Nationalizing Public Health Emergency Legal Responses

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Abstract: The fight for public health primacy in U.S. emergency preparedness and response to COVID-19 centers on which level of government — *federal or state* — should "call the shots" to quell national emergencies?

The COVID-19 pandemic has exposed a plethora of inadequacies, gaffes, and botches in U.S. preparedness and response that have contributed to massive deaths and injuries, many of which were preventable as evinced through efficacious responses in other industrialized nations.[1] Failures to equitably and efficiently allocate scarce resources, test and screen at-risk individuals, trace known contacts, treat infected patients, enforce social distancing, require masks, and remedy economic harms have pocked U.S. response efforts.[2] Consequently, a nation with extensive resources and public health capacities has grossly underperformed in controlling an infectious disease due in part to political resistance and inconsistent responses across its jurisdictions.

While the global pandemic is by no means over, improving epidemiological trends suggest prior infections and extensive vaccinations may result in herd immunity among Americans in 2021.[3] Forthcoming post-pandemic assessments will focus on why the U.S. is a global leader in how not to respond to a major public health crisis. Blame lies at every level of government. Meaningful analyses, however, may identify underlying sources of America's pandemic woes and forge better pathways to respond to similar or new public health threats.

Generating a revamped national response plan includes determining which level of government — *federal or state* — should "call the shots" to quell pandemics. The easy answer suggests both levels of governments have essential roles to play under constitutional principles of cooperative federalism.[4] Yet, real-time execution of respective federal and state public health responses to COVID-19 has (1) led to considerable political turmoil (costing President Trump a second term[5] and contributing to insurrection riots[6]), (2) ravaged the U.S. economy,[7] (3) revealed gross health inequities across subpopulations,[8] (4) risked the lives of hundreds of thousands of frontline responders and health care workers,[9] (5) contributed to substantial mental health consequences for tens of millions of Americans,[10] and (6) lowered life expectancy for all Americans by over a year.[11] Whether due to flawed planning, preparedness, or execution, no one seeks a repeat performance in subsequent pandemics. Avoiding it necessitates substantial resolution of who is actually in charge in the fight for public health primacy.

As explored below, state governments initially sought national guidance and resources while drawing legal lines in the sand leading to divergent approaches, disease spread, and ensuing deaths. Federal responses shifted from tepid[12] to tactless[13] to torrential[14] as the pandemic worsened and administrations changed hands. President Joe Biden

About This Column

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won the 2020 election with a promise to take on COVID-19[15] through national strategic planning.[16] In the end, federal assertions of public health emergency powers during both Presidential administrations will reshape the battle plan for U.S. public health emergency responses for decades to come.

State-Level Pandemic Responses via Cooperative Federalism

Foundational principles of cooperative federalism support the notion that federal and state governments share responsibility for preserving the nation's health.[17] States are reserved inherent police powers to generally protect public health and safety. Enumerated powers ascribed to the federal government are limited, but supreme. The COVID-19 pandemic has severely tested the boundaries of federalism, revealing substantial drawbacks of a nation of sovereign states attempting to respond to a disease that ignores boundaries. Within two weeks between February 29 and March 15, 2020, every state declared some sort of emergency in response to the pandemic — a first in U.S. history.[18] Resulting execution of emergency public health powers has since been scattershot, inconsistent, and at times contrary to known or emerging science and best practices.

Over the course of the pandemic, states (and localities) have diverged across nearly every facet of public health emergency response. Some have implemented extreme social distancing measures (e.g., shelter-in-place orders, travel bans, border controls, massive business closures) over long periods, sparking extensive litigation over individual constitutional protections.[19] Others have rushed repeatedly to re-open their economies despite clear evidence and actual experience that disease would spread.[20] Mask mandates have varied so extensively across the U.S. that President Biden challenged all Americans to use them for the first 100 days in office.[21] Several states including Texas dropped their mask requirements before half that time.[22]

However, when state emergency responses differ for political reasons unrelated to public health science, efficacy, and equity, novelties are instantly overshadowed by preventable injuries and deaths. Tens of thousands of Americans have died from COVID-19 based on their misfortune of living in a jurisdiction that did not prioritize effective emergency responses.

