qrulepubliccomments

From: Andrus, Katherine [KAndrus@airlines.org]
Sent: Wednesday, March 01, 2006 12:13 PM
To: qrulepubliccomments
Subject: Comments on Q Rule
Attachments: CDCNPRMcomments030106.pdf

Attached please find the comments of the Air Transport Association on the Notice of Proposed Rulemaking published in the Federal Registe on November 30, 2005.

Katherine B. Andrus
Assistant General Counsel
Air Transport Association of America, Inc.
1301 Pennsylvania Ave. N.W., Suite 1100
Washington, D.C. 20004-1707
tel: 202-626-4091
fax:202-626-4139
<<CDCNPRMcomments030106.pdf>>

AIR TRANSPORT ASSOCIATION

Ms. Jennifer Brooks
Centers for Disease Control and Prevention
Division of Global Migration and Quarantine
1600 Clifton Road, N.E. (E03)
Atlanta, GA 30333

Re: Control of Communicable Diseases ("Q Rule")

Dear Ms. Brooks:

The Air Transport Association of America, Inc. ("ATA") represents the major commercial airlines in the United States.[1] On behalf of its members, ATA respectfully submits the following comments on the Notice of Proposed Rulemaking ("NPRM") regarding Control of Communicable Diseases, published in the Federal Register on November 30, 2005.[2]

I. INTRODUCTION

In proposing to "update existing regulations related to preventing the introduction, transmission, or spread of communicable diseases," the Centers for Disease Control and Prevention ("CDC") is undertaking the task of modernizing, streamlining and clarifying requirements that in many cases have been in place for decades but rarely (if ever) invoked in recent times. In particular, harmonizing the provisions applicable to interstate activities (42 C.F.R. part 70) with those applicable to foreign arrivals (42 C.F.R. part 71)

[1] ATA airline members are: ABX Air, Inc., Alaska Airlines, Inc., Aloha Airlines, American Airlines, Inc., ASTAR Air Cargo, Inc., ATA Airlines, Inc., Atlas Air, Inc., Continental Airlines, Inc., Delta Air Lines, Inc., Evergreen International Airlines, Inc., FedEx Corporation, Hawaiian Airlines, JetBlue Airways Corp., Midwest Airlines, Inc., Northwest Airlines, Inc., Southwest Airlines Co., United Airlines, Inc., UPS Airlines, US Airways, Inc. ATA Airline Associate Members are: Aeromexico, Air Canada, Air Jamaica Ltd., and Mexicana.

[2] 70 Fed. Reg. 71892 (Nov. 30, 2005).

will simplify compliance for those airlines[3] that operate both domestically and internationally.

In several significant respects, however, the NPRM greatly exceeds the stated intent to *update existing* regulations by imposing *entirely new and unprecedented* regulatory requirements on one sector of private industry: commercial passenger airlines that provide scheduled service. In particular, the proposed requirements regarding the collection, storage and transmission of passenger data represent an unwarranted and insupportable burden on an industry sector that can ill-afford it, without adequate discussion or consideration of alternatives that could accomplish the same public health goals with greater efficiency and at less cost.

Similarly, the NPRM adds a new requirement for airlines to disseminate public health information, and expands the long-standing requirement for airports to provide space for carrying out federal quarantine responsibilities to include space suitable for the quarantine of large groups of passengers and crew for extended periods, thereby imposing another significant burden on the air transportation sector without any consideration of costs or alternatives, as required under the Unfunded Mandates Reform Act, 2 U.S.C. § 1501, and other law.

In addition, the NPRM presents no strong evidence that scheduled air travel uniquely facilitates communication of disease, begging the question of why airlines and cruise ships have been singled out for massive regulation and associated costs. The exclusion of non-scheduled operations is confounding, particularly as much of the international passenger service is conducted by charter operators. No other mode or sector has been similarly targeted despite ample evidence that disease can be spread in the course of travel on buses, subways and ferries, or in casinos, theaters, offices, and other settings. We urge CDC to refocus its proposed rulemaking to include all modes and settings where

[3] In industry parlance and under other laws, "air carrier" or "carrier" is used to refer to an airline (i.e., the company that operates the aircraft). The NPRM defines "airline" to include "air carrier," but also defines "carrier" to mean airline *or* aircraft. In the interest of clarity, these comments will use the terms "airline" to mean the corporate entity and "aircraft" to refer to the conveyance in paraphrasing or discussing the proposed provisions. We recommend that the definitions be revised to remove this ambiguity.

transmission of communicable disease may be a concern, and not to focus on airlines exclusively to protect the public health, which would be unfair, unlawful and discriminatory.

The Public Health Service Act and other legal authority discussed in the NPRM do not authorize regulations that are unnecessary, discriminatory or impose an unreasonable burden on airlines and, to the extent that certain provisions of the NPRM do so, ATA believes such provisions exceed CDC's authority. ATA urges CDC to revise its proposal to require only those measures appropriate to the current public health situation and necessary to enable a scaled response to future public health emergencies, and to refrain from embarking on extensive, costly and unjustified regulation of the airline industry.

We address each of these proposed requirements in detail below, along with proposed changes to existing provisions of 42 C.F.R. parts 70 and 71.[4] In addition, because many provisions of the existing regulations have been implemented so infrequently, we offer comments in some cases even where no change is proposed in the NPRM. Because of the scope and significance of proposed requirements relating to passenger information, we address that issue first. We also address the assumptions and conclusions of Regulatory Impact Analysis ("RIA") as it applies to the projected costs and benefits of the passenger information requirements in that section.[5] Next, we offer our views on the legal authority of CDC relative to interstate and intrastate airline operations. Other provisions are addressed in the general order in which they are presented in the NPRM, although we have grouped some related provisions out of sequence.

[4] All references are to Title 42 of the Code of Federal Regulations unless otherwise specified. Where there are parallel provisions in 42 C.F.R. part 70 and part 71 we address them together.

[5] ATA notes that the RIA cited in the NPRM and made available through the rulemaking record is dated September 26, 2005 and is labeled "Draft – Do Not Copy or Cite." It is unclear what the implications of relying on a draft analysis might be for the NPRM itself, and we question whether the analysis was in fact subjected to sufficient internal agency review and approval prior to its use in developing the NPRM. In any case, these comments will cite only to the Federal Register notice, and not to the Draft RIA in accordance with those instructions.

II. PASSENGER INFORMATION

Proposed §§ 70.4, 70.5, 71.10 and 71.11 would impose sweeping new requirements on airlines to solicit, retain, and transmit passenger and crew data.[6] The requirements would apply to U.S. *and* foreign flag airlines that provide scheduled service on international or interstate flights operating into any medium or large hub U.S. airport.[7] Some of the data that airlines would be required to solicit from passengers and crewmembers would go well beyond data currently collected for other governmental purposes or for commercial reasons and, as further detailed below, may conflict with foreign data privacy laws. Even more problematic, CDC reserves its authority to order the airline to transmit additional (but undefined) data in its possession when necessary.

CDC proposes that data collected must be retained in an electronic database for 60 days from the end of the flight, and upon request from the CDC, the airline must transmit the data electronically within 12 hours.[8] This requirement alone represents a significant change from the current system, under which airlines may house data in different locations, and not all data is stored electronically or in the same format. For example, information on crew members and nonrevenue passengers (*e.g.*, persons traveling on passes) typically is kept in a separate record system.

---

[6] Specifically, the CDC seeks to require the collection and retention of the following data elements: passenger's full name (first, last, middle initial, suffix); home address, phone number(s), e-mail address, traveling companion(s), "emergency contact information" [defined by CDC as the following information for a person or entity that can contact a passenger/crew member in case of emergency: Full name (first, last, middle initial, suffix), permanent address, phone number (home/work/mobile); "flight information" [defined by the CDC as: airline name (not airline code), flight number, city of arrival, date of arrival, date of departure, seat number for any passenger/crew member, arrival gate and arrival terminal]; returning flight information; passport number or travel document number (including the country of issuance for foreign nationals).

[7] The definition of "airline" at proposed § 70.1 covers "any air carrier, foreign or domestic, operating commercial passenger flights under regular schedules within the United States," while proposed §71.1 uses the same definition with the exception of the last clause, which reads "arriving in or departing from the United States. Putting aside the question of whether any foreign air carrier could, under existing law on cabotage, operate "within the United States," the definition excludes non-scheduled (i.e., charter and itinerant operations).

[8] The NPRM does not define "electronic database" or "electronic format." ATA assumes that the intent is to develop a single format, as discussed below, to allow CDC to receive electronic transmissions from all entities potentially subject to this requirement.

In many respects, CDC's proposals regarding collection and transmission of passenger information overlaps with or duplicates other efforts underway at the Department of Homeland Security ("DHS"): in particular, Advanced Passenger Information Quick Query ("AQQ"), under development by the Bureau of Customs and Border Protection ("CBP"), and the Transportation Security Administration's ("TSA") Secure Flight program or its successor.[9] In addition, some of the information requested is already collected under Department of Transportation ("DOT") regulations set forth at 14 C.F.R. part 243, although that regulation expressly precludes the data from being retained or shared with CDC**.**

Inexplicably, the NPRM includes no discussion of the Memorandum of Understanding ("MOU") recently executed between HHS and DHS. This MOU has not been made publicly available, but reportedly includes provisions for data sharing, including allowing CDC access to passenger information, including Passenger Name Records, through CBP. Although the NPRM's paperwork reduction analysis notes that CDC and DHS "are exploring options to reduce the potential burden of dual reporting" (70 Fed. Reg. 71925), there is no indication in the proposed regulations of how or when that might occur.

Until CDC has fully exhausted any possibility of receiving the data it requires from other U.S. government agencies it should suspend the passenger data collection element of this rulemaking. The staggering direct and indirect costs to airlines, passengers, intermediaries such as travel agents of CDC's proposed rule require that CDC not shift the burden of data solicitation, collection and storage to the travel industry and general public unless it can fully account for and justify all of these costs. This is necessary not only as a matter of public policy, but to satisfy the Office of Management and Budget ("OMB"), which must review all information collection requirements proposed by new regulations to validate that the burdens on the airline industry are justified and lawful. ATA urges CDC to defer any final action on this aspect of the NPRM until alternatives, including coordination with DHS and other federal departments and agencies, have been

[9] The CDC uniquely would require that airlines retain data that they may not require for commercial purposes beyond the end of a flight for an extended period after the end of the passenger's journey.

fully explored and evaluated with industry stakeholders. CDC, along with CBP, TSA, and any other relevant agencies must coordinate their activities and develop a single set of requirements for passenger information to ensure that airlines are not burdened with the cost of programming, collection and transmission under multiple systems.

