

# Federalism in Pandemic Prevention and Response

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**SUMMARY.** Federal-state conflicts over business regulations, controls on personal movement, and financial support and coordination of supply chains have dominated headlines during the coronavirus pandemic. States hold the reins on most community mitigation measures (e.g., quarantine and isolation, physical distancing, and mask wearing), which may vary depending on local conditions. The federal government has authority to promulgate national guidelines and surveillance capabilities that states rely on when implementing, modifying, and easing community mitigation measures, but these guidelines have been inconsistent or absent. The federal government has provided limited financial support and coordination of supply chains to provide a foundation for state and local implementation of more targeted mitigation measures, which depend on widespread testing and disease surveillance. Federal-state conflicts have stymied efforts to ramp up and coordinate need-based distribution of resources for: 1) implementing widespread testing, tracing, and supported isolation and quarantine of individuals; 2) ensuring widespread availability of adequate personal protective equipment for health workers, other essential workers, and the general public; and 3) ensuring widespread access to therapeutics and vaccination based on equitable and public health-based criteria.

## Introduction

In our federalist system, authority and responsibility for protecting the public's health is shared between the federal government, Tribal governments (addressed in Chapter 10), and the states, which typically delegate some of their authority to local governments. The federal government is limited to the exercise of powers enumerated in the Constitution. In contrast, states have plenary power to safeguard the public's health, safety, and welfare. Supreme Court precedents have interpreted limited federal powers—including powers to regulate interstate commerce and to spend for the general welfare—broadly, however, making it possible for Congress to encroach upon domains of traditional state and local authority. When the federal government acts, it can preempt state and local law. Similarly, state governments typically have broad authority to preempt local law.

Recognizing the substantial resources and interstate and international coordinating authority an effective public health crisis response requires, Congress has granted the federal administration a wide range of authorities that it can (but need not) use to address pandemics. Federal officials are authorized—but not obligated—to act: 1) to prevent the international or interstate spread of infection; and (2) in situations where state and local capacity is likely to be overwhelmed. These non-mandatory powers include providing critical supplies and financial resources. In some areas—including approval of laboratories, medical tests, vaccines, and drugs—Congress has preempted state authority. In other

areas—including travel restrictions, and isolation and quarantine of individuals—federal and state authority overlap. With so many overlapping authorities and responsibilities, it is unsurprising that inter-jurisdictional finger-pointing has marked nearly every major public health crisis in recent American history (Gostin & Wiley, 2016).

Federal-state conflicts over regulatory authorizations, business regulations, controls on personal movement, financial support, and coordination of supply chains have stymied the U.S. coronavirus response. Preventing a global pandemic from reaching the United States by stopping the spread of infection from international travelers and preventing community transmission from becoming widespread would have required more readily accessible testing than federal regulations, guidelines, and supply-chain coordination allowed. By the time community transmission was detected in multiple U.S. locations, targeted strategies relying on testing and isolating infected individuals and tracing and quarantining their contacts were not adequately funded to contain the spread of disease. As state and local governments entered the mitigation phase of the pandemic, most adopted restrictions on businesses and personal movement that exceeded the U.S. Centers for Disease Control and Prevention (CDC) (2020b) and White House (2020) guidelines. When the public became restless, state and local leaders eased restrictions more rapidly than federal guidelines recommended. At times, state and local efforts were coordinated regionally, but for the most part social distancing restrictions

varied considerably by jurisdiction. Throughout the crisis, federal financial support, legal protections (e.g., for employment, housing, and access to health care), and critical supply chain coordination have been needed, but inadequately provided, to: 1) implement widespread testing, tracing, and supported isolation and quarantine of individuals; 2) enable people and businesses to comply with social distancing while minimizing secondary harms; 3) ensure widespread availability of adequate personal protective equipment for health workers, other essential workers, and the general public; and 4) ensure widespread access to medical supplies and countermeasures based on equitable and public health-based criteria. The abdication of federal responsibility to support state and local efforts has exacerbated racial, socioeconomic, and geographic disparities in COVID-19 mortality and secondary impacts on housing, food, and economic security.

