine-stations-us.html> (posted May 15, 2024) (accessed April 4, 2025).
[160] *Id*.

(TB). Non-citizens can also be screened for communicable diseases that pose a public health emergency of international concern if there is a threat to the American public, generally defined to mean one that requires notification to the World Health Organization.

Under immigration law, CBP cannot detain U. S. citizens or lawfully admitted permanent residents. But under public health law, detention may occur regardless of immigration status. Further, under 42 USC 265, the president can suspend entry of individuals from countries where the Surgeon General has deemed there exists a serious danger of introducing a communicable disease into the U. S. and suspension of entry is needed to prevent this danger in the interest of the public's health.

B. State and Local Health Departments

Both MDHHS under MCL 333.2221(2)(g) and local health departments under MCL 333.2433(2)(f) have broad authority to take actions necessary for the prevention and control of diseases, except as prohibited by law. MDHHS under MCL 333.2226(d) and local health departments under MCL 333.2435(d) are also empowered to "safeguard properly the public health" and to "prevent the spread of diseases." MDHHS also has authority under MCL 333.5115 "to establish minimum procedures for health officers and others… relating to the discovery and care of an individual who has or is suspected of having a communicable disease or serious communicable disease or infection," so long as these procedures do not conflict with the Public Health Code.

Likewise, both MDHHS under MCL 333.2251 and local health departments under MCL 333.2451 may investigate, issue orders, and take other measures as needed to prevent "imminent danger" to the health or lives of people within their jurisdiction.

MDHHS and local health departments undertake the following actions to prevent or control spread of communicable diseases within the state:

- Disease surveillance (*See Section 4.4 below)*.
- Disease reporting (*See Section 4.5 below)*.
- Disease investigation and contact tracing (*See Section 4.6 below)*.
- Testing, examination, treatment (*See Section 4.7 below)*.

- Warning notice (*See Section 4.8 below)*.
- Isolation and quarantine (*See Section 4.11 below)*.
- Immunization/vaccination (*See Section 4.12 below)*; and
- Other measures.

While some actions taken by public health are mandatory, such as reporting, other measures are discretionary. To determine which measures to take to protect the public, a wide range of factors must be considered, including but not necessarily limited to:

- What is known about the disease.
- How the disease is transmitted.
- The symptoms.
- Treatments available.
- The incubation period (the time between being infected and exhibiting symptoms).
- The infectious period (when the disease can be transmitted to others),
- The severity of the disease; and
- How many people on average are likely to be infected by this person (called R° - “R-naught” or reproduction number).

In addition to characteristics of the disease, a wide range of factors regarding the measures to be implemented must also be considered, including whether legal authority exists, the likelihood of the measure being effective, who has authority to order and implement the measure, what procedural and substantive due process requirements are in place, how will compliance and enforcement be achieved, how long the measure can remain in place, how the measure can be renewed or ended, etc. Further, public health must also examine whether there are policy, economic, ethical, political, or logistical constraints when choosing which, if any, measures to employ, as well as what burdens the measure might create or exacerbate, particularly in already burdened communities.

Depending on the level of threat to the public, MDHHS or local health departments may prefer to first implement certain measures on a voluntary basis. But involuntary measures may be imposed via public health orders if needed, such as if compliance with voluntary measures is not sufficient or if the threat appears to require quick action. If faced with noncompliance, court proceedings to enforce public health orders may be sought.

The terms "mandatory" or "compulsory" may be used synonymously with "involuntary." Involuntary public health measures may condition participation of individuals on their compliance (e.g., requiring proof of vaccination to attend school, wearing a mask when using public transportation, requiring routine testing in employment settings if vaccination is declined). Occasionally, the alternative to complying with involuntary public health measures is a penalty, such as a fine or detention. Very rarely, under extreme circumstances, involuntary measures may offer individuals no choice but to comply (e.g., forcible vaccination, testing, or treatment).

4.4 Communicable Disease Surveillance

A. Public Health Surveillance, Defined

Public health surveillance is defined as:

> The ongoing, systematic collection, analysis, and interpretation of health-related data essential to planning, implementation, and evaluation of public health practice, with the timely dissemination of these data to those responsible for prevention and control.[161]

Data from surveillance is used to monitor public health concerns, identify patterns and variations, assess the efficacy of public health interventions, and to provide support for policies and programs.[162]

B. Passive Versus Active Surveillance

There are two types of public health surveillance: passive and active.

- **Passive surveillance** — Health departments receive information about disease occurrence within a population primarily from disease

[161] Centers for Disease Control & Prevention, Public Health 101 Series, *Introduction to Public Health Surveillance* (January 10, 2025) at slide 8, available at <https://www.cdc.gov/training-publichealth101/media/pdfs/introduction-to-surveillance.pdf> (accessed April 9, 2025).
[162] *Id*. at slide 47.

reporting by hospitals, physicians, and other community sources. Passive surveillance tends to gather data quickly and be less expensive but is not as accurate or as thorough.

- **Active surveillance** — Health departments take measures to identify all cases of disease, primarily by contacting and soliciting information from physicians, hospitals, clinics, laboratories, and other sources. Active surveillance is generally more comprehensive but also more resource intensive and requires more time to collect and analyze the data.

An example of passive surveillance at the federal level is the Vaccine Adverse Event Reporting System (VAERS). This system allows for earlier identification of potential clusters of adverse events that should be further examined for possible response. There is no way to know how many incidents were not reported or how many were reported by multiple people such as patient and provider. There is also generally no confirmation that the adverse event was caused by the vaccine.

Alternatively, an example of active surveillance at the federal level is the Vaccine Safety Data Link. This is a database compiled for researchers of all verified adverse events among a group of people who received these vaccines. The database also includes other social demographics and health characteristics that may be relevant to analysis.

An example of passive surveillance in Michigan is the Michigan Child Care Related Infectious Disease Surveillance Program (MCRISP).[163] This local surveillance system invites childcare centers in Washtenaw County to report instances of illness among the children in their programs to the Washtenaw County Department of Public Health, providing early warning on diseases circulating in the community.

An example of active surveillance in Michigan is the response to the avian influenza HPAI A(H5N1) outbreak beginning in 2024. The outbreak began in Texas in March. By the end of May, it had spread to other states, and Michigan had 23 dairy facilities across ten counties and seven poultry facilities in four counties with animals testing positive, as well as other backyard animals. More than 1,200 workers who had been exposed were

[163] Michigan Child Care Related Infectious Disease Surveillance Program, *Welcome to MCRISP* <https://mcrisp.org/> (accessed April 9, 2025).

monitored for symptoms. Because of this active surveillance, 52 individuals reporting symptoms were tested, and two had positive test results.[164]

C. Syndromic Surveillance

Syndromic surveillance involves monitoring for symptoms of a disease rather than for laboratory-confirmed cases.

For example, the Michigan Syndromic Surveillance System collects chief complaints from hospital emergency department visits to identify potential public health threats.[165]

D. Disease Surveillance Authority in Michigan

MCL 333.2221 provides broad authority to conduct surveillance.

1. Comprehensive Health Information System

MCL 333.2616 requires MDHHS to establish a comprehensive health information system for the "collection, compilation, coordination, analysis, indexing, dissemination, and utilization of both purposefully collected and extant health-related data and statistics."

According to MCL 333.2617, the health information system shall include statistics on the characteristics and impact of illness and disability of the people in Michigan; environmental, social and other hazards; determinants of health and behaviors; health resources; access to and utilization of health care; and health care financing. MCL 333.2617a requires that information on maternal mortality also be included.

MCL 333.2618 requires MDHHS to publish an annual report compiling and analyzing this information for the governor, legislature, and collaborating entities. A summary report must be published at least every five years, which should include any limitations of the data.

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[164] Coyle, et al., *Notes from the Field: Health Monitoring, Testing, and Case Identification Among Persons Exposed to Influenza A(H5N1) — Michigan, 2024*, MMWR, 73(29);656–658 (2024), <https://www.cdc.gov/mmwr/volumes/73/wr/mm7329a4.htm> (accessed April 9, 2025).
[165] MDHHS, *Michigan Syndromic Surveillance System* <https://www.michigan.gov/mdhhs/keep-mi-healthy/communicablediseases/mdss/michigan-syndromic-surveillance-system> (accessed April 5, 2025).

a. Registries

MDHHS is also authorized to establish and maintain several registries. These include:

- Birth defects registry (MCL 333.5271).
- Cancer registry (MCL 333.2619); and
- Immunization registry (MCL 333.9207).

See Section 4.12 Immunization/Vaccination, (H), Immunization Registry.

E. Screening

The terms screening and testing are often used interchangeably. But testing (*See Section 4.7, Medical Testing, Examination, and Treatment*) is a diagnostic procedure to determine whether an individual does or does not have a specific disease, while screening is a type of surveillance to ascertain the presence or absence of a disease or condition in groups or populations. People in the groups or populations being screened may not have exhibited symptoms or may not be aware of their risk for the disease being screened. Screening can help public health agencies determine the rate of disease within a population, disparities among different groups within the population, risk factors for the disease, and other important information. Screening can also help detect risk factors or early signs of disease so that individuals can be referred to diagnostic testing to confirm or treatment to prevent progression of the disease. Newborn screening, as outlined in MCL 333.5431, is an example in Michigan. More than 50 diseases and conditions, as well as hearing, are screened. Positive results are referred for further testing, and parents or guardians may agree to the use of blood spots for medical research.

4.5 Communicable Disease Reporting

A. Reportable Diseases, Defined

Reportable diseases are diseases designated by law or policy for which local or state public health must be informed due to the frequency, severity,

threat to others, or for other important public health reasons.[166] Some reportable diseases are also among those that MDHHS or local health departments report to the CDC for participation in the National Notifiable Disease Surveillance System.[167]

B. Disease Reporting Authority in Michigan

1. Authority to Promulgate Rules

Under MCL 333.5111, MDHHS may promulgate rules related to diseases, infections, and disabilities, and the potential for epidemics." Under MCL 333.5111(3) MDHHS must promulgate rules "providing for the confidentiality of reports, records, and data pertaining to testing, care, treatment, reporting, and research associated with communicable diseases and serious communicable diseases or infections."

2. Rules on Communicable Disease Reporting

The communicable disease reporting rules are found at R 325.172-173. MDHHS publishes the reportable diseases, infections, and disabilities on its website annually. The MDHHS website describes who is required to report, why reporting is important, and how and where to report, as well as changes from prior years. Further, the website contains links to downloadable files of the reporting requirements by condition and by pathogen. These files also contain the contact information for each local health department in Michigan.

3. Privacy

As the MDHHS website explains, disclosure of protected health information by covered entities for the purpose of reporting diseases to local health departments is permitted by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, 45 CFR § 164.512(b)(1)(i).

See Chapter 7, Public Health Information.

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[166] Nat'l Library of Med, Medline Plus, *Reportable diseases* <https://medlineplus.gov/ency/article/001929.htm> (2023) (access April 8, 2025).
[167] Centers for Disease Control & Prevention, National Notifiable Diseases Surveillance System (NNDSS), *About National Notifiable Disease Surveillance System* <https://www.cdc.gov/nndss/about/index.html> (posted November 20, 2024) (accessed April 8, 2025).

Further, under R 325.181 for all diseases covered under MCL 333.5111, except for Human Immunodeficiency Virus (HIV), all information gathered for epidemiological investigation and reporting is to be kept confidential unless the individual or their guardian consent, or unless a local health officer or the director determine disclosure is necessary to protect the public's health. Information released to the legislature may not contain identifying information.

C. Reporting of HIV

1. Report

Under MCL 333.5114(1) and R 325.175(12), if an individual is tested to determine if they are HIV infected and the test result is positive for HIV, or if a person who has already been diagnosed as HIV infected is tested for monitoring of the disease, the person or governmental entity conducting the test must, within a time frame determined by [MDHHS], report to the appropriate local health department or MDHHS (if requested) all of the following information (if available):

- The name and address of the person or governmental entity that submits the report.
- The name, address, and telephone number of the health care provider who diagnosed the test subject or who ordered the test.
- The name, date of birth, race, sex, address, and telephone number of the test subject.
- The date on which the specimen was collected for testing.
- The type of test performed.
- The test result.
- If known, whether or not the test subject has tested positive for the presence of HIV or an antibody to HIV on a previous occasion.
- The probable method of transmission.
- The purpose of the test; and

- Any other medical or epidemiological information considered necessary by MDHHS for the surveillance, control, and prevention of HIV infections, as promulgated in rules.

Forms for reporting are available at the MDHHS website.

2. **Private Testing**

Pursuant to MCL 333.5114(2), an individual who is tested for HIV by a physician or practice other than a MDHHS-funded facility or local health department "may request that the report made by the physician not include the name, address, and telephone number of the test subject." If the request is made, the physician must comply by submitting the test to the laboratory without the name, address or phone number of the individual, except as otherwise provided for partner notification.

3. **Privacy and Confidentiality**

MCL 333.5131 provides for protection of "reports, records and data pertaining to testing, care, treatment, reporting, and research, and information pertaining to partner notification" related to HIV. Except if otherwise required by law, this information is protected by physician-patient privilege under MCL 600.2157.

A court that is petitioned for an order to disclose this type of information must determine the following before it can issue such an order:

- That other ways of obtaining the information are not available or would not be effective.
- That the public interest and need for the disclosure outweigh the potential for injury to the patient.

If a court determines that an order to disclose this type of information is needed, the order issued must do all of the following:

- Limit disclosure to those parts of the patient's record that are determined by the court to be essential to fulfill the objective of the order.

- Limit disclosure to those persons whose need for the information is the basis for the order.

- Include any other measures as considered necessary by the court to limit disclosure for the protection of the patient.

There are also several statutory exemptions to the general prohibition on releasing this confidential data. MCL 333.5131(5). For example, when information is disclosed to MDHHS, a local health department, or a care provider for the purposes of protecting the health of an individual, preventing further transmission of HIV, or diagnosing and caring for a patient. MCL 333.5131(5)(a). Other exemptions include:

- For partner notification (MCL 333.5131(5)(b) or MCL 333.5114a);

- To prevent transmission of HIV to pupils of a school district. (MCL 333.5131(5)(c)).

- If the patient or patient's parent or legal guardian have given express written authorization (MCL 333.5131(5)(d)).

- If part of a report for child protection law (MCL 333.5131(5)(f)).

- To care for a minor or place a minor in a childcare organization (MCL 333.5131(5)(g)).

But many of these exemptions still prohibit disclosing personally identifying information about the patient unless it is "reasonably necessary to prevent a foreseeable risk of transmission of HIV, to protect the health of the individual to whom the information pertains, to prevent the further transmission of HIV, or to diagnose and care for a patient." MCL 333.5131(7). Again, the personally identifying information must be limited to the minimum information necessary. So long as the disclosure is complaint with these statutory provisions, the person making the disclosure is immune from civil or criminal liability. MCL 333.5131(6).

Violations of this section are punishable as follows:

- When prosecuted as a misdemeanor, by up to 1 year of prison or up to a $5,000 fine, or both
- In a civil action, by ordering payment of the greater of actual damages or $1,000.

MCL 333.5131(8). An employer of the person violating this section may also be liable unless they have taken reasonable precautions to prevent the violation.

4. Exemption from Freedom of Information Act Disclosure

Under MCL 333.5114a(7), records from MCL 333.5114 are exempt from disclosure under the state's Freedom of Information Act (FOIA).

4.6 Disease Investigation and Contact Tracing

A. Disease Investigation, Defined

Public health professionals, often epidemiologists, are sometimes nicknamed "disease detectives."[168] They conduct disease investigations to determine:

- Who became sick or was affected?
- What is the cause of the illness?
- When were people exposed?
- Where were people exposed?
- Why did people become ill (and why didn't others)?
- How can additional cases of illness be prevented?

Note, the term "investigate" is not defined in the Public Health Code or the Administrative Rules, nor is there case law to clarify what the duty to investigate entails. However, an opinion of the Attorney General provides

[168] Avdulla & Tachirai, *John Snow: The Pioneer of Modern Epidemiology and Anesthesia,* Cureus, 16(8):e67602, (2024). John Snow is often referred to as the "father of epidemiology" and the original disease detective.

insight into this duty, explaining that MDHHS fulfills the duty to investigate diseases and epidemics by securing all available information that will assist in protecting the health of all people of the state: OAG, 1985-1986, No 6376, p 10 (June 30, 1986). This opinion states:

> The receiving and monitoring of reports of reportable diseases is an important function of the Department of Public Health [now MDHHS] in the detection, treatment and prevention of diseases, but such activities fall short of the statutory mandate that the Department of Public Health [now MDHHS] shall both investigate the causes of disease and diligently endeavor to prevent disease.

Upon diagnosis of a patient infected with a communicable disease, a disease investigation begins. A trained disease investigator — usually an employee of the local health department — interviews the patient; the patient's family members, physicians, nurses; and anyone else who may have knowledge of the patient's recent contacts and activities. This is known as “contact tracing.” The goal of this investigation is to identify anyone who may have been exposed to the disease, as well as persons, animals, or places that may have been the source of the disease. Identified contacts are then screened for the disease and treated as is necessary.

See Section 4.8, Disease Carrier Warning Notice.

The investigative process is ideally repeated until the source of the disease (referred to as the "index case" if the source is a person) is identified and all known contacts have been screened.

The type of contact screened depends upon the nature of the disease in question. Investigation of a sexually transmitted disease (e.g., HIV) only requires screening of the sexual partners of infected individuals. In contrast, diseases spread through aerosolized droplets, such as tuberculosis, measles, or varicella (chickenpox), may require extensive screening of all casual contacts and any of those persons who were in proximity to the infected individual(s) or in places visited by the infected individual(s) even hours earlier.[169]

[169] Richards, Louisiana State Univ, Climate Change Law & Policy Project Blog, *Contact Tracing* <https://biotech.law.lsu.edu/Books/lbb/x578.htm> (accessed April 8, 2025).

B. Disease Investigation Authority in Michigan

Under MCL 333.2221(2)(d), MDHHS has a mandate to "make investigations and inquiries" into the cause of diseases, morbidity and mortality, and environmental health hazards, nuisances, and sources of illness. Local health departments also have this mandate under MCL 333.2433(2)(c). Further, under MCL 333.5111(2)(b), MDHHS is charged with investigating "cases, epidemics, and unusual occurrences of diseases, infections, and situations with a potential for causing diseases."

R 325.174(2) authorizes an MDHHS or local health department investigator investigating a disease to receive information about the following:

- Individual(s) who have the condition.
- Individuals who are part of the group where a condition has occurred, whether ill or not.
- Individuals who may have medical or epidemiological information about a condition.
- Individuals potentially exposed to a condition.
- Individuals who may be a carrier or health threat; and
- Any other information that may be relevant to the investigation of a condition.

The investigation can include human, animal, or environmental specimens if needed.

If the investigation is conducted by the local health department, the local health department must submit the appropriate report of the investigation to MDHHS.

4.7 Medical Testing, Examination, and Treatment

A. General Authority of Government to Compel Testing or Treatment

In certain situations, the government may seek to obtain information about an individual's medical status or subject the individual to medical treatment as part of its efforts to ensure the public's health. While some individuals may agree to provide such information or undergo such treatment

voluntarily, in some cases the government will need to compel compliance subject to U. S. Fourth Amendment Search and Seizure and Michigan law limiting bodily intrusions. Pursuant to their police powers, state and local governments may compel an individual to submit to reasonable medical testing and treatment in order to protect public health.[170]

See Section 3.3, Fourth Amendment – Search and Seizure.

B. Right to Refuse Medical Treatment, Testing, or Examination Based on Personal Religious Beliefs

MCL 333.5113 provides that individuals who object to medical treatment, testing, or examination as violations of their personal religious beliefs (or of the parent, guardian, or person *in loco parentis* of a minor) will not be required to undergo such treatment, testing, or examination, except as otherwise provided in other parts of the law. This right to object does not extend to compliance with sanitation or surveillance laws, rules, or regulations.

See Section 3.2, First Amendment – Free Speech, Expression, Assembly, and Religious Freedom, (C), Religious Freedom, and Section 8.4, Constitutional Challenges to Emergency Measures, (A), Religion.

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[170] *Jacobson v. Massachusetts*, 197 US 11, 25-30; 25 S Ct 358; 49 L Ed 643 (1905). The Court stated:

> According to settled principles, the police power of a state must be held to embrace, at least, such reasonable regulations established directly by legislative enactment as will protect the public health and by legislative enactment as will protect the public health and the public safety. It is not, therefore, true that the power of the public to guard itself against imminent danger depends in every case involving the control of one's body upon his willingness to submit to reasonable regulations established by the constituted authorities, under the sanction of the state, for the purpose of protecting the public collectively against such danger.

It is important to note that in *Jacobson,* the alternative to vaccination was a $5 fine (approximately $150 now) and the penalty for noncompliance was jail, rather than forcible vaccination.

Rock v. Carney, 216 Mich. 280, 294; 185 NW 798 (1921) (recognizing that a local health officer may quarantine, although actually meaning isolate, an individual if sufficient reasonable cause exists to believe that a person is afflicted with a communicable disease, "remembering that the persons so affected are to be treated as patients, not as criminals").

Reynolds v. McNichols, 488 F.2d 1378, 1382 (CA 10, 1973). The Court stated:

> Involuntary detention, for a limited period of time, of a person reasonably suspected to having a venereal disease for the purpose of permitting an examination of the person thus detained to determine the presence of a venereal disease and providing further for the treatment of such disease, if present, has been upheld by numerous state courts when challenged on a wide variety of constitutional grounds as valid exercise of the police power designed to protect the public health.

C. Laboratory Testing Requirements

Generally, laboratories must submit the first isolate, specimen, or subculture for the diseases listed at R 325.179a. Requirements for laboratories testing for TB are listed at R 325.179. Laboratories testing for HIV are required to submit remnant specimens as outlined in R 325.179b.

D. Special Circumstances for Requiring Testing

Under MCL 333.5204, "a police officer, fire fighter, local correctional officer or other county employee, court employee, or individual making a lawful arrest," who has had bloodborne pathogen training and determines they have been exposed to the "blood or other bodily fluid of an arrestee, correctional facility inmate, parolee, or probationer" can request the arrestee, correctional facility inmate, parolee, or probationer be tested for HIV, hepatitis B virus (HBV), and/or hepatitis C virus (HCV).

Similarly, under MCL 333.5133(6)(b), testing of a patient for HIV may be required if a "health professional, health facility employee, police officer, or fire fighter, or a medical first responder, emergency medical technician, emergency medical technician specialist, or paramedic" is exposed to a patient's blood or bodily fluid.[171]

The court should defer to legislative determinations regarding the necessity and expediency of compulsory testing and treatment, provided such determinations are not arbitrary or unreasonable.[172]

E. Treatment for Sexually Transmitted Infections

Under R 325.177, local health departments are responsible for providing "diagnosis, treatment, and case intervention" for people with sexually

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[171] Mich Dep't of Health & Human Servs & Bureau of HIV Statistics, Bureau of HIV & STI Programs, Michigan HIV Laws: How They Affect Physicians, Local Health Departments, Community Based Organizations, and Other Health Care Entities and Providers <https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Keeping-Michigan-Healthy/HIVSTI/Resources/Michigan-HIV-Laws.pdf> (April 2023) (access April 8, 2025).

[172] *Jacobson*, 197 US at 30-31. The Court stated:

> We must assume that, when the statute in question was passed, the legislature of Massachusetts was not unaware of these opposing theories, and was compelled, of necessity, to choose between them. It was not compelled to commit a matter involving the public health and safety to the final decision of a court or jury. It is no part of the function of a court or a jury to determine which one of two modes was likely to be the most effective for the protection of the public against disease.

transmitted infections (STIs)[173] in the district, without discrimination on the basis of "race, age, sex, national origin, or income." These services include the following:

- Relevant medical history and physical examination.
- Diagnostic tests.
- Treatment utilizing guidelines provided by the department.
- Follow-up examination and testing.
- Patient education.
- Identification and notification of sexual contacts; and
- The examination and treatment of sexual contacts and other designated high-risk individuals exposed to venereal disease cases.

The local health department must maintain records of syphilis cases for at least five years. Records of other STIs must be maintained for at least one year. If the test results are for a pregnant person under MCL 333.5123, the records must be maintained for at least three years.

F. Expedited Partner Therapy

According to the CDC, Expedited Partner Therapy (EPT) is "the clinical practice of treating the sex partners of patients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the patient to take to his/her partner without the health care provider first examining the partner."[174] EPT may be appropriate for other STIs as well. The goal of EPT is to prevent transmission and reinfection. As noted in MCL 333.5110(1), STIs can cause infertility and ectopic pregnancy.