The NPRM also ignores the substantial effort and significant achievement involved in the development of a passenger locator form ("PLF") since the outbreak of Severe Acute Respiratory Syndrome ("SARS") in 2003. As early as May 2003, representatives of CDC, the World Health Organization ("WHO"), ATA, the International Air Transport Association ("IATA") and the International Civil Aviation Organization ("ICAO") met to discuss ways to improve passenger contact tracing. Out of those initial conversations came an agreed-upon approach utilizing a machine-scannable format and standard data elements on a paper form to be completed by passengers and used in the event of a public health emergency with international implications.

CDC completed their version of this form, obtained clearance from the Office of Management and Budget, and distributed it to ATA members for use if directed by CDC. IATA more recently obtained approval from WHO for an international version of the PLF, and discussions about modifications to further harmonize and improve the forms are ongoing. While CDC may not consider this paper-based system ideal in the long-term, it represents a significant improvement over the situation experienced by CDC during the SARS outbreak when airlines express-mailed paper records to CDC, but CDC lacked the manpower to extract the relevant data from these records and transmit it efficiently to state health authorities.

Furthermore, and as discussed below, by failing to acknowledge the post-SARS improvements in passenger contact tracing the NPRM erroneously attributes greater benefit to the proposed system than it merits. The development of a machine-scannable form with consistent data elements would allow CDC to process this information far more rapidly, and provides an immediate mechanism for responding to outbreaks of disease. It also enables collection of information directly from passengers, thus avoiding

many practical and privacy concerns with requiring the airlines to collect such data.

As explained in greater detail below, this proposal constitutes an unwarranted financial and operational burden on certain segments of the airline industry and is unworkable on technical, legal and economic grounds. The airline industry simply cannot continually reprogram or create new computer systems to meet multiple uncoordinated government requirements. Passenger fatigue with government mandates unique to air travel is increasing. Moreover, any transfer of passenger information to government agencies raises privacy concerns both with U.S. citizens and foreign governments, and may in fact violate foreign laws – issues that can only be addressed at the federal level and must be consistently and fully settled before any rule becomes final. For all of the foregoing reasons, we believe it is essential that HHS and DHS coordinate closely on passenger information requirements for security and public health purposes.

In February 2006 a joint working group of ATA and IATA met in Atlanta to begin to identify shared concerns regarding provision of passenger information to government agencies and possible approaches to address them, including the "single window" concept under which airlines would send data to one agency, which in turn would be responsible for maintaining and protecting the data and disseminating the appropriate portions of the data to authorized government entities. This ATA/IATA working group, which is scheduled to meet for a second time in early March 2006 and which we anticipate will continue to meet on a regular basis, offers a forum for further discussion and exploration of potential solutions. While we believe it is premature to recommend a detailed substitute for the NPRM's proposed requirements pending further discussion among the relevant agencies, ATA believes that alternatives exist that would significantly reduce the burden on the airlines while still achieving CDC's public health goals. CDC should issue a new notice of proposed rulemaking following the completion of this process to avoid the proliferation of duplicative and conflicting requirements among federal departments and agencies and enable the public to comment on a more realistic and reasonable proposal.

A. Privacy Issues

CDC's passenger information collection and reporting proposal is unworkable and imposes an unjustified burden on not only airlines but passengers. In addition, and as indicated by many of the comments already received from private citizens, the proposal will not receive the cooperation of the general public. CDC discounts the potential for privacy concerns associated with the provision of personal data for public health purposes, and asserts that collection of this information "finds strong support in public opinions," based on a survey commissioned by CDC from the Harvard School of Public Health ("Harvard survey"). However, the NPRM's overall reliance on the results of the Harvard survey is misplaced.

The Harvard survey was conducted in June 2004, just one year after the well-publicized SARS outbreak which produced widespread public alarm about the threat of emerging diseases, and specifically mentioned SARS in many of the questions. The question that asked respondents whether they would be willing to provide personal information is prefaced by (and predicated on) the statement "If you had been on an airplane with someone who had a highly contagious disease, public health authorities would want to contact you as quickly as possible." This is akin to asking travelers whether, if they knew that one of their fellow passengers was carrying a bomb, they would be willing to be subjected to a full search at the security checkpoint. Asking if the respondent would be willing to provide the information on a speculative and prospective basis for each flight, on the remote chance that a particular flight might include someone in the communicable stage of a communicable disease with whom the respondent might have come in contact, might elicit a more realistic response.

Moreover, it appears that well over half of the respondents to the question asking how concerned they would be that the privacy of their emergency contact information would not be protected indicated that they would be very concerned or somewhat concerned.[10] This view is echoed in some of the comments already filed in the docket for the NPRM,

[10] ATA was unable to calculate the precise percentage due to insufficient information about the Harvard survey methods in the report provided to ATA.

which indicate that privacy concerns may in fact raise significant hurdles to CDC's proposal.[11]

Despite the fact that CDC's own contractor, Eastern Research Group, Inc. ("ERG"), noted that the proposal runs afoul of privacy law abroad, CDC's proposal completely disregards the impact of privacy laws in other countries. Airlines providing international service are placed airlines in an untenable position of being forced to choose between violating U.S. requirements or foreign laws to which they may also be subject. The most obvious example of a potential conflict with privacy concerns is with the European Union ("EU"), which imposes stringent requirements for protecting personal information, and particularly so-called "personal data" which includes home address, e-mail and telephone number, all of which the CDC proposal would cause airlines to solicit, retain and transmit to the CDC upon request. Under EU law, personal data can be collected only with the individual consent of the person to whom it belongs for the express purpose or use intended. In other words, provision of emergency contact information as proposed by CDC would also require the express consent of the individual listed as the contact, not just of the traveler. It would be a practical impossibility for airlines to obtain such consent from third parties.

The airline industry's recent experience with security requirements is instructive, and CDC should not assume that their rules would be met with a different response. It could be assumed that the public's interest in being protected against terrorist incidents is at least equal to its interest in being protected from serious health threats, yet post-9/11 security measures that involved sharing personal data with government agencies have met with significant opposition and concern from both U.S. citizens and foreign governments. DHS, through CBP, undertook lengthy negotiations with respect to requirements under U.S. law[12] for airlines to provide access to certain Passenger Name Record data for flights between the U.S. and EU member states. Those negotiations eventually produced a document containing a set of representations regarding the manner

[11] *See, e.g.,* Comments of the Electronic Privacy Information Center and joint comments submitted by Privacy Activism, Privacy Rights Clearinghouse, and the Fairfax County Privacy Council.
[12] 49 U.S.C. 44909 and implementing regulations at 10 C.F.R. 122.49b.

in which CBP would handle this data, which allowed the EU to make an "adequacy finding," and an international agreement executed by the European Council.[13] A recent opinion of the Advocate General of the European Court of Justice, however, throws into question not only the validity of that agreement and the adequacy finding but also leaves uncertain the correct EU interlocutor for agreements involving personal data. Airlines may, therefore, find themselves in their original position of being caught in a conflict between two applicable laws.

The NPRM states that "[a]irlines are expected to safeguard the confidentiality of the information collected" until such time as it may be requested by CDC. While airlines do have privacy policies in place, these privacy policies cannot ensure that the *government* would use the information it demands appropriately. Although CDC notes that it has a long history of managing sensitive data in a manner that protects confidentiality and privacy of the public, and proposes that it will create a records control schedule for data received from airlines (*see* 70 Fed. Reg. 71900), this may not be sufficient to satisfy privacy concerns, particularly with respect to the EU. Comments already in the docket make clear state and local public health authorities' and medical facilities' desire for data that may originate with airlines, raising another level of privacy concerns.

Moreover, privacy laws of multiple countries would have to be analyzed, since these laws may attach to data collected from a citizen of a particular country (or collected from that individual via telephone, travel agent or Internet reservation while that individual was in a particular country) even if the travel itself occurred elsewhere (*e.g.*, a German citizen providing information via telephone for a U.S. codeshare flight between Paris and New York might be covered under German privacy laws). These laws also pertain to data that is merely stored in EU member states, a potentially serious concern for airlines and GDSs that store data in member states. The CDC apparently has not yet fulfilled its obligation to perform and publish a Privacy Impact Assessment for this project as required by the E-government Act of 2002. ATA urges CDC to complete a PIA and looks forward to the opportunity to review it.

[13] *See* 69 Fed. Reg. 41543 (July 9, 2004).

Unless these requirements are harmonized, airlines are put in the untenable position of trying to comply with myriad and conflicting privacy laws and requirements, which likely would expose airlines to litigation for alleged violations of privacy laws of various countries. Complying with CDC or other federal government requirements would be objectionable to some other countries, which would be in the position to take enforcement action against airlines, and their nationals would likely be in the position to litigate against the airlines. CDC should coordinate with the U.S. State Department to harmonize these proposed requirements with other international privacy laws and regulations to avoid creating yet another legal quandary for airlines.

B. Scope of Data

Proposed §§ 70.4(e) and 71.10(e) would require airlines to solicit from each passenger not only their full name (first, last, middle initial and suffix) but also current home address (street, apartment #, city, state/province, postal code), at least one phone number (in order of preference: mobile, home, pager or work), e-mail address, emergency contact information (*i.e.*, the full name, address and phone for a person other than the passenger), passport/travel document number (for foreign nationals only), name(s) of traveling companion(s) or group, flight information (airline name, flight number, city of arrival, date of arrival, date of departure, seat number for any passenger or crewmember, arrival gate and arrival terminal), and returning flight (date, airline number and flight number). The proposed data elements are based on CDC's assessment of what information is useful in order to contact a person who may be traveling (*i.e.*, away from home). Their relative utility, according to CDC, is name, emergency contact, flight information, phone number, e-mail, home address, passport, traveling companions and return flight information, in that order.