### State and Federal Powers to Ensure Access to Testing

Testing is the foundation of modern pandemic prevention and response. If a virus is spread primarily by people who are symptomatic, isolation of the sick and quarantine of their contacts provides a highly effective and targeted approach to containing the spread of disease. The pre-symptomatic and asymptomatic spread of SARS-CoV-2 (the virus responsible for COVID-19) present greater challenges, requiring widespread and more or less continuous testing to screen the general population for infected cases so they can be isolated and their contacts can be traced, quarantined, and tested. In the absence of widespread testing, state and local governments have imposed restrictions on businesses and the general population.

A coordinated response to a novel virus requires suspension of Food and Drug Administration (FDA) regulations for approval of medical devices and laboratory certification (that would otherwise slow the release of test kits and processing of results, and which preempt state and local authority to approve new tests and other countermeasures) and an influx of federal funding for research, development, stockpiling, and distribution of critical supplies (Gostin & Wiley, 2016). The Defense Production Act authorizes the president to order manufacturers to produce these supplies and give priority to federal orders, but without adequate funding from Congress to pay for them, its usefulness is limited (see Chapter 23). CDC guidelines typically ensure uniform testing criteria, but if they are too rigid, they can impede local efforts to respond to dynamic conditions.

Federal efforts to ensure access to testing for SARS-CoV-2 have been largely unsuccessful (Shear et al., 2020). Upon Health and Human Services (HHS) Secretary Alex Azar's declaration of a public health emergency on January 30, 2020, federal agencies began to suspend FDA regulations and initiate public investments in research and production of test kits and other supplies. But a series of missteps led to a slow roll-out of testing. Secretary Azar decided to order CDC to develop a new test, rather than relying on tests the World Health Organization had deemed reliable. The initial CDC test kits were contaminated, stymying state and local containment efforts. Even as more reliable tests were pushed out, scarce supplies and laboratory capacity necessitated narrow CDC criteria that initially limited testing to symptomatic patients

with a history of travel to an affected area. In the last few days of February, shortly after CDC permitted state public health labs to begin processing tests and eased federal guidelines for who should be tested, community transmission was confirmed among several patients with no relevant travel history and no exposure to people known to have been infected (Shear et al., 2020). By that point, early efforts to contain the spread of infection from travelers to the general population had failed and the virus was already circulating widely in many parts of the United States. In March and April, with testing capacity still extremely limited, state and local leaders were left to make the only safe assumption: that community transmission was widespread throughout their jurisdictions and physical contacts among the general population must be drastically limited because anyone could be a silent carrier of infection. In the absence of a coordinated, federal approach, some governors have attempted to use interstate compacts to work together to secure supplies; others have been at odds with each other, using personal connections with suppliers and the president to obtain supplies for their own states while competing with others. On the whole, state efforts have been inadequate to shift to a more targeted pandemic mitigation or containment strategy.

The federal programs that have failed to ensure adequate access to testing are the same programs that are tasked with vaccine development and distribution. Unless supply chains, CDC guidelines which patients should be given priority for vaccination, and adequate funding for basic infrastructure—including PPE for the workers providing vaccinations and simple but scarce supplies like syringes, needles, and vials—can be secured by federal officials, the failures of early 2020 could be echoed in a massively failed vaccination campaign in 2021.

### State and Federal Powers to Ensure Quarantine and Isolation of Individuals

While we wait for safe, effective, and widely distributed vaccines and other medical countermeasures, community mitigation strategies to separate the infected and exposed from the unexposed are our best defense. State and local governments have primary responsibility for quarantine and isolation of individuals within their states. Federal statutes give the director of the CDC authority to issue federal quarantine and isolation orders to stop the international or interstate spread of disease, but this authority has been used rarely in the modern era (Gostin & Wiley, 2016).

Although federal and state quarantine and isolation authorities overlap, they have not created major conflicts during the coronavirus pandemic. There were early clashes between federal authorities and local governments over where repatriated Americans would be permitted to disembark and stay for the duration of their quarantine, but these were settled through the use of military facilities and changes to CDC quarantine protocols (Chappell, 2020). Federal quarantine orders were issued to confine Americans the U.S. State Department repatriated from Wuhan, China and cruise ships (CDC, 2020a). There was at least one report of a local authority issuing its own quarantine order when one of these individuals sought to leave federal quarantine (Wigglesworth, 2020). States like New York and California were unable to follow through on contract tracing and management of people entering

from outside the United States, in part because of the antiquated system for getting information from federal authorities at the border to state officials responsible for quarantine (Myers et al., 2020). Overall, quarantine and isolation orders have not played a significant role in the pandemic because, by the time testing was more widely available, community transmission had become so widespread as to overwhelm federal, state, and local capacity to issue and enforce individual orders.