MCL 333.5110(1) authorizes MDHHS to determine which diseases are appropriate for EPT. These diseases include chlamydia, trichomoniasis, and gonorrhea. MCL 333.5110(6) provides liability protection for providers of EPT, absent gross negligence, and MDHHS has developed guidance for

[173] R 325.177 uses the term "venereal disease" but the current terminology is "sexually transmitted infection" (STI).
[174] Centers for Disease Control & Prevention, Sexually Transmitted Infections (STIs), *Expedited Partner Therapy* <https://www.cdc.gov/sti/hcp/clinical-guidance/expedited-partner-therapy.html> (posted July 16, 2024) (accessed April 8, 2025).

health care providers to increase rates of EPT.[175] MDHHS and the Michigan Pharmacists Association have issued information on electronic prescriptions for sexual partners of patients.[176]

4.8 Disease Carrier Warning Notice

A. Disease Carriers

Informally, a carrier is someone who is infected with a disease and is asymptomatic, but who could pass it to someone else who might then exhibit symptoms, sometimes without the carrier ever being aware of their own status. However, under MCL 333.5201 "carrier" has a much broader definition. A “carrier” is defined as “an individual who serves as a potential source of infection and who harbors or who [MDHHS] reasonably believes to harbor a specific infectious agent or a serious communicable disease or infection, whether or not there is present discernible disease.”

B. Circumstances Warranting Warning Notice

A representative of MDHHS or the local health department may issue a “warning notice” to an individual who is determined to be a carrier *and* a “health threat” to others by being unwilling or unable to behave in a way that will not risk the spread of a serious communicable disease or infection to others. The following are examples of how an individual may present as a health threat to others:

- Behavior that has been “demonstrated epidemiologically to transmit”.
- “Careless disregard for transmission”.
- Substantial likelihood of transmission, based on “past behavior or statements made” that are credible indicators of intent; and

[175] MDHHS, Bureau of HIV and STI Programs, *Guidance for Health Care Providers: Expedited Partner Therapy (EPT) For Chlamydia, Gonorrhea, and Trichomoniasis* <https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder4/Folder32/Folder3/Folder132/Folder2/Folder232/Folder1/Folder332/Expedited_Partner_Therapy_Guidance_for_Health_Care_Providers.pdf?rev=56ab4e1a513b4fab803eafa823d24edd> (2021) (accessed April 8, 2025).
[176] Mich State Med Society, News & Media, *Expedited Partner Therapy (EPT) and Electronic Scripting* <https://www.msms.org/About-MSMS/News-Media/expedited-partner-therapy-ept-and-electronic-scripting> (posted March 13, 2023) (accessed April 8, 2025).

- "Affirmative misrepresentation" of "status as a carrier before engaging in behavior that has been demonstrated epidemiologically to transmit."

MCL 333.5201 and MCL 333.5203.

C. Prevention Measures

The warning notice demands a carrier's cooperation with MDHHS or a local health department to prevent the carrier's spread of the disease to others.

Under certain circumstances, a warning notice may require commitment, also referred to as isolation (for a person who is confirmed to have a communicable disease) or quarantine (for a person who is believed to have been exposed to a communicable disease but is not yet exhibiting symptoms). More commonly, a warning notice may require the carrier to participate in "education, counseling, or treatment programs, and to undergo medical tests to verify the person's status as a carrier." MCL 333.5203.

4.9 Partner Notification and Marriage Licenses – HIV

A. Partner Notification, Defined

Partner notification is the practice of contacting current, and past sexual or hypodermic needle-sharing partners of a person diagnosed with a certain disease so that the current and past partners can also be tested for the disease and seek treatment to prevent transmission to additional people.[177]

B. Legal Authority

To prevent the transmission of HIV, under MCL 333.5210 and MCL 333.5114a(3)(1), individuals who know they are positive for HIV must inform sexual partners of their disease status prior to engaging in anal or vaginal intercourse. Partner notification programs are also empowered to warn sexual partners or hypodermic needle-sharing partners of a person who has tested positive for HIV.

[177] HIV.gov, Limits on Constitutionality, *HIV Disclosure Policies and Procedures* <https://www.hiv.gov/hiv-basics/living-well-with-hiv/your-legal-rights/limits-on-confidentiality#:~:text=Many%20states%20and%20some%20cities,be%20charged%20with%20a%20crime> (updated September 16, 2024) (accessed April 9, 2025).

C. Necessary Information Shall Be Provided

Under MCL 333.5114a, "a person or governmental entity that refers an individual to a local health department shall provide the local health department with information determined necessary by the local health department to carry out partner notification." Required information may include, but is not limited to, the name, address, and telephone number of the individual.

D. Informing Individual of Duty to Warn

MCL 333.5114a(3) states that:

> [A] local health department to which an individual is referred…shall inform the individual that he or she has a legal obligation to inform each of his or her sexual partners of the individual's HIV infection before engaging in sexual relations with that sexual partner, and that the individual may be subject to criminal sanctions for failure to so inform a sexual partner.

E. Partner Notification

MCL 333.5114a(4) states that:

> [A] partner notification program operated by a local health department must include notification of individuals who are sexual or hypodermic needle-sharing partners of the individual tested under subsection (1). Partner notification is confidential and must be conducted in the form of a direct, one-on-one conversation between the employee of the local health department and the partner of the test subject.

F. Partner Notification Program

Under MCL 333.5114a(5), when a local health department receives a report under MCL 333.5114 indicating that a Michigan resident or an individual located in the state is HIV infected, the local health department shall make it a priority to:

1. Interview

The local health department must:

> Attempt to interview the individual and offer to contact the individual's sexual partners and, if applicable, hypodermic needle-sharing or drug-sharing partners. If

> the subject of the report is determined to have been infected with HIV in utero, the local health department shall attempt to interview the individual's parent or legal guardian, or both. The interview conducted is voluntary on the part of the individual being interviewed. A local health department shall perform the interview or attempted interview within 14 days after receipt of a report.

2. Inform

The local health department must:

> Within 35 days after the interview conducted, confidentially, privately, and in a discreet manner contact each individual identified as a sexual or hypodermic needle-sharing or drug-sharing partner regarding the individual's possible exposure to HIV. The local health department shall not reveal to an individual identified as a partner the identity of the individual who has tested positive for HIV or an antibody to HIV, except if authorized to do so by the individual who named the contact, and if needed to protect others from exposure to HIV or from transmitting HIV.

The local health department must also provide each individual interviewed or contacted with the following information:

- Available medical tests for HIV, an antibody to HIV, and any other indicator of HIV infection.
- Steps to take in order to avoid transmission of HIV; and
- Other information considered appropriate by [MDHHS].

G. Reporting to MDHHS

Under MCL 333.5114a(6), "[e]ach local health department shall report to [MDHHS] on the reports, records, and data pertaining to information acquired by the local health department…"

H. Information Storage and Disclosure

Under MCL 333.5114a(6), paper and electronic records must be destroyed no later than 365 days after the local health department receives the information, unless prevented by federal law.

Under MCL 333.5114a(7), records from MCL 333.5114a are exempt from disclosure under the state's FOIA.

I. Marriage Licenses and HIV Notification

Under MCL 333.5119, couples seeking a marriage license are to be provided educational materials on STIs, HIV, and prenatal care. This statute also requires medical professionals to inform both partners applying for a marriage license if either applicant tests positive for HIV. Under MCL 333.5121(a), the county clerk is guilty of a misdemeanor if they provide a marriage license without the couple affirming receipt of the educational materials.

Under MCL 333.5121(b), a person who discloses without authorization that a marriage applicant has taken a test and/or the results of the test for sexually transmitted infection or HIV is also guilty of a misdemeanor.

J. Criminal Penalties for Not Informing Sexual Partners of HIV Status

According to MCL 333.5210, a person who is aware they are positive for HIV and engages in anal or vaginal intercourse with another person who is negative for HIV without informing them of their HIV positive status is guilty of a felony if:

- The person who is HIV positive has specific intent to infect the other person; or
- The person who is HIV positive acts with reckless disregard and infects the other person.

According to MCL 333.5210, a person who is aware they are HIV positive and engages in anal or vaginal intercourse with another person who is HIV negative without informing them of their HIV positive status is guilty of a misdemeanor if:

- The person who is HIV positive acts with reckless disregard but does not transmit HIV the other person.

A person who is HIV positive, who is undergoing treatment, and who has a suppressed viral load (meaning that risk of transmission is low according to medical standards) is not acting with reckless disregard.

4.10 Imminent Danger Communicable Disease Notification

A. Imminent Danger, Defined

Under the Public Health Code, "imminent danger" is defined as:

> [A] condition or practice which could reasonably be expected to cause death, disease, or serious physical harm immediately or before the imminence of the danger can be eliminated through enforcement procedures otherwise provided.

MCL 333.2251(5)(b); MCL 333.2451(3)(a).

B. Imminent Danger Order

Under MCL 333.2251(1):

> Upon a determination that an imminent danger to the health or lives of individuals exists in this state, the director immediately shall inform the individuals affected by the imminent danger and issue an order that shall be delivered to a person authorized to avoid, correct, or remove the imminent danger or be posted at or near the imminent danger.

Under MCL 333.2451(1), the local health officer shall issue the order if the imminent danger is in an area served by the local health department.

C. The Order

Pursuant to MCL 333.2251(1) and MCL 333.2451(1), the order:

- Shall incorporate the director's findings [or the findings of the local health department] and require immediate action necessary to avoid, correct, or remove the imminent danger.
- May specify action to be taken or prohibit the presence of individuals in locations or under conditions where the imminent danger exists, except individuals whose presence is necessary to avoid, correct, or remove the imminent danger.

D. Failure to Comply

Under MCL 333.2251(2) and MCL 333.2451(2), upon the failure of a person to comply promptly with an imminent danger order, MDHHS or a local health department may petition a circuit or district court having jurisdiction to

restrain a condition or practice which the director or local health officer determines causes the imminent danger or to require action to avoid, correct, or remove the imminent danger.

E. Emergency Order

The director has additional authority to issue an emergency order under MCL 333.2251(4).

See Chapter 8, Public Health Emergency Preparedness and Response.

4.11 Isolation and Quarantine

A. Isolation and Quarantine, Defined

"Isolation" is defined as **"**separating sick individuals from society in order to contain the spread of the illness."[178]

"Quarantine" is defined as "separating and restricting the movements of healthy individuals who may have been exposed to an illness to determine whether they are sick (and would require isolation)."[179]

B. Isolation and Quarantine, Explained

Isolation and quarantine are long standing, foundational public health tools used to contain the spread of infectious diseases.[180] Both require the separation of infected and potentially infected persons from the public. This separation is achieved by separating the infected and/or potentially infected person(s) in treatment facilities, residences, and/or other locations, depending on the nature of the implicated disease and the available facilities.

Both isolation and quarantine are measures that may restrict personal freedom, particularly in the case of diseases characterized by prolonged incubation periods. In Michigan, the U.S. Supreme Court has long

[178] Merriam-Webster Dictionary, *'Quarantine' vs 'Isolation': The vocabulary of keeping some distance,* <https://www.merriam-webster.com/grammar/quarantine-and-isolation-difference> (accessed April 9, 2025).
[179] *Id.*
[180] See, e.g., *Compagnie Francaise de Navigation a Vapeur v. Louisiana State Bd of Health*, 186 US 380, 392-393; 22 S Ct 811; 46 L Ed 1209 (1902) (recognizing power of states to institute quarantine to protect their citizens from infectious diseases).

recognized the authority of state and local health officers to issue reasonable orders or regulations to control the spread of disease.[181]

In many cases, individuals will voluntarily undertake isolation and quarantine procedures at the request of the state or local health department, and courts will not be required to intervene. However, in situations where individuals are unwilling to undertake isolation or quarantine procedures or become noncompliant with procedures already in place, the courts' assistance may be required. Given the inherently limiting nature of both isolation and quarantine, as well as the state of anxiety and tension likely to accompany these proceedings, courts should be attuned to the due process, economic, and logistical concerns of those potentially subject to such measures and attempt to address these concerns when issuing orders.

C. Use of Warning Notice

Michigan uses the process under "Warning Notice" to issue disease control orders for individuals, such as isolation or quarantine.

See Section 4.13, Proceedings for Warning Notice and Due Process Requirements.

4.12 Immunization/Vaccination

A. Immunization/Vaccination, Defined

Vaccination, also known as immunization (and used interchangeably below), is one of the 10 great public health achievements of the 20th century.[182] Smallpox was eradicated due to targeted efforts of contact tracing and vaccination (and its predecessors: inoculation and variolation). During the 1900s, debilitating and deadly diseases such as polio, measles, pertussis, diphtheria, rubella, and others were reduced by greater than 97% in the U. S. . In addition to the millions of lives saved by vaccination, vaccination has also prevented lifelong disability, blindness, deafness, and chronic illnesses caused by these diseases.

[181] *People ex rel Hill v. Bd of Ed of City of Lansing*, 224 Mich 388, 195 NW 95 (1923).
[182] Centers for Disease Control & Prevention, *Morbidity and Mortality Weekly Report (MMWR), Ten Great Public Health Achievements – United States, 1900-1999* <https://www.cdc.gov/mmwr/preview/mmwrhtml/00056796.htm> (accessed April 14, 2025).

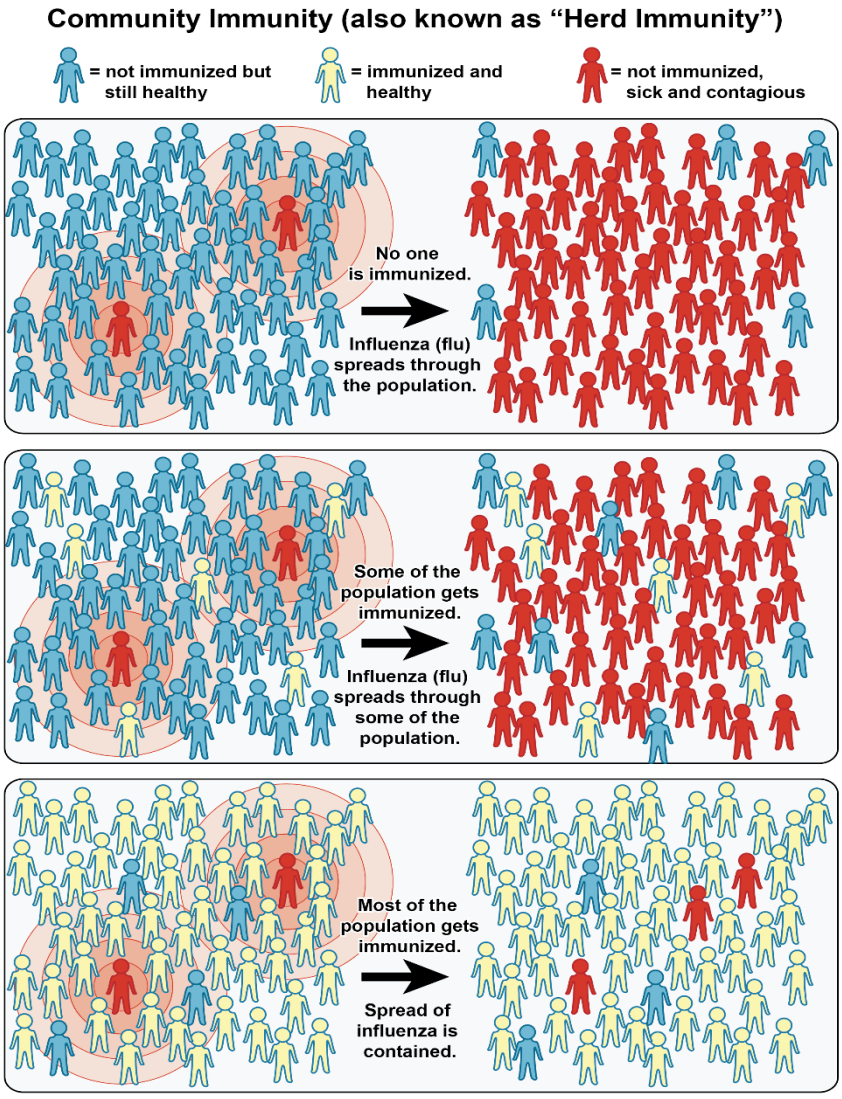
Vaccines are “injections (shots), liquids, pills, or nasal sprays” that are used to elicit a response from the body to recognize and fight against a harmful germ.[183] Vaccination is the act of getting a vaccine. Immunization is a term used for both being vaccinated for and becoming protected against a particular disease.[184] MCL 333.5101 defines “immunization” as “the process of increasing an individual's immunity to a disease by use of a vaccine, antibody preparation, or other substance.”

A person may build immunity to a disease from immunization, or, for some diseases, a person may develop immunity after having had a disease. According to MCL 333.9201, an “immunizing agent” is “a vaccine, antibody preparation, or other substance used to increase an individual's immunity to a disease or infectious agent.” And according to R 325.176, “‘Vaccine’ means an agent for immunization against an infection or disease caused by an infectious agent.”

A threshold rate of vaccination, different for each disease, must be maintained to protect the community from outbreaks. This is called “herd immunity” or “community immunity.” Vaccines are safe and effective. Maintaining the threshold rate of vaccination by ensuring that everyone able to be vaccinated gets vaccinated is critical to protect people who cannot be vaccinated, such as people who are too young or too old, who have suppressed immune systems, who are allergic to components of the vaccines, or are otherwise contraindicated.

[183] Nat’l Library of Med, Medline Plus, *Vaccines* <https://medlineplus.gov/vaccines.html> (accessed April 8, 2025).
[184] *Id.*

Figure 7[185]



Strong herd immunity prevents outbreaks of disease in a community.

In recent years, vaccine hesitancy has increased. Vaccine hesitancy may be specific to time, place, or specific disease. Vaccine hesitancy has existed as long as vaccination and occurs for a variety of reasons, such as:

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[185] National Institute of Allergy and Infectious Disease, *Community Immunity ("Herd" Immunity)* <https://www.flickr.com/photos/niaid/5149339976> (posted November 5, 2010) (accessed April 11, 2025). See also Heleft & Willingham, Pub Broadcasting Serv, *What is Herd Immunity?* <https://www.pbs.org/wgbh/nova/article/herd-immunity/> (posted September 5, 2014) (accessed April 8, 2025); and Vally, The Conversation, *What is herd immunity and how many people need to be vaccinated to protect a community?* <https://theconversation.com/what-is-herd-immunity-and-how-many-people-need-to-be-vaccinated-to-protect-a-community-116355> (posted August 1, 2019) (accessed April 8, 2025).

- Inaccessibility, logistical obstacles, or cost concerns.
- Belief that vaccines are no longer needed for diseases seen infrequently.
- Fear of harmful side effects or vaccine injury.
- Religious or personal belief objections.
- Distrust or mistrust of science or experts in vaccination; and
- Resistance to government intrusion.

The anti-vaccination movement plays on many of these concerns, with attempts to prevent legislation or overturn vaccination laws. Efforts have also included tactics to provide mis- or dis-information on vaccine risk or effectiveness, relying on false or disproven science. Vaccine hesitancy can reduce herd immunity and often occurs at greater rates in pockets, causing certain communities to fall below the threshold rates required to prevent against outbreaks. For example, in 2024, cases of pertussis (whooping cough) in Michigan surged with a decline in vaccination rates for 19–to 36-month-olds.[186] Nationwide, the first quarter of 2025 alone has seen more than 600 cases of measles, with 97% of those infected unvaccinated or having unknown status, 12% resulting in hospitalization, and one confirmed death.[187] The majority of these cases were in Texas, stemming from an outbreak in an under-vaccinated community; however, Michigan has also had cases, including the first case in Kent County in more than a decade.[188]

B. Immunization Mandates

Immunization mandates have been demonstrated to be the most effective way to ensure that vaccination threshold rates remain high enough to maintain strong herd immunity. The most common immunization mandates are tied to school entry. However, mandates are also seen in childcare,

[186] Mich Dep't of Health & Human Servs, *MDHHS warns Michigan residents about increase in pertussis* (whopping cough) cases <https://www.michigan.gov/mdhhs/inside-mdhhs/newsroom/2024/11/04/pertussis> (posted November 4, 2024) (accessed April 8, 2025); Guillen, AXIOS: *Detroit, Michigan's whopping cough cases spike amid falling vaccination rates* <https://www.axios.com/local/detroit/2024/11/27/michigan-whooping-cough-spike-vaccination-rates> (posted November 27, 2024) (accessed April 8, 2025).
[187] CDC, *Measles Cases and Outbreaks* <https://www.cdc.gov/measles/data-research/index.html> (accessed April 8, 2025).
[188] Mich Dep't of Health & Human Servs, *Measles Updates* <https://www.michigan.gov/mdhhs/adult-child-serv/childrenfamilies/immunizations/measlesupdates> (posted 2025) (accessed April 8, 2025).

health care facilities, incarceration, assisted living, and other settings (private businesses and organizations may also have vaccination requirements). Mandates may also be necessary during disease outbreaks.

Discussed earlier in this benchbook, *Jacobson v. Massachusetts* (1905) is a seminal case establishing authority for public health action generally and vaccination specifically. The case outlined the balancing test weighing individual rights against protection of the public's health, finding in favor of vaccination.

See Chapter 3, Section 3.1, Overview, for full discussion on Jacobson v. Massachusetts.

1. Childhood Immunization Mandates

In Michigan, under MCL 333.9205 a child's parent, guardian, or the person acting *in loco parentis* is required to have the child immunized according to the MDHHS schedule.[189] The immunization can be done by an authorized health professional, physician, local health department, clinic, or other agency offering immunizations.

a. Preschool and School Mandates

Barely two decades after *Jacobson*, the U. S. Supreme Court heard another vaccination case. In *Zucht v. King,* with a very short opinion, the court upheld vaccination requirements for school attendance.[190] A year later the Michigan Supreme Court affirmed the government's authority to require vaccination for school attendance in *People ex rel. Hill v. Board of Education of City of Lansing*.[191] The opinion cites *Jacobson* and also thoroughly walks through cases from across the country supporting compulsory vaccination. The court also affirmed the delegation of authority to local government and deference of the court to the legislature.

After federal support in the late 1970s, and empirical data demonstrating that jurisdictions with school vaccination

[189] MDHHS, Vaccine Schedules <https://www.michigan.gov/mihp/providers/current-mihp-providers/initiatives/immunization-toolkit/vaccine-schedules
[190] *Zucht v. King*, 260 US 174, 43 S Ct 24, 67 L Ed 194 (1922).
[191] *People ex rel Hill v. Bd of Ed of City of Lansing*, 224 Mich 388, 195 NW 95 (1923).

mandates had lower incidence of measles, all states had a school vaccination mandate of some kind by 1980.

School vaccination mandates vary by state in a variety of ways, such as which vaccines are required and at what age or grade level, what documentation is required and how often, how many days new students have to come into compliance, and what reporting school systems are subject to. There are also variations in the exemptions allowed. All states must allow students who have medical contraindications to a vaccine to be exempt from that vaccination. Although not constitutionally required, many states also allow religious and/or personal belief exemptions, although dicta has supported that vaccination is so necessary to protect the public's health as to still be permitted even if a state does not offer an exemption for religious beliefs.[192] These exemptions differ by how often documentation must be provided, whether medical professional or other signatures are required, whether notarization is required, etc.[193] Stricter vaccination requirements, with less likelihood of exemptions being granted, are associated with higher rates of kindergarten vaccination and lower incidence of vaccine preventable disease outbreaks.[194]

Per MCL 333.9208, MCL 333.9211, and R 325.176, the parent or guardian or person acting *in loco parentis* of a child enrolling in public or non-public grade school or in a preschool, group residence, care, or camping must provide the certificate of immunization under MCL 333.9206 or exemption under MCL 333.9215, or statement of a physician that certifies the child is in progress with complying with

[192] *Workman v. Mingo Cty. Bd. of Educ.*, 419 Fed. Appx, 348, 353 (4th Cir. 2011); 132 S.Ct. 590 (2011) cert denied.
[193] Nat'l Conference of State Legislatures, *State Non-Medical Exemptions from School Immunization Requirements* <https://www.ncsl.org/health/state-non-medical-exemptions-from-school-immunization-requirements> (posted August 13, 2024) (April 8, 2025); Centers for Disease Control & Prevention, Public Health, *Vaccination Laws* <https://www.cdc.gov/phlp/php/publications/vaccination-laws.html> (posted May 16, 2024) (April 8, 2025); see also Yang & Silverman, *Legislative Prescriptions for Controlling Nonmedical Vaccine Exemptions*, 313 JAMA 247, 247-248 (2015) <https://jamanetwork.com/journals/jama/article-abstract/2091313> (April 8, 2025).
[194] Shaw, et al., *Immunization Mandates, Vaccination Coverage, and Exemption Rates in the United States*, Open Forum Infectious Disease Volume 5, Issue 6 (2018) <https://pubmed.ncbi.nlm.nih.gov/29977973>.

immunization requirements (e.g., when the child needs to catch up to the immunization schedule, and all doses cannot be given at the same time). The Revised School Code at MCL 380.1177 and the State School Aid Act at MCL 388.1767 also support this requirement. For school-aged children, this certificate must be provided upon first registering for school and when enrolling in 7th grade. For preschool or group residence, care, or camping, this must be provided no later than the first day of attendance. A teacher or principal may not allow a child to attend school who has not at least had a minimum of one dose of the required immunizations. For immunizations requiring more than one dose, the child must come into compliance within four months to continue to attend school.

