

A Chronological Overview of the Federal, State, and Local Response to COVID-19

Lindsay K. Cloud, JD, Katie Moran-McCabe, JD, Elizabeth Platt, JD, MA, Nadya Prood, MPH
Temple University Beasley School of Law, Center for Public Health Law Research

SUMMARY. Since the first case of COVID-19 was confirmed in the United States, federal, state, and local governments have taken varying degrees of legal action to prevent the spread of the virus and mitigate its impact on the public's health and health care systems. Federal action has primarily consisted of national emergency declarations, travel bans, guidance on social distancing measures, and laws aimed at mitigating the economic impacts of COVID-19. Legal action at the state and local level has focused heavily on social distancing requirements and other emergency measures to reduce the spread of the virus, including stay-at-home orders, prohibitions on large gatherings, closures of non-essential businesses and schools, and the mandatory use of face masks. This Chapter provides an overview of these actions, chronicling the federal and state legal response from January to July 2020, and highlighting policy trends at the local level from March to July 2020.

Introduction

The World Health Organization (WHO) declared the 2019 outbreak of COVID-19 a pandemic on March 11, 2020. Although researchers believe isolated incidents of coronavirus hit the U.S. in December 2019, the first U.S. case of COVID-19 was confirmed by the Centers for Disease Control and Prevention (CDC) on January 21, 2020 – with cases totaling 2,624,873 and deaths reaching 127,229 as of July 1, 2020. Since its arrival, federal, state, and local governments have taken legal action to prevent the spread of COVID-19 and mitigate its devastating impact on population health.

The U.S. Federal Response to COVID-19

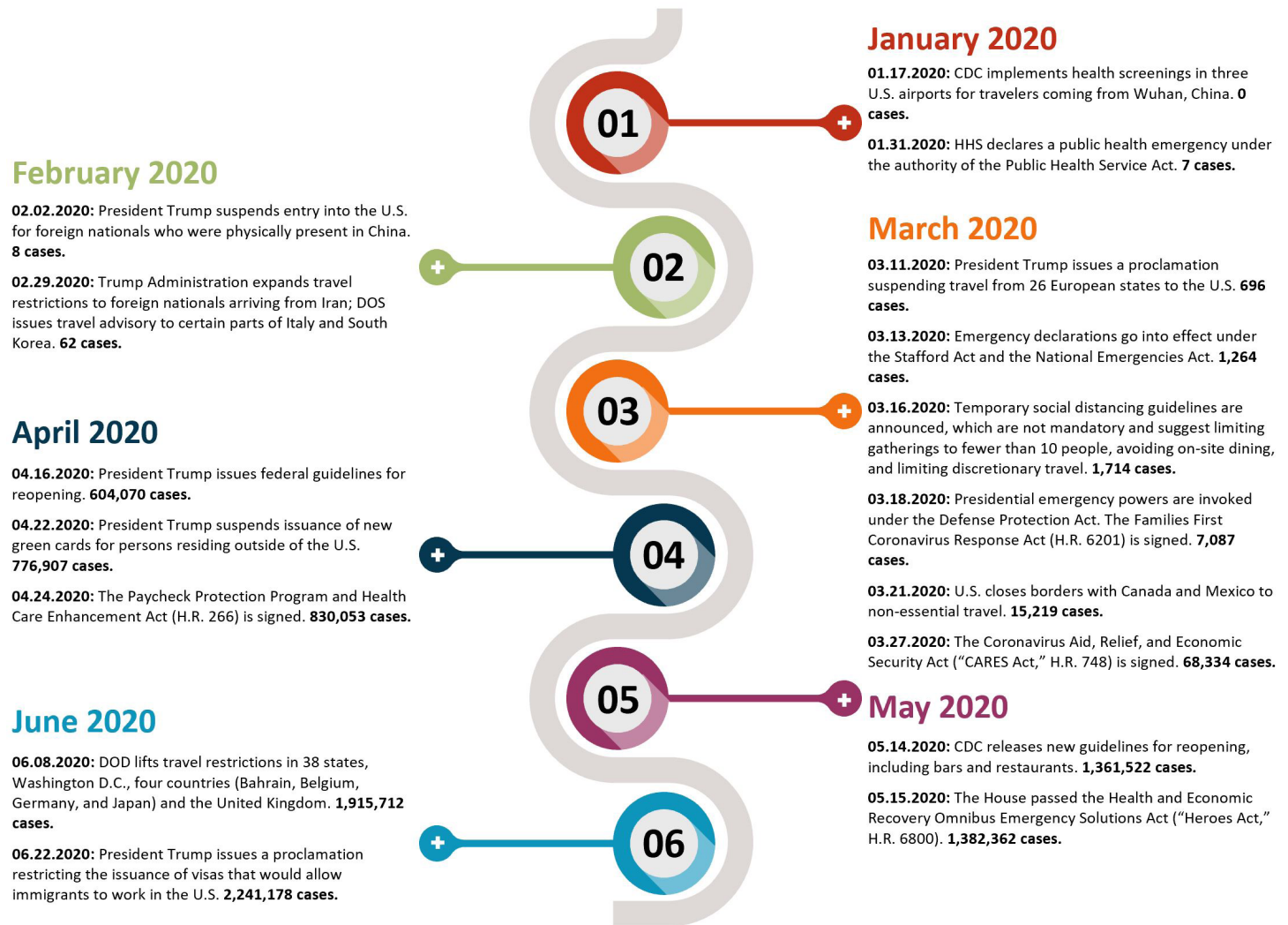
In times of national emergencies, the U.S. federal government has the broad legal authority to activate federal emergency powers to protect health and human life. Three primary sources of statutory authority – the Public Health Service Act, the Stafford Disaster Relief and Emergency Assistance Act (the Stafford Act), and the National Emergencies Act – allow the federal government to issue emergency declarations, which enables the release of funds and activates immediate response efforts to reduce the spread of a virus. Each of these has been activated in the wake of COVID-19; however, the chronology of these declarations exposes the delay in action in what could have been a united, sweeping, and life-saving federal response.