Each of these elements must be assessed not only in terms of potential utility in contacting an individual, but also in terms of marginal utility (when seen in addition to other passenger data), availability, privacy, ease or difficulty of establishing standards for data entry, time required to provide (for the passenger or the passenger's representative) and record the information (for the airline, agent or traveler), and likelihood that the

information would be accurate or remain current. Airlines have no ability to validate data that would be required by CDC, or otherwise to ensure that it is correct and reliable for the public health purposes for which it would be collected. Based on the consistent experience of airlines in collecting extensive personal data, they also would experience substantial difficulty in obtaining passenger cooperation. Even if passengers were willing to provide personal data, many people would not have all of this information readily available at the time of booking or at the airport. This process will inevitably slow the process of purchasing air transportation and/or increase the time needed to check in for a flight at the airport, and would create enormous burdens on airlines and passengers alike.

The enormous information collection burdens on airlines and on passengers will be subject to OMB review. Before investing more resources in the formal rulemaking process for this proposal, CDC should carefully consider the comments received on this NPRM and craft a more reasonable and workable proposal based on those comments and on coordination with other government agencies. Interested parties should be given another opportunity to comment after this consideration takes place.

While the availability of some passenger information may depend in large part on the outcome of pending initiatives related to security, many data elements present obvious problems in other respects. The following are just some examples:

- Asking passengers to provide personal data about another person (*i.e.*, emergency contact) adds a level of complexity to compliance with European privacy laws that makes it infeasible and potentially illegal for an airline to carry out. Merely correctly identifying those to whom such data protections apply would be a staggering task.
- Identifying traveling companions is an extremely complicated issue, particularly where reservations have been made and tickets paid for separately.
- E-mail addresses are carefully guarded by many people as a means of protecting themselves against unsolicited e-mail or spam.
- Home addresses outside of the U.S. pose challenges because conventions for addresses vary considerably from country to country.
- Return flight information may be unavailable (many travelers make open-ended reservations even on a round-trip ticket) and is always subject to change. CDC's purpose in requiring return flight information is unclear. Moreover, it is unclear

what authority CDC would have to contact individuals who are no longer in the U.S., or whether the intent is to further share this personal data with the health authority in another country.

- Obtaining travel document information would present challenges unless it is limited to those individuals for whom this information is already collected for customs and immigrations purposes. Even if limited to foreign nationals, collecting this information on domestic flights, as required under proposed § 70.4(e)(5), would necessitate that airlines inquire about a passenger's citizenship status in a context where that information is otherwise irrelevant.
- Arrival gate (and in some cases arrival terminal) information generally is not determined until shortly before the flight departs, and even then is subject to change. It is unclear how CDC would use this information, or why it should be collected for each passenger on a given flight.

The NPRM does not make provision of any of this data mandatory – passengers who decline to furnish the information requested by the airline would not be prohibited from traveling (70 Fed. Reg. 71899). CDC assumes that travelers will be willing to provide this information voluntarily, but that assumption appears to be based almost entirely on the flawed Harvard survey, discussed above. The airline industry's experience with the DOT requirements, under which most of the data elements are optional, suggests otherwise. In a survey conducted by one member airline in January 2006, it found that less than one percent of a sample of over 500 passengers on three international flights provided the information sought in DOT's voluntary information collection procedure. We note that the information sought in the DOT requirement is far more limited than that which CDC seeks, and that the same member's experience with surveys generally shows that longer surveys enjoy lower completion rates.

In order to protect public health by making timely contact with individuals exposed to a serious communicable disease, CDC requires reliable and complete data on a relatively small number of people in an even smaller number of instances. Requiring the airlines to solicit information that is unlikely to be provided on any consistent basis, and create systems that can handle data fields that may never be filled in is over-regulation of the worst kind. The fact that the NPRM is based on the voluntary provision of data guarantees that airlines would be forced to collect massive amounts of information that will never be used while the data airlines receive and store may well be inaccurate or

insufficient to contact such individuals quickly. Simply put, a low voluntary compliance rate and/or provision by passengers of less-than-accurate information would destroy the purported benefit of the proposal.

Rather than unreflectively imposing a redundant system to collect data that already exist, CDC should reduce the burden on airlines and explore ways to use data already collected for other public purposes or commercial reasons. Data elements that do not clearly further CDC's stated goal of contacting passengers and crew members, such as arrival gate and return flight information, should be omitted altogether. CDC should evaluate the need for additional data based on the factors suggested above, and consider other means of obtaining data that might be desirable but cannot reasonably be collected, verified or maintained by airlines. By way of example, CDC should examine the Travel Registration program, which allows U.S. citizens to register information about their intended travel directly with the Department of State via the agency's web site (*see* https://travelregistration.state.gov/ibrs/). Use of the PLF or some other version of a paper-based, machine-scannable system should also be considered as an interim or supplemental measure to obtain data elements that are not otherwise readily available or that raise particularly sensitive privacy concerns. In both of these examples, information is provided by the passenger on a voluntary basis directly to the U.S. government, thus bypassing some of the privacy issues associated with the proposed rule.

C. Collection of Data

Under proposed §§ 70.4(h) and 71.10(h), airlines must ensure that passengers are informed of the purposes of collecting the information at the time they make their travel arrangements. This requirement is both impossible for airlines to guarantee given the many intermediaries that take travel reservations, and unlikely to yield the result that CDC appears to seek (*i.e.*, greater compliance on the part of passengers). Moreover, this requirement would add a significant amount of time, and hence cost, to the reservations process and would preclude efficient use of data that is already being collected for other purposes since it would introduce an additional and unnecessary step to the reservations process.

For data elements that also are required by other agencies, or that may be collected by airlines for their own purposes, requiring this additional step is simply a waste of time and effort. One can envision the almost-comical scene in which a passenger is first asked for his phone number for security purposes, then again for public health purposes, and again so that the airline can contact him in the event of a schedule change. For other data elements, requiring that passengers are informed of the purpose of collecting the information at the time of booking could give rise to protracted discussions between the passenger and the booking agent regarding specific health risks, and possible scenarios under which the information might employed, that airline employees and travel agents might be ill-equipped to handle.

Finally, the time required to adequately inform the passenger and answer ensuing questions could be many times that estimated in the RIA. One ATA member estimates that explaining and justifying the additional data request could take an additional *5-10 minutes*, instead of the 75-90 seconds assumed by CDC. This added time would significantly adversely impact airline operations as well as the public's ability to travel. For example, a 5-minute-per-passenger check in time could translate to a requirement for passenger to arrive at the airport several hours prior to flight departure in order to provide the additional information during check-in. Moreover, the cost of this requirement could be hundreds of millions of dollars. This represents an unacceptable burden on airlines and the traveling public, particularly when there are other available means to address public health emergencies with scaled responses and the continued cooperation of airlines in this process.

The requirement that passengers be informed of the purposes of collecting the information at the time they arrange their travel is not reflected in the RIA, which presents only two scenarios: collection of passenger data at point of sale ("POS") and at point of departure ("POD") (70 Fed. Reg. 71914, 71916). It is unclear whether by "point of sale" the RIA is referring to the same event as when "passengers arrange their travel," since passengers may make reservations well in advance of booking their ticket.

Moreover, the description of data collection under the POS scenario as "relatively invisible to the traveler," 70 Fed. Reg. 71914, is at odds with this requirement. However, it is clear that under the POD scenario, airlines would have to have informed the passenger of the purpose of collecting the data at some prior point and through another mechanism, adding additional costs and operational impacts.

Proposed §§ 70.4(g) and 71.10(g), requires that information collected solely in order to comply with the regulation may only be used for that purpose. Given the overlapping information requirement of other federal agencies, as well as the need for some of this data for customer service reasons, it is unlikely that airlines could easily segregate data collected solely for purposes of compliance with this rule. Furthermore, it is unclear what this requirement would accomplish. While passengers can be expected to have concerns about the use that their personal data might be put to by the government, airlines are not in a position to guarantee the use of the data for specific purposes once it is turned over to the CDC.

While the proposed rule itself does not prescribe the means by which this information would be collected, the RIA, as mentioned above, describes two possibilities. Neither scenario addresses collection of crew information, which could not reasonably be collected at either of these points and which is maintained and updated in a separate system. Under the POS scenario, CDC assumes that data would be gathered primarily by travel agents and/or Global Distribution Systems ("GDS") and shared with the airlines for storage and future retrieval. This is an unrealistic assumption, and ignores the strong competitive reasons that these companies might have for refusing to collect and/or to share this data or the costs associated with its collection, storage and transmittal.

Furthermore, airlines may have to pay GDSs for any data that is stored on their behalf, and may be required to negotiate an agreement for the format for data exchange, adding to the airlines' costs. Since the proposed requirements do not place travel agents and GDSs under any direct legal obligation, they would not be motivated to collect such data (due to associated costs) and would furthermore have a disincentive to provide valuable

marketing information to the airlines, which compete with them for this business. Also, without a legal compulsion to collect passengers' personal data, privacy laws in the countries where travel agents and GDSs are sited likely would limit or prohibit collection or data for ultimate dissemination to CDC.

Significantly more than half of total airline bookings are made through intermediaries such as travel agents and GDSs. Because these intermediaries would not be legally required to solicit, collect or share passenger information with the airlines under the NPRM, even under the POS scenario airlines could be placed in the position of having to solicit data at the point of departure if an agent has failed to do so during the booking process. Such a requirement would guarantee airport congestion and traveler confusion. It would also disadvantage airlines in two ways relative to agents in taking bookings: first through imposing the cost of soliciting information during reservations process for those that book through airlines (as opposed to agents who might chose not to bear this cost), and again through the direct and indirect costs of data solicitation for only some passengers at the point of departure.

Furthermore, the RIA ignores the airlines' in-house reservation sales, which include telephone and on-line services and can account for a significant portion of bookings. One ATA member reports that in 2005, its North American reservations center handled 51 *million* calls, and notes that not all phone calls with reservations agents result in an actual ticket purchase.