### State and Federal Powers to Ensure Social Distancing and Face Covering Among the General Population

Federalism constraints were a significant barrier to the uniform, nationwide “lockdown” restrictions and face covering requirements some commentators argue would have ensured a more effective response to the coronavirus pandemic (Haffajee & Mello, 2020). At one point, the president asserted that social distancing restrictions were not within governors’ control because “[t]hey can’t do anything without approval of the president of the United States,” and “the authority of the president of the United States [over social distancing restrictions] is total” (White, 2020). In July, the president threatened to withhold federal funding from schools that did not fully return to in-person instruction. Legal scholars were quick to rebut his assertions of authority, clarifying that governors hold the reins on social distancing and face covering, subject to preemptive legislation by Congress (Gordon et al., 2020). Under the Constitution, federal restrictions on business operations and personal movement or requirements to wear face coverings must be adopted as a valid exercise of federal powers enumerated in the Constitution. Power to regulate interstate commerce and impose conditions on the acceptance of federal funds would probably be sufficient to permit Congress to adopt uniform social distancing restrictions and face covering requirements, but without a more specific delegation than the Public Health Service Act currently provides, the president does not have authority to interfere with state social distancing or face covering orders.

The federal government has authority to provide national guidelines and coordinate disease surveillance for states to rely on when implementing, modifying, and easing community mitigation measures, but CDC and the White House have exercised this authority in ways that have created inconsistency and even outright conflict (Wiley, 2020). For example, CDC’s community mitigation framework for COVID-19 was not widely publicized and its recommendations were contingent on data that was missing due to lack of widespread testing (CDC, 2020b). On March 16, the White House issued “15 Days to Slow the Spread,” which recommended that certain groups—people who feel ill, people who test positive for COVID-19 and their family members, and people who are older or who have serious underlying health conditions that put them at increased risk—should stay at home (White House, 2020). They also recommended that “[i]n states with evidence of community transmission, bars, restaurants, food courts, gyms, and other indoor and outdoor venues where groups of people congregate should be closed” (White House, 2020). By the end of March, when the White House extended its guidelines to “30 Days,” the majority of state and local governments had already implemented orders that went further than the White House recommended, ordering all

nonessential businesses to close and the general population to stay at home. Federal guidelines for easing social distancing restrictions were issued by the White House, not CDC. The guidelines were cautious but were nonetheless perceived as politically motivated by several governors, who announced that they would adopt their own plans. Some state and local officials adopted criteria for lifting social distancing restrictions only after testing, tracing, and isolation had been ramped up to provide an alternative mitigation strategy. When it became very clear that comprehensive federal support for testing and tracing was not forthcoming, and as the public began to question whether hospitals were truly at risk of becoming overwhelmed if restrictions were lifted, most governors lifted restrictions without regard to the cautious gating criteria they initially announced. Though their actions were inconsistent with official White House guidelines, they were cheered on by President Trump and his supporters.

Some state and local governments relied on informal compacts to coordinate their efforts to regulate businesses and restrict personal movement. Commentators suggested inter-jurisdictional coordination was critical to limit the incentive for residents to travel across jurisdictional lines for purchases or services not offered in their home jurisdiction. It may also have offered a modicum of political cover by minimizing the risk that any given official would be perceived as an outlier. On March 16, for example, the governors of New York, New Jersey, and Connecticut announced they would coordinate their prohibitions on gatherings and restrictions on bars, restaurants, gyms, movie theaters, and casinos other than those operated on tribal lands. The same day, several local health officers in the Bay Area of California issued nearly identical shelter in place orders, breaking the floodgates on “lockdown” style restrictions in the United States. Months later, some state and local governments coordinated their reopening strategies. For example, in April, governors of New York, New Jersey, Connecticut, Pennsylvania, Delaware, Rhode Island, and Massachusetts said they would launch a coordinated effort to reopen on their own terms. The governors of California, Washington, and Oregon made a similar joint announcement (White, 2020). But regional coordination gave way to varying reopening approaches in May. In late June, New York, Connecticut, and New Jersey coordinated their quarantines on travelers from states with rising case counts, including states like Florida that had previously issued quarantines on travelers from New York, Connecticut, and New Jersey.