Figure 1.1 provides a timeline of the legal and regulatory actions the federal government took in response to the COVID-19 outbreak from

January 2020 through June 2020, including the respective national case counts (World Health Organization, 2020).

Together, the Public Health Service Act, the Stafford Act, and the National Emergencies Act trigger additional statutory powers that grant the government broad sweeping authority to rapidly deploy prevention and safety measures and respond to the financial needs of U.S. citizens. More specifically, the authority of Section 319 of the Public Health Service Act allows the Secretary of Health and Human Services (HHS) to declare a public health emergency, make grants, activate certain federal funds (e.g., the Public Health Emergency Fund), and investigate the cause, treatment, or prevention of a disease. The public health emergency initially declared on January 31, 2020, was renewed on July 23, 2020. Both the Stafford Act and the National Emergencies Act provide the federal government statutory authority to declare a national emergency. A national emergency declaration, as opposed to a public health emergency, directly empowers the president to activate certain presidential authority, such as the ability to activate the National Guard and seize control of the internet. In response to the COVID-19 pandemic, the declaration of a national emergency freed up \$50 billion in federal funds for states and territories, assisted with the allocation of medical resources across the country (see Chapter 24), initiated the emergency powers of the Federal Emergency Management Agency, and waived certain insurance provisions. Additional presidential powers were also invoked under the Defense Production Act, including the ability

Figure 1.1: A chronology of the U.S. federal response to COVID-19, January – June 2020.



to allocate materials (e.g., the production and distribution of ventilators), services, and facilities as needed to assist in public defense (see Chapter 23).

In addition to exercising existing statutory power, the federal government passed new laws in response to COVID-19. The Families First Coronavirus Response Act (H.R. 6201) was signed to fund free coronavirus testing, provide extended family medical leave and paid sick leave for workers, and expand unemployment benefits. The Act temporarily expanded the Family Medical Leave Act by covering leave for an employee who is unable to work or telework because they need to care for a child under 18 if the child’s school or daycare is closed due to COVID-19. This Act also required employers with fewer than 500 employees to provide paid sick leave for employees unable to work due to medical advice, a government quarantine or isolation order, caring for others under a government order, seeking medical treatment for COVID-19 symptoms, or caring for children at home due to school or daycare closures. The Coronavirus Aid, Relief, and Economic Security (CARES) Act (H.R. 748), a \$2 trillion stimulus bill, provided direct payments to eligible individuals with income of less than \$99,000, or individuals with a household income of less than \$198,000. The

CARES Act also included substantial funding for small business relief (\$375 billion) through the Paycheck Protection Program and Healthcare Enhancement Act (H.R. 266), expanded unemployment benefits (\$260 billion), and suspended federal student loan repayments without interest until September 30, 2020.

While the federal government took legal measures to stimulate the economy, issue international travel bans, and provide discretionary guidance and expertise, state and local governments used their authority to issue a wide array of mandatory social distancing requirements in an effort to mitigate the spread of COVID-19.

The U.S. State Response to COVID-19

The Center for Public Health Law Research (CPHLR) at Temple University’s Beasley School of Law is tracking COVID-19 emergency declarations and mitigation policies at the state level from January 20, 2020 through July 1, 2020 (Center for Public Health Law Research, 2020). CPHLR is utilizing a rapid assessment policy surveillance process to expedite the publication of open-source longitudinal data, accompanied by direct legal citations and full text versions of the state orders for all 50 states and the District of Columbia. By July 1, 2020, the states had collectively made more



Figure 1.2: A chronology of the first states to issue select measures in response to COVID-19, February – June 2020.

than 1,000 legal changes, including emergency declarations, travel restrictions, stay-at-home orders, business closures, gathering bans, elective medical procedure restrictions, and face mask requirements. Figure 1.2 provides a timeline of the first states to implement certain measures, along with the corresponding national COVID-19 case numbers as reported by the WHO.

Washington was the first state to declare an emergency due to COVID-19 on February 29, 2020. Similar to declaring an emergency at the federal level through the National Emergencies Act, state emergency declarations activate the power of the state executive or the state health officer to suspend or waive regulatory rules, streamline administrative procedures, or expend emergency funds. By March 16, 2020, all 50 states and the District of Columbia had issued an emergency declaration. Figure 1.3 shows the daily progression of the state emergency declarations that were issued between February 28, 2020 and July 1, 2020.

Once declaring an emergency, states began to issue mitigation policies at a rapid pace of just about every day. State governors

began announcing statewide school closures, and by March 20, 2020, 39 states and the District of Columbia closed K-12 public schools by executive order. These initial closures were intended to last for a matter of weeks, only to later be extended through the end of the school year by subsequent executive orders. On March 19, 2020, California started a trend of statewide stay-at-home orders. Within the subsequent two weeks, 32 more states and the District of Columbia issued statewide stay-at-home orders, as depicted in Figure 1.4. The remaining six states implemented stay-at-home orders by April 7, 2020, while Arkansas, Connecticut, Iowa, Kentucky, Massachusetts, Nebraska, North Dakota, Oklahoma, South Dakota, Texas, Utah, and Wyoming never issued explicit statewide stay-at-home orders as of July 1, 2020.

By April 1, 2020, 47 states and the District of Columbia issued various orders closing non-essential businesses statewide, which may include retail businesses, bars, restaurants, entertainment businesses (e.g., movie theaters, concert halls), gyms, and personal service businesses (e.g., hair salons, barber shops). Other state actions included restrictions on elective medical procedures,

Figure 1.3: New statewide emergency declarations by the day, February 28, 2020 – July 1, 2020.