D. Data Storage, Retrieval and Transmission

Proposed §§ 70.4(b) and 71.10(b) would require that airlines retain data for 60 days after the end of a flight segment. In fact, this could require data to be kept in a readily-accessible format for upwards of one year, depending upon the point of collection, since reservations generally may be made a year in advance of the actual flight. Under current practices airlines may keep some data for as little as 24 hours after a flight, while other data elements may be retained for much longer but in a format that is not readily

accessible. Proposed §§ 70.4(d) and 71.10(d) would require the airline to submit the data to CDC in an electronic format within 12 hours of a request.

The RIA assumes that the costs associated with archiving data for 60 days would be incremental costs associated with purchase of 50-gigabyte tapes. Because these tapes can be reused, the cost on an annual basis is assumed to be minimal. However, this assumption fails on at least two counts. First, it is not necessarily the case that indefinite reuse of these tapes is technically feasible. Second, the requirement to access and transmit the data stored on these tapes within 12 hours of a request from CDC may necessitate more real-time data storage media (*e.g.*, server-based secondary storage). There is also a significant potential cost associated with electronic data transmission utilizing a medium that is not currently available.

Furthermore, CDC does not explain the basis for extending the 12-hour turnaround over the entire 60 days that the data must be stored. There appears to be an inverse relationship between the time elapsed since a flight and the urgency to contact passengers quickly. In fact, the only likely scenario in which data could be required for passengers on a flight that occurred more than 30 days in the past would be cases in which another passenger or crew member was diagnosed with tuberculosis subsequent to the flight and determined to have been infectious at the time. Consistent with past CDC guidance, airlines have provided notification to those individuals who may have been exposed by letter or phone call. Although this guidance encourages airlines to make such notification "in a timely manner," the option of contacting potentially-exposed individuals by mail indicates a lack of urgency that does not support the need for a 12-hour turnaround to retrieve the contact information.

Data is to be transmitted to CDC "electronically," but otherwise the mode of transmission is not specified. The global standard for transmission of data for customs purposes is UN EDIFACT, but CDC does not currently have the capability to receive data in this format. Without further consideration and discussion of CDC's capabilities, or of the possible use of another agency's system to receive and store this data until such a time as CDC

requires it, it is impossible for ATA to evaluate the technological challenges and costs associated with transmission of data.

E. Costs

CDC estimates that each major airline would incur costs of $10 million dollars for reprogramming and recurring annual costs of $676,000 to $710,000 for archiving and administrative tasks. Even if these projections were accurate, which they are not, these estimates would amount to hundreds of millions of dollars to the collective industry and should not be treated as an insignificant expense to an industry that is experiencing its fifth straight year of significant losses. These projections are based on incomplete and uninformed assumptions about the way in which these requirements would or could be implemented, and should not be given any credence in evaluating the burden of the NPRM. As noted above, the RIA available for review in the rulemaking record is labeled "Draft," and ATA asks that an additional opportunity be provided to review and comment on a final RIA prior to the finalization of the rule.

The premature and speculative nature of the NPRM, factual and intellectual errors and inconsistencies in the NPRM RIA make it impossible to fully and accurately estimate the impacts of any final rule. While it was not feasible for ATA to conduct an independent analysis of all of the costs potentially associated with the passenger information requirements of the NPRM in the 60 days initially provided for comment, it is painfully obvious that the CDC's estimate is far short of the actual costs that would fall on the airlines. In broad terms, under the least-costly scenario and with regard to the passenger contact requirement alone, ATA airlines conservatively would incur hundreds of millions of dollars in annual incremental costs simply in explaining CDC's requirements and collecting data at the point of sale for passengers who book directly through ATA airlines using call centers. Additional costs may be attributed to those whose bookings originate through travel agents or airline web sites but who ultimately would need to interact with reservation agents or airline personnel at airports to provide additional or updated information. Incremental costs of passenger data collection alone would increase many times under any data collection at point of departure. These very rough estimates do not

include all other direct and indirect costs of the passenger data collection and other elements of the proposed rule.

The RIA contains serious flaws, including the fact that it unjustifiably imposes all of the costs of the rule on the private sector and traveling public. In fact, for the benefits of the rule to be realized, significant public sector investments would need to be made without which the airline element of the rule would have minimal benefits. Even perfect contact information, which is highly unlikely to be obtainable under this proposal, would not produce the public health benefits claimed if CDC had insufficient resources for contacting those possibly exposed to a communicable disease during flight, or inadequate treatment options available. Any airline industry support for some version of passenger data collection, storage and sharing with the CDC will be entirely dependent on a showing that the CDC has or will have the capacity to effectively use this information. It would be totally unacceptable for the CDC to impose costs on the airlines without making the required investment in its own capacity to guarantee the benefits envisioned in the RIA.

Furthermore, the RIA uses as the baseline for evaluating the benefits of the NPRM the situation as it existed during the SARS outbreak of 2003. As referenced above, the development and current availability of machine-scannable forms along with the MOU between HHS and DHS makes this a misleading and inapt comparison. Most of the impediments associated with passenger contact tracing in the baseline scenario – manifests containing only the passenger name and seat number, illegible customs declarations, and incomplete or inconsistent information on customs forms – have been cured by these subsequent developments. Therefore, the RIA is flawed not only in its cost projections but in its estimate of benefits that would be produced under the NPRM. The RIA both understates costs and overstates benefits of the proposed rule.

The costs estimated for data collection under the POS scenario are assumed to be primarily associated with programming by airlines, opportunity costs of passenger time, and other costs borne by travel agencies and similar entities. This ignores the substantial

costs which would be borne by airlines in connection with their own reservations processes. One ATA member, who attributes 30% of ticket sales to in-house reservations, estimates that once training, additional manpower requirements, new equipment and programming are taken into account it could see a cost increase of approximately *$46,500,000 per year*. Another ATA member has estimated that each additional minute of "talk time" for North American reservations would cost the company $1.00. Merely for the sake of illustration, even a conservative assumption of an average of one minute in incremental time for airline reservation agent to just to inform the passenger of the reason for data collection and to collect passenger data could yield hundreds of millions of dollars in incremental costs.

CDC's assumption of 45 seconds to collect passenger data (70 Fed. Reg. 71917) is based on industry estimates in another matter that envisioned address collection only. By contrast, the CDC proposal anticipates collection of many data elements of which address is just one. Even with the allowance of an additional 15 seconds for passengers to locate emergency contact information or other information that is usually not at the passenger's fingertips, the time estimated is unrealistically short. A more reasonable assumption of the periods required to provide/collect data alone could double estimates of the time and cost of POS data collection to airlines (when they take the booking) or travel agents.

Moreover, CDC implicitly assumes in considering POS data collection that incremental passenger data collection costs are associated only with flown tickets. This assumption overlooks the fact that not every inquiry about booking a ticket results in a booking and not every booking results in a flight flown. There are costs associated with informing passengers about the data collection requirement and collecting the data for such potential passengers even in transactions that do not ultimately result in a flown ticket. In a POS collection scenario, airlines and travel agents would bear the costs of data collection for passengers who initiate but do not complete the reservations process or who book a ticket but never fly.

Data collection at the point of departure is absolutely unacceptable to the airline industry.

Under the POD scenario, costs fall even more heavily on the airlines by CDC's own estimate. Under this situation a wholly separate information collection process would be undertaken at departure, adding to check-in times and requiring airlines to hire additional personnel to facilitate information-gathering and avoid excessive queuing time for passengers.

CDC assumes that these additional airline employees would be provided portable workstations to allow the information to be gathered from passengers while they are waiting in line or at the departure gates. This assumption flies in the face of reality. As anyone who has traveled in the past few years knows all too well, the challenge of incorporating new security procedures into existing space at airports has resulted in less room for airline ticket counters and increased the time required to clear security and get to the gate before departure. In addition, adding personnel and requiring each passenger to interact with an airline employee would be counter to recent efforts to cut operating expenses and speed the check-in process by increasingly relying on self-service kiosks and on-line check in. Reprogramming these kiosks to accept additional passenger information and elevated waits at self-service kiosks argue against a POD data collection approach. Moreover, CDC fails to take into account passengers' reactions to being asked to provide extensive personal information, some of which they have already supplied, at a time when they are most likely to be stressed and time-constrained.

In calculating costs associated with POD data collection, the RIA ignores the cumulative effect of individual passenger data input delays on others in the queue. This delay cascade would eventually lead to operational delays, as passengers miss flights and have to be re-booked. The RIA also underestimates the cost of portable workstations, which is estimated to be $400 per unit. While it is unclear precisely what type of portable workstation the CDC envisions being used in this situation, based on current development work being undertaken on wireless, handheld devices suitable for use in an airport environment, the unit cost is more likely to fall in the $1,500 to $3,000 range. The cost of equipment, is estimated by one ATA member to range from *$14 million to*

$26.6 million; with an *annual* cost for additional personnel of *$24 million* for just that one company.

Many inbound international passengers' travel begins on an airline different from that which provides the international service. This could require airlines subject to the NPRM to solicit additional information of passengers whose itinerary began on another carrier and in another country, creating additional serious operational complexity and cost in complying with the proposed rule.

As an example, a passenger could originate in Berlin on Lufthansa airlines and connect to a flight in Frankfurt for travel to the United States. In a POD data collection scenario, the carrier providing Frankfurt-U.S. service would be compelled to solicit contact information at the Frankfurt gate. Such a POD requirement would increase data collection time for passengers connecting from other airlines from the current 60 seconds to 1 to 1½ minutes per passenger under CDC's estimate. (It should be noted that ERG/CDC's estimates seem to grossly understate the amount of time needed to collect the data elements CDC seeks and is premised on their belief that access to frequent flier information will greatly diminish the collection times. ERG claims that it will take only an additional 30 seconds, on average, to confirm or update information for a frequent flier.) This scenario would be further complicated under a POS scenario if the airline providing the first leg of service did not have a code share arrangement with the airline providing the international service.

Multiplying this increase in data collection time by a realistic 100 connecting passengers per international flights inbound to the United States would potentially force increased connection times at international airports, possibly disrupting international schedules and jeopardizing use of allotted departure times at congested international airports ("slots"). A mere 30 minute delay for 82 flights would cost one airline alone $11.2 million.