Proponents of very strict social distancing and face covering orders expressed concern about lack of national uniformity (Haffajee & Mello, 2020), but it is unlikely they would have approved of a federally-controlled response that resulted in nationally uniform, but lighter, restrictions or preemption of state and local face covering mandates. Along with separation of powers constraints (discussed in the preceding Chapter), federalism constraints have allowed state and local governments to adopt and maintain health measures the president clearly opposes. Regardless of whether tighter or looser restrictions and mandates would have been a better approach, inconsistent messaging from federal, Tribal, and local leaders about the goals of social distancing, the level

of restrictions needed, and for how long may have eroded public cooperation and trust. Inconsistent federal messaging on face coverings certainly has.

Although social distancing strategies have focused primarily on restrictions on businesses and personal movement, supports to enable people to comply with public health recommendations are equally important. Federal efforts to provide financial support (e.g., stimulus payments and unemployment insurance), legal protections (e.g., paid family, medical, and quarantine leave), and accommodations (e.g., adapting federal school meal programs to allow pick-up service) to ensure that everyone is able to comply with social distancing restrictions and recommendations while minimizing secondary harms were spotty and inconsistent. Many state and local governments took steps to freeze evictions and utility shut-offs and provide nutrition support, but without more federal assistance, these efforts were largely stop-gaps.

### **State and Federal Powers to Support Other Strategies to Minimize Reliance on Social Distancing**

State constitutional and statutory prohibitions on deficit spending and limited authority and capacity to coordinate international and national supply chains have hampered states' ability to implement less disruptive, more targeted strategies for mitigating the spread of the novel coronavirus. A scale-up of testing and tracing sufficient to safely ease restrictions would have required significantly more funding and coordination of complex international and national supply chains for scarce testing supplies. State and local governments have moved forward with easing social distancing restrictions in spite of not having adequate testing capacity to reliably detect and control outbreaks. Many state and local governments have relied on recommendations and mandates for the general population to wear face masks while looking to vaccination as a strategy for ending the pandemic some time in 2021. But even if a safe and effective vaccine is developed, its public health impact will depend on wide distribution. Distribution of vaccine supplies, if and when they become available, will depend on the same federal-state partnership that was intended to widely distribute testing supplies, medical equipment, and medicines. 🌐

# Recommendations for Action

## Federal government:

- Congress should use its appropriations power to:
  - o Provide more resources to state and local governments to implement supports, accommodations, and legal protections to enable individuals, families, employers, landlords, and local communities to comply with social distancing recommendations and restrictions. This financial support should not be conditioned on adopting a less cautious approach to social distancing restrictions (including school closures) or face covering requirements;
  - o Provide more funding to state and local governments to support testing and contact tracing.
- To strengthen capacity and reduce political interference with scientific analysis, Congress should urgently consider legislation to reorganize the CDC as an independent agency, on the model of the Federal Reserve.
- Congress should mandate and fund an effort to rebuild CDC's information infrastructure to ensure its disease surveillance reports and guidelines to governments, clinicians, businesses, private organizations, and individuals are accurate and free from political interference.
- To address shortages, bottlenecks, and interstate competition for scarce supplies, Congress should:
  - o Fund the purchase of PPE and test kits – including more accurate, less invasive tests that provide faster results – for distribution to state and local governments via the Strategic National Stockpile;
  - o Replace permissive language in the Public Health Services Act with mandatory language to direct the Department of Health and Human Services to support state and local efforts by acquiring and distributing supplies via the Strategic National Stockpile.
- Congress should amend the Public Health Service Act to add transparency and accountability mechanisms requiring the secretary of HHS and director of CDC to articulate the scientific basis for any guidance or orders issued pursuant to the authority provided by the Public Health Service Act to control the spread of communicable disease.

## State governments:

- Every emergency declaration should include the following information:
  - o Specific epidemiological data supporting the order;
  - o Specific requirements for social distancing and mask wearing;
  - o An explanation of why the order is needed;
  - o An explanation of why the order does not violate personal freedoms.
- States should consider amending their constitutions and/or statutes imposing balanced budget requirements to permit deficit spending in times of crisis.
- In the absence of effective federal action, governors should take greater advantage of interstate compacts to coordinate acquisition and need-based distribution of supplies, and, eventually, vaccines.



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