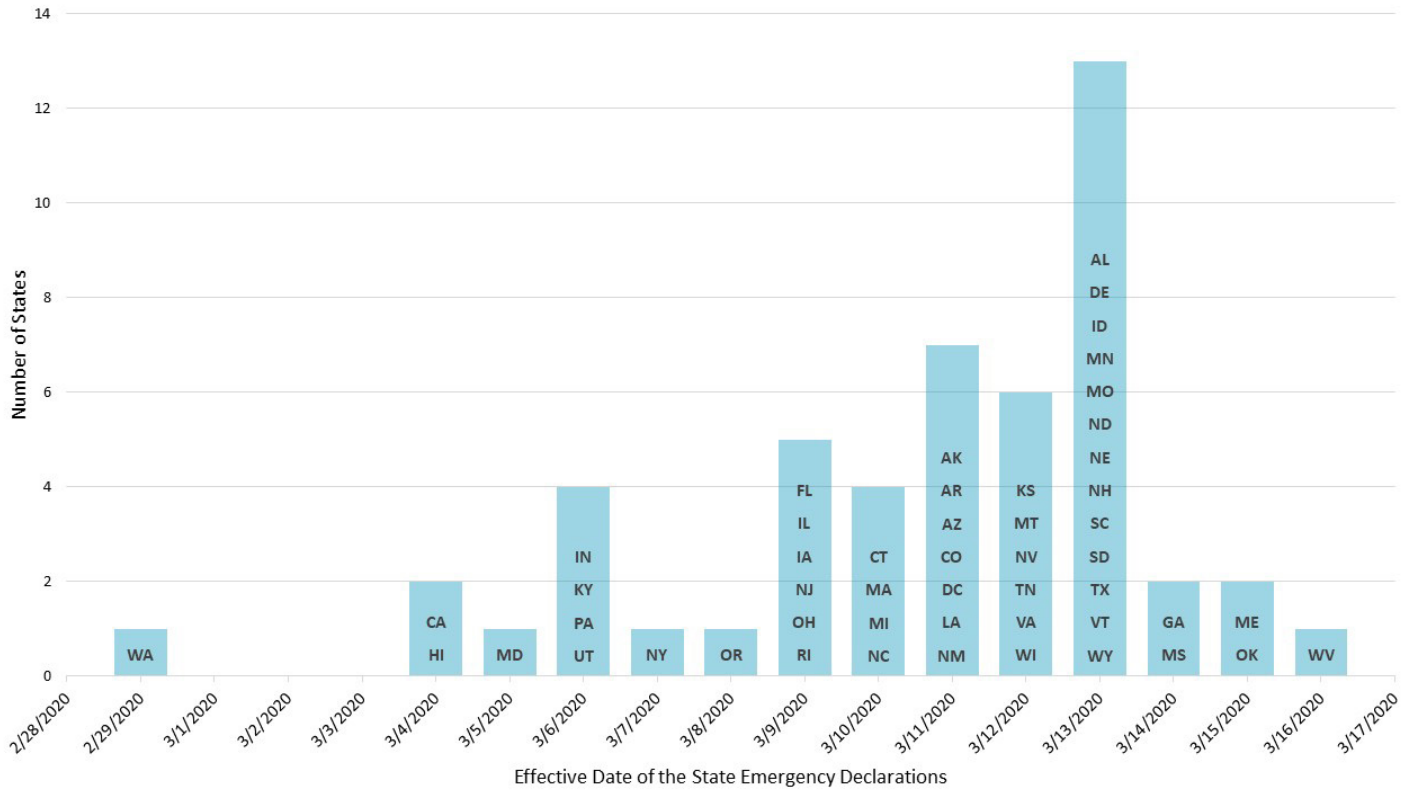


Figure 1.4: New statewide stay-at-home orders by day, March 18, 2020 – July 1, 2020.