Even as free vaccines rolled out of President Trump's successful Operation Warp Speed,[23] states crafted variable priorities for their allocation notwithstanding federal guidance.[24] Residents in some states crossed borders to access vaccines denied them in their own jurisdictions.[25]

Not all legal variations are problematic given contrasting impacts of the pandemic among state populations.[26] By design federalism encourages state-based experimentation as a source of governmental innovation.[27] State and local initial responses to shutter select businesses, schools, and events, for example, revealed real-time public health benefits mimicked elsewhere.[28] However, when state emergency responses differ for political reasons unrelated to public health science, efficacy, and equity, novelties are instantly overshadowed by preventable injuries and deaths. Tens of thousands of Americans have died from COVID-19 based on their misfortune of living in a jurisdiction that did not prioritize effective emergency responses.[29]

Federal Assertions of Public Health Authorities

The Trump administration fueled incongruities among states by initially encouraging and largely deferring to their emergency response efforts.[30] The federal Department of Health and Human Services (HHS) declared a public health emergency on January 31, 2020,[31] but six more weeks passed before President Trump issued concurrent national emergency declarations on March 13.[32] At that moment, national and state emergency responses seemed to be aligning. Yet, by mid-April, against the backdrop of widespread social distancing, religious fervor over closures, and mounting economic impacts, President Trump fanned the flames of an emerging federalism firestorm by aggressively calling for states to re-open.[33] States like Arizona,[34] Florida,[35] and Texas[36] acquiesced. Other states (e.g., California,[37] Michigan,[38] and New York[39]) resisted despite threats from the Department of Justice to legally challenge conflicting state actions.[40] Deleterious outcomes of premature state-based re-opening strategies followed. Infection rates sky-rocketed in a second wave of cases by June 2020 leading to renewed calls for greater social distancing with vaccines still months away.[41]

Even as President Trump endorsed reckless state-based responses, the federal government embarked on a series of its own critical legal interventions. HHS Secretary Alex Azar invoked the Public Readiness and Emergency Preparedness (PREP) Act[42] on January 31, 2020 to extend liability protections for persons and entities utilizing medical countermeasures (MCMs) and preempt contrary state or local actions.[43] When Nevada health authorities restricted use of a MCM (i.e., a specific COVID-19 test they deemed inaccurate in nursing facilities) in October 2020,[44] federal authorities retorted that the PREP Act declaration negated their objections.[45] Nevada officials relented. The declaration was later

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amended to preempt contrary state laws related to medical licensure and personnel needed to distribute vaccinations,[46] despite clear intrusions on the domain of state-based professional regulatory boards.

The Centers for Medicare and Medicaid Services (CMS) waived extensive regulations to enable wider uses of telehealth across publicly-funded health services.[47] The Food and Drug Administration (FDA) stretched its emergency use authorities to usher specific products to market (including some treatments proven later to be ineffective).[48] The Centers for Disease Control and Prevention (CDC) flexed its regulatory powers to quarantine entire plane loads of Americans early on in the pandemic.[49] It subsequently used the same interstate disease control powers to expand mask requirements to all public transportation hubs[50] and impose a residential eviction moratorium,[51] currently under judicial review.[52] With Presidential approval Congress passed multiple bills like the CARES Act[53] to provide unprecedented economic relief to individuals and businesses.