MCL 333.9215 allows the following exemptions/waivers:

- **Medical –** a child may be exempt from a specific immunization if "a physician certifies the specific immunization is or may be detrimental to the child's health or is inappropriate." R 325.176(1)(c) further clarifies that this "means a written statement from a physician that a vaccination is medically contraindicated for a particular child for a specified period of time."

- **Religious Conviction or Other Objection** – a child may be exempt from immunization requirements for school if the parent, guardian, or person acting *in loco parentis* presents a written statement that the immunization requirement cannot be met due to religious conviction or other objection. MCL 333.9215. Under R 325.176(1)(d), the written statement must include the name and date of birth of the child, be signed by the parent, guardian, or person *in loco parentis*, and certify that the immunization is in conflict with religious or other convictions of the signer.

R 325.176(12) requires that each medical, religious, or other exemption be recognized by the school or program. Nonmedical exemptions must use the prescribed waiver form

and be certified by the local health department that "the individual received education on the risks of not receiving the vaccines being waived and the benefits of vaccination to the individual and the community."[195]

Note, as the Sixth Circuit Court stated in *Nikolao v. Lyon*, citing *Jacobson*, there is no constitutional right to a religious exemption.[196] In 2015, a devout Catholic mother sought a medical exemption from vaccination for her two children. Two county health office nurses, under the Certification Rule, R 325.176(12) requiring education on the risks of not receiving vaccines and importance of vaccines to the community, "tried to disabuse Nikolao of the notion that her Catholic faith prevented her from vaccinating her children." They informed her that there were no religions that have objections to vaccines and provided the state's Religious Waiver Note that had a quote from a Catholic leader supporting vaccines, but which was misattributed to a different Catholic leader. Although ultimately Nikolao received the exemption, the exemption did not state her religious belief as the reason, and she sued for violation of her First Amendment religious rights. Under the Free Exercise Clause, the court found she was not coerced to go against her beliefs, and the logistics of seeking the exemption did not burden her religious practice any more than anyone seeking a non-religious exemption would be burdened. Under the Establishment Clause, the court found that both the Certification Rule and Religious Waiver Note have a secular purpose to protect the health and safety of public-school children, the purpose neither advances nor inhibits religion, and that the conversation required of health workers under the Certification Rule and information on the Religious Waiver Note did not have excessive entanglement of the government in religion.

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[195] For a sample waiver, see Mich Dep't of Health & Human Servs, *2022 Immunization Waiver Form* <https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder4/Folder24/Folder3/Folder124/Folder2/Folder224/Folder1/Folder324/2022_SAMPLE_Immunization_Waiver_1-3-22_FINAL.pdf> (accessed April 8, 2025).

[196] *Nikolao v. Lyon*, 875 F.3d 310 (6th Cir. 2017), cert den 584 U.S. 979 (2018).

See Section 3.2, First Amendment – Free Speech, Expression, Assembly, and Religious Freedom, (C), Religious Freedom, for further discussion.

MCL 333.9208 requires MDHHS to issue "a report showing year-to-year comparison of the percentage of children by age who are immunized appropriately upon entering the seventh grade." Further, subject to the consent requirements under the Family Educational Rights and Privacy Act (FERPA), MCL 380.1177(3), MCL 388.1767(3), and R 325.176 authorize the school principals and group program operators to provide records to MDHHS or to local health departments. MDHHS must report year-over-year improvement of rates of fully immunized children entering 7th grade.

Local health departments may share immunization information from public clinics with schools or programs to verify immunization status for enrollment. Pursuant to HIPAA, the local health department may disclose protected health information (PHI) to a school about a student or prospective student of the school if the PHI is "limited to proof of immunization," "the school is required by State or other law to have such proof of immunization prior to admitting the individual," and "the covered entity obtains and documents the agreement to the disclosure from either" the parent, guardian, or other person acting *in loco parentis* of the student or the student if they are an adult or emancipated minor.

See Section 7.4, Select Federal Privacy Laws, (A), Family Educational Rights and Privacy Act, for further information on FERPA and the relationship between FERPA and the Health Insurance Portability and Accountability Act (HIPAA), as well as health clinics that may be operated at schools.

Under MCL 333.9212, if the immunization level of any grade has dropped below what is necessary to prevent spread of disease (as determined by the director of MDHHS or the local health department), the requirements in MCL 333.9208 can be imposed as condition for admittance to the grade in which the immunization level is low.

A person violating Part 92 of the Public Health Code (Immunizations) or any rules promulgated under this section is guilty of a misdemeanor under MCL 333.9229.

b. Child Custody

Where a dispute arose between divorced parents who had joint legal custody of a child, and thus shared decision making as to the child's welfare, and where one parent wanted to have the child vaccinated and the other had religious beliefs against vaccination, the trial court's determination that the best interest of the child was to be vaccinated was affirmed on appeal.[197]

c. Juvenile Code

Relying on the juvenile code, the Court of Appeals held that if a child has been deemed a ward of the court, whether temporarily or permanently, due to substantiated parental abuse or neglect, the parent is adjudicated as unfit and loses their authority to make decisions, including whether or not to have the child vaccinated. It is within the right of the court, and in the best interest of the child, to order that the child be brought up to date with vaccinations, even over the parent's religious and parental rights objections.[198]

2. Employment Mandates

Immunization mandates in the employment context operate slightly differently because the mandate may be from the government or from a private employer as a condition of employment. Following the onset of the COVID-19 pandemic, many lawsuits have arisen challenging employment mandates. Setting aside questions related to the initial emergency use authorization (EUA) approval process of the COVID-19 vaccine, which has since been fully approved by the Food and Drug Administration (FDA), challenges have been brought under the Americans with Disabilities Act (ADA), under Title VII of the

[197] *Matheson v. Schmitt,* unpublished opinion of the Court of Appeals, issued Nov. 21, 2019 (Docket No. 347022).
[198] *In re Deng*, 314 Mich App 615, 887 NW2d 445 (2016), lv den 500 Mich 860, 884 NW2d 580 (2016).

Civil Rights Act of 1964 (Title VII), and under the First Amendment of the U. S. Constitution.

a. Americans with Disabilities Act – Medical Exemption

Under the ADA, reasonable accommodations must generally be provided for employees with disabilities in need of accommodation. Examples might include, but are not limited to, requiring testing or use of personal protective equipment such as masks in lieu of vaccination, or working from home. An employer may not always be able to provide a reasonable accommodation. For example, an employer may not have a reasonable accommodation for an employee who works closely with high-risk patients without an alternative non-patient facing position. Accommodations offered to people seeking exemptions can also be offered to all personnel, if an employer wishes to do so.

For public and private employers with more than 15 employees, a vaccine contraindication is likely to be considered a disability. Here, an employer would have to provide an accommodation, unless the employer can demonstrate an undue hardship such as a significant difficulty or expense (this is theoretically a higher bar than for religious exemptions).

b. Title VII – Religious Exemption

Under Title VII, public and private employers with more than 15 employees may not discriminate on the basis of religion. Employers must provide a reasonable accommodation to an employee who seeks a religious exemption from a vaccination mandate unless it creates an undue burden. The employee must have a sincere religious belief, which does not have to be based on a specific religion or doctrine and should not require proof from a religious leader. The employer might require the employee to make a written or oral statement to ensure that the objection is sincere and religious in nature.

i. Religious Discrimination Example

Domski v. Blue Cross Blue Shield of Michigan is an employment-related vaccination exemption case. The jury found in favor of the plaintiff who argued that under Title VII, she was unfairly terminated from her IT position when she requested an exemption from her employer's vaccination mandate. The defendant-employer objected that she had not participated in a required follow-up interview to evaluate her religious beliefs, which they stated was in line with Equal Employment Opportunity Commission (EEOC) guidance. The jury found that the defendant-employer had discriminated against the plaintiff by not providing a reasonable religious accommodation. The jury awarded $2.69 million in compensatory damages and $10 million in punitive damages.[199]

See Section 3.2, First Amendment – Free Speech, Expression, Assembly, and Religious Freedom, (C), Religious Freedom, for further discussion.

3. "Vaccine Passports"

During an outbreak of a disease that is easily transmitted in crowded places, restrictions on capacity may be required. When a vaccine becomes available, monitoring the vaccine status of individuals for access and entry to these elective spaces, such as sporting events, concerts, restaurants, or bars, is one way to expand the capacity while not increasing the potential transmission of the disease. Requiring verifiable proof of vaccination, whether as a physical card or electronic app, referred to colloquially as a "vaccine passport," became common during the COVID-19 outbreak.

In many places, including Michigan,[200] there was backlash against the concept of requiring proof of vaccination status. Opponents argued that vaccine status was private and personal and that

[199] *Domski v. Blue Cross Blue Shield of Mich*, opinion of the United States District Court for the Eastern District of Michigan, issued Nov 8, 2024 (Case No. 2:23-cv-12023). See also *Brown v MGM Grand Casino*, opinion of the United States District Court for the Eastern District of Michigan, issued Jan 16, 2025 (Case No. 2:22-cv-12978).

[200] 2021 HB 4789 and 2021 HB 4790 were introduced but did not become law.

denying access to those who could not present proof of vaccination was discriminatory.

C. State and Local Immunization Data

Immunization and exemption/waiver data for the state of Michigan and local counties is available on the state dashboard.

D. Certificate

Under MCL 333.9206, the health care provider administering the immunizations must provide the child's parent, guardian, or person acting *in loco parentis* a certificate of immunizations which must be on MDHHS's required form. It must include the diseases "for which the child has been immunized, the number of doses given, the dates when administered, and whether future immunizations are indicated."[201]

The provider must also let the parent, guardian, or person acting *in loco parentis* know the immunization information will be submitted to the immunization registry specified in MCL 333.9227 unless the parent, guardian, or person acting *in loco parentis* provides written notice of objection prior to the provider reporting.

E. Who Can Immunize?

MCL 333.9204 authorizes the following professionals to "administer an immunizing agent":

- A health professional under direction of a physician; and
- A pharmacist, complying with MCL 333.17724.

F. Mass Immunization Programs

During an epidemic or threat of epidemic, local health departments may host mass immunization clinics for the public to prevent or mitigate the spread of a communicable disease. If ordered by the Director of MDHHS, such clinics would be provided at no cost to the public. MCL 333.9203(1).

These mass immunization clinics are not the same as the childhood immunization clinics local health departments offer for children as part of

[201] Note, beginning in 2024, under MCL 333.9206, the certificate also includes a space for indicating whether the child has been tested for lead poisoning.

their routine operations under MCL 333.9203(2). These clinics are usually held at the local health department offices and only offer childhood immunizations.

G. Liability

Under MCL 333.9203(3) when mass immunization programs are offered, health employees or authorized volunteers are not civilly liable for an act or omission that causes illness, reaction, or adverse effect from the vaccine, unless the act or omission is due to gross negligence or willful and wanton misconduct.

MCL 333.9203(3) specifically excludes a drug manufacturer whose product is used during the mass vaccination program from the liability exemption.

Under MCL 333.9206, health care providers are not civilly liable for an act or omission complying with immunization reporting to the registry pursuant to rules under MCL 333.9227, unless the act or omission is due to gross negligence or willful and wanton misconduct.

H. Immunization Registry

1. Establishment

MCL 333.9207 directs MDHHS to establish a registry to record information regarding immunizations, called the "Michigan care improvement registry." MDHHS shall enter information received under MCL 333.2821 and MCL 333.9206 into the registry.

2. Confidentiality of Information

MCL 333.9207 also indicates that the information contained in the registry is subject to the confidentiality and disclosure requirements of MCL 333.2637, MCL 333.2888, and the rules promulgated under MCL 333.9227.

MCL 333.9207 further states that MDHHS shall use the information in the registry when necessary to fulfill its duties. "Upon receipt of a written request from an individual who is twenty years of age or older, [MDHHS] shall make any immunization information in the registry pertaining to that individual inaccessible."

3. Reporting of Information

Unless the parent, guardian, or person *in loco parentis* of the child who received the immunizing agent objects, by written notice, received by the health care provider prior to reporting, a health care provider shall report to MDHHS each immunization administered by the health care provider, pursuant to rules promulgated under MCL 333.9227. If the parent, guardian, or person *in loco parentis* of the child who was immunized objects to the reporting requirement by written notice received by the health care provider prior to notification, the health care provider shall not report the immunization under MCL 333.9206.

I. Information on Meningococcal Disease and Human Papillomavirus

MDHHS is to select and provide materials on meningococcal disease under MCL 333.9205a to each high school and institution of higher education (public or private) and human papillomavirus (HPV) under MCL 333.9205b to each public school, public school academy, and non-public school. These materials should describe the risk of the disease and the availability, effectiveness, and potential risks of the associated immunizations.

J. Violations

A person who violates these immunization statutes or rules is also guilty of a misdemeanor under MCL 333.9229.

K. Federal Authority Related to Vaccines

It is important to note that the federal government has authority over other areas of vaccine policy, including the following:

1. The National Childhood Vaccine Injury Act of 1986, as Amended[202]

The National Childhood Vaccine Injury Act (NCVIA) establishes the federal office responsible for directing national vaccine policy, research and development; issuing a national vaccine plan; coordinating among federal, state, and tribal governments, as well as the private sector; and reporting.

[202] National Childhood Vaccine Injury Act (NCVIA) of 1986, 42 USC §§ 300aa-1 to 300aa-34.

2. Vaccine Development and Approval[203]

During non-emergencies, vaccines must undergo an extensive vetting process before the FDA will grant approval for a license. The vetting process includes submission of an Investigational New Drug Application and premarket clinical studies. The vaccine must be demonstrated to be safe and effective, and the benefits must outweigh the risks. Even after the vaccine is on the market, studies will continue to be conducted for safety, efficacy, purity and potency.

3. Advisory Recommendations[204]

The Public Health Service Act establishes the Advisory Committee on Immunization Practices (ACIP). ACIP is comprised of voting experts on vaccines as well as a consumer representative, nonvoting experts, and ex officio government agency representatives. ACIP meets regularly to review data and recommend adoption or revision of vaccine schedules. These schedules include which vaccines should be given to which age group and at which dosage. The CDC director then decides whether to adopt the ACIP recommendations.

4. Injury Reporting and Compensation

While data overwhelmingly demonstrates that vaccines are safe, adverse events, although rare, can occur. Some adverse events are minor, while others are more serious. Two reporting mechanisms exist for tracking adverse effects:

a. Vaccine Adverse Event Reporting System[205]

The Vaccine Adverse Event Reporting System (VAERS) is operated jointly between CDC and FDA. Health care providers are required to report suspected vaccine adverse events (and individuals who suspect they have been injured by a vaccine can also report) to VAERS. However, some suspected events might be coincidental and not related to vaccines at all. VAERS serves as an early warning system

[203] Food, Drug, and Cosmetic Act (FDCA) of 1938, 21 USC § 301 *et seq.*
[204] Public Health Service Act (PHSA) of 1944, 42 USC § 2l7a.
[205] Food & Drug Admin, Vaccine Adverse Events, *VAERS Overview* <https://www.fda.gov/vaccines-blood-biologics/vaccine-adverse-events/vaers-overview> (accessed April 8, 2025).

should problematic patterns arise, such as a bad batch or common side effects.

b. National Vaccine Injury Compensation Program[206]

The National Vaccine Injury Compensation Program (NVICP) is operated by the Health Resources & Services Administration. It was created as an alternative to lawsuits against the industry, providing immunity from state tort claims, in order to encourage vaccine development and production and keep costs down. Individuals who have evidence of a vaccine injury from one of the routine vaccines for children or pregnant women may file a claim. If the claim is one on the vaccine injury table, and no unrelated cause has been identified, the injured individual will be compensated. For injuries not on the vaccine table, individuals face a higher standard – they must prove the vaccine is the cause in fact in order to be compensated.

Funds for compensation from the NVICP are collected by the Department of Treasury from an excise tax charged for each vaccine dose.

5. Coverage of Vaccine Costs

Authority for coverage for vaccination costs is split between federal and state. As this topic leans more toward health care than public health, it is outside the scope of this benchbook.

4.13 Proceedings for Warning Notice and Due Process Requirements

A. Warning Notice for Non-emergency Disease Control Measures

Under MCL 333.5203:

> Upon a determination by a department representative or a local health officer that an individual is a carrier and is a health threat to others, the [MDHHS] representative or local health officer shall issue a warning notice to the individual requiring the individual to cooperate with the [MDHHS] or the local

[206] National Childhood Vaccine Injury Act (NCVIA) of 1986, 42 USC §§ 300aa-1 to 300aa-34.

health department in efforts to prevent or control transmission of serious communicable diseases or infections.

The warning notice may also require the individual to participate in education, counseling, or treatment programs, and to undergo medical tests to verify the person's status as a carrier.

Under MCL 333.5203 the notice must:

- Be in writing.
    - In urgent situations, the warning notice may be oral, followed by a written statement no more than 3 days later.
- Be individual, to a specific person, not to a class or group.
- Be delivered personally by a representative, either employed or contracted by MDHHS or the local health department; or delivered by registered mail, return receipt requested.
- Include a statement about the action to be taken by the carrier, or, if not taken, an order will be sought from the appropriate court;[207] and,
- Include a statement that the carrier has a right to notice and a hearing, except in cases of emergency.

B. Petition for Failure to Comply with Warning Notice

Under MCL 333.5205, if an individual who has received warning notice under MCL 333.5203 fails to or refuses to comply, the department can petition the circuit court.

Due process requirements under MCL 333.5205 specify that this petition must include:

- Grounds and underlying facts demonstrating the carrier is a health threat to others and has failed to or refused to comply with the warning notice.

[207] While MCL 333.5203 references probate court, the remainder of the part refers to circuit court, so this is likely an oversight that occurred as this part was amended over the years.

- Efforts taken by MDHHS or the local health department prior to issuing the warning notice.
- Type of relief sought; and
- Request for court hearing on these allegations.

C. Circuit Court Hearing

When the circuit court receives the petition for failure to comply with warning notice under MCL 333.5203, the court must assign a date for the hearing as soon as possible, but no later than 14 days after the petition is filed.

Due process requirements under MCL 333.5205 specify that notice of the petition and time and place of the hearing be personally served on the individual and petitioner at least three days before the hearing date. The notice must include:

- The date, time, and place of the hearing.
- The right to appear at the hearing.
- The right to present and cross-examine witnesses; and
- The right to counsel, or to have counsel appointed if the individual cannot afford the cost.

Alternatively, the individual and petitioner may waive the notice in writing, allowing the circuit court to hear the petition immediately.

D. Circuit Court Order (Non-emergency)

If the circuit court finds there is clear and convincing evidence of non-compliance with the warning notice, the court can order that the individual:

- Participate in a designated education, counseling, or treatment program.
- Undergo tests to verify status as a carrier or for diagnosis.
- Appear before designated health officials for verification of status, testing or other purposes consistent with monitoring.
- Cease and desist activities that threaten the health of others.

- Live in a supervised setting (part or full time; setting and conditions established by the court).

- Be committed to an appropriate facility, for up to six months, with conditions established by the court; and

- The circuit court may also enter any other just order.

The individual will be responsible for bearing the cost of the order. If the circuit court determines the individual is unable to pay all or part of the cost, then the state will pay. MCL 333.5205.

E. Appeal of Circuit Court Order

A circuit court order, as described above, may be appealed to the court of appeals. The court of appeals must hear the appeal no later than 30 days from filing. The circuit court order will not be stayed pending appeal, unless ordered on a motion for good cause.

F. Special Circumstances for Civil Commitment

If the circuit court orders civil commitment, additional due process procedures are required:

- The circuit court may only order civil commitment for up to six months, unless the facility director, upon motion, can show good cause for continued commitment beyond six months.

- The court must appoint a commitment review panel including at least three physicians from a list supplied by MDHHS, including at least two with specific expertise in communicable diseases. Upon a motion, the court will also include one physician selected by the individual. The panel must review the record, interview the individual (or document why an interview did not occur), recommend commitment or an alternative, and document the reasons for this recommendation.

- The individual may appeal their commitment. The court will reconvene the commitment review panel, as soon as possible, within 14 days of the appeal being filed. The panel must review the appeal and other relevant information, interview the individual (or document why an interview did not occur), recommend termination or continued commitment, and document the reasons for this recommendation.

On receipt of the recommendation, the circuit court may terminate or continue the commitment.

- If the individual leaves the facility before the end of the civil commitment order without permission of the circuit court, they are guilty of contempt.

G. Affidavit for Emergency Disease Control Measures

Under MCL 333.5207, to protect the public's health in an emergency (such as when involuntary detention and treatment is necessary for an individual with a hazardous communicable disease pursuant to MCL 333.2453(2)), an MDHHS representative or a local health officer may file an affidavit with the circuit court. The affidavit must set forth the specific facts upon which the order is sought.

H. Circuit Court Order (Emergency)

The circuit court shall issue an order upon a determination that reasonable cause exists to believe that there is a substantial likelihood that the individual is a carrier and a health threat to others.

The circuit court may order a representative of MDHHS, a local health department officer, or a peace officer to take the individual into custody and transport the individual to an appropriate emergency care or treatment facility for observation, examination, testing, diagnosis, or treatment, and if determined necessary by the court, temporary detention.

The order may be executed on any day and at any time and shall be served upon the individual who is the subject of the order immediately upon apprehension or detention. This order may be issued ex parte.

I. Hearing for Continued Detention

An individual held by an emergency detention order shall not be held for more than 72 hours without a court hearing to determine whether the detention should continue. (The 72 hours does not include Saturdays, Sundays, or legal holidays).

Notice of the hearing must be served a minimum of 24 hours before the hearing is held. Due process requirements specify the notice of the hearing must contain:

- The date, time, and place of the hearing.
- The grounds underlying the facts on which continued detention is sought.
- The right to appear at the hearing.
- The right to present and cross-examine witnesses; and,
- The right to counsel, or to have counsel appointed if the individual cannot afford the cost.

The circuit court may order that the individual continue to be temporarily detained if the court finds, by a preponderance of the evidence, that the individual would pose a health threat to others if released.

An order of continued temporary detention shall not continue longer than five days, unless a petition is filed under MCL 333.5205. If a petition is filed under MCL 333.5205, the temporary detention shall continue until a hearing on the petition is held.

J. Right to Counsel

The person who is the subject of an affidavit to the court has a right to counsel throughout proceedings under MCL 333.5205 for failure to comply with warning notice in a non-emergency, and MCL 333.5207 for an emergency court order.

4.14 Proceedings for Testing and Due Process Requirements – Special Circumstances

A. Blood or Bodily Fluid Exposure

Under MCL 333.5204, a police officer, fire fighter, local correctional officer or other county employee, court employee, or individual making a lawful arrest (employee), who has had bloodborne pathogen training, determines they have been exposed to the blood or other bodily fluid of an arrestee, correctional facility inmate, parolee, or probationer (test subject), the employee can request the test subject be tested for HIV, HBV, and/or HCV.

B. Request

The employee must make the request to their employer as soon as possible, and no later than 72 hours after exposure. The request form shall include:

- Date.
- Name and address of the employee making the request.
- Description of the exposure to blood or other bodily fluid of the test subject; and
- Statement that the requester is subject to confidentiality requirements of MCL 333.5204 and MCL 333.5131 (for HIV).

The request form shall not contain information that would identify the test subject unless necessary to identify the test subject for purposes of testing. The employer shall accept these facts as provided by the employee.

C. Testing

The employer will have the test subject tested for HIV, HBV, and/or HCV by the local health department or a health care provider designated by the local health department, as soon as practicable after the request is received by the employer.

The employee is responsible for the reasonable and customary cost of each test. The charge may be paid by the employer if there is an agreement in place or by the employee's health benefits.

The local health department or health care provider, using a specified form, must notify the employee of the test results within two days. This notification may not contain information identifying the test subject.

The local health department or health care provider does not have to provide HIV counseling to the employee under MCL 333.5133 unless the employee is also tested for HIV.

D. Confidentiality

Unauthorized disclosure of confidential information of the test subject is a misdemeanor and also subject to the penalties in MCL 333.5111 and MCL 333.5131.

E. Liability

A person or government entity who makes a good faith effort to comply with the process requirements for testing of this section, with the exception of confidentiality, is immune from civil liability or criminal penalty.

F. Petition for Failure to Comply with Testing

Under MCL 333.5205, if the test subject under MCL 333.5204 fails to or refuses to comply with testing for one or more diseases (HIV, HBV, HCV), the employer can petition the circuit court or district court.

Due process requirements under MCL 333.5205 specify that this petition must include:

- Substantially the same information as stated in the request submitted by the employee under MCL 333.5204:
    - Date.
    - Name and address of the employee making the request.
    - Description of the exposure to blood or other bodily fluid of the test subject.
    - Statement that the employee is subject to confidentiality requirements of MCL 333.5204 and MCL 333.5131 (for HIV); and
    - The name of the test subject (this identifiable information is generally not included in the original test request to the supervisor).
- The reasons supporting the determination that the exposure described in the request could have transmitted HIV, HBV, and/or HCV.
- Date and place the officer, employee, or arresting individual received bloodborne disease training.
- Fact that the individual has refused to undergo the requested tests.
- Type of relief sought; and

- Request for court hearing on these allegations.