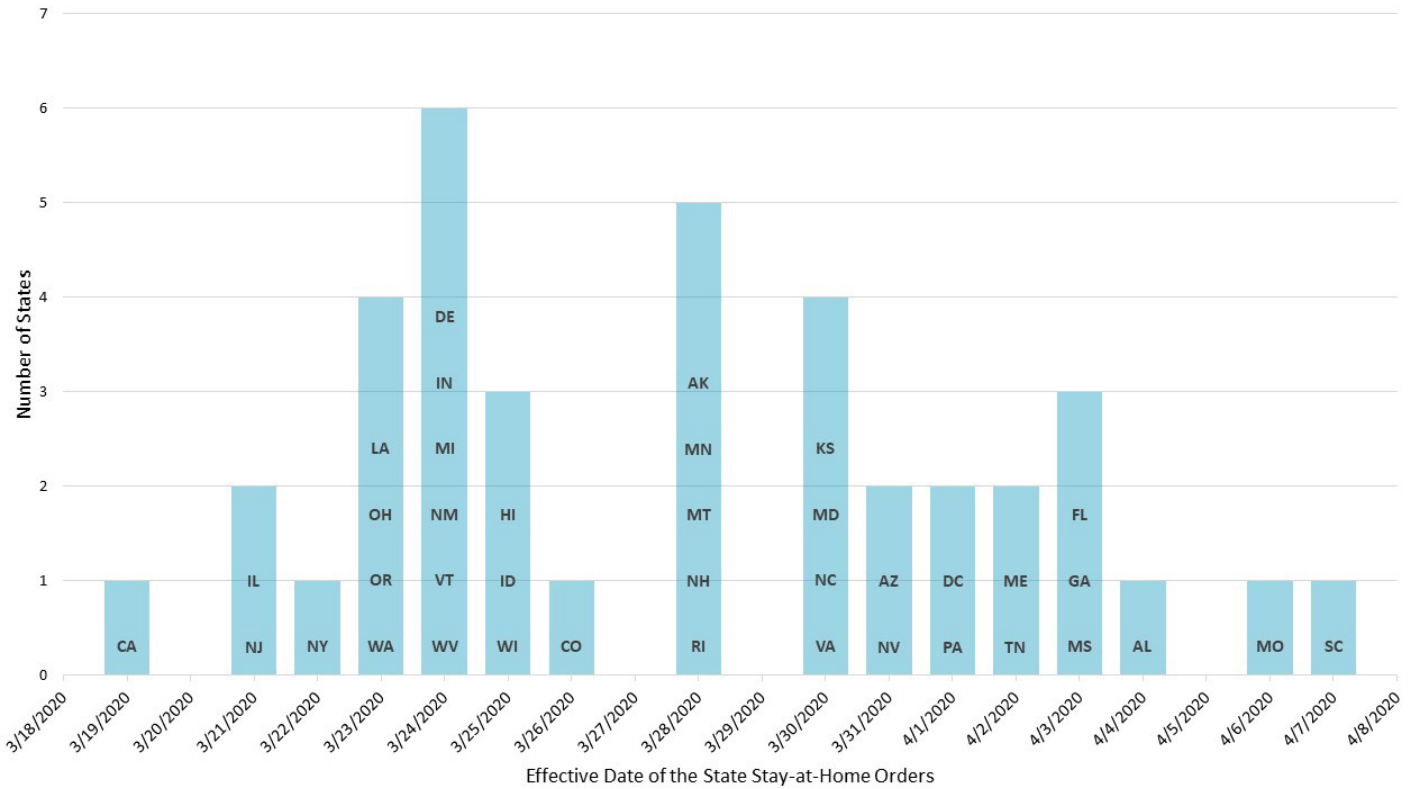
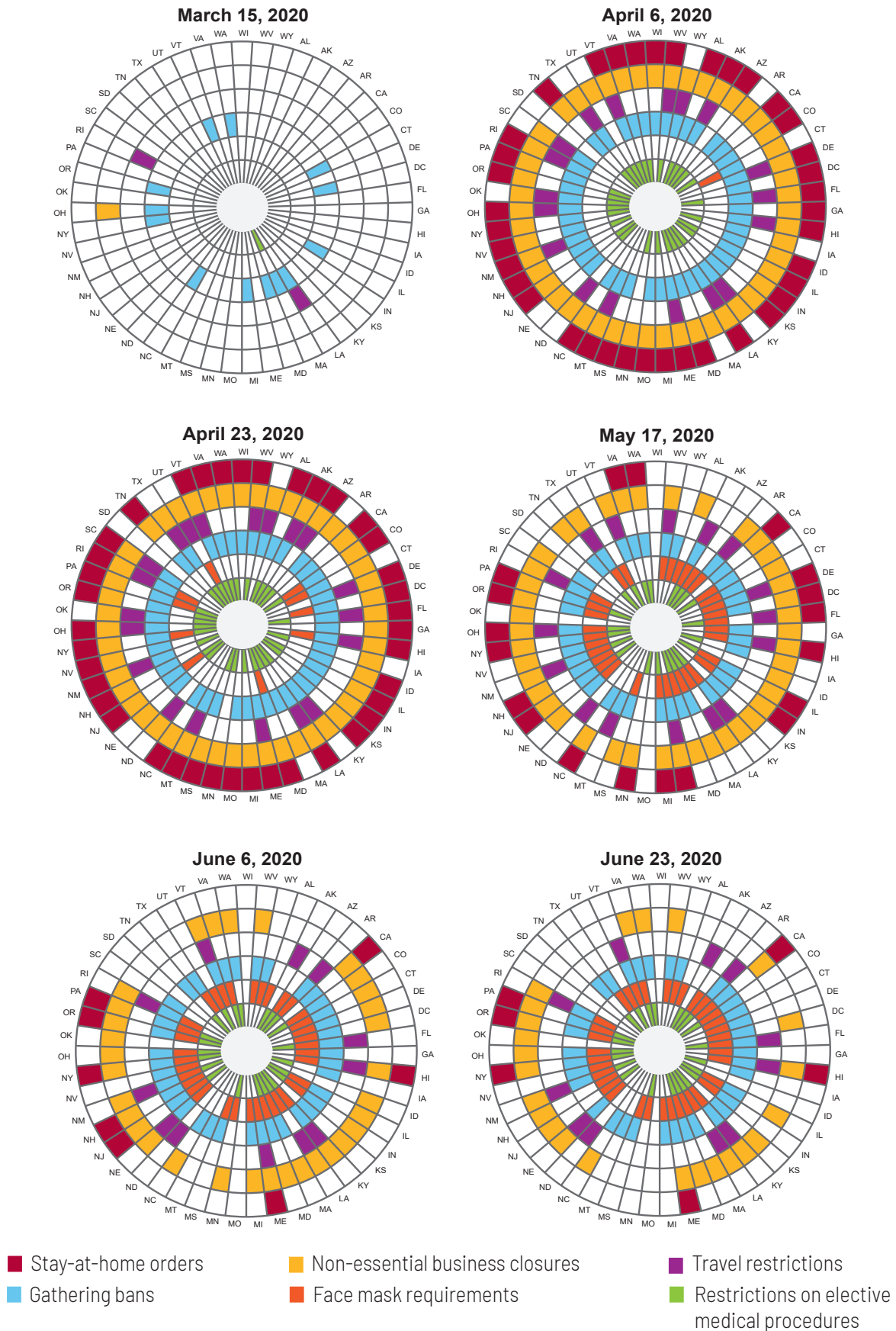


Figure 1.5: State COVID-19 mitigation measures, March 15, 2020 – June 23, 2020.



including abortion, and temporary policies for correctional facilities to limit physical contact and mitigate spread (see Chapters 15 and 31). State action also extended to housing issues by imposing temporary moratoriums on eviction and foreclosure proceedings, as well as utility and water shutoffs (The Eviction Lab, 2020) (see Chapter 25). In terms of legislation, state legislatures passed appropriations bills, created unemployment relief programs, and amended state telehealth laws to increase access to care (see Chapter 16).

Between March 11, 2020 and April 11, 2020, 20 states instituted restrictions on travelers, 12 of which required all travelers entering the state to self-quarantine for 14 days. Six of these states required people entering the state from early hotspot states, like New York, New Jersey, and Connecticut to quarantine for 14 days. As of June 1, 2020, only 12 states still had restrictions on travelers. By late June, due to the emerging hotspots in the South and Southwest, and the decrease of new cases in the Northeast, the travel restrictions traded places as the original hotspot states of New York, New Jersey, and Connecticut began issuing advisories for travelers from states like Arizona, Texas, and Florida (Stracqualursi, 2020).