The increased connection time that the proposed rule would require could decrease U.S. carriers' competitiveness for transoceanic service for passengers who chose solely

foreign carrier service (where data could be efficiently collected at the first flight leg), thus avoiding delays for the U.S. bound flight. Connecting international passengers from other U.S. carriers would create similar data collection and exchange difficulties. In the long term carriers would be likely to be able to modify procedures to permit exchange of contact information from other carriers, but it will require additional time and resources to do so.

Additional unquantified costs such as congestion in check-in areas (including unintended security concerns and costs), passenger wait time and potential rescheduling of flights to permit needed processing would impose staggering costs and disruptions to the airline industry. These problems would be exacerbated at key international airports such as London Heathrow, which is highly constrained in terms of both terminal space and arrival/departure slots. As a single example, the counter space required for longer collection of passenger information at Heathrow is unlikely to be available at all, particularly if all airlines require additional space for this data collection. Airlines might conceivable have to retime flights at Heathrow were a POD data collection procedure in place, potentially losing valuable departure slots.

The POD scenario assumes that only "incremental data" would need to be collected at the airport, since would already be available from loyalty program (frequent flyer) databases. Airlines are understandably reluctant to make this information available to competitors. In addition, airlines may not have a ready means of ascertaining that the information in these databases is complete and up-to-date at the departure point. We have not assessed the privacy implications of CDC's assumption that loyalty program information would be made available for public health purposes, but loyalty program members may be less willing to participate in such programs if their personal data were used in this way. Finally, this proposal ignores the fact that a great number of passengers are not members of a given airline's loyalty program or have not provided or updated personal information to that airline's program.

In fact, neither of the scenarios for data collection analyzed as part of the RIA is sufficiently realistic to generate meaningful cost estimates, nor can ATA generate its own cost estimates without further consideration of how this requirement might be coordinated with other government initiatives. It is easy to see, however, that the cost of compliance with this proposed rule could be $1 billion or more. CDC should be required to justify *all* of the costs associated with this proposal. Given that the underlying public health responsibility rests with the Government and not the airlines, CDC should be prepared to reimburse airlines for costs that are attributable to the broad goal protecting the general public from the spread of disease.

F. Compliance

Proposed §§ 70.5 and 71.11 require that within six months of the final rule, each airline would develop a written plan for carrying out these requirements and implement the plan within two years of the issuance of the final rule. To accomplish the programming necessary for collecting the proposed data, build the required transmission vehicle, and train staff, more than 18 months may be required. Airlines would have to test and evaluate the effectiveness of the plan within 60 days of implementation, then annually thereafter and revise as necessary. Although it is anticipated that most airlines would develop a written plan for internal purposes as part of implementing these requirements, CDC appears to view the plan as a means of tweaking requirements indefinitely.

As outlined in proposed §§ 70.5(d) and 71.11(d), airlines would be required not only to review the plan on an annual basis, but to conduct drills or exercises to evaluate the effectiveness of the plan if the airline has not transmitted data under these requirements in the prior year. In addition, while airlines are not required to verify the accuracy of the information or prohibit passengers from flying if they refuse to provide it, the NPRM states that CDC would seek revisions to an airline's plan if sufficient data is not obtained or proves to be unreliable.

Inexplicably, CDC entertains imposing hundreds of millions of dollars of costs on the industry without even pilot testing voluntary data collection. Experience both with

DOT's emergency contact cards and the broad literature regarding survey response strongly suggest that airlines would experience well short of the 90% + rate of voluntary compliance projected by CDC. Thus, revisions to an airline's plan to improve the collection of data likely would involve requiring changes related not to the effectiveness of the plan itself, but to gaps, erroneous assumptions and missteps in the regulatory requirements. For example, if CDC's assumption that passengers would more willingly provide information for public health purposes proved to be incorrect, airlines might be asked to come up with other incentives to get passengers to volunteer data. Similarly, if passengers were found to routinely supply false or out-of-date information, airlines might be required to amend their plans to provide a means of verifying or updating information. The cost of this review and revision is nowhere addressed in the NPRM or RIA. The prospect of creating and paying for two systems (assuming failure of the initial voluntary system) and then facing stiff monetary penalties, as discussed below, for failure to meet some unspecified standard of "effectiveness," makes this of even greater concern to the airlines.

Finally, and as discussed below with reference to the written plan for reporting illness and death on board aircraft, the requirement in proposed §§ 70.5(b)(3) and 71.11(b)(3) to identify an airline agent (including full name) who will serve as the point of contact between the Director and the airline concerning requests for passenger and crew information is impractical, since in many cases, the appropriate point of contact is a position rather than an individual (*e.g.*, the duty officer or emergency operations center). ATA recommends that airlines be given the option to identify a point of contact by individual name or position, accompanied by contact information that is valid 24-hour basis, 7 days of the week for purposes of emergency situations.

III. CDC'S AUTHORITY WITH RESPECT TO INTERSTATE AND INTRASTATE TRAVEL

To the extent there is any basis to regulate airlines with respect to public health, that authority rests with the federal government, not with state or local governments. The responsibility of the federal government to prevent the introduction and spread of

communicable disease from other countries dates back to the earliest days of the United States. (70 Fed. Reg. 71893-71896). The federal government also has authority under the Constitution to prevent the introduction and spread of communicable disease from one state to another. This authority also is derived from the Commerce Clause, while the states' authority over communicable disease is based on the police power reserved to them by the 10th Amendment. As the NPRM's preamble explains, the federal government's authority extends to: (1) The use of the channels of interstate commerce; (2) the instrumentalities of interstate commerce, or persons or things in interstate commerce, even though the threat to interstate commerce may come only from intrastate activities; and (3) activities that substantially affect interstate commerce.

This authority over interstate activities was until recently implemented through regulations administered by the Food and Drug Administration (FDA). In August 2000, these regulations were transferred to CDC and are now contained at 42 C.F.R. part 70. Many of the inconsistencies between these parts are the result of this history, and the proposed rule does much to reconcile and harmonize them.

Commercial airlines are inherently instrumentalities of interstate commerce. Moreover, as entities that typically operate in multiple states and often in multiple countries, airlines seek consistency and harmonization of requirements whenever possible. Although most airlines distinguish between international and domestic operations, there are few situations in which there is a relevant distinction between interstate and intrastate service. As a practical matter, on any given intrastate flight passengers may have connected from an interstate or international segment, while the flight crews are often based in another state entirely and maintenance of the aircraft carried out in yet another state. In some aspects of the NPRM, CDC explicitly includes intrastate travel under its authority: For example, under proposed § 70.14(a), provisional quarantine could be imposed on anyone in the qualifying stage of a quarantinable disease who the Director reasonably believes is *either* moving or about to move from one State to another State *or* is a probable source of infection to others who will be in interstate travel. Similarly, under proposed § 70.6(d), the Director may apply the requirements for travel permits to persons and aircraft

traveling entirely within a state or possession when it is determined that there is inadequate local control.

As a legal matter, states have no authority to regulate air transport. Whether viewed as the use of the channels of interstate commerce, an instrumentality of interstate commerce, or an activity that substantially affect interstate commerce, commercial airline routes within a single state are part of a national, and in some cases an international route structure. We question the authority of CDC to issue the proposed regulations with respect to some aspects of the NPRM because they appear to be an unnecessary and unreasonable burden on airlines. The lack of federal authority with respect to those aspects of the NPRM should by no means be interpreted as an invitation for state or local governments to impose regulations instead.

IV. REPORTING REQUIREMENTS FOR DEATH OR ILLNESS ON BOARD AIRCRAFT

Under existing regulations, the "person in charge of any conveyance" in interstate traffic must notify the local public health authority of "a case or suspected case of a communicable disease" at the next stop as soon as practicable (current § 70.4); while in international transport the "commander of an aircraft destined for a U.S. airport" must report any death or ill person immediately to the quarantine station at or nearest to the destination airport (current § 71.21). The inconsistencies between these provisions has caused confusion and hindered rapid compliance despite efforts on the part of CDC staff to reconcile the requirements.

The proposed revisions as set forth in §§ 70.2(a) and 71.6(a) would make the requirements identical for interstate and international flights by requiring the report to be made to the Director of the CDC as soon as the death or illness is made known to the aircraft commander, and where possible, at least one hour prior to arrival. Although ATA supports the concept of a single set of requirements regardless of whether the flight is operating in interstate or international traffic, we are concerned that the proposed revisions could increase the reporting burden on airlines and miss an opportunity to

further streamline implementation. Specifically, while operators of international flights have been required to report "any death," the provision applicable to domestic flights only covered cases (or suspected cases) of communicable disease.

Based on anecdotal reports from ATA's members, naturally-occurring deaths during flight, while not common, are most often associated with pre-existing terminal illness or cardiac arrest unrelated to communicable disease. Such occurrences are handled as medical emergencies, with arrangements made by the airline for emergency medical services ("EMS") to meet the flight on arrival. Therefore, we recommend that the language of proposed §§ 70.2(a) and 71.6(a) be amended to read "any deaths *related to a suspected communicable disease."* This requirement would be more closely tailored to the CDC's goal of identifying and tracing the spread of disease. Since *any* death on board an aircraft would be handled by medical professionals once the plane has landed, deaths from other causes still would be reported by these responders to the appropriate local authorities.

The regulation should clarify that reports of illness are to be based on readily observable symptoms and/or information provided voluntarily by the ill person or his or her traveling companions. Aircraft crew members are trained to deal with emergency medical situations but are not medical professionals, and must be sensitive to a passenger's privacy and dignity. The definition of "ill person" (proposed §§ 70.1, 71.1), although intended to rely on "descriptive terms that are overt and commonly understood by lay persons," (70 Fed. Reg. 71896), is overly-specific in that it relies on seemingly precise medical measurements (*e.g.* temperature 100.4º F or 38º C or greater), technical terms not readily understood by non-medical personnel (*e.g.*, changes in level of cognitive function, bloody sputum, respiratory distress) and information that is not readily observable and may be difficult to obtain from an ill passenger, particularly when there may be language or cultural barriers (*e.g.*, occurrence in a 24-hour period of three or more loose stools).