G. District or Circuit Court Hearing

When the district or circuit court receives the petition for failure to comply with testing under MCL 333.5204, the court must assign a date for the hearing as soon as possible, but no later than 24 hours after the petition is filed.

Due process requirements under MCL 333.5205 specify that notice of the petition and time and place of the hearing be personally served on the employee and test subject in a reasonable period of time under the circumstances. The notice must include:

- The date, time, and place of the hearing.
- The right to appear at the hearing.
- The right to present and cross-examine witnesses; and
- The right of the test subject to counsel.

Alternatively, the employee and test subject may waive the notice in writing, allowing the district or circuit court to hear the petition immediately.

H. District or Circuit Court Orders

If the district or circuit court finds the employee has proven the allegations in the petition, the court may order the test subject to undergo testing for HIV, HBV, and/or HCV. The test subject is responsible for the cost of implementing an order for testing.

I. Right to Counsel

The person who is the subject of a petition to the court has a right to counsel throughout the proceedings.

J. Penalty for Unauthorized Disclosure of Test Results

Unauthorized disclosure of testing or test results for HIV infection, HBV infection, or HCV infection, which was requested by law enforcement, first responders, or other government employees who may have come in contact with someone's blood or bodily fluid, is punishable as a misdemeanor under MCL 333.5204.

Chapter 5: Environmental Health Hazards Prevention and Control

5.1 Overview

Though the protection and preservation of Michigan's natural resources does not fall under the purview of public health, environmental factors that may affect the health of individuals do. Clean air and water, functioning sewerage systems, zoonotic diseases, and other potentially harmful environmental conditions are key concerns under the Public Health Code.

But, even under the Public Health Code, it is not only the MDHHS and local health departments that are empowered with authority to prevent, control, and protect against environmental health hazards. Authority in this area is also given to other state agencies, including EGLE and MDARD) In fact, these other state agencies are granted primary authority to address many of the state's environmental health threats. Even though the public's health is impacted by the environment, public health agencies cannot and should not address all aspects of environmental health. That said, general authority is provided to public health agencies to take action where a primary authority does not act.

The following sections provide information and insight into some key environmental health considerations in the Public Health Code. These sections also review and clarify the different state agency roles and how these agencies support one another – embodying the Health in All Policies approach to protect the public's health against environmental health hazards.

See Section 1.2, Public Health, Public Health Law, and Health Equity, (C), Health Equity and Health in All Policies

5.2 Environmental Health, Defined

The Michigan Public Health Code defines environmental health as:

> [T]he area of activity which deals with the protection of human health through the management, control, and prevention of environmental factors which may adversely affect the health of individuals. This activity is concerned with the existence of substances, conditions, or facilities in quantities, of characteristics, and under conditions, circumstances, or duration which are or can be injurious to human health. MCL 333.12101(1).

Environmental health hazards may include, but are not limited to, air and water pollution, exposure to chemicals or toxins, and extreme weather events.

5.3 General Authority

The Public Health Code provides MDHHS authority over environmental health and the "general supervision of the health and life of the people of the state," including "making investigations and inquiries as to…the causes, prevention, and control of environmental health hazards, nuisances, and sources of illness." MCL 333.2221(2)(a) and (d)(iii). A comparable provision is provided to give local health departments the same authority within their jurisdictions. MCL 333.2433(2)(c)(iii). The Public Health Code also charges MDHHS and local health departments with continually and diligently endeavoring to "prevent disease, prolong life, and promote the public health through organized programs, including prevention and control of environmental health hazards." MCL 333.2221(1) and MCL 333.2433(1).

EGLE, the state's environmental agency, is tasked with facilitating "a uniform approach to environmental health by the various public and private entities involved in that field…" MCL 333.12103(1). Among other duties, EGLE advises the governor and others on environmental health matters and cooperates with and provides support to state and local health agencies. EGLE also monitors and evaluates conditions that represent both potential and actual environmental health hazards. MCL 333.12103(1).

In addition, the Michigan Department of Natural Resources (DNR) is responsible for the protection and conservation of the air, water, and other natural resources of the state. MCL 324.503. DNR is governed by the Natural Resources and Environmental Protection Act (NREPA). MCL 324.101 *et seq.*

Environmental health is a prime example of an area of overlapping authority between MDHHS, local health departments, and other state agencies. EGLE, MDHHS, and local health departments partner to address environmental hazards along with other local, state, and federal partners. These environmental hazards may arise in the natural environment (e.g., in water and air) and in the built environment (e.g., sewerage systems).

5.4 Natural Environment

A. Clean Water

Michigan's Safe Drinking Water Act was enacted in 1976, two years after the U. S. Congress passed the national Safe Drinking Water Act. MCL 325.1001 *et seq.* EGLE maintains control over the public drinking water program in the state. MCL 325.1003. EGLE is permitted to enter into

agreements, contracts, or cooperative agreements with local health departments and others to administer the Act. MCL 325.1016(1).

EGLE is an important part of the Michigan PFAS[208] Action Response Team (MPART), established to address the threat of PFAS contamination and protect the state's land, air, and water as well as to facilitate inter-agency coordination, require standards, and increase transparency.[209] MPART is composed of seven state agencies, including MDHHS, whose activities are enforced under the Safe Drinking Water Act. EGLE also has authority under NREPA to protect and conserve water resources of the state. MCL 324.3103.

Local health departments are the primary regulatory agencies that monitor residential wells and issue construction permits. Local health departments are empowered to "adopt regulations necessary or appropriate to implement or carry out the duties or functions vested by law in the local health department." MCL 333.2441. EGLE promulgates the rules and a construction code, while local health departments are empowered to implement and enforce codes regarding water wells. See MCL 333.12714 and MCL 333.12715.

B. Clean Air

Among other air quality concerns are those regarding ozone depletion, asbestos, carbon monoxide, lead, mercury, and particulates. EGLE's Air Quality Division has authority to prevent the significant deterioration of air quality under the Michigan Administrative Code. R 325.17101-336.2908.

MDHHS implements Michigan's Clean Indoor Air Act, which prohibits smoking in most places of employment and most public places. MCL 333.12601 *et seq.* The Act does allow MDHHS to issue exemptions to cigar bars and tobacco specialty retail stores (MCL 333.12606a) as well to allow smoking in casino gaming areas (MCL 333.12606b). MDHHS is permitted to delegate enforcement authority to local health departments under this

[208]US Environmental Protection Agency, PFOA, PFOS and Other PFAS, *PFAS Explained* <https://www.epa.gov/pfas/pfas-explained> (2024) (accessed March 14, 2025). Polyfluoroalkyl substances (known as PFAS) are long-lasting chemicals used widely that break down slowly over time. PFAS are found all over the globe and are present in many food products, the environment, and even in the blood of both people and animals.

[209] Governor Gretchen Whitmer, *Executive Order 2019-03: Michigan PFAS Action Response Team* <https://www.michigan.gov/whitmer/news/state-orders-and-directives/2019/02/04/executive-order-2019-3> (posted February 4, 2019) (accessed March 14, 2025). MPART became an enduring body under an Executive Order issued in 2019. *Id.*

Act. MCL 333.12613. MDARD implements the Smoke-Free Food Service Establishments law and is similarly permitted to delegate enforcement authority to local health departments under MCL 333.12613. MCL 333.12905.

5.5 Built Environment

The built environment refers to the "buildings we live in, the distribution systems that provide us with water and electricity, and the roads, bridges, and transportation systems we use to get from place to place."[210] Several aspects of the built environment require oversight by different state agencies to protect the public's health.

A. Sewerage Systems

Michigan does not have a statewide septic code. Instead, each local health department sets sewerage system standards. The Public Health Code does reflect a "strong public policy preference for public sanitary sewer systems."[211] See MCL 333.12752. However, the "exploration of alternative waste disposal systems in a manner consistent with state and federal law" is permitted. MCL 333.12195. Over 1.3 million septic systems are used across the state to treat wastewater generated in homes.[212]

1. EGLE

All public sewerage systems in the state are regulated by EGLE. Under NREPA, EGLE is tasked with protecting and conserving the water resources of the state and controlling pollution of state waters that may be affected by waste disposal of any person. MCL 324.3103. EGLE is also authorized under NREPA to review, approve, and permit sewerage systems[213] used or intended to be used by the

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[210] US Environmental Protection Agency, *Basic Information About the Built Environment* <https://www.epa.gov/smm/basic-information-about-built-environment> (2024) (accessed March 15, 2025).

[211] Strichartz, Commentary of the Michigan Public Health Code (ICLE, 1982), p 451.

[212] Mich Dep't of Environment, Great Lakes, and Energy, *FAQ: Septic Systems* <https://www.michigan.gov/egle/faqs/drinking-water/septic-systems> (accessed March 15, 2025).

[213] MCL 324.4101(h) provides, in relevant part:

> "Sewerage system" means a system of pipes and structures including pipes, channels, conduits, manholes, pumping stations, sewage or waste treatment works, diversion and regulatory devices, outfall structures, and appurtenances, collectively or severally, actually used or intended for use by the public for the purpose of collecting, conveying, transporting, treating, or otherwise handling sanitary sewage or other industrial liquid wastes that are capable of adversely affecting the public health.

public. MCL 324.4101 *et seq.* EGLE is permitted to promulgate and enforce rules it considers necessary to govern and to conduct and operate all or parts of sewerage systems, including sewage treatment works. MCL 324.4104. They are further directed to "exercise due care to see that sewerage systems are properly planned, constructed, and operated to prevent unlawful pollution of the streams, lakes, and other water resources of the state." MCL 324.4108.

EGLE may also, at reasonable times, enter the sewerage systems and other property of persons to inspect a system and carry out authority vested in the department. MCL 324.4103. To enforce its authority, EGLE may request that the attorney general bring a civil action (MCL 324.4110(1)) and is separately empowered to bring appropriate actions to enforce this authority in the name of the people of the state (MCL 324.4111).

2. Local Health Departments and EGLE

Though EGLE regulates public sewerage systems in the state, local health departments are authorized to adopt, amend, and enforce ordinances regarding sewerage systems. See MCL 333.12758.[214] Local codes must be referenced when seeking to enforce septic system regulations while the Public Health Code provides authority for enforcement of these regulations. The level of protection afforded by each local code varies.

The Michigan Administrative Rules outline requirements, prohibitions, and other standards for the protection of state groundwater, which also authorize subsurface sewage disposal if certain criteria are met, and a disposal system is approved by the appropriate local health department. R 323.2201 *et seq.* If sanitary sewage discharge, not mixed with other waste, is more than 1,000 gallons per day but less than 10,000 gallons per day, the disposal system, in addition to being approved by the local health department,

[214] Strichartz, Commentary of the Michigan Public Health Code (ICLE, 1982), p 451. ("Section 12758 raises the issue of compliance with local laws (§ 1203) and authority given to local governmental units to control their public sanitary sewer system (§1115)."). See also MCL 333.2441 (authorizing a local health department to "adopt regulations necessary or appropriate to implement or carry out the duties or functions vested by law in the local health department"); MCL 333.2433 (tasking local health departments with a responsibility to prevent and control environmental health hazards, among other duties); and MCL 333.2443, 333.2461(1), 333.2465, and 333.1299 (providing local health departments with enforcement mechanisms).

must also be constructed in accordance with provisions provided in the "Michigan Criteria for Subsurface Sewage Disposal" (MCSSD). Where sanitary sewage discharge, not mixed with other waste, is greater than 6,000 gallons per day, but less than 10,000, approval from the local health department is needed in accordance with the MCSSD and a groundwater discharge permit must also be issued by EGLE. All groundwater discharges must meet the requirements laid out in R 323.2204, even those permitted solely by a local health department.

Under the Public Health Code, EGLE is authorized to promulgate rules for the construction and maintenance of outhouses. MCL 333.12771(2). The Michigan Administrative Rules also set minimum standards for outhouses, earth-pit outhouses, septic tank privies or septic toilets, and chemical closets that are implemented by EGLE. R 325.421 *et seq.* This does not, however, "curtail the right of any local governmental agency to make and enforce immediate sewer connection regulations." R 325.426.

3. Land Divisions and Subdivisions

Though Michigan does not have a statewide septic code for public sewerage systems, the state's Condominium Act (MCL 559.101 *et seq.*) and Land Division Act (MCL 560.101 *et seq.*), along with the Public Health Code, provide authority for the Michigan Administrative Rules that govern on-site water supply and sewage disposal for land divisions and subdivisions (R 560.401 - 560.428).

Both the Condominium Act (MCL 559.171a) and the Land Division Act (MCL 560.105(g)) provide for instances where there is a lack of public sewerage system availability for a proposed land project or a subdivision.

B. Nuisance

1. Public Nuisance

"A public nuisance is an unreasonable interference with a right common to the general public."[215] Although Michigan law does not explicitly require conduct constituting a public nuisance to be

[215] *Sanford v. Detroit*, 143 Mich App 194, 199; 371 NW2d 904, 907 (1985), quoting 4 Restatement Torts, 2d, § 821B, p 87.

determined as "unreasonable," Michigan courts have incorporated a reasonableness standard into their analysis of nuisance law.[216]

In the context of public health, determining that interference with a public right is unreasonable involves consideration of several factors, including:

> (a) Whether the conduct involves a significant interference with the public health, the public safety, the public peace, the public comfort or the public convenience, or,
>
> (b) whether the conduct is proscribed by a statute, ordinance or administrative regulation, or
>
> (c) whether the conduct is of a continuing nature or has produced a permanent or long-lasting effect, and, as the actor knows or has reason to know, has a significant effect upon the public right.[217]

Interference with a property right is *not* a prerequisite to determining that a public nuisance exists.[218]

Pursuant to their police powers, state and local government entities may require remediation of public nuisances.[219] The extent of remediation required will range in degree with the severity of the nuisance and may, in extreme cases, entail the destruction of property or forcible cessation of conduct.[220]

Michigan statute explicitly defines certain conduct and uses of property as public nuisances. For example, any structure or vehicle in which an alcoholic beverage is sold or possessed in violation of Michigan law is a public nuisance. MCL 600.3801(d).

a. Nuisance Per Se v. Nuisance Per Accidens

Michigan law recognizes that a public nuisance may be a nuisance per se or a nuisance per accidens.

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[216] *Sanford*, 143 Mich App at 204.
[217] *Dinger v. Dep't of Natural Resources,* 191 Mich App 630, 636; 479 NW 2d 353 (1991).
[218] *Bloss v. Paris Twp,* 380 Mich 466 (1968); *Bronson v Oscoda Twp*, 188 Mich 679 (1991).
[219] See *Lawton v. Steele,* 152 US 133, 136; 14 S Ct 499; 38 L Ed 385 (1894).
[220] *Id.*

i. Nuisance Per Se (Nuisance at Law)

Some uses of property and conduct are deemed incapable of being maintained without unreasonably interfering with the rights of others. This may be "an act, occupation or structure which is a nuisance at all times and under all circumstances."[221]

ii. Nuisance Per Accidens (Nuisance in Fact)

Some uses of property and conduct are deemed to unreasonably interfere with the right of others only under certain circumstances. In contrast, this may be "an act, occupation or structure which becomes a nuisance because of circumstances and surroundings."[222]

2. Private Nuisance

A private nuisance is defined as:

> [A]nything done to the hurt or annoyance of the lands, tenements, or hereditaments of another. Any unwarrantable, unreasonable, or unlawful use by a person of his own property, real or personal, to the injury of another, falls within this definition and renders the owner or possessor liable for all damages arising from such use.[223]

Interference with a property right *is* a prerequisite for determining that a private nuisance exists. [224]

3. Abatement

MDHHS and local health departments are authorized to inspect both public buildings and private dwellings to ensure compliance with sanitary laws and regulations.

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[221] *Ford v. City of Detroit,* 91 Mich App 333, 335; 283 NW2d 739 (1979).
[222] *Id.*
[223] *Whittemore v. Baxter Laundry Co*, 181 Mich 564, 564 (1914), citing *Heeg v Licht*, 80 NY 579 (1880) (citations omitted).
[224] *Id.* at 566.

See Section 5.5, Built Environment, (C) Premises Inspections, below, and Section 3.3, Fourth Amendment – Search and Seizure.

Michigan law provides for several remedies upon a finding that a building or dwelling is not in compliance with sanitary standards. For example, if a nuisance violation is found under MCL 600.3801 either the "attorney general, the prosecuting attorney or any resident of the county" as well as the attorney for the city or village or township where the nuisance is located may bring an action in the name of the state concerning the nuisance. MCL 600.3805.

a. Michigan Public Health Code

Under MCL 333.2455(1), a local health department or MDHHS is empowered to "issue an order to avoid, correct, or remove, at the owner's expense, a building or condition which violates health laws or which the local health officer or director reasonably believes to be a nuisance, unsanitary condition or cause of illness." Subsection (2) authorizes a health officer, in the event of noncompliance, to remove the violation, nuisance, unsanitary condition, or cause of illness at the expense of the owner, and they may seek a warrant for that purpose. Should an owner refuse to pay the expenses incurred, they will be assessed against the property and "treated in the same manner as taxes assessed," but should an occupant or another be the cause of the offending violation, they are liable to the owner who may seek recovery, as stated under subsection (3). Subsection (4) permits a court, upon a finding that the violation or nuisance could be injurious to the public health, to order the removal, abatement, or the destruction of the same at the expense of the defendant.

b. Michigan Housing Law

The Housing Law of Michigan (HLM) also provides for inspection and enforcement of violations. See the Michigan Residential Landlord-Tenant Law Benchbook for further information. Though health departments are granted some authority under the HLM, health officers will generally refrain from acting in related matters as the laws are administered by the governing body of a municipality. MCL 125.523

i. Serious and Imminent Hazard

Should a violation constitute a "serious and imminent hazard" to the health or safety of the occupants, MDHHS must be notified by the enforcing agency within 48 hours.[225] MCL 125.532(5). An enforcing agency must let an owner know of the violation in writing and is required to notify the occupant of the violation only if it is a serious and imminent hazard.

(1) Illegal Drug Manufacturing Site

The discovery of an illegal drug manufacturing site, often referred to as a clandestine drug laboratory, requires state or local law enforcement agencies to notify the local health department and MDHHS within 48 hours of discovery, among other requirements. MCL 333.12103(3).

ii. Dangerous Buildings

"[I]f a building or structure is found to be a dangerous building, the enforcing agency shall issue a notice that the building or structure is a dangerous building." MCL 125.540(1). The owner, agent, or lessee registered with the enforcing agency (or if not registered, each owner or party in interest in the building or structure whose name appears on the last local tax assessment record) shall be served a notice of hearing and will be given an opportunity to oppose the order at the hearing. MCL 125.540(2) and (3).

iii. Conditions Promoting Disease

If an inspector or health officer certifies that a dwelling is infected with contagious disease or is unfit for human habitation, or otherwise poses a danger to life or health due to repairs needed, or "defects in drainage,

[225] MCL 125.532(6) "'[A] serious and imminent hazard' means a dangerous condition in a premises that could reasonably be expected to cause death or serious bodily harm to the occupants of the premises if that dangerous condition is not immediately corrected by the owner."

plumbing, lighting, ventilation or the construction of the same, or by reason of the existence on the premises of a nuisance likely to cause sickness among the occupants of said dwelling, or for any cause, the health officer or such other appropriate public official" is permitted to issue an order for the dwelling to be vacated in no less than 24 hours and no more than 10 days. MCL 125.485. If the order is not complied with in the time specified, the dwelling may be vacated and it is up to the discretion of the issuing health officer or official to designate when they are satisfied that the danger no longer exists or that it is fit for human habitation and may revoke the order or even extend the time to comply with the order. MCL 125.485.

C. Premises Inspections

To assure compliance with laws enforced by the department, MDHHS "may inspect, investigate, or authorize an inspection or investigation to be made of any matter, thing, premises, place, person, record, vehicle, incident, or event" pursuant to MCL 333.2241(1). These powers are not only granted to MDHHS, local health departments are also empowered with the same authority. MCL 333.2446.[226] MCL 333.2241(2) allows MDHHS to "apply for inspection or investigation warrant under section 2242 to carry out this section."

Authority for state license inspection is often delegated to local health departments by other state agencies. Where MDHHS delegates a license inspection function to a local health department and the local health department denies a license that MDHHS later approves, MDHHS must provide an explanation regarding the approval. MCL 333.12106. EGLE is permitted to delegate the inspection of dry-cleaning facilities to local health departments. MCL 333.13307(2). Inspection authority is also explicitly assigned by statute to local health departments, for example the authority to inspect bathing beaches (MCL 333.12541 and MCL 333.12546) and body art facilities (MCL 333.13105).

An affidavit is required for the issuance of a warrant and there must be grounds for a warrant to be issued. MCL 333.2242 and MCL 333.2243. A

[226] MCL 333.2446 further notes that sections empowering MDHHS, 2241 to 2257, also apply to inspections and investigations made by local health departments.

"magistrate's finding of cause shall be based on facts stated in the affidavit." MCL 333.2244. The affidavit must be based upon reliable information. MCL 333.2244. A warrant may be directed to the sheriff or any law enforcement officer. MCL 333.2245. The warrant must "state the grounds or cause for its issuance" or attach a copy of the affidavit and it must "designate and describe the location or thing to be inspected and the property or thing to be seized." MCL 333.2245.

Under MCL 333.2246,

> The officer to whom an inspection or investigation warrant is directed or a person assisting the officer may break an outer or inner door or window of a house or building, or anything therein, to execute the warrant, if, after notice of his or her authority and purpose, the officer is refused admittance, or when necessary to liberate the officer or person assisting the officer in execution of the warrant.

A person who procures a warrant for inspection or investigation maliciously and without cause is guilty of a misdemeanor under MCL 333.2247.

See Section 3.3, Fourth Amendment – Search and Seizure.

5.6 Zoonotic Disease Prevention and Control

Animal health can impact public health. A number of animal diseases are zoonotic. "Zoonotic diseases (also known as zoonoses) are caused by germs that spread between animals and people."[227] These diseases are "caused by harmful germs like viruses, bacterial, parasites, and fungi."[228] Zoonotic diseases can cause infection through direct contact, indirect contact (for example, through a chicken coop or water in an aquarium tank), through an insect bite (referred to as vector-borne), or through consuming contaminated food or water.[229]

Some animal diseases, although not initially transmissible to humans, may acquire this capability by mutating in certain hosts. Disease epidemics in animals also frequently lead to widespread animal death and slaughter. For example, at the time of this writing, health officials are monitoring an evolving avian influenza virus, HPAI A(H5N1) bird flu, which is widespread in birds across the globe and is causing

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[227] Centers for Disease Control & Prevention, One Health, *About Zoonotic Diseases* <https://www.cdc.gov/one-health/about/about-zoonotic-diseases.html> (posted February 29, 2024) (accessed March 15, 2025).
[228] *Id.*
[229] *Id.*

outbreaks in both poultry and cows.[230] Dozens of people, including several U. S. dairy workers, have been diagnosed with the virus and at least one individual has died, but, at the time of this writing, there is no evidence of person-to-person transmission of the virus.[231]

Considering the potential threat to the public's health, Michigan law empowers both state and local governments to closely monitor animal health and act to prevent disease epidemics among animals within the state. MDARD is the state agency that bears the bulk of this responsibility, though MDHHS remains responsible for the general supervision of human health, and DNR is responsible for the state's wildlife.

A. Animal Industry Act

Michigan's Animal Industry Act, MCL 287.701 *et seq.*, provides MDARD with several tools to prevent, identify, and control animal diseases.

1. Extraordinary Emergency

If the MDARD director finds that a disease or a condition in animals poses an "extraordinary emergency to the animal industry, public health, or human food chain of this state," MCL 287.703a(1) requires that the director notifies the governor and recommends procedures considered necessary to eliminate the threat. Under subsection (2) the governor is then empowered to declare a state of emergency and to expedite the procedures that are considered necessary to either control or eradicate the disease or condition. Subsection (3) states that any such emergency order may not be in effect for longer than 72 hours unless there has been notification to and advice from the animal industry that will be impacted and, even then, may not remain in effect for more than six months.

2. Scientifically Based Orders

MCL 287.703b(1) allows the MDARD director to "develop, implement, and enforce scientifically based orders." The orders could include testing requirements, identification of animals or

[230] Centers for Disease Control & Prevention, Avian Influenza (Bird Flu), Avian Influenza Type A Viruses <https://www.cdc.gov/bird-flu/about/avian-influenza-type-a.html> (posted December 20, 2024) (accessed March 15, 2025).
[231] Centers for Disease Control & Prevention, Avian Influenza (Bird Flu), *H5 Bird Flu: Current Situation* <https://www.cdc.gov/bird-flu/situation-summary/index.html> (posted March 7, 2025) (accessed March 15, 2025).

premises, documentation related to animal movement, and record keeping. Under subsection (2), MDARD must comply with requirements to ensure both public notice and the opportunity for comment before issuing these orders. The director is permitted to create an order that establishes high-risk and potential high-risk areas as well as disease-free, infected, or surveillance zones based on a finding of a reportable animal disease or scientifically based epidemiology under subsection (4). Under subsection (5), "[t]he director may call upon a law enforcement agency to assist in enforcing the director's quarantines, orders, or any other provision of this act." The director may also enter into agreements with either the federal government, other state governments, or tribal governments as well as any other person, as stated under subsection (6).