Between January 20, 2020 and July 1, 2020, states enacted mitigation policies covering at least six major topics, including stay-at-home orders, gathering bans, non-essential business closures, face mask requirements, travel restrictions, and restrictions on elective medical procedures. The charts in Figure

1.5 provide snapshots of these legal measures at approximately three-week intervals between March 15, 2020 and June 23, 2020. The highpoints for almost all of these legal measures occurred during the month of April: as of April 6, 2020 and April 23, 2020, 50 states issued a business closure order and 46 states issued gathering bans. As of April 23, 2020, 39 states issued explicit stay-at-home orders, 20 states had travel restrictions in place, and 31 states restricted elective medical procedures. As states began to reopen, they started to implement face mask requirements, with 37 states requiring individuals in public settings, customers, or employees to wear face masks as of June 23, 2020.

Beginning in late April, states began to relax restrictions. After the White House issued guidelines for reopening on April 16, 2020, states started developing their own reopening plans. Alaska was the first state to lift its stay-at-home order on April 24, 2020. By June 22, 2020, 34 states and the District of Columbia explicitly lifted their stay-at-home orders. Figure 1.6 shows the progression of states explicitly lifting stay-at-home orders through July 1, 2020 alongside the total number of national COVID-19 cases, according to the WHO.

From mid-April through the beginning of May, states implemented reopening plans often with county- or region-specific phases, allowing certain types of businesses (e.g., personal service businesses and fitness centers) to reopen at a reduced capacity following strict social distancing measures. After a spike in cases in late June, however, some states like Texas paused their reopening

Figure 1.6: Total number of states explicitly lifting stay-at-home orders (left y-axis) with the total number of COVID-19 cases in the U.S. (right y-axis), April 23, 2020 – July 1, 2020.