At the same time, the definition is over-broad because it potentially describes many illnesses or sets of symptoms that are *not* related to a serious communicable disease. As

noted in the preamble, this definition is important because it determines the scope of the reporting requirement. If this were the only implication, over-inclusion (*i.e.*, reporting illness that is *not* associated with a communicable disease) might be a prudent course. However, as described in other provisions of the NPRM, reporting an ill person in accordance with this definition, which the NPRM acknowledges is broad by design, could trigger a response that might include extreme measures such as quarantine of the entire planeload of people.

ATA recommends that this problem be addressed on two levels. First, the definition of "ill person" should be revised to mean "a person who exhibits symptoms associated with communicable disease" and should be expanded to include more commonly understood and easily recognized indicators. For example, fever could be identified as a symptom of many communicable diseases, indicated by a flushed or unusually pale complexion, excessive perspiration or shivering, or a temperature of 100.4º F or 38º C or greater. Similarly, the signs of diarrhea could include odors and frequent or prolonged use of aircraft lavatories in addition to the more clinical description provided. Crew members are trained and responsible for safety of the flight and the passengers on board, and should not be placed in situations where they would be required to make technical medical decisions. Nor should airlines be penalized for failure to diagnose a communicable disease when a passenger presents only nonspecific symptoms that do not otherwise require medical attention.

Second, in order to prevent this even broader definition from triggering an unnecessary response, the regulation should provide that the initial report of an "ill person" is to be followed by screening of the case with the assistance of the airline medical advisor(s) and CDC personnel to determine if the symptoms are in fact indicative of a communicable disease of interest to CDC (although the definition of "communicable disease" does not include any reference to severity or public health consequences, presumably, CDC is not concerned with common colds and the like). It is already common practice for aircraft crew members to relay symptoms to medical professionals on the ground in order to obtain advice regarding on-board management and to assist in the decision of whether to

divert the aircraft to a closer destination. Including CDC experts in this communication (either directly or by having the medical advisor make the report to CDC) would enable CDC to identify situations that warrant a public health response more quickly and accurately, while those that do not warrant such a response could be handled as appropriate by the airline under existing protocols for medical emergencies.

Providing a single point of contact for reports of disease is an improvement over the existing regulations, under which the CDC quarantine station was to be notified in the case of international flights but local public health authorities were to be notified of illness on domestic flights. Where local authorities deploy fire and rescue personnel to respond to a report of communicable disease, the result may be an "over-response" based on their training, which typically does not include this type of incident. While there may be reasons for CDC to coordinate with local and state public health authorities, the prospect of having to contact one of potentially thousands of local health departments in an emergency situation unnecessarily complicated the airlines' reporting function. ATA recommends that the requirement to make the report to the Director of the CDC be clarified to expressly allow the report to be made either to the CDC Emergency Operations Center or to one of the CDC Quarantine Stations. In either case, ATA believes that CDC is in the best position to relay the report to the appropriate Quarantine Station and/or local public health authorities.

The NPRM contains a new requirement for airlines to prepare and submit to CDC a written plan for reporting deaths and illnesses on board flights (proposed §§ 70.3, 71.7). As noted in the NPRM, airlines already have procedures in place for managing illness during flight; however, these procedures may not be contained in a single document or "plan," but may instead need to be assembled from various internal guidelines and protocols (*e.g.*, there may be separate procedures for flight attendants and pilots). While the requirement for a written plan is not in itself unduly burdensome, it is important that CDC recognize the variations among airline corporate structure, labor agreements, operational patterns and experience and the different ways in which these might be reflected in the reporting plans.

Identification of an airline agent (including full name) who will serve as the point of contact between the Director and the airline regarding reports of death or ill passengers (proposed §§ 70.3(b), 71.7(b)) is overly rigid. In many cases, the appropriate point of contact is a position rather than an individual (*e.g.*, the duty officer or emergency operations center). Even where there is a single person assigned to such a position, these individuals may change positions, take medical or personal leave or otherwise be unavailable on occasion. In such cases a full name may be irrelevant. Airlines should be given the discretion to identify a point of contact by individual name or position, accompanied by contact information that is valid 24-hour basis, 7 days of the week for purposes of emergency situations. If CDC also seeks to identify an airline agent for other purposes (*e.g.*, the person responsible for submitting or updating the written plan) this should be clarified in the rule. Here again, this may be a title or position, rather than an individual's name.

The proposed requirement to review the plans on an annual basis is sufficient to ensure the currency and effectiveness of the plan; mandating that airlines that have not reported illness or death in the previous year undertake drills or exercises is unnecessary micromanaging (proposed §§ 70.3(f), 71.7(f)). Aircraft crew members are already subject to ongoing training requirements under Federal Aviation Administration (FAA) regulations. Airlines should have discretion to evaluate the plan and determine whether any drills or exercises would be helpful in its implementation. The mandatory requirement to conduct drills or exercises should be eliminated from the final rule.

V. DISSEMINATION OF PUBLIC HEALTH INFORMATION

Although it is included under the provision entitled "Report of Death or Illness on board flights," proposed §§ 70.2(b) and 71.6(b), which would require airlines to distribute information "at the time and in a manner specified" by an order of the Director of the CDC, imposes a new and open-ended obligation unrelated to the reporting function. Without knowing the manner that might be specified at some uncertain date in the future

it is difficult to assess the impact of this requirement on the airlines; however, it is obvious that an order requiring distribution of materials during flight (which would require a sufficient supply of materials to be carried on board) would present very different logistical challenges and impose different costs than one which allowed distribution after landing (which would allow materials to be stocked at airport stations).

While ATA member airlines have in the past cooperated with CDC in distributing or preparing to distribute health information in certain situations, this was done on a voluntary basis and with the understanding that each airline would have the flexibility needed to carry this out in the most efficient manner possible. In fact, CDC previously proposed that "airlines be afforded complete flexibility in determining how these materials are distributed, as long as they can ensure that each passenger receives them prior to disembarkation in the U.S."[14] Authorizing the Director to order distribution of materials in a manner specified, with no recognition of the need for flexibility or the potential impact on airline operations, is inconsistent with this statement and with the spirit of cooperation that has thus far characterized discussions between the CDC and ATA members on this issue.

The preamble to the NPRM explains that "CDC expects to exercise this requirement in situations where a significant outbreak of a quarantinable disease is detected abroad and there is the potential for exposure among interstate travelers," yet the language of the proposed regulations gives the CDC Director untrammeled authority to invoke this requirement to distribute public health information any time that it is deemed necessary to prevent the spread of communicable disease, whether or not related to air travel.

ATA recommends that the proposed regulation be recast as a separate provision, entitled "Dissemination of Public Health Information," to read as follows:

The Director may request that airlines voluntarily assist in the dissemination of public health notices, recommended public health measures, and other public health

[14] Letter from James E. Barrow, Acting Director of the Division of Global Migration and Quarantine, to Katherine Andrus, Assistant General Counsel, ATA (June 29, 2004).

information related to the introduction, transmission or spread of communicable diseases by air travelers. Where voluntary measures are determined to be insufficient to prevent the introduction, transmission or spread of communicable diseases by air travelers, CDC will distribute such materials at arrival points in a manner designed to minimize disruption and delay of passenger disembarkation and facilitation.

VI. TRAVEL PERMITS, BILLS OF HEALTH, AND HEALTH DECLARATIONS

The NPRM includes several provisions that generally relate to clearance for travel. While some of these are carried forward essentially unchanged from existing regulations, they have been so seldom invoked since the advent of commercial flight that it is essential that they be subject to careful consideration and review.

A. Travel Permits

The first of these, and the only one to apply to domestic travel, would require a person who *knows* he or she is in the communicable or pre-communicable phase of a quarantinable disease to get a travel permit from CDC prior to travel, and further prohibits airlines from knowingly carrying such a person in the absence of such a permit (proposed § 70.6). This is similar to the existing requirements of current § 70.5, although that requirement has not been enforced recently to ATA's knowledge. Under the proposed rule airlines must comply with any permit conditions, and take any other measures necessary to prevent the spread of the disease. Again, this is similar to the current § 70.5. However, neither the current nor the proposed regulation is harmonized with another existing regulation, issued by DOT and set forth at 49 C.F.R. § 382.51(c) as part of its regulations governing nondiscrimination in air travel on the basis of disability. This provision requires airlines to transport persons with communicable diseases *unless* the individual's condition poses a direct threat to the health or safety of others, and the airline makes an individualized assessment that the potential harm will actually occur and that reasonable modifications of policies, practices or procedures will mitigate the risk.

The lack of public familiarity with the concept of travel permits, coupled with DOT's nondiscrimination regulations, make it difficult for airlines to implement this provision as proposed. In practical terms, unless passengers self-identify as having been diagnosed

with a quarantinable disease, airlines have no means of differentiating between those who are prohibited from traveling under this provision and those who must be allowed to travel under DOT's regulations. ATA recommends that CDC accompany this provision with a comprehensive education campaign targeted to health care professionals who are in a position to diagnose such diseases, and who could in turn inform their patients about potential restrictions on travel and their responsibility under the law.

ATA also recommends that the provision be revised to clarify that it is the responsibility of the medical professional(s) treating an individual, and not the airline, to determine whether and when such individual is in the qualifying stage of a quarantinable disease. Any travel permit issued to such an individual should specify the extent of the qualifying stage. This is particularly relevant for diseases like tuberculosis. Furthermore, airlines should not be required to transport such individuals if compliance with the conditions of the travel permit is infeasible. The provision should also clarify that airlines have no liability as a result of the travel permit requirement.

B. Bills of Health

Proposed § 71.4 would authorize the Director of CDC to require aircraft departing a foreign airport for the U.S. to obtain or deliver a bill of health prior to take-off, a reversal of the existing regulation (current § 71.11) which expressly states that this is not required. Although the term "bill of health" is not defined in the NPRM, we understand it to mean a clearance issued by U.S. officials indicating that no communicable disease is present on board the aircraft prior to its departure for the United States. The NPRM notes that CDC does not intend to require bills of health for routine traffic, but cites concerns about bioterrorism and emerging disease as potential triggers for using this tool. It is unclear under what authority CDC would act, particularly where the aircraft is operated by a non-U.S. airline, and what types of inspections or other procedures would be needed to obtain the requisite bill of health. The term "bill of health" should be defined and the procedures and criteria for obtaining such a document described and published before the issuance of a Final Rule so that interested parties have adequate time to comment.