3. State Veterinarian

The MDARD director is required to appoint a state veterinarian to develop and enforce policy, supervise activities, serve as authority for animal welfare oversight on issues related to livestock, maintain a list of reportable animal diseases and veterinary biologicals, develop and implement scientifically based surveillance and monitoring programs, and promulgate rules for the use of veterinary biologicals. MCL 287.707.[232] The director is permitted to enter into agreements with the U.S. Department of Agriculture's Secretary of Agriculture, the secretary's authorized representative, or another person to protect or enhance either the growth of Michigan's livestock industry or the state's human food chain. MCL 287.711.

4. Contaminated or Diseased Animal

MCL 287.709(1) requires that a person who "discovers, suspects, or has reason to believe that an animal is either affected by a reportable animal disease or contaminated with a toxic substance" must immediately report such to MDARD. The MDARD director must then take appropriate action to investigate the report and is authorized to seize and withhold animal products or feed from the premises. Animal owners are directed to provide "reasonable" assistance to the director during exam and testing under subsection (2). Subsection (3) contains confidentiality requirements to protect the identity of the

[232] MCL 287.703(www) (defining "state veterinarian" as "the chief animal health official of this state as appointed by the director under section 7, or his or her authorized representative)."

owners of animals and limited exceptions when necessary to protect public health. The director of MDARD is also permitted to order surveillance testing of animals for either a specific reportable disease in the state, to comply with rules and regulations adopted by the U. S. Secretary of Agriculture, or to complete epidemiologic investigations for a specific reportable disease or in an instance where a reportable animal disease is suspected. MCL 287.717b.

5. Quarantine Authority

Under MCL 287.712(1), the MDARD director has authority to quarantine animals, equipment, vehicles, structures, premises, or any area of the state – or the entire state, if necessary – to control or prevent the spread of known or suspected infectious or toxicological disease. Subsections (2) - (5) restrict movement of animals or other items included in a quarantine and do not allow animals under quarantine to have contact with non-quarantined animals without the director's permission. Director permission is also needed to import animals under quarantine from another jurisdiction or animal species from another jurisdiction under quarantine. Subsections (6) and (7) provide the director authority to prescribe procedures for both quarantined animals and animals in a quarantined area and to prescribe required procedures "before any animal, structure, premises, or area or zone in this state, including the entirety of this state, if necessary, are released from quarantine." Finally, under subsection (8), law enforcement is given authority to kill any animal found "running at large in violation of a quarantine" and "[t]he director may enlist the cooperation of a law enforcement agency to enforce the provisions of this quarantine." A law enforcement agency that kills an animal under this provision will not be subject to liability for the animal.

If animals are imported into Michigan without the required official tests, vaccinations, identification, or documents, the MDARD director may order that the animals are quarantined, the premises are quarantined, or both. The director may also require that the animals be returned to the state of origin or that the animals are slaughtered or destroyed. MCL 287.722(1).

6. Bovine Tuberculosis

Bovine tuberculosis (TB) is an infectious disease that can infect all mammals, including humans, and that is caused by the bacterium *Mycobacterium bovis*.[233] It can be transmitted either through direct contact or indirectly, for example, through contaminated feed and water or the consumption of unpasteurized milk or undercooked meat. Additional requirements are added to the movement of privately owned cervids in order to help prevent the spread of this disease. MCL 287.712b. In addition, "[t]he owner of a newly established privately owned cervid operation shall initiate testing for tuberculosis within 18 months following assembly of the herd." MCL 287.717d. Requirements are also in place to prevent the introduction of imported animals with tuberculosis. MCL 287.719(3) and (4). Testing and surveillance procedures for bovine tuberculosis are outlined under MCL 287.742(6).

7. Seizure, Slaughter, and Destruction of Livestock

Should the director determine it is necessary to control or eradicate a disease or condition of livestock, the director is authorized to allow entry onto property where the livestock or domestic animals are located for the purposes of seizure, slaughter, or destruction or to by other means dispose of the livestock or animals at issue. MCL 287.714(1). The director is also authorized to approve facilities and procedures for the disposal of the animals or animal-related materials and may select a site and method with the advice of the director of EGLE. MCL 287.714(3). The director is permitted to allow indemnification for the slaughter or destruction of livestock and domestic animals under MCL 287.714a. Should the director choose to indemnify an owner, the livestock or animals must be appraised. MCL 287.714a. Should an owner accept compensation under the Act; it amounts to a full and complete release of any claim the owner may have had against the state. MCL 287.714a(5).

8. Imported Livestock

In addition to the requirements cited above, livestock imported into Michigan must be accompanied by an official interstate health

[233] Mich Dep't of Natural Resources, Wildlife Disease, *Bovine tuberculosis* <https://www.michigan.gov/dnr/managing-resources/wildlife/wildlife-disease/disease-monitoring/bovine-tuberculosis> (accessed March 15, 2025).

certificate or an official interstate certificate of veterinary inspection, among other items, including permission from the MDARD director. MCL 287.719. The MDARD director may also refuse animals entry into the state if there is a reason to believe they pose a threat to the public health or the health of the animals in the state. MCL 287.719(9).

9. Enforcement

MCL 287.744 provides enforcement mechanisms for the Animal Industry Act, which includes the authority of the MDARD director to enlist the aid of law enforcement to enforce the Act, under subsection (1).

10. Dead Animals

The bodies of dead animals can be a nuisance and a conduit for the spread of disease. Most animals must be disposed of within 24 hours after death. MCL 287.671(2).

Chapter 6: Food Safety

6.1 Overview

This chapter provides information on foodborne illness and food establishment licensure and inspections under the Michigan Food Law codified at MCL 289.1101 *et seq.* It also includes a discussion of penalties that may be imposed upon the finding of violations during such inspections and in circumstances that present an imminent threat to the public's health, safety, or welfare.

6.2 Foodborne Illness, Defined

"Foodborne illness," sometimes referred to colloquially as food poisoning, is an illness acquired after consuming contaminated food or drink; "[t]he onset of symptoms may occur within minutes to weeks and often presents itself as flu-like symptoms, as the ill person may experience symptoms such as nausea, vomiting, diarrhea, or fever. Because the symptoms are often flu-like, many people may not recognize that the illness is caused by harmful bacteria or other pathogens in food."[234] There are more than 250 bacteria, viruses, parasites, and chemicals known to cause foodborne illness.[235] Contamination of a food or drink product may occur at various points in the food production chain. Contamination may occur, for example, at a farm, at a production plant, during transportation, or at a grocery store, restaurant, or one's home.

Michigan law defines a "foodborne disease outbreak" as "the occurrence of two or more cases of a similar illness resulting from the ingestion of a common food."[236] "Food" is defined as "a raw, cooked, or processed edible substance, ice, beverage, or ingredient used or intended for use or for sale in whole or in part for human consumption, or chewing gum."[237]

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[234] US Dep't of Agric, *Foodborne Illness and Disease* <https://www.fsis.usda.gov/food-safety/foodborne-illness-and-disease> (accessed April 10, 2025).
[235] Centers for Disease Control & Prevention, National Outbreak Reporting System (NORS), *Foodborne Disease Outbreak Surveillance System,* <https://www.cdc.gov/nors/about/fdoss.html> (posted September 6, 2024) (accessed Mar. 24, 2025).
[236] Mich Dep't of Agriculture and Rural Dev, Michigan Modified Food Code, p9 (October 1, 2012), <https://www.michigan.gov/mdard/-/media/Project/Websites/mdard/documents/food-dairy/laws/mi_modified_2009_food_code.pdf?rev=f69c9a99cc3248bf953c37e782e6e1f7&hash=6752D13DC282B6A6A80024EFEA687C2D>. See also MCL 289.1113(1) (adopting the definitions used in the Food Code where not otherwise defined in Michigan's Food Law).
[237] *Id.*

6.3 Food Establishment Licensure and Inspections

The Michigan Department of Agriculture and Rural Development (MDARD) is the primary state agency responsible for food safety in Michigan. MDARD is required to "delegate the authority and responsibility for the enforcement of the requirements pertaining to food service establishments contained in the Michigan Food Act and rules to local health departments meeting the program criteria provided for in this act and rules." See MCL 289.3105

See also Section 4.4, Communicable Disease Surveillance, and Section 4.6, Disease Investigation and Contact Tracing, for further discussion on public health surveillance and investigation, including foodborne illnesses.

A. Food Establishment, Defined

Pursuant to MCL 289.1107(p), a food establishment is "an operation where food is processed, packed, canned, preserved, frozen, fabricated, stored, prepared, served, vended, sold, or offered for sale." The definition "includes, but is not limited to, a food processor, a food warehouse, a food service establishment, a vending machine location, and a retail grocery."

The Michigan Food Law's definition of food establishment does not include the following:

(i) a charitable, religious, fraternal, or other nonprofit organization operating a home-prepared baked goods sale or serving only home-prepared food in connection with its meetings or as part of a fund-raising event.
(ii) an inpatient food operation located in a health facility or agency subject to licensure under article 17 of the Public Health Code.
(iii) a food operation located in a prison, jail, state mental health institute, boarding house, fraternity or sorority house, convent, or other facility where the facility is the primary residence for the occupants and the food operation is limited to serving meals to the occupants as part of their living arrangement.

B. Food Establishment Licensure

Pursuant to MCL 289.4101, "a person shall not operate a food establishment unless licensed by [MDARD] as a food establishment."[238] There are two statutory exemptions to the licensure requirement. MCL 289.4102, MCL 289.4105. Chapter IV of the Michigan Food Law at MCL 289.4101 *et seq.* addresses food establishment licensure.

1. Revocation or Suspension of Licensure

After an opportunity for a hearing, MDARD may:

> [R]evoke or suspend a food establishment license, a registration for bottled water, or a shellfish dealer certificate issued under this act for failure to comply with requirements of this act or a rule. A person whose food establishment license, registration for bottled water, or shellfish dealer certificate is revoked or suspended shall discontinue the sale and offering for sale of food, the bottled water, or shellfish, respectively, until he or she complies with this act and the director issues a new registration or removes the suspension.

MCL 289.4125(2).[239]

Further, "[i]f a person's food establishment license is revoked for egregious violations under section 5101(a), (b), (c), or (k), the director [of MDARD] may refuse to issue or reissue a license to any establishment in which that person has ownership or management

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[238] See MCL 289.4102 regarding cottage food operations, which are exempt from the licensing and evaluation provisions of the Michigan Food Law though "[t]his exemption does not include an exemption from the adulteration and other standards imposed in this section or under this act, or both, and does not limit the ability of [MDARD] to take appropriate enforcement action for applicable violations as described in section 5101."

[239] See *Dep't of Agric and Rural Dev v. Zante,* 348 Mich App 293 (2023), in which MDARD suspended a food establishment's license for violating requirements of public health orders related to the COVID-19 pandemic. The food establishment continued to operate with a suspended license and MDARD filed an action; the Circuit Court held the business in contempt, ordered it to pay a fine, issued a preliminary injunction, and ordered that if the restaurant continued to operate without a license the owner would be arrested. The owner was ultimately arrested for noncompliance, held in contempt, and ordered to pay a fine and serve 93-days in jail or until she complied. On appeal, the Court of Appeals affirmed the decision while instructing the Circuit Court to refashion the latter fine to be civil in nature. *See also Section 8.3, Public Health and Emergency Authority, (C), State Public Health Emergency Preparedness and Response*.

interest for a period of 2 years after the revocation." MCL 289.4125(3).

2. Imminent Threats to Public Health, Safety, or Welfare

Pursuant to MCL 289.4125(4):

> Based upon facts submitted by a person familiar with those facts or upon information and belief alleging that an imminent threat to the public health, safety, or welfare exists, the director may summarily suspend a license, registration, or certificate issued under this act. A person whose license, registration, or certificate has been summarily suspended under this section may petition the director to dissolve the order. Upon receipt of such a petition, the director shall immediately schedule a hearing to decide whether to grant or deny the petition to dissolve. The presiding officer shall grant the requested relief dissolving the summary suspension order unless sufficient evidence is presented that an imminent threat to the public health, safety, or welfare exists requiring emergency action and continuation of the director's summary suspension order.

C. Right to Enter and Inspect Food Establishments

1. Compliance Evaluations

Pursuant to MCL 289.3123(1):

> A compliance evaluation of each food service establishment shall be performed by the director [of MDARD] at least once every six months or as required by a statewide department approved risk-based schedule. Risk-based schedules shall be developed in consultation with local health departments.

Subsection (2) states that food service establishments which operate "for nine or fewer months each year shall be inspected at least once during the period of operation by the director [of MDARD] or as prescribed in the department's risk-based schedule."

2. Evaluation Reports

Pursuant to MCL 289.3127(1), "[t]he findings of an evaluation of a food service establishment shall be recorded on an evaluation report form approved by [MDARD]." The report must summarize findings relative to compliance with the requirements of the Michigan Food Law at MCL 289.1101 *et seq.* and:

> [A] copy of the completed evaluation report form shall be furnished to the person in charge of the food service establishment. If the person in charge does not sign the report form acknowledging receipt, delivery of the report form to the person in charge shall be otherwise documented by the director.

MCL 289.3127(3).

D. Penalties upon Findings of Violations

Chapter VI of the Michigan Food Law at MCL 289.6101 *et seq.* extensively outlines the standards by which food establishments must operate. Chapter V of the Michigan Food Law at MCL 289.5101 *et seq.* sets forth prohibited acts and the potential penalties.

1. Administrative Fines

Pursuant to MCL 289.5105(1):

> Upon finding that a person has violated a provision of [the Food Law] or a rule promulgated under this act, [MDARD] may impose an administrative fine of not more than $500.00 for the first offense and not more than $1,000.00 for a second or subsequent offense and the actual costs of the investigation of the violation. Each day of a continuing violation is not considered a separate violation of [the Food Law] or a rule promulgated under this act. [MDARD] shall not impose upon any licensee or registrant administrative fines in the aggregate amount of more than $4,000.00 per location for a firm with annual gross receipts of $500,000.00 or less and $8,000.00 per location for a firm with annual gross receipts of over $500,000.00 during any 12-month period.

Subsection (3) states that MDARD is not required "to issue an administrative fine for minor violations of this act if the department

believes that the public interest will be adequately served under the circumstances by a suitable written notice or warning."

2. Misdemeanor

> Except as otherwise provided under [the Food Law], a person who violates any provision of this act or rules promulgated under this act is guilty of a misdemeanor and shall be punished by a fine of not less than $250.00 or more than $2,500.00, or by imprisonment for not more than 90 days, or both.
>
> MCL 289.5107(1).

3. Restraining Order

Pursuant to MCL 289.5111:

> In addition to the remedies provided for in [the Food Law], the department may apply to the circuit court for, and the court shall have jurisdiction upon hearing and for cause shown, a temporary or permanent injunction restraining any person from violating any provision of this act or rules promulgated under this act, irrespective of whether or not there exists an adequate remedy at law.

4. Application of Remedies

Pursuant to MCL 289.5113, "the regulatory authority shall justly apply the remedies according to law and this act consistent with the licensee's right to due process." Moreover, under MCL 289.5115:

> When a license holder or registrant has exhausted all administrative remedies available under this act and is aggrieved by a final decision or order in a contested case, the decision or order is subject to direct review by the courts as provided by law.

Chapter 7: Public Health Information

7.1 Overview

Public health data provides health departments and other agencies with the information necessary to predict, prevent, and control disease and threats to public health. Health departments regularly publish aggregate health data to inform the public about levels of disease in their communities. While critical to the work of public health agencies, health data is often highly personal and sensitive. The collection, sharing, and use of health information, including for public health purposes, is governed by privacy laws. This chapter discusses several of the privacy laws that govern health information including the Health Insurance Portability and Accountability Act and state laws. It also provides an overview of Michigan's Freedom of Information Act.

7.2 Disclosure of Health Information and the Health Insurance Portability and Accountability Act

Health information privacy laws are designed to balance personal privacy interests with the public good and the need for information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) contains provisions intended to protect the privacy of certain individually identifiable health information (referred to as "protected heath information" or PHI). 45 CFR 160.103. Generally, HIPAA limits the ability of certain entities to use and disclose an individual's PHI without notifying and/or obtaining authorization from that individual.

See Section 7.3, Identifiable Health Information and De-identification.

HIPAA includes several exceptions to this general rule. One of the most significant of these exceptions involves uses and disclosures of PHI for public health activities.

HIPAA sets the floor for privacy standards, and state law may provide more stringent privacy protections for health information than the applicable HIPAA provisions.

See Section 7.4, State Privacy Law, (A), HIPAA Preemption of State Law.

A. Applicability of HIPAA Requirements

1. Covered Entities

Pursuant to 45 CFR 164.104, HIPAA's privacy requirements apply to only three types of entities (referred to as "covered entities"):

- **Health plan –** An individual or group plan that provides or pays the cost of medical care.
- **Health care clearinghouse –** A public or private entity that processes or facilitates the processing of health information; and
- **Health care provider –** A provider of medical or health services or any person or organization who transmits any health information in electronic form in connection transactions covered by HIPAA.

Many health departments provide health care services or operate one or more health plans, and, as such, are covered entities.

2. Hybrid Entities

Pursuant to 45 CFR 164.103, a “hybrid entity” is defined as:

> [A] single legal entity:
> (1) That is a covered entity.
> (2) Whose business activities include both covered and non-covered functions; and
> (3) That designates health care components in accordance with paragraph § 164.105(a)(2)(iii)(D).

A health department may provide HIPAA-covered health care services because it operates a hospital or a health clinic or electronically bills for testing services provided by the state public health laboratory, for example. It may also operate a HIPAA-covered health plan such as Medicaid or a Children’s Health Insurance Program (CHIP). When a health department provides HIPAA-covered services, it is a covered entity and must ensure HIPAA-compliance. A covered entity may limit HIPAA to those organizational components that are regulated by HIPAA. This is known as becoming a hybrid entity. Becoming a hybrid entity enables a health department to carve out its traditional public health activities — disease or injury

registry functions, vital events record functions, and conducting public health surveillance, investigations, or interventions — from HIPAA coverage. This election requires the covered entity to assess itself against HIPAA and to document the results in a written hybrid entity policy.

At the time of this writing, MDHHS operates as a hybrid entity.

3. Business Associates

Covered entities may establish a written agreement with a business associate for that business associate to perform certain functions that involve the use or disclosure of protected health information on behalf of a covered entity. Covered entities can be a business associate of another covered entity.

> Except as provided in paragraph (4) of this definition, business associate means, with respect to a covered entity, a person who:
>
> > (i) On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or
> >
> > (ii) Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in § 164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business

> associate of such covered entity or arrangement, to the person. 45 CFR 160.103.

B. Prohibited Uses and Disclosures

The HIPAA Privacy Rule includes three prohibited uses and disclosures.

- Use and disclosure of genetic information for underwriting purposes (45 CFR 164.502(5)(i));
- Sale of protected health information (45 CFR 164.502(5)(ii)); and
- Certain uses related to reproductive health care (45 CFR 164.502(5)(iii));

> A covered entity or business associate may not use or disclose protected health information for any of the following activities:
>
> (1) To conduct a criminal, civil, or administrative investigation into any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care.
>
> (2) To impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care.
>
> (3) To identify any person for any purpose described in (1) or (2) above.

C. Required Disclosures

Covered entities "may use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law." 45 CFR 164.512(a)(1).

Under HIPAA, "required by law" means:

> [A] mandate contained in law that compels an entity to make a use or disclosure of protected health information and that is enforceable in a court of law. *Required by law* includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a

> governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits. 45 CFR 164.103.

D. Use and Disclosure for Public Health Activities

Public health agencies collect PHI from health care providers, laboratories, and other covered entities for public health activities. Under 45 CFR 164.512(b)(1), a covered entity may disclose PHI for public health purposes without an individual's authorization, provided such disclosures are made to:

- A public health authority authorized by law to collect or receive such information to prevent or control disease, injury, or disability. According to 45 CFR 164.501, a "public health authority" is:

  > an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.

- At the direction of a public health authority, an official of a foreign government agency that is acting in collaboration with a public health authority.

- A public health authority or other government authority legally authorized to receive reports of child abuse or neglect.

- A person subject to the jurisdiction of the Food and Drug Administration (FDA) for the purpose of activities related to the quality, safety, or effectiveness of an FDA-regulated product or activity.

- A person who may have been exposed to a communicable disease or may be at risk of contracting or spreading a disease or condition,

if the covered entity or public health authority is authorized by law to notify such a person as necessary in the conduct of a public health intervention or investigation.

- An employer, under specific conditions, if such information is related to an employee's workplace injury or workplace medical surveillance; or

- A school, under specific conditions and with documented consent, about a student or prospective student's proof of immunization.

Pursuant to 45 CFR 164.512(b)(2), "if the covered entity also is a public health authority, the covered entity is permitted to use protected health information in all cases in which it is permitted to disclose such information for public health activities" enumerated in 45 CFR 164.512(b)(1).

The law recognizes the need for public health authorities to have access to protected health information to protect the public's health through activities such as communicable disease reporting and surveillance. The provisions permit, for example, disclosures to the Centers for Disease Control and Prevention (CDC) for public health reporting purposes. In addition, these provisions permit covered entities, like hospitals, to report protected health information to MDHHS and local health departments for public health activities without individual consent.

E. Other Permitted Disclosures

Under 45 CFR 164.512(c)-(i), subject to the specified conditions, a covered entity is not required to obtain an individual's authorization for:

- Disclosures about victims of abuse, neglect, or domestic violence to a government authority authorized to receive such reports.

- Disclosures for health oversight activities, such as audits, criminal investigations, or licensing actions.

- Disclosures for judicial and administrative proceedings in response to a court or tribunal order or subpoena and, after notice or protective order, to a discovery request or other lawful process not accompanied by an order of a court or tribunal.

- Disclosures for law enforcement purposes, such as identification of a suspect, apprehension of a criminal suspect, or ascertainment of a potential victim's cause of death or injury.

- Disclosures about decedents for purposes such as identifying a deceased person or determining a cause or death.

- Disclosures for cadaveric organ, eye, or tissue donation purposes to organ procurement, banking, or transplantation organizations.

- Disclosures for public health research purposes regardless of the source of the research funding, provided that an Institutional Review Board or privacy board has provided a waiver of authorization for release.

- Disclosures to avert a serious threat to health or safety.

- Disclosures for specialized governmental functions, such as military activities, intelligence gathering, or law enforcement custodial situations; or

- Disclosures for workers' compensation.

F. Minimum Necessary Standard

Pursuant to 45 CFR 164.502(b),

> When using or disclosing protected health information or when requesting protected health information from another covered entity or business associate, a covered entity or business associate must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.
>
> This requirement does not apply to:
>
> > (i) Disclosures to or requests by a health care provider for treatment.
> > (ii) Uses or disclosures made to the individual, as permitted under paragraph (a)(1)(i) of this section or as required by paragraph (a)(2)(i) of this section;
> > (iii) Uses or disclosures made pursuant to an authorization under § 164.508;

(iv) Disclosures made to the secretary in accordance with subpart C of part 160 of this subchapter.
(v) Uses or disclosures that are required by law, as described by § 164.512(a); and
(vi) Uses or disclosures that are required for compliance with applicable requirements of this subchapter.

7.3 Identifiable Health Information and De-identification

A. Identifiable Health Information

Pursuant to HIPAA at 45 CFR 160.103, "individually identifiable health information" is defined as:

> [I]nformation that is a subset of health information, including demographic information collected from an individual, and:
> (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
> (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
> (i) That identifies the individual; or
> (ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

B. Protected Health Information

> "Protected health information" means individually identifiable health information:
> (1) Except as provided in paragraph (2) of this definition, that is:
> (i) Transmitted by electronic media.
> (ii) Maintained in electronic media; or
> (iii) Transmitted or maintained in any other form or medium.
> (2) Protected health information excludes individually identifiable health information:
> (i) In education records covered by the Family Educational Rights and Privacy Act, as amended, 20 USC 1232g;
> (ii) In records described at 20 USC 1232g(a)(4)(B)(iv);
> (iii) In employment records held by a covered entity in its role as employer; and

(iv) Regarding a person who has been deceased for more than 50 years.

45 CFR 160.103.

See Section 7.5, Select Federal Privacy Laws, (A), Family Educational Rights and Privacy Act.

C. De-identification

The HIPAA Privacy Rule provides two methods for de-identification of protected health information — the "Expert Determination" method and the "Safe Harbor" method. The Privacy Rule standard for de-identification is: "Health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information." 45 CFR 164.514(a). De-identified information is not subject to the Privacy Rule's restrictions on use or disclosure because it is no longer considered PHI.

Advances in technology and linkages between de-identified data and publicly available information present ongoing and increasing risks of re-identification despite compliance with de-identification methods under the law.

1. Expert Determination Method

A covered entity may determine that health information is not individually identifiable health information only if:

(1) A person with appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods for rendering information not individually identifiable:

(i) Applying such principles and methods determines that the risk is very small that the information could be used, alone or in combination with other reasonably available information, by an anticipated recipient to identify an individual who is a subject of the information; and

(ii) Documents the methods and results of the analysis that justify such determination.