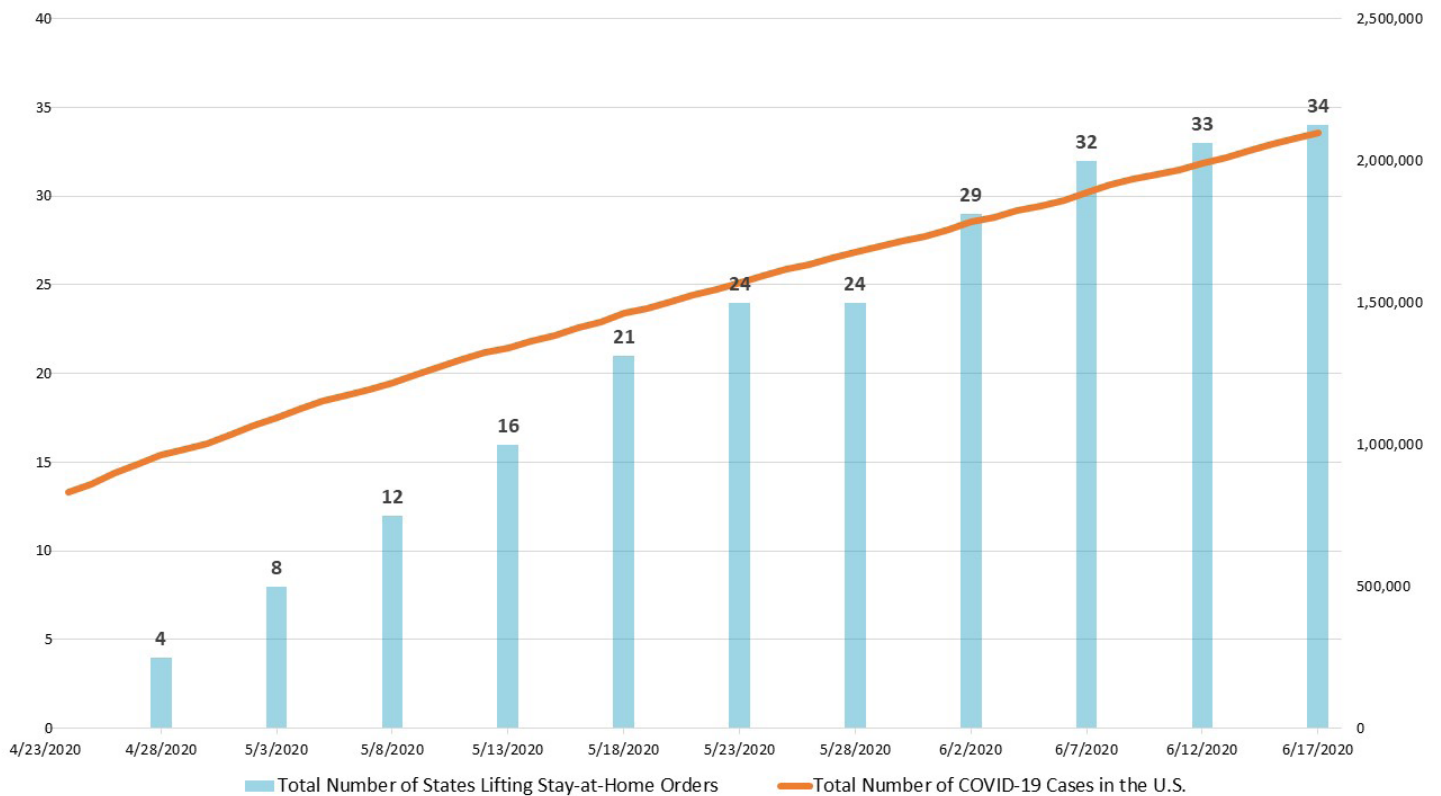
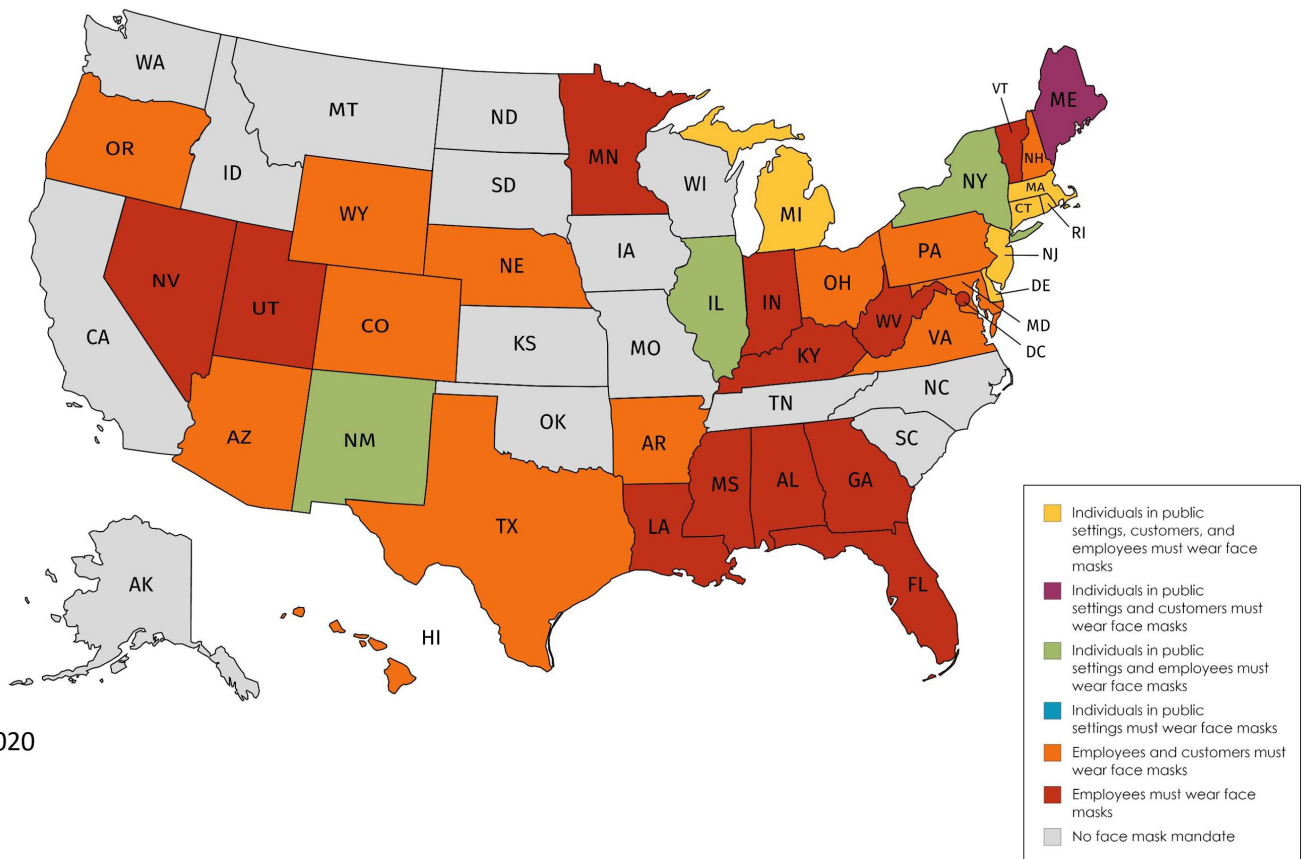
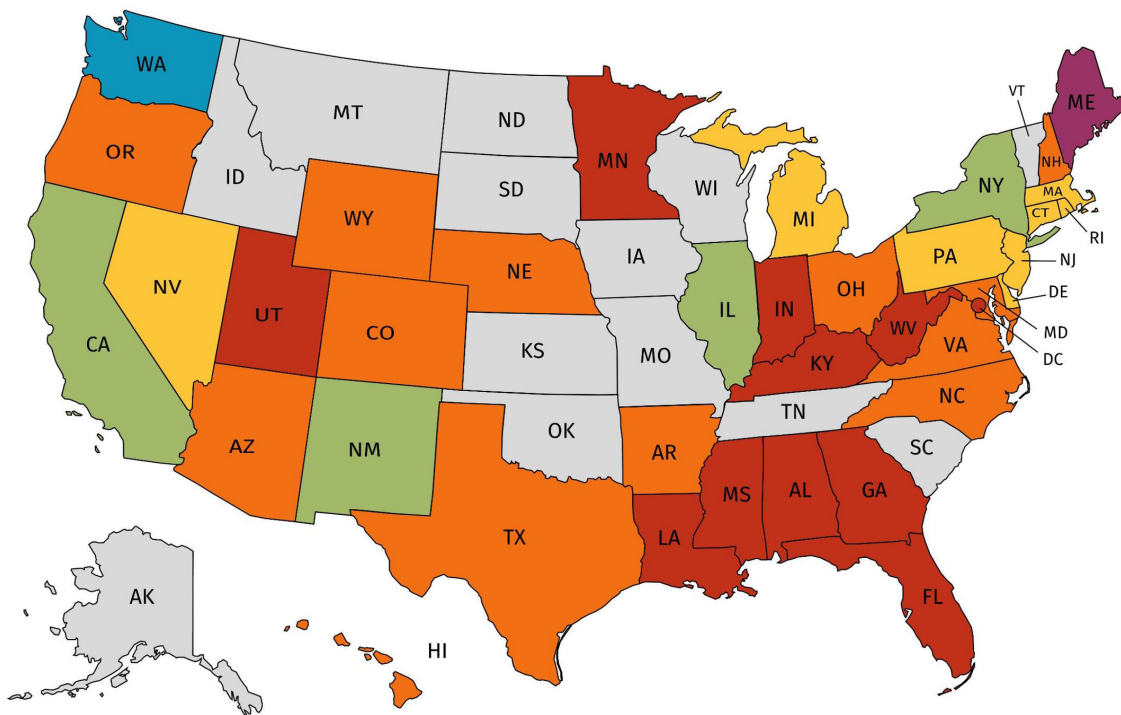


Figure 1.7: State emergency orders requiring face mask use on June 1, 2020 and July 1, 2020.



June 1, 2020



July 1, 2020

plans by delaying plans for indoor dining or re-instituting closures. By July 1, 2020, five states began to re-close bars, movie theaters, and gyms.

With the stay-at-home orders lifting and businesses reopening, states began to require people to wear face coverings in public places, while taking public transportation, or while shopping at newly reopened retail businesses. As of June 1, 2020, 36 states had some type of face mask mandate in place, six of which required individuals in public settings, customers, and employees to wear face masks. By July 1, 2020, 38 states had a face mask mandate, with eight states requiring individuals in public settings, customers, and employees to wear face masks, as illustrated in Figure 1.7.