Furthermore, we note that the potential requirement for a bill of health appears inconsistent with Article 35 of the International Health Regulations, which states that no health documents other than those provided under the newly revised International Health Regulations ("IHR") shall be required in international traffic. As discussed below, the IHRs were subject to considerable international deliberation and were adopted by the World Health Organization just last year. CDC should be cautious in deviating from the agreed-upon provisions in the absence of a compelling reason.

C. Health Declarations

The NPRM describes proposed § 71.28 as carrying over the provisions of current § 71.46, which addresses rodent infestation inspections and deratting certificates. While proposed § 71.28(a) does carry over the existing provisions, § 71.28(b) further clarifies that the Health Part of the Aircraft General Declaration, as described in Article 38 of the IHR, is not currently required as a condition of arrival in the U.S. However, the language of the provision, which states that this is the case "[u]nless otherwise determined by the Director, appears to reserve to the CDC authority of the CDC to require a Health Declaration at some point in the future. It is not clear whether CDC intends there to be a meaningful distinction between a bill of health, as the term is used in these regulations, and a health declaration under the IHR.

As noted above, the IHRs were adopted by the WHO in 2005 after prolonged consideration, and have widespread international support. Airlines operating on international routes already are subject to multiple and sometimes conflicting requirements imposed by individual nations, and therefore ATA supports the use of international standards whenever possible and appropriate. CDC should consider harmonizing potential requirements under this rule with the international standards set forth in the IHR.

VII. INSPECTIONS AND SANITARY MEASURES

A. Inspections

Proposed §§ 70.11(a)(1) and 71.13(a)(1) provide for CDC to inspect the aircraft and things on board whenever the Director reasonably believes that the aircraft or things on board the aircraft are or may be infected with a communicable disease. These provisions consolidate and make applicable to interstate transport various requirements for international arrivals in current § 71.32 (disinfection, disinfestation, fumigation and related measures), current § 71.42 (disinfection of imports), and current §71.44 (disinsection of aircraft). There is no guidance or discussion as to how these inspections might be carried out, or who might conduct them.

There is potential overlapping jurisdiction with the Food and Drug Administration ("FDA"), which has a well-established program for inspecting aircraft with respect to sanitary conditions, the Department of Agriculture ("USDA"), which under the Plant Protection and Quarantine ("PPQ") program is responsible for inspecting international arrivals, and with the Environmental Protection Agency ("EPA")'s regulations, guidance and administrative orders with respect to aircraft drinking water. ATA encourages CDC to develop an agreement with those agencies to ensure efficient implementation of any inspections. Guidance should be provided to all inspection agencies specifically outlining protocols that address:

- The agency responsible for making the determination whether inspection, detention, decontamination, quarantine, or release should occur;
- the agency with authority to determine disposition of the cargo, *e.g.*, detain on board aircraft or remove to remote cargo quarantine area; and
- agency guidelines relating to maximum timeframes for detention of commercial cargo that was not directly contaminated by infectious passengers.

Various additional existing provisions relating to the inspection of conveyances arriving at a U.S. port are consolidated in proposed § 71.12. The proposed language provides that carriers arriving at a U.S. port are subject to detention and inspection to determine the existence of rodent, insect or vermin infestation, contaminated food or water or other unsanitary conditions that may require sanitary measures to prevent the introduction or

spread of communicable disease, similar to current § 71.41. Proposed § 71.12 also provides for inspection when there is a threat of communicable disease (*e.g.*, when an illness or death has been reported on board). This is similar to current §71.31(a), although that provision is expressed in the negative (inspection will not be required unless the CDC determines that failure to inspect will present a threat of communicable disease). Carriers in international transit between U.S. ports also are subject to inspection when there is a death or illness on board (similar to current § 71.48). It is unclear to what extent the proposed provision is intended to differ meaningfully from proposed § 71.13(a)(1). ATA recommends that CDC consider whether these regulations might be further streamlined and made consistent as between international and domestic operations. ATA also recommends that any revisions made should be subject to public comments before a Final Rule is issued.

B. Sanitary Measures

Under proposed §§ 70.11(a)(2) and 71.13(a)(2), the Director may, in consultation with such other federal agencies as appropriate, order measures deemed necessary to prevent introduction, transmission or spread of communicable disease. The NPRM explains that CDC would determine which sanitary measures should be employed in a given circumstance based on scientific and public health principles applicable to the threat to human health. ATA recommends that CDC develop a process for pre-approval of measures, including methods and materials, which would be acceptable and appropriate in specific situations. This process should include review by the FAA and airframe manufacturers to ensure that any measures ordered are compatible with aircraft safety.

An established list of approved measures would allow airlines to familiarize themselves with the requirements and raise any concerns with the CDC well in advance of an order to implement them. In addition, the NPRM notes that a written order would not be the exclusive method for ordering sanitary measures – a CDC quarantine officer could issue verbal (oral) orders. A pre-approved list of measures, which could be referenced in such situations, would help to ensure that non-written orders are not subject to confusion or debate.

Proposed §§ 70.11(b) and 71.13(b) state that CDC will not bear the expense of any sanitary measures so ordered. Without any constraints on its authority, CDC could order implementation of measures that go far beyond what is necessary and reasonably related to ensuring that the aircraft does not present a health risk. The final rule should include language limiting the measures ordered to the least costly method of removing any demonstrable threat to the health of future passengers and crew, or allowing airlines to substitute a less-costly method that has been demonstrated to be equally effective. The cost of any sanitary measures that are intended to benefit the public health more broadly should be borne entirely by CDC or another agency of the state or federal government.

C. Detention

Proposed §§ 70.12 and 71.14 provide for the detention of an aircraft and all things on board until the completion of sanitary measures, similar to current §§ 71.31(b) and 71.32(b). Since taking an aircraft out of service, even for a short period, imposes real costs the airline has an incentive to complete such measures as expeditiously as possible. However, the proposed regulations do not include a provision for re-inspection and release, leaving open the possibility that additional detention will result from ambiguity and delay in obtaining confirmation that the sanitary measures have been completed

ATA recommends that the final rule include explicit procedures for releasing an aircraft from detention, and that these procedures provide for release without the need for further inspection wherever possible (e.g., where an airline is carrying out pre-approved measures in accordance with its established protocols). Any additional detention of the aircraft or delay imposed on its return to service following completion of sanitary measures would impose a cost on the airlines that should be fully reimbursed by CDC.

VIII. SCREENINGS OF ILL PERSONS

Proposed §§ 70.13 and 71.16 authorize CDC to conduct screenings at airports and other locations to detect the presence of ill persons using visual inspection, electronic temperature monitors, or other means determined appropriate. This appropriately places

the responsibility for screening on the CDC, rather than on the airport or airline. CDC should bear the expense of purchasing and operating equipment such as electronic temperature monitors. In addition, CDC should coordinate closely with DHS to avoid further inconvenience or delay of passengers. Space requirements for the screening of passengers for signs of illness should not come out of airline leaseholds and airlines should not be asked nor bear any responsibility for paying rent to airports for space utilized by CDC. Additionally, CDC must put in place measures to assure that the line waits already common for TSA security screening do not increase by these medical screening procedures.

IX. QUARANTINE

"Quarantine" is defined at proposed §§70.1 and 71.1 to include holding people on a voluntary or involuntary basis to prevent the spread of infection and illness, and includes isolation. In other contexts, CDC distinguishes between isolation, which applies to ill people, and quarantine, which applies to people who may have been exposed but are not yet ill. Although the concept of quarantine has been well-known for centuries, and the authority of the federal government to impose quarantine is well-established, it has not been invoked in modern times. Simply by proposing detailed regulations for implementing quarantine, CDC has raised the specter of this extreme public health measure coming into use. The mere prospect of quarantine may induce ill individuals to mask symptoms or discourage healthy individuals from travel and social interaction, and therefore the authority to quarantine must be carefully construed to avoid misuse and unintended consequences.

A. Provisional Quarantine of Airline Passengers and Crew

Proposed §§70.14 and 71.17 provide for CDC to impose "provisional quarantine" of a person or group reasonably believed to be in the qualifying stage (*i.e.*, communicable or precommunicable) of a quarantinable disease. Provisional quarantine is defined at proposed §§70.1 and 71.1 to mean, in effect, quarantine until such a time as a longer-term order has been issued or it has been determined that quarantine is unnecessary. Because

provisional quarantine is likely to be invoked in cases where there is imperfect information as to the existence of a quarantinable disease, it is more likely to be erroneously imposed than long-term quarantine. The potential for "false alarms" and the implications of these for public acceptance of such measures as well as public confidence in CDC cannot be ignored.

As described in the NPRM, Quarantine officers routinely conduct short term examinations of ill passengers at airports to assess the presence of disease on a voluntary basis, but provisional quarantine might be invoked in situations where the ill passenger withholds his or her consent. (70 Fed. Reg. 71902). However, the recent tabletop exercises conducted at various airports made clear that CDC is contemplating using its quarantine authority to detain entire planeloads of people at an arrival airport for the period of a provisional quarantine, and we have reviewed the proposed provisions in light of that possible scenario.

While provisional quarantine may be necessitated in situations involving serious public health risks, its use should be rare and extremely well-justified. Alternative methods of accomplishing the same goal should be considered (*e.g.*, medical examination and monitoring, vaccination or prophylaxis and/or "social distancing" at each individual's home) and quarantine should not be used in situations where it has not been demonstrated through experience or modeling to be an effective tool in preventing the spread of a particular disease. The chilling effect on travel of even a single quarantine incident at a U.S. airport should be taken into account in each and every case in which it is potentially applicable, and the economic and social impact weighed against the potential benefit.

Moreover, the character of the response to a situation involving a possible quarantinable disease can have an impact on public perception. One well-publicized incident during the SARS outbreak in 2003 featured a local response to a report of arriving passengers displaying SARS-like symptoms, which included fire trucks surrounding the aircraft and personnel clad in "moon suits" boarding the plane. Footage of this incident was played repeatedly on television news for several days, despite the fact that the passengers were

quickly identified as being disease-free. In that case, part of the problem may have been related to the fact that the airport did not have a CDC quarantine station, and the lack of familiarity of the local public health authorities with airline procedures. CDC must understand the significant ramifications of its action *before* decisions are made, and public perception and costs must be included in this evaluation.