These and other initiatives were punctuated later by President Biden through "war-like" strategic responses[54] framed in the realm of national security and global prioritization. The Biden-Harris administration envisioned increasing federal roles and responsibilities toward (1) implementing a comprehensive, domestic vaccination program;[55] (2) prioritizing CDC's national standards for disease control;[56] (3) hiring 100,000 new public health workers;[57] (4) increasing access to testing, including a new FDA-authorized at-home test;[58] (5) expediting the manufacture of vaccines and other essential products through the Defense Production Act (DPA);[59] (6) overhauling public health data surveillance and reporting;[60] (7) re-opening schools and businesses safely;[61] (8) expanding access to health care services via the Affordable Care Act;[62] and (9) assuring equity across racial, ethnic, socio-economic, and other lines.[63] States retained key roles in the new national strategy, but the objectives to combat COVID-19 were indubitably and unapologetically cast as federal in nature.[64] On March 10, Congress passed the American Rescue Plan Act of 2021,[65] infusing hundreds of billions into COVID-19 response efforts based on expanded federal priorities.[66]

End Game: A New Paradigm for National Emergency Responses

Despite lingering and active state resistance on largely political grounds, a stronger, enhanced federal presence in pandemic response efforts has already positively impacted public health outcomes. Rates of infections and hospitalizations have declined drastically.[67] Vaccinations have escalated weekly.[68] Viable plans to safely re-open schools[69] and businesses have emerged.[70] Economic recoveries are projected or underway in some sectors.[71] Virulent, unpredictable new strains of coronavirus resistant to current vaccines may diminish hopes but returns to a level of normalcy in 2021 are squarely in sight.

Execution of the Biden-Harris strategic plan to combat COVID-19 is likely a primary contributing factor to improved health outcomes. Less certain is whether the current strategy serves as a definitive battle plan to quell the next major emerging infectious disease. Multiple factors related to the source of disease spread (e.g., whether natural or via bioterrorism), ease of transmission, affected populations, timing of initial responses, duration, economic aspects, and shifting political ideologies mean the next substantial health menace may not assimilate the current one.

However, key legal themes surfacing from the COVID-19 pandemic point to a new paradigm for U.S. domestic responses through federal authorities, including:

- *Focus on national security interests* — characterizing future emerging infectious diseases as threats to national security allots pre-eminent control to federal authorities uniquely positioned constitutionally to address them via effective, coordinated responses.[72]
- *Assertive use of federal interstate commerce authorities* — increasing applications of the federal commerce power extend the reach of national public health priorities across states to combat conditions that thrive amid disparate approaches.
- *Federal controls over acquisition, production, and distribution* — national emergency declarations and corresponding Presidential executive orders vault federal contracts for essential goods to the "top of the list" over competing state deals.[73] Expanded use of the DPA envelops private industry in emergency responses under federal direction.
- *Conditional spending to promote uniformity* — as per the 2021 campaign to vaccinate America, national control of the purse includes setting constitutional conditions for receipt of federal funds and resources to which jurisdictions must abide.[74] On March 11, President Biden asserted that states must open vaccination registries to all adults by May 1, 2021.[75] States' non-adherence may require alternative federal interventions to reach affected state populations.
- *Centralized oversight of testing, screening, surveillance, and health services* — HHS, CMS, CDC, and other federal agencies (when allowed politically to fully function) have considerable powers, resources, and clout to oversee and coordinate public health and health care services and data collections in emergencies.
- *Federal preemption of dissension* — even as multiple state legislatures introduce bills to limit executive authorities and restrict localities,[76] broadening exercises of the PREP Act and other federal laws may preempt conflicting state actions (or inactions) provided federal powers fall within the gambit of national security responses.

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- *States as players* — enhanced exercises of federal public health emergency authorities do not displace states' essential roles on the frontlines of response. States not only retain the capacity to intervene in promotion of their population's health but will also be counted on to effectuate national health priorities. Limiting ad hoc, state-by-state reactions to an equivalent health threat resulting in gross inequities entails appropriate federal assertions of power and use of resources to (a) assure greater uniformities across states and (b) maximize every American's chance to survive the next calamity.

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