During the COVID-19 outbreak, states explicitly preempted local governments from enacting specific mitigation policies, or superseded local orders covering the same subject matter in the state order. Preemption is a legal doctrine that allows a higher level of government to restrict, or prevent, the authority of a lower level of government (see Chapter 9). As of June 1, 2020, 18

states blocked local action by preempting county, municipal, or tribal governments. For example, the Mississippi stay-at-home order blocked local authorities from enforcing more restrictive orders, which required cities to cancel earlier issued city-level mitigation measures (Davidson & Haddow, 2020). States also exerted their power over localities in the absence of explicit preemption provisions. For instance, the governor of Nebraska told counties they would not receive money under the federal CARES Act if they required people to wear masks in government buildings (Mena, 2020). On the other hand, as of June 1, 2020, 17 states expressly allowed local governments to impose more restrictive requirements that went beyond state measures. Further, states have also both blocked and permitted local action. For example, the governor of Arizona partially reversed his previous preemption mandate, allowing local officials to set face mask requirements, but maintained the preemption impacting other business restrictions (Local Solutions Support Center, 2020).

The U.S. Local Response to COVID-19

The local level emergency response to COVID-19 includes policies issued by municipalities and counties aimed at reducing the spread

Figure 1.8: A chronology of select municipal measures in response to COVID-19, March – June 2020.

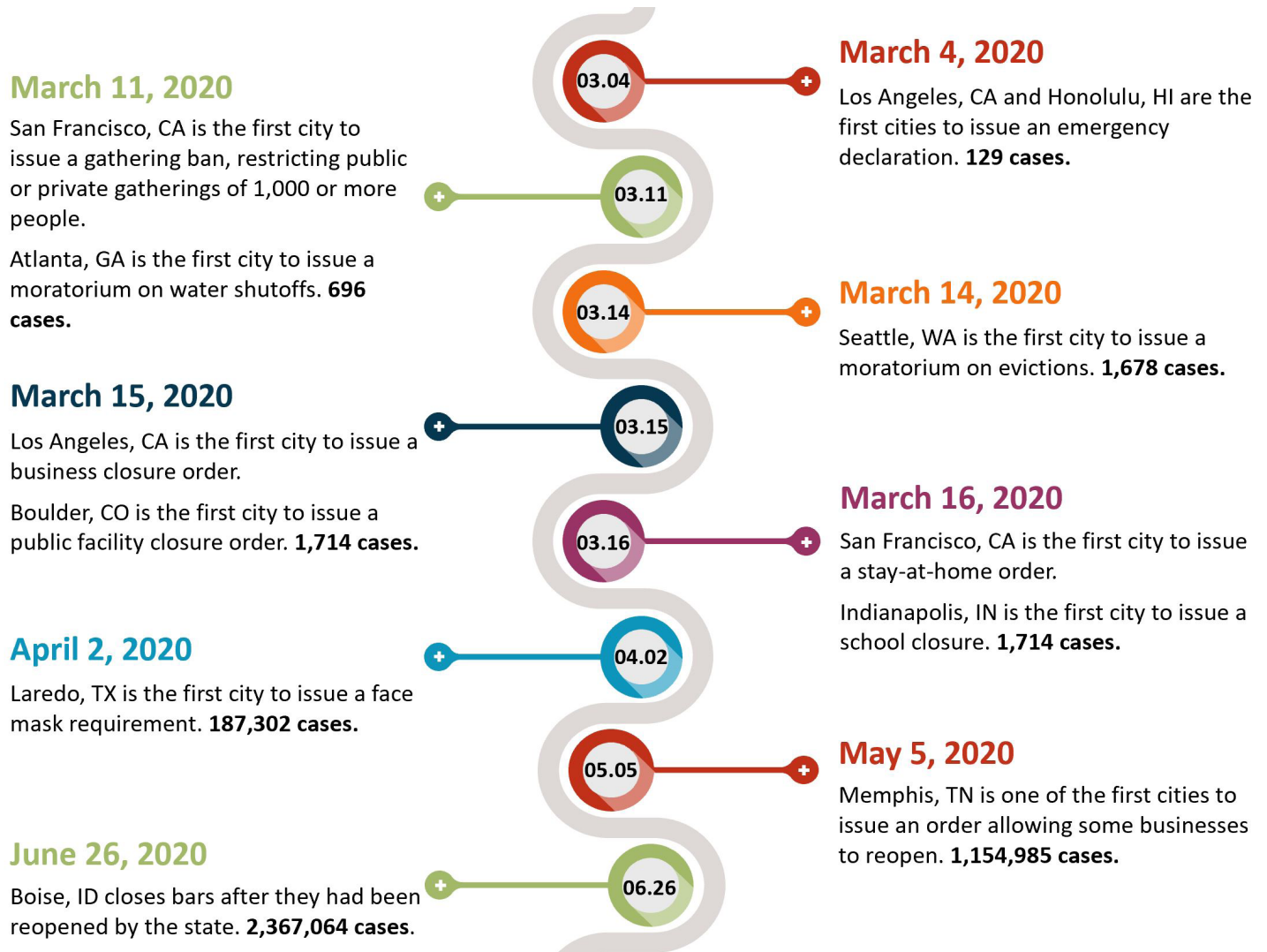
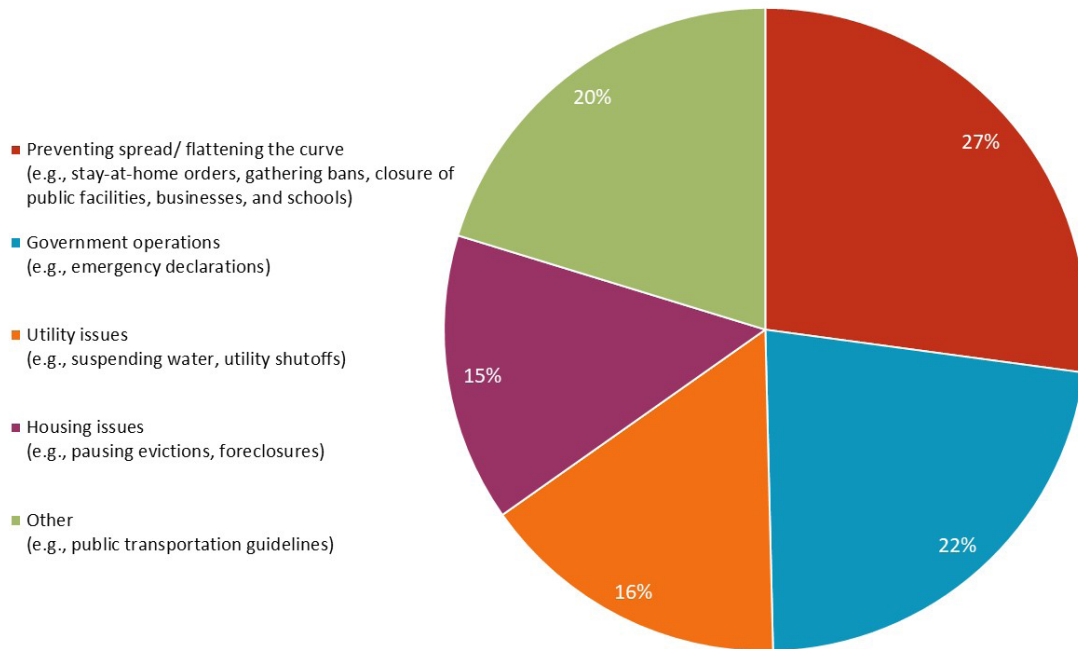