45 CFR 164.514(b)(1).

2. Safe Harbor Method

Pursuant to 45 CFR 164.514(b)(2), the Safe Harbor method of de-identification requires the removal of the following identifiers of the individual or of relatives, employers, or household members of the individual:

> (A) Names.
> (B) All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:
>
> (*1*) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and
>
> (*2*) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.
>
> (C) All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older.
> (D) Telephone numbers.
> (E) Fax numbers.
> (F) Electronic mail addresses.
> (G) Social security numbers.
> (H) Medical record numbers.
> (I) Health plan beneficiary numbers.
> (J) Account numbers.
> (K) Certificate/license numbers.
> (L) Vehicle identifiers and serial numbers, including license plate numbers.
> (M) Device identifiers and serial numbers.
> (N) Web Universal Resource Locators (URLs).
> (O) Internet Protocol (IP) address numbers.
> (P) Biometric identifiers, including finger and voice prints.
> (Q) Full face photographic images and any comparable images; and

(R) Any other unique identifying number, characteristic, or code, except as permitted by paragraph (c) of this section.

The Safe Harbor method also requires that "the covered entity does not have actual knowledge that the information could be used alone or in combination with other information to identify an individual who is a subject of the information." 45 CFR 164.514(b)(2)(ii).

7.4 State Privacy Law

A. HIPAA Preemption of State Privacy Law

HIPAA requirements preempt contrary provisions of state law unless the state law is necessary to prevent fraud and abuse related to the provision of or payment for health care; is necessary to ensure appropriate state regulation of insurance and health plans; is necessary for state reporting on health care delivery or costs; serves a compelling need related to public health, safety, or welfare; the principal purpose of the state law relates to the control of any controlled substance; or the state law provides more stringent privacy protections for health information than the applicable HIPAA provisions. State law may also control in cases where it provides for reporting of disease, injury, child abuse, birth, death, or public health surveillance or investigation; or requires health plans to report or provide access to health information for purposes of financial audits or other programmatic monitoring. 45 CFR 160.203. Such exceptions to the general rule of preemption must be approved pursuant to the process outlined in 45 CFR 160.204.

B. Specific Protections under State Law

State law extends specific protections to particular types of health information and medical records. For example:

- Reportable diseases, infections, and disabilities (R 325.181);

  See Section 4.5, Communicable Disease Reporting, (A), Reportable Diseases, Defined, for further information on reportable diseases.

- HIV data (MCL 333.5114a and MCL 333.5131);

  See Section 4.5, Communicable Disease Reporting, (C), Reporting of HIV, for further information on HIV data.

- Mental health records (MCL 330.1748); and
- Medical research projects (MCL 333.2631-2633).

See Section 7.6, Access to Public Records, (C), Health Department Records, for more information on privacy protections under the Public Health Code.

7.5 Select Federal Privacy Laws

A. Family Educational Rights and Privacy Act

Under 20 USC 1232g and 34 CFR Part 99, the Family Educational Rights and Privacy Act (FERPA) protects the privacy of students' "education records" at entities that receive funding under any program administered by the U. S. Department of Education. Education records are records that are "directly related to a student" and "maintained by an educational agency or institution or by a party acting for the agency or institution." 34 CFR 99.3. Public school districts, public elementary and secondary schools, and public postsecondary institutions receive Department of Education funding, while private and religious elementary and secondary schools generally do not. The U.S. Department of Health and Human Services updated its guidance on the application of FERPA and HIPAA to student health records in 2019.

FERPA prohibits the disclosure of education records or personally identifiable information (PII) without the prior written consent of a parent (or a student who is 18 years of age or attending a postsecondary institution) unless an exception applies. 34 CFR 99.30.

In connection with an emergency, determined in consideration of "the totality of the circumstances pertaining to a threat to the health or safety of a student or other individuals," FERPA authorizes the disclosure of information from education records "to any person whose knowledge of the information is necessary to protect the health or safety of the student or other individuals." 34 CFR 99.36.

HIPAA specifically excludes education records covered by FERPA in its definition of protected health information (i.e., information subject to the HIPAA Privacy Rule). 42 CFR 160.103. In other words, education records subject to FERPA are not subject to HIPAA's privacy requirements.

1. Student Health Records and the Relationship Between HIPAA and FERPA

Many schools employ nurses, psychologists, or other health care providers, but they are not HIPAA covered entities because they do not engage in any covered transactions such as electronic billing for services. Health records from school health care providers at schools subject to FERPA constitute FERPA-protected education records.

Some schools may house health clinics sponsored by HIPAA covered entities such as hospitals, in which case records maintained by the school would be educational records subject to FERPA while those maintained by the HIPAA covered entity would be subject to HIPAA.

Schools, even those covered by FERPA, may be HIPAA covered entities if they engage in covered transactions such as billing Medicaid, but the health records are nonetheless considered education records if they are maintained by the school (or an entity acting on behalf of the school). As such, those records are subject to FERPA's privacy requirements, not the requirements of the HIPAA Privacy Rule. However, a private or religious school that does not receive U.S. Department of Education funding but is a HIPAA covered entity would be subject to HIPAA.

If a local health department's public health nurses offer a vaccination clinic for students located at a public elementary school, for example, the vaccination records created from those encounters would not constitute education records under FERPA. Student health records maintained by a provider not acting on behalf of a FERPA-covered entity are not subject to FERPA, though such records may be subject to HIPAA.

Pursuant to 45 CFR 164.512(b)(1)(vi), a HIPAA-covered entity may disclose PHI to a school about a student or prospective student of the school if the PHI is "limited to proof of immunization," "the school is required by State or other law to have such proof of immunization prior to admitting the individual," and "the covered entity obtains and documents the agreement to the disclosure from either" the parent, guardian, or other person acting *in loco parentis* of the individual or the individual if they are an adult or emancipated minor.

HIPAA permits disclosure of PHI for treatment purposes, which could include a private health provider sharing information with a school nurse, for example. 45 CFR 164.506(c)(1). In contrast, a school nurse would need written consent under FERPA to disclose education records to an outside health care provider, except in cases of emergency as described above. 34 CFR 99.30.

See Section 7.2, Disclosure of Health Information and the Health Insurance Portability and Accountability Act, for further information on the application of the HIPAA Privacy Rule.

B. Protections for Substance Use Patient Records

42 CFR Part 2 provides confidentiality protections for substance use disorder patient records maintained in connection with a federally assisted substance use disorder program. The intent of the law is "to ensure that a patient receiving treatment for a substance use disorder in a Part 2 program is not made more vulnerable by reason of the availability of their record than an individual with a substance use disorder who does not seek treatment." 42 CFR 2.2(b)(2).

In 2024, the U.S. Department of Health and Human Services, through the Substance Abuse and Mental Health Services Administration (SAMHSA) announced a final rule modifying the Part 2 regulations. The final rule became effective April 16, 2024, and the compliance date is February 16, 2026.

Generally, a Part 2 program cannot share information without consent unless an exception applies. 42 CFR Part 2 Subpart D.

Under the revised regulations, a Part 2 program may disclose records for public health purposes without patient consent so long as the disclosure is made to a public health authority, and the content of the record has been de-identified in accordance with the deidentification requirements in HIPAA. 42 CFR 2.54.

Patients may sign a single written consent to authorize all future uses and disclosures of their records for treatment, payment, or operations (TPO). 42 CFR 2.31(a)(4)(i). A recipient Part 2 program, HIPAA covered entity, or business associate receiving Part 2 records with such consent, unless and until revoked, may use and disclose the records for TPO as permitted by HIPAA and a covered entity or business associate may further disclose

those records "in accordance with the HIPAA regulations, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against the patient". 42 CFR 2.33(b)(1). Each disclosure with the patient's written consent must be accompanied by the information provided in 42 CFR 2.32.

A court order may authorize use or disclosure of patient information which would otherwise be prohibited, but it does not compel disclosure. A subpoena or similar legal mandate must be issued to compel use or disclosure. 42 CFR 2.61. Disclosing records in response to a subpoena without a Part 2 compliant court order authorizing the disclosure would subject an entity to non-compliance with Part 2.

C. Privacy Act

The federal Privacy Act of 1974 at 5 USC 552a governs federal agencies' access, use, and disclosure of individually identifiable information. Under the law, agencies cannot disclose records without the prior written consent of the individual to whom the record pertains. 5 USC 552a(b). "Record" means:

> [A]ny item, collection, or grouping of information about an individual that is maintained by an agency, including, but not limited to, his education, financial transactions, medical history, and criminal or employment history and that contains his name, or the identifying number, symbol, or other identifying particular assigned to the individual, such as a finger or voice print or a photograph. 5 USC 552a(a)(4).

Pursuant to 5 USC 552a(b), there are 12 exceptions to the consent requirement, primarily related to the performance of certain federal government duties or pursuant to a court order.

Individuals may request access to their record and may request amendment of a record pertaining to them. 5 USC 552a(d).

See Section 3.7, Right to Privacy, for a discussion on privacy under constitutional law.

7.6 Access to Public Records

A. General Rule

As a general rule, pursuant to the state's Freedom of Information Act codified at MCL 15.231 *et seq.*, all persons "are entitled to full and complete information regarding the affairs of government and the official acts of those who represent them as public officials and public employees." Michigan law provides that any person (except those who are incarcerated) may request access to inspect and copy the public records of any public agency, without stating the purpose of such request, during the agency's regular business hours. MCL 15.233. Such requests are often referred to as Freedom of Information Act (FOIA) requests.

Information regarding the public health actions of federal agencies, officials, and employees is also subject to public disclosure requirements pursuant to the federal Freedom of Information Act. 5 USC 552.

B. Restrictions on Access to Public Records

In some situations, such as during an infectious disease outbreak, the government may seek to maintain the confidentiality of certain public records to protect individuals and the public at large. However, the government's ability to restrict access to public records is limited.

Michigan law provides that a public agency may deny disclosure of certain public records under MCL 15.243, including:

- Records exempted from disclosure by statute.
- Patient medical records where an individual's identity would be revealed by disclosure, including protected health information.
- Information of a personal nature if public disclosure of the information would constitute a clearly unwarranted invasion of an individual's privacy.
- Law enforcement investigatory records to the extent that public disclosure would interfere with law enforcement proceedings, deprive a person of a right to a fair trial, constitute an unwarranted invasion of privacy, disclose the identity of a confidential source, disclose investigative techniques, endanger law enforcement personnel, or disclose the identity of a party who proceeds

anonymously in a civil action in which the party alleges they were the victim of sexual misconduct; and

- Records of measures designed to protect the public safety from vulnerabilities to terrorist attacks.

C. Health Department Records

Health department records containing medical information about an individual are generally confidential and may not be disclosed without the individual's consent. MCL 333.5715 and MCL 333.2637. Certain sections of the Public Health Code also provide confidentiality for:

- Medical information obtained in the course of a medical research project (MCL 333.2631).
- Vital records (MCL 333.2888).
- Communicable diseases and serious communicable diseases or infections (MCL 333.5111).
- HIV records (MCL 333.5114a and MCL 333.5131);
- Occupational disease investigations if required to protect trade secrets (MCL 333.5613); and
- Childhood immunization registry (MCL 333.9207).

7.7 Artificial Intelligence

Health care and public health systems are increasingly integrating artificial intelligence (AI) tools. Among the potential legal issues related to the use of artificial intelligence in public health are constitutional rights, civil rights, data use, and privacy.

AI tools include:

- Generative AI: machine-based learning that can create original content including text and media and make predictions, recommendations, or decisions; and
- Data scraping: extracts data from websites, documents, or other sources.

The Michigan Public Health Code does not address artificial intelligence nor are there other Michigan statutes regulating artificial intelligence that are generally applicable to public health activities. While state law does not, as of the time of this writing, speak specifically to artificial intelligence, existing privacy laws apply to any use or disclosure and may preclude certain uses of artificial intelligence, at least without appropriate legal agreements in place.

Chapter 8: Public Health Emergency Preparedness and Response

8.1 Overview

Public health emergencies are situations that cause or have the potential to cause a high number of deaths, illnesses, injuries, or disabilities to a group of people. Public health emergencies, like other emergencies or disasters, require advance planning, preparation, and practice to efficiently and effectively respond. During an emergency, public health leaders may have to make decisions quickly with incomplete information or information that is changing. Clear communication is critical and transparent decision-making necessary. Public health practitioners, health care workers, attorneys, judges, and many others may have to respond to the emergency in their professional capacity, while also protecting and caring for those in their personal lives.

Public health emergencies generally fall into the following categories:

- **Communicable Disease Outbreaks**.
- **Natural Catastrophes**, such as tornadoes, hurricanes, floods, earthquakes, fires, and extreme temperatures.
- **Man-made Catastrophes**, such as nuclear power plant meltdowns, radiation exposures, or chemical spills; and,
- **Intentional Acts**, such as mass shootings, terrorism, or bio-terrorist attacks.

This section focuses mainly on the first category of communicable disease outbreaks. As noted earlier in this benchbook, almost all public health begins at the local level. This includes emergencies. It is also true that diseases do not recognize borders. Thus, a public health emergency may begin with an outbreak of disease in a single township, city, or village and then expand across a county or municipality, and across a state to many states, and eventually across the U. S. or even globally, as in a pandemic.

It is critical that local, state, tribal, and federal governments each understand their roles and responsibilities as well as the legal authority and limitations on their actions. Other sectors may also have authority, relevant to public health, with or without a declared emergency. For example, local education agencies may have the authority to close schools in the event of a threat of inclement weather such as snow or ice or if there is an outbreak of a communicable disease that may endanger a large number of students or staff. In an emergency, coordination across different agencies and departments, as well as across levels of

government, is necessary, particularly when overlapping authority to respond may exist. Redundancy without communication can cause confusion or conflict, but intentional redundancy with communication may provide a slate of options with back-ups should an initial choice of authority be overturned.[240]

8.2 Emergency and Disaster, Defined

A. Emergency, Defined

Federally, 42 USC 5122(1) defines "emergency" as:

> [A]ny occasion or instance for which, in the determination of the president, Federal assistance is needed to supplement State and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States.

Similarly, in Michigan, MCL 30.402(h) defines "emergency" as:

> [A]ny occasion or instance in which the governor determines state assistance is needed to supplement local efforts and capabilities to save lives, protect property and the public health and safety, or to lessen or avert the threat of a catastrophe in any part of the state.

B. Disaster, Defined

Federally, 42 USC 5122(2) defines a "major disaster" as:

> [A]ny natural catastrophe (including any hurricane, tornado, storm, high water, wind driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought), or, regardless of cause, any fire, flood, or explosion, in any part of the United States, which in the determination of the president causes damage of sufficient severity and magnitude to warrant major disaster assistance under this chapter to supplement the efforts and available resources of States, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby.

[240] Gable & Meier, *Complementarity in Public Health Systems: Using Redundancy as a Tool of Public Health Governance*, 22 Annals Health L 224 (2013).

Similarly, Michigan's Emergency Management Act at MCL 30.402(e) defines "disaster" as:

> [A]n occurrence or threat of widespread or severe damage, injury, or loss of life or property resulting from a natural or human-made cause, including, but not limited to, fire, flood, snowstorm, ice storm, tornado, windstorm, wave action, oil spill, water contamination, utility failure, hazardous peacetime radiological incident, major transportation accident, hazardous materials incident, epidemic, air contamination, blight, drought, infestation, explosion, or hostile military action or paramilitary action, or similar occurrences resulting from terrorist activities, riots, or civil disorders.[241]

C. Public Health Emergency, Defined

Federally, 42 USC 247d(a) defines a "public health emergency" as one in which the secretary of the Department of Health and Human Services determines either "(1) a disease or disorder presents a public health emergency;" or "(2) a public health emergency, including significant outbreaks of infectious diseases or bioterrorist attacks, otherwise exists."

Michigan does not have a separate definition of "public health emergency." While not officially adopted by Michigan, the Model Public Health Emergency Authority Act provides a helpful, thorough definition:

> An imminent threat or actual appearance of an infectious, biologic, radiologic, or chemical agent or toxin, regardless of cause, that poses a high probability of:
>
> (A) a large number of deaths of individuals in the affected population.
>
> (B) a large number of serious or long-term disabilities of individuals in the affected population.
>
> (C) widespread exposure to the agent or toxin that poses a significant risk of substantial harm to a large number of individuals in the affected population; or

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[241] This definition has slight differences from the definition in Emergency Medical Services at MCL 333.20902(8) which states:

> "Disaster" means an occurrence of imminent threat of widespread or severe damage, injury, or loss of life or property resulting from a natural or man-made cause, including but not limited to, fire, flood, snow, ice, windstorm, wave action, oil spill, water contamination requiring emergency action to avert danger or damage, utility failure, hazardous peacetime radiological incident, major transportation accident, hazardous materials accident, epidemic, air contamination, drought, infestation, or explosion. Disaster does not include a riot or other civil disorder unless it directly results from and is an aggravating element of the disaster.

> (D) a substantial adverse impact on the availability of medical, public health, or other emergency resources.[242]

In lieu of a "public health emergency," Michigan has other terms that are also important in the disease outbreak context.

The first is "imminent danger," defined in MCL 333.2251(5)(b) and MCL 333.2451(3(b) as when "a condition or practice exists that could reasonably be expected to cause death, disease, or serious physical harm immediately or before the imminence of the danger can be eliminated through enforcement procedures otherwise provided."

The second is "menace to the public health," at MCL 333.2251(3). Although found in the same section as "imminent danger," this term is undefined.

The third is "epidemic," found in MCL 333.2253 and MCL 333.2453, which is also not defined in Michigan statute.

8.3 Public Health and Emergency Authority

A. Authority Generally

Throughout this benchbook, legal authorities that can be used to respond to a public health crisis or concern have been described. Thus far, these authorities are ones that have not required a declared emergency. For example, at the federal level, many efforts to prevent and control communicable diseases under the Public Health Service Act, 42 USC § 201 et seq. do not require a federal emergency declaration. Similarly in Michigan, the Public Health Code, MCL 333.1101 *et seq.* is the key source of legal authority for public health efforts, granting nearly parallel authority to the MDHHS and local health departments, empowering the departments at both levels to issue orders to address communicable disease outbreaks and imminent dangers to the public's health through general, non-emergency powers.

See Chapter 4, Communicable Disease Prevention and Control, for further discussion on non-emergency powers.

However, some situations may require an emergency declaration to enable actions that are not available under general powers. At the federal level and

[242] Nat'l Conference of Comm'rs on Uniform State Laws, *Model Public-Health Emergency Authority Act* § 2 (2003).

at the state and local levels, public health and emergency management have different, but sometimes concurrent, authority to respond to a public health emergency.

Under MCL 333.2251 and MCL 333.2451, the director of MDHHS and local health department officials can determine that an "imminent danger to the health or lives of individuals exists" in the state or area that the local department serves, respectively, and issue an order to "avoid, correct, or remove" that danger. Under MCL 333.2251(3), if the director of MDHHS determines that "conditions anywhere in the state constitute a menace to the public health, the director may take full charge of the administration of applicable state and local health laws, rules, regulations, and ordinances in addressing that menace."

Under MCL 333.2253 and MCL 333.2453, the director of MDHHS and local health department officials can issue emergency orders. If necessary to protect the public's health, the emergency order can be used to "prohibit the gathering of people for any purpose and establish procedures to be followed during the epidemic to ensure continuation of essential public health services and enforcement of health laws."

Further, the Michigan Emergency Management Act (EMA) of 1976, MCL 30.401 *et seq.* provides authority for many actions necessary in an emergency. MCL 30.403 of the EMA authorizes the governor to declare that an emergency exists in the state and to take action to address the emergency via "executive orders, proclamations, and directives having the force and effect of law..."[243] This authority extends past what the director of MDHHS can do, such as suspending laws pertaining to scope of practice or open meetings. On the other hand, the EMA is time limited, and orders issued by the governor expire if not renewed by the legislature.

B. Federal Public Health Emergency Preparedness and Response

1. Structure

Presidential Policy Directive 8 (2011) is intended to facilitate "an integrated, all-of-Nation, capabilities-based approach to

[243] Previously, the Powers of the Governor Act of 1945, MCL 10.31-33, also authorized the governor to "promulgate reasonable orders, rules, and regulations as he or she considers necessary to protect life and property or to bring the emergency situation within the affected area under control." MCL 10.31-33. However, the Act was repealed by PA 2021, No. 77 (March 30, 2022). See *In re Certified Questions*, 506 Mich 332 (2020).

preparedness" and recognizes the importance of "strengthening the security and resilience of the United States through systematic preparation for the threats that pose the greatest risk to the security of the Nation, including acts of terrorism, cyber-attacks, pandemics, and catastrophic natural disasters."

The National Response Framework provides national guidance and structure to conduct an all-hazards response to emergencies, outlining the responsibilities of different agencies and departments in Emergency Support Function (ESF) Annexes. Public Health and Medical Services are included in ESF 8, with the U.S. Department of Health & Human Services designated as the primary agency. Depending on the type of emergency, other ESF Annexes may be implicated.

2. Declarations

a. Stafford Act Declaration

At the federal level, the president can issue a declaration of a "major disaster" or "emergency" in an affected state under the Stafford Act, 42 USC §§ 5121–5207, upon request of the state governor, stating that 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." The governor must have executed the state's response plans before making this request. The Federal Emergency Management Agency (FEMA) is responsible for coordinating disaster relief to the states.

One example of a Stafford Act declaration is from 2023 in response to Michigan's request for support to respond to damage from "severe storms, tornadoes and flooding." Other declarations can be found here.

A request from a governor is not required for the president to declare a Stafford Act Emergency when the emergency involves "federal primary responsibility," such as an event occurring on federal property. Examples include the terrorist

attacks of September 11, 2001, and the bombing of the Murrah Federal Building in 1995.[244]

Under MCL 30.416, if there has been a Stafford Act declaration that an emergency or disaster exists in Michigan, the governor is authorized to "apply for, accept, and disburse grants from the federal government" as well as to enter into agreements that pledge the state's share for these funds. See also MCL 30.418 (3)-(5).

b. National Emergencies Act Proclamation

The president can declare a "national emergency" under the National Emergencies Act, immediately transmitting the proclamation to Congress and publishing in the Federal Register. The proclamation should specify "[a]ny provisions of law conferring powers and authorities to be exercised." The proclamation can be terminated by the president through a proclamation, or by a joint resolution from Congress, or automatically on its anniversary, unless renewed by the president after submitting notice to Congress and published in the Federal Register. A running list of proclamations is available here.

c. Public Health Emergency

The secretary of the U.S. Department of Health and Human Services (HHS) is authorized under the Public Health Service Act, 42 USC § 247d, to determine that a public health emergency exists. When the secretary determines that:

> (1) a disease or disorder presents a public health emergency; or
>
> (2) a public health emergency, including significant outbreaks of infectious diseases or bioterrorist attacks, otherwise exists, the secretary may take such action as may be appropriate to respond to the public health

[244] Cong Rsch Serv, *Stafford Act Emergency Declarations for Attacks on Federal Property* <https://crsreports.congress.gov/product/pdf/IN/IN11571> (posted January 12, 2021) (accessed April 9, 2025).

> emergency, including making grants, providing awards for expenses, and entering into contracts and conducting and supporting investigations into the cause, treatment, or prevention of a disease or disorder as described in paragraphs (1) and (2). 42 USC § 247d(a).

With a public health emergency determination, the secretary can also access funds from the Public Health Emergency Fund. 42 USC § 247d(b). These funds are to "supplement and not supplant" other federal, state, or local funds. 42 USC § 247d(c).

The public health emergency determination ends when either the secretary declares that the emergency no longer exists, or at the expiration of 90 days, whichever occurs first. The secretary can also renew the determination in 90-day increments if warranted. 42 USC § 247d(a).

Recent public health emergencies at the time of writing this benchbook include the California wildfires (2025), hurricanes and flooding in Florida, Georgia, and North Carolina (2024), the COVID-19 pandemic and the opioid crisis.

d. Combined Additional Authority

If there is a Stafford Act or National Emergencies Act declaration plus a public health emergency determination, the president can declare a Social Security Act Section 1135 waiver that waives or modifies certain requirements of benefit programs such as Medicare, Medicaid, the Children's Health Insurance Program (CHIP), etc.

C. State Public Health Emergency Preparedness and Response

1. Public Health Code

a. Imminent Danger to Public Health

Under MCL 333.2251, the director of MDHHS may determine that "an imminent danger to the health or lives of individuals exists in the state." Upon this determination, the director must inform individuals affected by the imminent danger and issue an order to a person "authorized to avoid, correct or remove the imminent danger or be posted at or near the imminent danger."