Under the NPRM, provisional quarantine may be applied to an individual who is "precommunicable." This is a change from the existing language, which bases quarantine on a reasonable belief that a person "has been exposed to" a quarantinable disease, but it is unclear what CDC intends by this change. "Precommunicable," which is not in itself defined, suggests that a person has been infected but is not yet at the stage of the disease where he or she can transmit the disease to others. As a practical matter, it may be difficult to determine at an early stage which of those individuals exposed to contagion have been infected. Could this definition be applied to a group of airline passengers that has visited a region experiencing an outbreak, even if no one in the group is symptomatic? The rule should include further criteria for identifying an individual or group as "precommunicable," and limits on triggering provisional quarantine based solely on asymptomatic individuals. Otherwise, the authority to quarantine could be used to detain people on a speculative basis, merely to see if they develop symptoms of a disease.

As proposed, provisional quarantine may last up to three business days, ostensibly to allow time for collection and analysis of samples needed to confirm an initial diagnosis of a quarantinable disease. The NPRM notes that in most circumstances, provisional quarantine would last only as long as necessary to ascertain whether the person or persons are possible carriers of the quarantinable disease, suggesting that in some cases laboratory confirmation may not be necessary. Given the advent of more rapid analytical methods (*e.g.*, the test recently approved by HHS that provides preliminary results on suspected avian influenza samples within four hours) and the availability of 24/7 laboratory facilities in an emergency situation, three business days – which could extend to six actual days if provisional quarantine went into effect at the start of a holiday

weekend – is excessive. The final rule should limit provisional quarantine to no longer than is absolutely necessary to ascertain (or rule out) the presence of a quarantinable disease.

B. Use of Airport Facilities for Quarantine

As noted above, recent tabletop exercises indicate that CDC intends to utilize its provisional quarantine authority with respect to airline passengers and crew arriving on board a flight that also carries a person with symptoms of a quarantinable disease. According to these planning scenarios, passengers and crew members who are not symptomatic and do not require medical treatment would be detained at the airport until a further quarantine order is issued or they are cleared of any quarantinable disease.

Proposed § 71.29(a) carries over a requirement from current § 71.47 for airports that receive international traffic to provide, without cost to the government, exclusive space for carrying out federal responsibilities under these regulations.[15] However, whereas the existing regulation cites as examples office and *isolation* space, the proposed rule refers to office, examination and *quarantine* space. Here the distinction between "isolation" and "quarantine" is significant; whereas only a small number of ill people from a given flight might need to be isolated and likely would be transferred to a community medical facility within a short period of time, hundreds of people might be quarantined at the airport for more extended periods.

As evidence of a change in the scope of this requirement, proposed § 71.29(b) would require each international airport to identify space suitable for the quarantine of an arriving person *or group*, under guidelines or instructions issued by the Director. While existing quarantine stations at international airports occupy relatively modest spaces – generally an office and small examining room – and are typically part of the Federal Inspection Service ("FIS") facilities, the new requirement could necessitate identifying (and presumably make available as needed) space to house hundreds of people for several

[15] 8 C.F.R. § 234.4 requires airports to fulfill requirements established by various federal agencies in order to be designated as "international airports."

days. Airports that have participated in the CDC tabletop exercises in the past year have struggled with finding appropriate space on-airport, as well as determining how best to equip and manage such a facility.

The NPRM notes that the specifications for space requirements to carry out quarantine activities are incorporated into the FIS manual; however, this guidance does not appear to cover space to implement provisional quarantine of large groups. Discussions at various tabletop exercises suggest that in addition to a substantial enclosed space, these requirements may include power, water, climate control, sleeping and eating arrangements, security and entertainment for several days. Providing this type of facility on even a prospective basis would require airports to incur significant costs. Many of these costs would be incurred irrespective of whether the facility was ever used for quarantine purposes – simply by excluding other uses that would preclude speedy conversion into a quarantine facility the airport would forego potential revenue. While this requirement applies directly to airports, in fact it is the airport tenants – predominantly airlines – who provide the revenue that airports would use to fund this massive undertaking.[16] ATA believes that any cost created by this proposal should be the responsibility of the Federal Government, not the private sector.

Constructing or reserving use of a facility at each international airport that could accommodate several hundred people in quarantine would shift the burden of preparing and paying for potential quarantine to one sector: aviation. In fact, it is just as likely that, should the need for quarantine arise in the United States, it would involve individuals who do not happen to be at an airport. As part of overall planning for potential pandemics, bioterrorist attacks or other incidents where quarantine might be invoked CDC should work with states and localities to identify facilities in each community – including airport communities – that might serve this purpose. If, in the course of such planning, an appropriate facility is identified on airport property, costs

[16] None of the commercial service airports in the United States receive state or local funding. Airports derive their revenue primarily from tenant rents and landing fees charged to aircraft operators. Airports may also receive money from the Airport and Airways Trust Fund, which though administered by the FAA is funded entirely with ticket taxes and other charges assessed on users of the aviation system.

associated with preparing this facility should be borne by the general public through tax-supported grants or other mechanisms, not by the airline industry.

X. SUSPENSION OF ENTRIES AND IMPORTS

Proposed § 71.5 implements the provisions of 42 U.S.C. 265 and authorizes the CDC, to the extent permitted by law and in consultation with other federal agencies, to prohibit the introduction of persons and property from foreign countries when there is serious danger of the introduction of communicable disease through such introduction. This prohibition would be implemented through an order of the Director, designating the persons and property subject to such a prohibition and the period of time it would remain in effect. While the underlying statutory authority for this has been in place at least since 1944, it has not been invoked often in recent history. The criteria under which this authority would be invoked should be outlined in the final rule, and the economic, social and political implications should be fully considered. Specific provisions for release of cargo loaded in cargo holds of aircraft where the cargo is not accessible from the aircraft cabin, should be outlined. It should not be necessary or appropriate in all instances for all commercial cargo shipments to be detained even if a passenger quarantine is potentially warranted.

XI. MILITARY EXEMPTION

Current § 70.8 exempts members of the military from requirements for travel permits, reporting disease and other requirements under current §§ 70.3-5 and 70.7. Proposed § 70.8 carries over those exemptions, but in addition allows the CDC to exempt aircraft belonging to the military from the requirements of proposed §70.6(a) (travel permits), and §§ 70.11-12 (sanitary measures) provided that such carriers take "adequate" sanitary measures to prevent the introduction and spread of disease. The language of proposed § 70.8 differs from both current and proposed § 71.15 in that it applies only to aircraft belonging to the military, rather than belonging to *or operated by* the military. This raised questions about civilian aircraft used for military transport under a charter arrangement or through the Civil Reserve Air Fleet ("CRAF") program. While most such

aircraft would be operating internationally (and thus covered by proposed § 71.15), it is not clear why the distinction is made.

The NPRM notes that although not explicitly exempt, military aircraft would not be subject to requirements for reporting death or illness on board or providing passenger information because these apply only to aircraft operated "commercially" (the regulations use the term "operating flights in interstate traffic.") This suggests that there may be situations in which civilian aircraft are not subject to these requirements if they are not operating "commercially." Clarification on this point is needed. The regulations should not apply to any aircraft that is being operated under contract to, or otherwise on behalf of the U.S. Department of Defense ("DOD") or other U.S. government agencies, since it can be assumed that specific requirements to protect the health and safety of passengers and crew would be in place. Cargo carried under contract to DOD (including human remains) and diplomatic pouches carried by commercial airlines similarly should be exempt from the requirements of this part, since special rules apply to their handling.

XII. PENALTIES

Proposed §§ 70.29, 71.31 would drastically increase or impose new penalties by subjecting persons in violation of the regulations to a fine of no more than $250,000 and/or one year in jail and organizations to a fine of no more than $500,000 per event. Currently, there is no penalty specified for violations under part 70, while existing penalties under § 71.2 are no more than $1,000 and/or imprisonment for not more than one year. The NPRM cites 42 U.S.C. § 271 as imposing criminal penalties for violation of federal quarantine rules, which sets the same amount (*i.e.*, not more than $1,000) as the existing regulation. The NPRM asserts that under federal sentencing classifications set forth at 18 U.S.C. §§ 3559 and 3571, violations of quarantine regulations would be classified as Class A misdemeanors subject to these proposed penalties. Without further legal analysis, we are unable to address that argument in these comments. However, ATA notes that many of the potential requirements in proposed parts 70 and 71 are unspecified in the regulations themselves and subject to the discretion of the Director of the CDC. It may be difficult or impossible for an airline to ascertain what is required in

terms of compliance in advance of an incident which produces a violation subject to these significant penalties. Lack of notice, vagueness, and failure to subject specific requirements to notice and comment would make enforcement of these requirements and imposition of penalties for their violation problematic from a Constitutional standpoint.

XIII. CONCLUSION

For the foregoing reasons, ATA strongly recommends that CDC defer taking any final action with respect to the proposed passenger information requirements until further consideration has been given to a more efficient, feasible and coordinated approach. Before CDC issues a regulation to require passenger information collection and reporting, it should work with the relevant departments and agencies of the federal government to develop uniform, consistent and workable approaches across the federal government and ensure that any resulting requirements imposed on the airline industry represent the minimum collection burdens necessary to achieve legitimate governmental objectives. The federal government needs to coordinate collection of airline passenger information and to develop one system that will work to achieve the various governmental objectives involved. The proliferation of different regulations and proposals for airline information collection, methods and requirements must be harmonized with the airline's need for uniform and workable standards.

If any new regulation of private industry is warranted, which we question, it should not be imposed only on the transportation sector and air transportation in particular, but should be implemented in a uniform manner across industry to allocate responsibilities for compliance in a reasonable and equitable manner. The airline industry should not be required to carry an unfair and disproportionate burden for these public health concerns.

Respectfully submitted,

Katherine B. Andrus
Assistant General Counsel
Air Transport Association, Inc.