Figure 1.9: Types of COVID-19 municipal policies in the U.S., March – June 2020.



of the virus and mitigating the economic impact on residents. Localities have taken many of the same measures as the states, by issuing emergency declarations, stay-at-home orders, and business closure orders. As of April 15, 2020, at least 864 counties had issued an emergency declaration, and at least 169 counties had established either a safer-at-home or a business closure policy (National Association of Counties, 2020). As of July 1, 2020, at least 511 cities had established one or more policies in response to the COVID-19 outbreak.

Figure 1.8 provides a timeline of the first cities to implement certain measures along with the corresponding national COVID-19 case numbers as reported by the WHO. The policy information included in the timeline is based on data from the National League of Cities (NLC) which could be independently verified by CPHLR (National League of Cities, 2020).

In addition to issuing emergency declarations and closure orders, cities established other types of measures, including temporarily suspending evictions, temporarily suspending water and utility shutoffs, and addressing public transportation issues. Figure 1.9 illustrates the composition of the primary types of municipal policies that were issued in response to COVID-19 using the data tracked by NLC (National League of Cities, 2020).

Other types of local-level response include: government actions to protect incarcerated individuals, including ordering the release of people in jail; providing emergency paid leave for workers not covered by the federal Families First Coronavirus Response Act; and protecting access to food, including defining essential services to include food banks, and defining essential activities to include obtaining or providing fresh food (A Better Balance, 2020; Healthy Food Policy Project, 2020; Prison Policy Initiative, 2020). Local policies, when not preempted, may establish additional measures that are not required by the federal or state responses to COVID-19.

Conclusion

The U.S. legal response to the COVID-19 outbreak was comprised of a range of actions taken by the federal, state, and local governments. The federal government exercised its statutory authority to declare a national emergency, which allowed the government to release funds and initiate immediate response efforts. The federal government also issued guidance regarding social distancing and reopening measures. State and local governments went beyond issuing permissive guidance and established mandatory social distancing requirements. States and localities issued orders or proclamations requiring residents to stay home, closing businesses and schools, banning large gatherings, and requiring the use of face coverings. Among other measures, state and local governments also acted to temporarily suspend evictions, foreclosures, and utility and water shutoffs.

New state mitigation orders appeared almost daily between mid-March and early April. Legal activity began with closures and social distancing restrictions, then moved towards easing those measures and reopening businesses. With the resurgence of COVID-19 cases in June, states put reopening plans on hold, reverted to stricter mitigation policies, or even closed newly reopened businesses, as was the case in seven states by July 1, 2020. Many localities also established measures in response to COVID-19, with more than 850 counties and 500 cities having done so by July 1, 2020.

The legal response at the federal, state, and local level to COVID-19 has been unprecedented and continues to rapidly evolve across the United States. 🌞

About the Authors

Lindsay K. Cloud, JD, is the director of the Policy Surveillance Program at the Center for Public Health Law Research (CPHLR) at Temple University Beasley School of Law. Her work focuses on the intersection of law and public health. She oversees the creation of large-scale public health law research projects using legal epidemiology to scientifically analyze and track state, local, and international policies across various public health law domains. In addition to managing the creation of CPHLR projects, Lindsay trains government agencies, policymakers, researchers, and other external organizations on the tools and transdisciplinary methods used in public health law research with an aim towards applying law as an intervention to influence better health, well-being, and equity. She also serves as an adjunct professor within Temple University's College of Public Health teaching courses in public health and legal issues.

Katie Moran-McCabe, JD, is a Special Projects Manager with the Center for Public Health Law Research at Temple University Beasley School of Law. She has been very involved in the production of multiple datasets, including the CPHLR State COVID-19: Emergency Declarations and Mitigation Policies dataset, as well as datasets regarding city nuisance property ordinances and state abortion laws. She has also played a lead role in managing the Center's Legal Levers for Health Equity through Housing project.

Elizabeth Platt, JD/MA, is the director of the Policy Research Technology Program at the Center for Public Health Law Research at Temple University Beasley School of Law. She leads the development and production of the CPHLR State COVID-19: Emergency Declarations and Mitigation Policies dataset. Her other work at CPHLR focuses on custom legal research projects using technology-based tools for legal research and public health law practice. She leads the development of the Prescription Drug Abuse Policy System (PDAPS) and the legal research for the CityHealth project.

Nadya Prood, MPH, is the Technical Research Coordinator for the Center for Public Health Law Research at Temple University Beasley School of Law. She assists with researching and evaluating the implications of public health laws on society, and the writing of reports and articles. Prior to joining the CPHLR, she completed her MPH where she worked as a graduate research assistant under three principal investigators on research studies in the areas of mental health and substance abuse. For her master's thesis, Nadya conducted a qualitative analysis of message boards discussing opioid use.

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