The order must specify the director's findings and require immediate action to remedy the danger. It may also specify actions to be taken and limit who may be present in certain locations or conditions. If the person to whom the order is directed doesn't promptly comply, the director can petition the circuit court with jurisdiction over the area where the imminent danger exists to either restrain action causing the dangerous conditions or require action to "avoid, correct, or remove the imminent danger."

b. Menace to Public Health

Under MCL 333.2251(3):

> If the director determines that conditions anywhere in this state constitute a menace to the public health, the director may take full charge of the administration of applicable state and local health laws, rules, regulations, and ordinances in addressing that menace.

c. Epidemic

Under MCL 333.2253, the director of MDHHS may issue an emergency order if they determine "that control of an epidemic is necessary to protect the public health." This

statute does not require the director to give notice, allow comment, or obtain approval before issuing an order.[245]

An emergency order during the COVID-19 pandemic limiting gathering sizes and requiring mask wearing under MCL 333.2253 was challenged in *T & V Associates, Inc v. Director of Health and Human Services*.[246] The plaintiff, a catering and banquet company, challenged the MDHHS director's order arguing that MCL 333.2253 is an unconstitutional delegation of legislative authority. Deeming the case moot, the Michigan Supreme Court overturned the appellate court's decision in favor of the plaintiff. Thus, MCL 333.2253, which was "substantially amended"[247] in 2022, stands in its current iteration at the time of writing this benchbook.

i. Powers Under the Order

Powers under MCL 333.2253 are broad and, as the statute states, "are not limited to this code."

(1) Prohibit Gatherings

The order may "prohibit the gathering of people for any purpose." MCL 333.2253.

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[245] See also *Flynn v. Ottawa Cnty Dep't of Pub Health*, 344 Mich App 709, 1 NW3d 853 (2022). While this suit addresses authority of the local health departments, the language is parallel to that of the state statute here.

[246] *T & V Assocs, Inc v. Dir of Dep't of Health & Human Servs*, 12 NW3d 594 (Mich 2024), overturning *T & V Assocs, Inc v. Dir of Health & Hum Servs*, 347 Mich App 486, 15 NW3d 313 (2023). *See also Dep't of Agric and Rural Dev v. Zante,* 348 Mich App 293 (2023) in which Michigan Department of Agriculture & Rural Development (MDARD) suspended a food establishment's license for violating requirements of public health orders related to the COVID-19 pandemic. The food establishment continued to operate with a suspended license and MDARD filed an action; the Circuit Court held the business in contempt, ordered it to pay a fine, issued a preliminary injunction, and ordered that if the restaurant continued to operate without a license the owner would be arrested. The owner was ultimately arrested for noncompliance, held in contempt, and ordered to pay a fine and serve 93-days in jail or until she complied. On appeal, the Court of Appeals affirmed the decision while instructing the Circuit Court to refashion the latter fine to be civil in nature. *See also Section 6.3, Food Establishment Licensure and Inspections, (B), Food Establishment Licensure*.

[247] *T & V Assocs, Inc*, 12 NW3d at 596.

(2) Establish Procedures

The order may "establish procedures to be followed during the epidemic to ensure continuation of essential public health services and enforcement of health laws." MCL 333.2253. These procedures may include actions often termed "social distancing measures" (also known as "physical distancing measures," "prevention measures," or "community mitigation measures").[248]

ii. Limitations

Under MCL 333.2253 (4)-(6), the MDHHS director may restrict visitation of a patient or resident of a health facility or agency, assisted living facility or physician's private practice for up to 30 days. After 30 days, for patients with cognitive impairments, the patient's family member, advocate, or person who has power of attorney must be allowed to visit, subject to reasonable safety measures such as prescheduling the visit, limiting the number of visitors at a time, testing for the disease, etc.

iii. Enforcement

(1) Criminal

Violation of an MDHHS order is a misdemeanor, punishable with imprisonment up to six months and/or a fine of up to $200, under MCL 333.2261. A peace officer who has reasonable cause to believe a person has committed a misdemeanor punishable by greater than 92 days may arrest the person without a warrant under MCL 764.15.

[248] For a list of common measures and considerations related to public health authority, see The Network for Public Health Law and The Association of State and Territorial Health Officials, *The Prevention Measures Law Project 3.0: User Guide* < *https://www.astho.org/49009b/globalassets/pdf/the-prevention-measures-law-project-3-user-guide.pdf*> (accessed April 11, 2025).

(2) Civil

MDHHS may seek injunctive relief from the courts to restrain, prevent, or correct a violation of an order of MDHHS that adversely affects the public health under MCL 333.2255.

iv. Other

(1) Involuntary Detention and Treatment of Individuals

In the same section as local health department emergency orders for an epidemic, MCL 333.2453(2), it states that MDHHS "may provide for the involuntary detention and treatment of individuals with hazardous communicable disease." Warning notice is required for due process.

See MCL 333.5201 to MCL 333.5210, specifically MCL 333.5207, as described in Section 4.13, Proceedings for Warning Notice and Due Process Requirements.

2. Emergency Management Act

In recognition of the threat to public health and safety posed by emergencies and disasters of both manmade and natural causes, the Michigan Emergency Management Act, 1976 PA 390, MCL 30.401 *et seq.* sets forth Michigan's emergency management procedures which include, but are not limited to, preparation of state emergency plans and preparedness efforts (MCL 30.407a(2)); provision of increased powers to the governor and local agencies (MCL 30.405 and MCL 30.410); enactment of an Interstate Emergency Management and Disaster Compact for the provision of equipment, personnel, and services by other states in the event of an emergency or disaster (2001 PA 247 and 2001 PA 248, MCL 3.991 *et seq.*); and use of private property to cope with an emergency or disaster and compensation for such use (MCL 30.405(1)(d)). The provision of necessary medical and health services is included within emergency management. MCL 30.411.

a. Emergency Declaration

Under MCL 30.403, the governor must declare a state of disaster or emergency upon determining that a disaster or emergency has occurred or that the threat of a disaster or emergency exists.

The governor may declare a disaster or emergency by executive order or proclamation. All executive orders or proclamations declaring a state of disaster or emergency must indicate the nature of the disaster or emergency; the area(s) threatened; the conditions that have brought about the disaster or emergency; and the conditions permitting the termination of the state of disaster or emergency.

A gubernatorial-declared state of disaster or emergency remains in effect until the governor determines that the threat or danger has passed, the disaster has been dealt with such that emergency conditions no longer exist, or the passage of 28 days. The governor may request an extension from the legislature. The legislature, by joint resolution, may extend the state of emergency or disaster. The governor may not unilaterally renew the order or redeclare an emergency or disaster.[249]

Under MCL 30.407, the state director of emergency management (the director of the department of state police or their designee) is charged with implementing the governor's orders and directives under a state of emergency or disaster and coordinating all operations. At the direction of the governor, the director may also command all disaster relief, mitigation, and recovery forces except the national guard or state defense force.

i. Powers Under a Declaration

The powers of the governor during a declared disaster or emergency are extremely broad. See MCL 30.405.

[249] *In re Certified Questions from the United States Dist Court, W Dist of Michigan,* 506 Mich 332; 958 NW2d 1 (2020).

Of relevance to public health law, the gubernatorial powers would allow the governor to:

- "Suspend a statute, order, or rule prescribing the procedures for conducting state business, [other than criminal procedures,] when strict compliance with the statute, order, or rule would prevent, hinder, or delay necessary action in coping with the disaster or emergency." MCL 30.405(1)(a);

- Employ any measure and give any direction to MDHHS or local health boards as is reasonably necessary for securing compliance with Michigan's emergency management laws or the findings or recommendations of MDHHS or local boards of health, see MCL 30.405(1)(c), MCL 30.404(1);

- Issue an executive order to state and local law enforcement officers and agencies as is reasonable and necessary to secure compliance with Michigan's emergency management laws, see MCL 30.403(2);

- Serve as commander-in-chief of the militia and all other forces available for emergency duty, see MCL 30.404(1);

- Control ingress to and egress from the disaster area, as well as the movement of persons within the disaster area and the occupancy of premises in the disaster area, MCL 30.405(1)(g);

- Give authority to allocate drugs, food, and other essential materials and services, see MCL 30.404(1);

- Commandeer or use private property as necessary to cope with the disaster or

emergency, subject to appropriate compensation, MCL 30.405(1)(d);

- Allow persons holding licenses to practice medicine, dentistry, pharmacy, nursing, and other similar professions in other localities to practice their respective profession in Michigan during the disaster or emergency, MCL 30.404(3);

- Expend funds from the disaster and emergency contingency fund for reasonable expenses of employees of the state "acting at the direction of the director in a disaster or emergency related operation." (MCL 30.418); and

- Authorize an expenditure from the disaster and emergency contingency fund to counties or municipalities if the counties or municipalities have exhausted local capacity and federal assistance is not available, MCL 30.419.

ii. Violations

"A person who willfully disobeys or interferes with the implementation of a rule, order or directive issued by the governor pursuant to [MCL 30.405] is guilty of a misdemeanor." MCL 30.405(3).

iii. Repealed

Prior to March 30, 2022, alternative authority was found in the Emergency Powers of Governor Act (EPGA). However, the EPGA, MCL 10.31 - MCL 333.10.33, was repealed in 2021, after being determined to be an unconstitutional delegation of

legislative power to the executive branch in *In re Certified Questions*.[250]

b. Heightened State of Alert

Under MCL 30.421, the governor can issue an executive order or a heightened state of alert for suspected terrorism, including bioterrorism as outlined in MCL 750.543b.

A heightened state of alert can remain in effect until the threat has passed, the conditions no longer exist, or 60 days have passed. After 60 days, the governor can request an extension from the legislature.

A person who willfully disobeys or interferes with a "rule, order or directive of the governor" under this statute is "guilty of a misdemeanor punishable by imprisonment for not more than 90 days or a fine of not more than $100.00, or both." The statute also provides that, "[n]otwithstanding any provision in this section, a prosecuting agency shall not prosecute any person or seize any property for conduct presumptively protected by the first amendment to the constitution of the United States in a manner that violates any constitutional provision." MCL 30.421(2).

D. Local Public Health Emergency Preparedness and Response

1. Public Health Code

a. Imminent Danger to Public Health

Under MCL 333.2451, a local health officer may determine that "an imminent danger to the health or lives of individuals exists in the area served by the local health department." Upon this determination, the official must inform individuals affected by the imminent danger and issue an order to a person "authorized to avoid, correct or remove the imminent danger or be posted at or near the imminent danger."

The order must specify the official's findings and require immediate action to remedy the danger. It may also specify

[250] *Id.*

actions to be taken and limit who may be present in certain locations or conditions. If the person to whom the order is directed doesn't promptly comply, the director can petition the circuit or district court with jurisdiction over the area where the imminent danger exists to either restrain action causing the dangerous conditions or require action to "avoid, correct, or remove the imminent danger."

b. Public Health Emergency

Under MCL 333.2453, a local health officer may issue an emergency order if he or she determines "that control of an epidemic is necessary to protect the public health."[251] This statute does not require the local health officer to give notice, allow comment, or obtain approval before issuing an order.[252]

i. Powers Under a Declaration

Powers under MCL 333.2453, are very broad and not limited to the Public Health Code.

(1) Prohibit Gatherings

The order may "prohibit the gathering of people for any purpose." MCL 333.2453.

(2) Establish Procedures

The order may "establish procedures to be followed by persons, including a local governmental entity, during the epidemic to ensure continuation of essential public health

[251] A cease-and-desist order against a restaurant violating limitations on gathering sizes during COVID-19 issued under MCL 333.2453 was challenged in *Moore Murphy Hosp, LLC v. Health Dept of NW Michigan,* 11 NW3d 505 (Mich, 2024). In a declaratory action, the state court found in favor of Iron Pig and overturned fines for violations of COVID-19 orders, stating that MCL 333.2453 was an unconstitutional delegation of legislative authority, under the same arguments as applied to the director of MDHHS under MCL 333.2253 in the appellate decision in *T & V Assocs, Inc. v. Director of Health and Human Services*. However, even though the Michigan Supreme Court has since overturned the appellate decision in *T & V Assocs, Inc v. Dir of Health and Hum Servs,* the owner of the Iron Pig continued to pursue a lawsuit against the Health Department of Northwest Michigan, as of the writing of this Benchbook (April 2025).

[252] *Flynn v. Ottawa Cnty Dep't of Pub Health*, 344 Mich App 709, 1 NW3d 853 (2022).

services and enforcement of health laws." MCL 333.2453.

ii. Limitations

Under MCL 333.2453 the local health officer may restrict visitation of a patient or resident of a health facility or agency, assisted living facility or physician's private practice for up to 30 days. After 30 days, for patients with cognitive impairments, the patient's family member, advocate, or person who has power of attorney must be allowed to visit, subject to reasonable safety measures such as prescheduling the visit, limiting the number of visitors at a time, testing for the disease, etc.

iii. Enforcement

(1) Criminal

Violation of an order of a local health officer is a misdemeanor, punishable with imprisonment up to 6 months and/or a fine of up to $200.00, under MCL 333.2443. A peace officer who has reasonable cause to believe a person has committed a misdemeanor punishable by greater than 92 days may arrest the person without a warrant under MCL 764.15.

Local health departments do not generally have the authority to require law enforcement to assist with carrying out public health orders. However, in some cases, a court might order law enforcement to act.

(2) Civil

A local health officer may seek injunctive relief from the court to restrain, prevent, or correct a violation of an order the officer is authorized to enforce if such violation adversely affects the public health. MCL 333.2465.

iv. Other

(1) Involuntary Detention and Treatment of Individuals

In the same section as local health department emergency orders for an epidemic, MCL 333.2453(2), the local health department "may provide for the involuntary detention and treatment of individuals with hazardous communicable disease." Warning notice is required for due process.

See MCL 333.5201 to MCL 333.5210, *specifically MCL 333.5207, as described in Section 4.13, Proceedings for Warning Notice and Due Process Requirements.*

2. Emergency Management Act

a. Emergency Declaration

For a county or municipality that has appointed an emergency management coordinator, pursuant to MCL 30.410(1)(b), the chief executive officer of a county or municipality or the official designated by charter may:

> Declare a local state of emergency if circumstances within the county or municipality indicate that the occurrence or threat of widespread or severe damage, injury, or loss of life or property from a natural or human-made cause exists and, under a declaration of a local state of emergency, issue directives as to travel restrictions on county or local roads.

The declaration may last longer than seven days only with the consent of the governing body of the local jurisdiction. The order must be promptly filed with the emergency management division unless circumstances of the emergency or disaster prevent timely filing.

b. Powers Under a Declaration

A county, municipality, or other agency designated by the governor may make, amend, and rescind orders, rules, and regulations necessary for emergency management purposes and supplementary to a rule, order, or directive issued by the governor or a state agency exercising a power delegated to it by the governor. A rule or order is temporary and upon declaration by the governor of a state of disaster or emergency, is terminated.

MCL 30.412(2).

Among other additional emergency authorities, some relevant to public health include the authority to:

- Appropriate funds, contract, obtain and distribute equipment and supplies, MCL 30.410(1)(c);
- "Provide for the health and safety of persons and property, including emergency assistance to the victims of a disaster." MCL 30.410(1)(d);
- Direct and coordinate a multi-agency response, MCL 30.410(1)(e);
- Appoint paid or volunteer rescue teams and other disaster workers, MCL 30.410(1)(f);
- Enter into mutual aid agreements, MCL 30.410(2); and,
- If complying with an existing state emergency or disaster declaration, the local jurisdiction can also direct personnel, equipment, and resources to support the response, MCL 30.410(1)(h).

c. Requesting a State Emergency

If no state emergency or disaster has been declared, and if the chief executive official of the municipality or the governing body or the county in which the emergency or disaster is

occurring considers it to be beyond the control of the county or municipality, they can request a state emergency.

Pursuant to MCL 30.414, the following steps are required:

- If the emergency is solely within the boundaries of a township, city, or village within the county, the chief executive officer of the township, city, or village within the county must request the county or municipality to seek assistance from the state.

- If requested by the chief executive officer of the township, city, or village within the county, or if the emergency or disaster is beyond the boundaries of a township, city, or village within the county and exceeds the county's ability to respond, the emergency management coordinator shall contact the state police emergency management district coordinator.

- The district coordinator shall "assess the nature and scope of the disaster or emergency, and they shall recommend the personnel, services, and equipment that will be required for its prevention, mitigation, or relief."

- The district coordinator shall notify the state director of emergency management (the director of the department of state police or their designee) of findings and recommendations.

- The director shall immediately notify the governor; however, if the director determines that "immediate action is essential to the preservation of life and property, the director may initiate temporary assistance to the affected area as necessary and compatible with the policies and procedures of the Michigan emergency management plan."

- The director must advise the governor of the magnitude, and the governor may then take the actions they find appropriate to mitigate the disaster

or emergency. Acting on the local request does not prevent the governor from moving forward with any other actions under the emergency management act.

8.4 Constitutional Challenges to Emergency Measures

A. Religion

During the COVID-19 pandemic, the U.S. Supreme Court decided several cases on its "Shadow Docket" related to the treatment of religious organizations. The “Shadow Docket” is an emergency docket with cases that have come before the court not as an appeal from a decision on the merits, but rather as a preliminary matter such as injunctions, stays, summary decisions, etc. These cases are generally handled much more quickly and have opinions that may be only a few brief sentences, unsigned, and without a count of how each justice voted. Whether cases on the Shadow Docket can be considered precedent is debated. Many states, including Michigan, issued public health orders limiting gathering sizes. These gathering restrictions varied with some being tied to the type of gathering, length, size of the space, capacity, activity taking place, and other factors. Gathering restrictions also changed over time, as information about COVID-19 developed and as the needs of the community were assessed. Several challenges were raised by religious organizations asserting the gathering restrictions infringed on free exercise of religion under the First Amendment.

The first case to come before the court on the Shadow Docket was *South Bay United Pentecostal Church, et al. v. Newsom, et al.* in May 2020.[253] Relying on *Jacobson v.. Massachusetts*,[254] the court denied injunctive relief to the worship organizations. The written concurrence by Chief Justice John Roberts explained that public health restrictions on religious gatherings were consistent with “comparable secular gatherings, including lectures, concerts, movie showings, spectator sports, and theatrical performances, where large groups of people gather in close proximity for extended periods of time.” The court found religious gatherings were different than “grocery stores, banks and laundromats” where people did not gather in groups or for a long time.

[253] *S Bay United Pentecostal Church v. Newsom,* 140 S Ct 1613, 207 L Ed 2d 154 (2020).
[254] *Jacobson v. Massachusetts*, 197 US 11; 25 S Ct 358; 49 L Ed 643 (1905).

In November of 2020, *Roman Catholic Diocese of Brooklyn, New York v. Cuomo* was decided on very similar facts.[255] However, the court found in a 5-4 decision that New York was treating places of worship more severely than how it was treating what the court described as comparable institutions. The religious organizations argued that essential businesses had no capacity limits. Essential businesses included grocery stores but also included places like liquor stores. The reasoning for which businesses were considered essential was not fully described. The state and the dissent argued that religious organizations were being treated the same as lectures, concerts, movie showings, spectator sports, and theatrical performances, like in the earlier case. Rather than deferring to public health completely, the court gave a more limited deference and granted injunctive relief.

The court again struck down gathering restrictions in *Tandon v. Newsom*. In *Tandon*, California was limiting the number of people from different families who could gather in homes.[256] The law appeared to be facially neutral – it applied to all in-home gatherings, religious and secular alike. But the majority found that California was treating secular and religious activities differently by allowing commercial establishments such as hair salons, retail stores, personal care services, and movie theaters to operate without the same restriction. The dissent reasoned that home religious gatherings were not comparable to gatherings at businesses; houses have less space, people tend to stay longer, and enforcement is more difficult. But the majority held that the state had not demonstrated why these at-home religious gatherings were being treated differently than secular activities in other settings.

See Section 3.2, First Amendment – Free Speech, Expression, Assembly, and Religious Freedom, (C), Religious Freedom.

B. Takings

Although the governor is entitled to commandeer or use private property to the extent necessary during a disaster or emergency, compensation must be paid to the property owner(s) under certain circumstances as outlined in MCL 30.406. An individual is entitled to compensation for the taking or use of the individual's property only if the taking or use exceeds the individual's obligation to permit appropriate use or restrictions on the use of his or her property during a disaster or emergency; the individual did not volunteer the

[255] *Roman Cath Diocese of Brooklyn v. Cuomo*, 592 US 14; 141 S Ct 63; 208 L Ed 2d 206 (2020).
[256] *Tandon v. Newsom*, 593 US 61; 141 S Ct 1294; 209 L Ed 2d 355 (2021).

use of his or her property without compensation; the property was commandeered or otherwise used to cope with a disaster or emergency; and the use or destruction of the property was ordered by the governor or the director of the Department of State Police or his designee.

The government is not required to provide compensation for the destruction of standing timber or other property in order to provide a fire break; the release of waters or the breach of impoundments in order to reduce pressure or other danger from actual or threatened flood; or personal services, except pursuant to statute, local law, or ordinance.

Under *Gym 24/7 Fitness, LLC v. State*, the court found that the temporary closure of businesses under an emergency order to prevent the spread of COVID-19 did not constitute a taking requiring just compensation under the Takings Clauses of the Michigan and U.S. Constitutions.[257] The government did not physically take possession of the gym. Nor did a regulatory taking occur where the temporary closure did not deprive the gym owner of all economically productive use of the property. Notably, the court also listed cases from every other state with a takings challenge "stemming from the government's closure of a business as a safeguard against the spread of COVID-19" and found that no other jurisdiction held this situation to be a taking requiring compensation.

See Section 3.5, Fifth, Tenth, and 14th Amendments – Takings.

8.5 Liability Protections

A. Generally

Liability is a concern for many in a public health emergency response, especially when responding amid limited or unfolding information and in circumstances where there may be personnel or resource shortages. There is a patchwork of policies at the federal and state levels that attempt to address the concern of liability and to encourage both paid employees and volunteers to continue to respond while still preventing negligent acts or omissions that may increase preventable injuries, deaths, or property damages.

[257] *Gym 24/7 Fitness, LLC v. State*, 341 Mich App 238, 989 NW2d 844 (2022); See also *Mount Clemens Recreational Bowl, Inc v. Dir of Dep't of Health & Hum Servs*, 344 Mich App 227, 998 NW2d 917 (2022).

B. Select Liability Protections

1. General Government Immunity, Including Public Health

MCL 691.1405 imposes liability on government agencies for motor vehicle accidents in government owned vehicles caused by ordinary negligence. MCL 691.1406 imposes premises liability on government agencies for:

> bodily injury and property damage resulting from a dangerous or defective condition of a public building if the governmental agency had actual or constructive knowledge of the defect and, for a reasonable time after acquiring knowledge, failed to remedy the condition or to take action reasonably necessary to protect the public against the condition.

Under MCL 691.1407, state and local governmental agencies engaged in the exercise or discharge of a governmental function are immune from tort liability. Similarly, the officers, employees, volunteers, and members of boards, councils, commissions or statutory task forces, and judges, legislators, and other elected officials who reasonably believe they are acting in the scope of their authority are immune from tort liability unless their actions amount to "gross negligence that is the proximate cause of injury or damage." Gross negligence is "conduct so reckless as to demonstrate a substantial lack of concern for whether an injury results."

Immunity is not granted to governmental agencies or employees providing medical care, except those owned or operated by MDHHS or the Michigan Department of Corrections, or for "care or treatment provided by an uncompensated search and rescue operation medical assistant or tactical operation medical assistant."

2. Immunity Under the Public Health Code for Mass Immunization Programs

Pursuant to MCL 333.9203, government employees and volunteers of mass immunization programs are immune from liability, "except for gross negligence or willful and wanton misconduct." Drug manufacturers are not exempt.

3. Immunity Under the Emergency Management Act

Pursuant to MCL 30.411, personnel of “disaster relief forces" engaged in "disaster relief activities" are immune from liability for death or injury to any person or for damage to property as a result of any activity taken to comply or reasonably attempt to comply with Michigan's emergency management laws. Such immunity is provided in the General Governmental Immunity Act, MCL 691.1407, as described above.

MCL 30.411(3) defines "disaster relief activity," which “includes training for or responding to an actual, impending, mock, or practice disaster or emergency.” "Disaster relief forces" is defined by MCL 30.402(f) to include “all agencies of state, county, and municipal government, private and volunteer personnel, public officers and employees, and all other persons or groups of persons having duties or responsibilities under [the Emergency Management Act] or pursuant to a lawful order or directive authorized by [the Emergency Management Act].”

Under MCL 30.411 (4)-(6), specified medical professionals or facilities, licensed in Michigan, another state, or by the federal government or armed forces, that are rendering services during a declared emergency or disaster at the explicit or implied request of a state or local official are not liable for injury while delivering those services. Acts or omissions that are willful or gross negligence are not immune, and the injured party can file a civil action for malpractice.

Immunity is also extended to a person owning or controlling real property who voluntarily and without compensation allows the use of property during an actual or mock emergency under MCL 30.411(7). But such person is legally obligated to disclose any known hidden safety hazards or dangers on the property under MCL 30.411(8).

Under MCL 30.402(m), a "person" eligible for immunity includes an individual, partnership, corporation, association, government entity, or any other entity.

4. The Emergency Management Assistance Compact (EMAC) Act

EMAC contains provisions providing immunity for officers and employees of a party state rendering aid in another state, gross negligence excepted, under MCL 3.1001 (Article VI).

5. Public Readiness and Emergency Preparedness Act of 2005

The Public Readiness and Emergency Preparedness Act (PREP) Act, 42 USC § 247d-6d, authorizes the secretary of the Department of Health and Human Services to issue a declaration that provides immunity from tort liability, except willful misconduct, "caused by, arising out of, relating to, or resulting from the administration to or the use by an individual of a covered countermeasure" to a "disease or other health condition or other threat to health" that the secretary has declared "constitutes a public health emergency." The immunity applies to entities and individuals involved in the development, manufacture, testing, distribution, administration, and use of such countermeasures. The PREP Act, 42 USC § 247d-6e, also authorizes the "Covered Countermeasure Process Fund" to provide alternate compensation for such injuries.

6. Other

The Federal Volunteer Protection Act of 1997 (42 USC 14503) provides immunity for a volunteer of any nonprofit or governmental agency for work within the volunteer's scope of duties and, as appropriate, for which the volunteer is properly licensed. Immunity is not provided for harm that is the result of criminal or willful misconduct, gross negligence, reckless misconduct, or a flagrant indifference to the rights or safety of others. Similarly, immunity is not granted when the harm was caused by the operation of "a motor vehicle, vessel, aircraft, or other vehicle" for which insurance and a license are required.

Other laws providing immunity for emergency workers include the Good Samaritan Act (MCL 691.1501); the Emergency Medical Care Act (MCL 691.1502); the Public Health Code (MCL 333.20965); and the Fire Code (MCL 29.7c).

C. Crisis Standards of Care

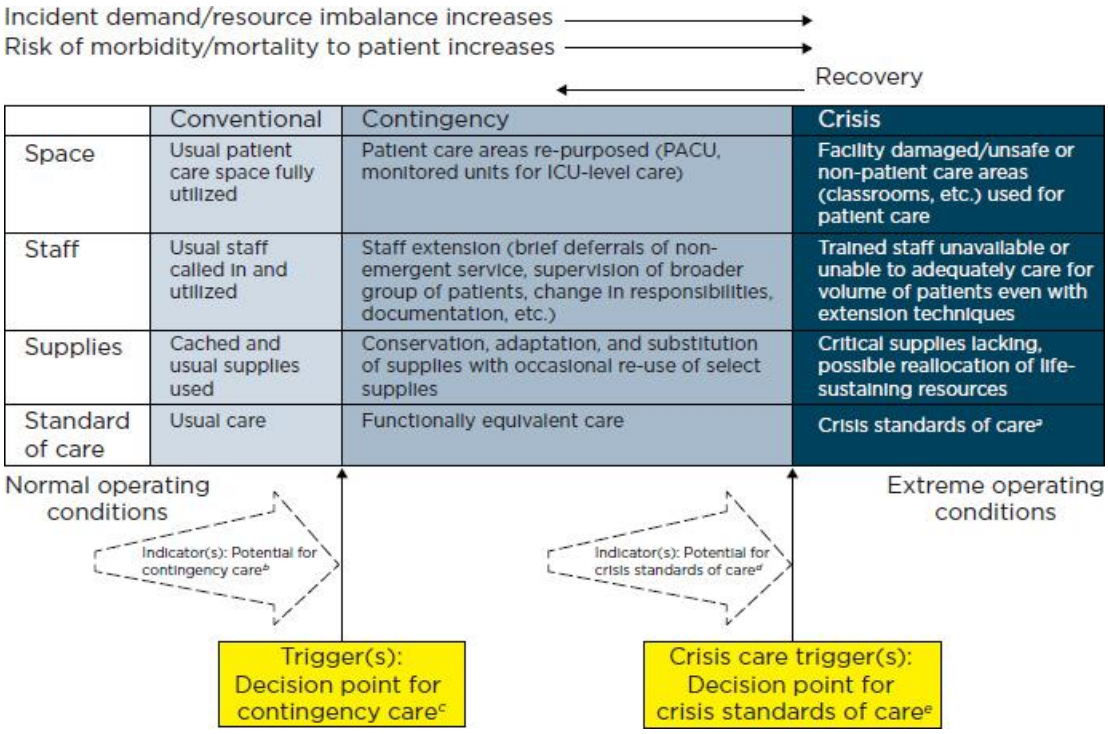
In Michigan, under MCL 600.2912a, a patient is owed "the recognized standard of acceptable professional practice or care in the community in which the [general practitioner] practices or in a similar community," or for a specialist, "the recognized standard of practice or care within that specialty as reasonably applied in light of the facilities available in the community or other facilities reasonably available under the circumstances." While the legal standard of care is generally presumed to be flexible to encompass changing circumstances within a community, in reality, critical choices must be made while under a situation where there is a need for substantial deviation from conventional care, such as personnel, resources, or space shortages. There may be many different ways to proceed under these circumstances, and medical professionals may have to make spur-of-the-moment value judgments absent guidance.

Crisis standards of care are intended to reduce judgment calls by thinking through potential situations in advance while not under actual stress of an emergency or disaster. Crisis standards of care can help ensure that laws are not broken (such as disability discrimination), that ethical decisions are made (to avoid disparate impact on vulnerable communities), that communities have input, that there is transparency in decision making, and that the potential is reduced for conflicting decisions made by different decision-makers. The relevant guidelines can then be implemented when certain indicators are met during an emergency or disaster.[258]

Michigan's crisis standards of care were last significantly updated in 2021 and can be found on the MDHHS website.

[258] Levin, Hodge & Wetter, The Network for Public Health Law, *FAQ: Crisis Standards of Care and Health Provider Liability* <https://www.networkforphl.org/resources/faqs-crisis-standards-of-care-and-health-provider-liability/> (posted March 23, 2020) (accessed April 9, 2025).

Figure 8[259]



[259] MDHHS, *Michigan Guidelines for Implementation of Crisis Standards of Care and Ethical Allocation of Scarce Medical Resources and Services During Emergencies and Disasters* <https://www.michigan.gov/mdhhs/-/media/Project/Websites/coronavirus/Folder2/MDHHS_Ethical_Guidlines_-_November_30_2021_FINAL_12-6-21.pdf?rev=3222862e468f4e12a19b16bd1521b30f&hash=7E396147C7643E933B3459F6DEF039B3> (posted June 2020) (accessed April 9, 2025), citing Institute of Med, *Crisis Standards of Care: A Toolkit for Indicators and Triggers* (2013).

Appendix A: Acronyms and Abbreviations

ACIP – Advisory Committee on Immunization Practices
ADA – Americans with Disabilities Act
AI – Artificial intelligence
APA – Administrative Procedures Act of 1969
BCBS – Blue Cross Blue Shield
CBP – Customs and Border Protection
CDC – Centers for Disease Control and Prevention
CHIP – Children's Health Insurance Program
COVID-19 – Coronavirus disease 2019 caused by the coronavirus SARS-CoV-2
DNR – Michigan Department of Natural Resources
EEOC – Equal Employment Opportunity Commission
EGLE – Michigan Department of Environment, Great Lakes, and Energy
EMA – Michigan Emergency Management Act
EMAC – Emergency Management Assistance Compact
EPGA – Emergency Powers of Governor Act
EPT – Expedited Partner Therapy
ESF – Emergency Support Function
EUA – Emergency Use Authorization
FDA – Food and Drug Administration
FEMA – Federal Emergency Management Agency
FERPA – Family Educational Rights and Privacy Act
FOIA – Freedom of Information Act
HBV – Hepatitis B virus
HCV – Hepatitis C virus
HHS – U.S. Department of Health and Human Services
HiAP – Health in all policies
HIPAA – Health Insurance Portability and Accountability Act
HIV – Human Immunodeficiency Virus
HPV – Human Papillomavirus
ICE – Immigration and Customs Enforcement
LINDA – Loved individuals need dedicated attention
MCL – Michigan Compiled Laws
MCRH – Michigan Center for Rural Health
MCRISP – Michigan Child Care Related Infectious Disease Surveillance Program
MCSSD – Michigan Criteria for Subsurface Sewage Disposal

MDARD – Michigan Department of Agriculture and Rural Development
MDHHS – Michigan Department of Health and Human Services
MFSA – Michigan Fireworks Safety Act
MPART – Michigan Per- and Polyfluoroalkyl Substances (PFAS) Action Response Team
NDMS – National Disaster Medical System
NREPA – National Resources and Environmental Protection Act
NVICP – National Vaccine Injury Compensation Program
PFAS – Polyfluoroalkyl substances
PHI – Protected health information
PHS – Public Health Service
PHSA – Public Health Service Act
PII – Personally identifiable information
PREP – Public Readiness and Emergency Preparedness
RFRA – Religious Freedom Restoration Act
SAMHSA – Substance Abuse and Mental Health Services Administration
STI – Sexually transmitted infection
SORH – State Offices of Rural Health
TB – Tuberculosis
Title VII – Title VII of the Civil Rights Act of 1964
TPO – Treatment, payment, or operations
VAERS – Vaccine Adverse Event Reporting Systems

Appendix B: Glossary

A

Acute Disease

- A disease (such as bronchitis, gastroenteritis, or the flu) of rapid onset and relatively short duration. [260]

C

Case

- An instance of disease or injury. Also, a patient.[261]
- A suit or action in law or equity.[262]
- A situation requiring investigation or action (as by the police).[263]

Causation

- The act or agency which produces an effect.[264]

Chronic Disease

- A disease (such as asthma, coronary heart disease, or diabetes) that continues or occurs again and again for a long time: a medical condition of prolonged duration.[265]

Communicable Disease

- An infectious disease (such as cholera, hepatitis, influenza, malaria, measles, or tuberculosis) that is transmissible by contact with infected individuals or their bodily discharges or fluids (such as respiratory droplets, blood, or semen), by contact with contaminated surfaces or objects, by ingestion of contaminated food or water, or by direct or indirect contact with disease vectors (such as mosquitoes, fleas, or mice). Note, the terms contagious disease and

[260] Merriman-Webster Dictionary (2025)
[261] ibid
[262] ibid
[263] ibid
[264] ibid
[265] ibid

communicable disease are often used interchangeably. However, communicable diseases such as malaria or schistosomiasis that are spread by contact with disease vectors (such as mosquitoes or ticks) are not typically considered to be "contagious" diseases since they cannot be spread from direct contact with another person.[266]

Contagious Disease

- An infectious disease (such as influenza, measles, or tuberculosis) that is transmitted by contact with an infected individual or infected bodily discharges or fluids (such as respiratory droplets), by contact with a contaminated surface or object, or by ingestion of contaminated food or water. See note under Communicable Disease.[267]

Correlation

- The state or relation of being correlated specifically: a relation existing between phenomena or things or between mathematical or statistical variables which tend to vary, be associated, or occur together in a way not expected on the basis of chance alone.[268]

D

Disease

- A condition of the living animal or plant body that impairs normal functioning and is typically manifested by distinguishing signs and symptoms.[269]

E

Effectiveness

- A measure of the accuracy or success of a diagnostic or therapeutic technique when carried out in an average clinical environment.[270]

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[266] Merriman-Webster Dictionary (2025)
[267] ibid
[268] ibid
[269] ibid
[270] STEDMAN'S MEDICAL DICTIONARY (2006).

Efficacy

- The extent to which a specific intervention, procedure, regimen or service produces a beneficial result under ideal circumstances.[271]

Emergency

- Any natural or manmade situation that results in injury, harm, or loss to humans or property.[272]

Endemic

- Prevalent in or peculiar to a locality or region.[273]

Epidemic

- See Outbreak.

Epidemiology

- The study of the distribution and determinants of health conditions or events among populations and the application of that study to control health problems.[274]

Eradicate

- To do away with as completely as by pulling up by the roots.[275]

Evidence

- Something that furnishes proof; specifically: something legally submitted to a tribunal to ascertain the truth of a matter.[276]

[271] Steadman's Medical Dictionary (2006)
[272] Public Health Accreditation Board Acronyms and Glossary of Terms (2022), citing Turnock, BJ. Public Health: What It Is and How Works (2009)
[273] Merriman-Webster Dictionary (2025)
[274] Public Health Accreditation Board Acronyms and Glossary of Terms (2022), citing Centers for Disease Control and Prevention, Principles of Epidemiology in Public Health Practice (ND).
[275] Merriman-Webster Dictionary (2025)
[276] Ibid

F

Fomite

- An object (such as a dish, doorknob, or article of clothing) that may be contaminated with infectious agents (such as bacteria or viruses) and serve in their transmission.[277]

Foodborne Illness

- An illness acquired after consuming contaminated food or drink.[278]

H

Health

- A dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity.[279]

Health Disparity

- A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion. See also Health Inequity.[280]

Health Equity

- Achieved when everyone has an opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their

[277] Merriman-Webster Dictionary (2025)
[278] United States Department of Agriculture (2025)
[279] Public Health Accreditation Board Acronyms and Glossary of Terms (2022), citing World Health Organization, 101st Session of the WHO Executive Board, Resolution EB101.R2 (1998).
[280] Public Health Accreditation Board Acronyms and Glossary of Terms (2022), citing the United States Department of Health and Human Services. The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. Health Equity Healthy People 2030 (2020).

consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.[281]

Health Inequity

- Differences in population health status and mortality rates that are systemic, patterned, unfair, unjust, and actionable, as opposed to random or caused by those who become ill. See also Health Disparity.[282]

Host

- A living organism on or in which a parasite lives.[283]

I

Immunization

- The act of making someone or something immune or the state of being immune: the act or result of immunizing someone or something: such as the production of immunity in a living organism against a disease or pathogenic agent; also: treatment (as by vaccination) for the purpose of making an organism immune to a disease or pathogenic agent: the administration of an immune-producing substance. See also Vaccine.[284]

- **Incidence**

  - The number of specified new events, e.g., people falling ill with a specified disease, during a specified period in a specified population.[285]

Incubation Period

- The period between the infection of an individual by a pathogen and the manifestation of the illness or disease it causes.[286]

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[281] Public Health Accreditation Board Acronyms and Glossary of Terms (2022), citing the PHAB IDEA Glossary of Terms (2022).
[282] Public Health Accreditation Board Acronyms and Glossary of Terms (2022), citing Whitehead, MM. The Concepts and Principles of Equity and Health (1992).
[283] Merriman-Webster Dictionary (2025)
[284] ibid
[285] Steadman's Medical Dictionary (2006)
[286] Merriman-Webster Dictionary (2025)

Infectious Disease

- A disease (such as influenza, malaria, meningitis, rabies, or tetanus) caused by the entrance into the body of pathogenic agents or microorganisms (such as bacteria, viruses, protozoans, or fungi) which grow and multiply there.[287]

Isolation

- The separation of persons who have a specific infectious illness from those who are healthy and the restriction of their movement to stop the spread of that illness. Isolation allows for the focused delivery of specialized health care to people who are ill and protects healthy people from getting sick.[288]

L

Legal Epidemiology

- The scientific study of law as a factor in the cause, distribution, and prevention of disease and injury.[289]

M

Morbidity

- The incidence of disease: the rate of illness (as in a specified population or group).[290]

Mortality

- The number of deaths in a population during a given time or place: the proportion of deaths to population.[291]

O

[287] Merriman-Webster Dictionary (2025)
[288] Public Health Accreditation Board Acronyms and Glossary of Terms (2022), citing Centers for Disease Control and Prevention. Public health emergency preparedness and response capabilities (2018).
[289] Public Health Accreditation Board Acronyms and Glossary of Terms (2022), citing Burris, et al. A Transdisciplinary Approach to Public Health Law: The Emerging Practice of Legal Epidemiology (2016).
[290] Merriman-Webster Dictionary (2025)
[291] Ibid

Outbreak

- The occurrence of cases of disease in excess of what would normally be expected in a defined community, geographical area or season. An outbreak may occur in a restricted geographical area or may extend over several countries. It may last for a few days or weeks, or for several years. A single case of a communicable disease long absent from a population or caused by an agent (e.g. bacterium or virus) not previously recognized in that community or area, or the emergence of a previously unknown disease, may also constitute an outbreak and should be reported and investigated.[292]

P

Pandemic

- An outbreak of a disease that occurs over a wide geographic area (such as multiple countries or continents) and typically affects a significant proportion of the population: a pandemic outbreak of a disease.[293]

Prevalence

- The degree to which something is prevalent especially: the percentage of a population that is affected with a particular disease at a given time.[294]

Public Health

- The mission of public health is to fulfill society's desire to create conditions so that people can be healthy. Public health includes the activities that society undertakes to assure the conditions in which people can be healthy. These include organized community efforts to prevent, identify and counter threats to the health of the public.

  Public health is the:

  - science and the art of preventing disease, prolonging life, and promoting physical health and mental health and efficiency through organized community efforts toward a sanitary environment.

[292] Public Health Accreditation Board Acronyms and Glossary of Terms (2022), citing World Health Organization. Disease Outbreaks (2022).
[293] Merriman-Webster Dictionary (2025)
[294] Ibid

- control of community infections; the education of the individual in principles of personal hygiene.

- organization of medical and nursing service for the early diagnosis and treatment of disease; and

- development of the social machinery to ensure every individual in the community a standard of living adequate for the maintenance of health.[295]

Public Health Emergency

- An occurrence or imminent threat of an illness or health condition, caused by bioterrorism, epidemic or pandemic disease, or novel and highly infectious agent or biological toxin, that poses a substantial risk of a significant number of human fatalities or incidents of permanent or long-term disability. Such illness or health condition includes, but is not limited to, an illness or health condition resulting from a natural disaster.[296]

Public Health Law

- The study of the legal powers and duties of the state to assure the conditions for people to be healthy (e.g., to identify, prevent, and ameliorate risks to health in the population) and the limitations on the power of the state to constrain the autonomy, privacy, liberty, proprietary, or other legally protected interests of individuals for the protection or promotion of community health. The prime objective of public health law is to pursue the highest possible level of physical and mental health in the population, consistent with the values of social justice.[297]

[295] Public Health Accreditation Board Acronyms and Glossary of Terms (2022), citing Gostin, L. et al. Public Health Statute Modernization National Excellence Collaborative, Turning Point, Model State Public Health Act: A Tool for Assessing Public Health Laws 15 (Sept. 2003)
[296] Public Health Accreditation Board Acronyms and Glossary of Terms (2022)
[297] Lawrence O. Gostin, "A Theory and Definition of Public Health Law," 10 J. Health Care L. & Pol'y 1-12 (2007).

Q

Quarantine

- The separation and restriction of movement of people who were exposed to a contagious disease to see if they become sick.[298]

R

Reportable Disease

- A reportable disease is a disease that, by law, must be reported to public health authorities upon diagnosis.[299]

S

Sample

- A finite part of a statistical population whose properties are studied to gain information about the whole.[300]

Screen

- To examine usually methodically in order to make a separation into different groups; (2) to select or eliminate by a screening process; (3) to test or examine for the presence of something (such as a disease).[301]

Social Determinants of Health

- The conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities – the unfair

[298] Public Health Accreditation Board Acronyms and Glossary of Terms (2022), citing Centers for Disease Control and Prevention. Public health emergency preparedness and response capabilities (2018).
[299] Public Health Accreditation Board Acronyms and Glossary of Terms (2022), citing Centers for Disease Control and Prevention. Principles of Epidemiology in Public Health Practice (2012).
[300] Merriman-Webster Dictionary (2025)
[301] Ibid

and avoidable differences in health status seen within and between countries.[302]

Species

- A group of organisms that generally bear a close resemblance to one another in the more essential features of their organization, and breed effectively producing fertile progeny.[303]

Specificity

- The quality or condition of being specific: such as the condition of being peculiar to a particular individual or group of organisms.[304]

Surveillance

- The ongoing, systematic collection, analysis, and interpretation of health-related data essential to planning, implementation, and evaluation of public health practice.[305]

- Close watch kept over someone or something (as by a detective).[306]

Suspect

- To think a person guilty without proof. One that is suspected, such as of a crime, or of a disease.[307]

T

Toxin

- A poisonous substance that is a specific product of the metabolic activities of a living organism and is usually very unstable, notably toxic when introduced into the tissues, and typically capable of inducing antibody formation.[308]

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[302] Public Health Accreditation Board Acronyms and Glossary of Terms (2022), citing World Health Organization. Health Topics: Social Determinants of Health (2012).
[303] Merriman-Webster Dictionary (2025)
[304] ibid
[305] Public Health Accreditation Board Acronyms and Glossary of Terms (2022), citing Thacker, SB, Birkhead, GS. Surveillance, in Gregg MB ed. Field Epidemiology (2008).
[306] Merriman-Webster Dictionary (2025)
[307] ibid
[308] ibid

Transmission

- The conveyance of disease from one person to another.[309]

V

Vaccine

- A preparation that is administered (as by injection) to stimulate the body's immune response against a specific infectious agent or disease. Note, vaccination is the act of getting a vaccine. See also Immunization.[310]

Validity

- The quality of being well-grounded, sound, or correct.[311]

Vector

- An organism (such as an insect) that transmits a pathogen from one organism or source to another.[312]

Virus

- Any of a large group of submicroscopic infectious agents that are usually regarded as nonliving extremely complex molecules, that typically contain a protein coat surrounding an RNA or DNA core of genetic material but no semipermeable membrane, that are capable of growth and multiplication only in living cells, and that cause various important diseases in humans, animals, and plants symptomatology, and other factors; b) a disease or illness caused by a virus; c) the causative agent of an infectious disease.[313]

Vital Statistics

- Statistics relating to births, deaths, marriages, health, and disease.[314]

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[309] Steadman's Medical Dictionary (2006)
[310] Merriman-Webster Dictionary (2025)
[311] ibid
[312] ibid
[313] ibid
[314] ibid

Z

Zoonosis

- An infection or disease that is transmissible from animals to humans under natural conditions.[315]

[315] Merriman-Webster Dictionary (2025)

Appendix C: Table of Cases

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Appendix D: Select Model Judicial Petitions and Orders

A. Transport and/or Temporary Detention

- PC 109, Affidavit to Accompany Petition for Transport and/or Temporary Detention
- PC 110, Petition and Ex Parte Order for Transport and/or Temporary Detention
- PC 111, Notice of Hearing on Petition for Temporary Detention
- PC 112, Order Following Hearing on Petition to Continue Temporary Detention

B. Commitment Review Panel

- PC 107, Order Appointing Commitment Review Panel
- PC 108, Recommendation of Commitment Review Panel
- PC 113, Appeal of Commitment and Order to Reconvene Commitment Review Panel

C. Infectious Disease Testing

- MC 72, Petition for Testing of Infectious Disease
- MC 73, Notice of Hearing on Petition for Testing of Infectious Disease
- MC 74, Order Following Hearing on Petition for Testing of Infectious Disease

D. Infectious Disease Treatment

- PC 104, Petition for Treatment of Infectious Disease
- PC 105, Notice of Hearing on Petition for Treatment of Infectious Disease

- PC 106, Order Following Hearing on Petition for Treatment of Infectious Disease

- PC 114, Order Following Appeal of Commitment for Treatment of Infectious Disease

E. Continued Infectious Disease Treatment

- PC 115, Petition for Continued Commitment for Treatment of Infectious Disease and Order to Reconvene Commitment Review Panel

- PC 116, Order Following Hearing on Petition for Continued Commitment for Treatment of Infectious Disease

F. Request for Interpreter

- Request, and Review of Request for Interpreter Forms

G. Authorization for Release of Medical Information

- MC 315, Authorization for Release of Medical Information

Appendix E: Additional Resources

A. Michigan Laws

- Michigan Public Health Code
- Michigan Administrative Rules
- Communicable and Related Diseases
- Supplying Water to the Public
- Michigan Food Law
- Michigan Food Code
- Michigan Freedom of Information Act

B. Michigan Specific Resources

- Michigan's Guide to Public Health for Local Governing Entities
- Michigan HIV Law Guide
- Commentary on the Michigan Public Health Code
- Wastewater Permitting Authorities – Explained: A Guide for Local Health Departments

C. General State Resources

- Legal Aspects of Public Health Emergency Preparedness
- Practical Law for Public Health Officials
- Resolve to Save Lives: 12 Characteristics of an Effective Public Health Emergency Law
- Prevention Measures Law Project 3.0
- Protected Health Information Consent Tool

D. Federal Laws

- Health Insurance Portability and Accountability Act
- Public Health Service Act
- Title 42, Code of Federal Regulations

E. Federal Resources

- ASPR Legal Authorities, Policies and Strategies
- Selected Federal Public Health Legal Authorities Pertinent to Public Health Emergencies

F. Books/Chapters

- Health Policy 101: U.S. Public Health
- The New Public Health Law
- Public Health Law in a Nutshell

G. Legal Datasets

- Emergency Law Inventory
- Law Atlas
- National Conference of State Legislatures Legislative Tracking Database

H. Organizations Involved in Public Health Law

- Association of State and Territorial Health Officials (ASTHO) State Health Policy Department
- CDC Office of Public Health Law Services
- ChangeLab Solutions
- National Association of County & City Health Officials (NACCHO) Public Health Law and Policy
- Network for Public Health Law

- Public Health Law Center
- Public Health Law Watch
- Public Health Law Research

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MDHHS-Pub-2198 (6-25).