Federalism in Pandemic Prevention and Response

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**SUMMARY.** An underfunded, uncoordinated patchwork of state-led interventions failed to protect the American people from the 2020 coronavirus pandemic and contributed to stark geographic, racial, ethnic, and socioeconomic disparities. In most cases, state, Tribal, and local governments are in the best position for on-the-ground implementation of community mitigation and medical countermeasures tailored to local conditions. But only the federal government has the inter-jurisdictional coordinating authority and deficit-spending ability necessary to support and harmonize public health activities and ensure equity during a nation-wide emergency. In 2020, the Trump administration failed to adopt clear guidelines for coordination among agencies and jurisdictions. Congress failed to provide adequate funding to ramp up federal, state, Tribal, and local public health infrastructure, to support the ability of businesses and households to comply with public health recommendations, and to protect disempowered workers and tenants. For the most part, the federal government left financially stressed, budget-constrained state governments to fend for themselves. In September 2020, the Centers for Disease Control and Prevention (CDC) took an important step to protect vulnerable renters by issuing an unprecedented nationwide eviction moratorium order, pushing the boundaries of the agency’s authority. Legal challenges to the federal moratorium were rejected by two federal district courts. The resulting judicial opinions could pave the way for a more expansive federal role in direct regulation of businesses and individuals, but questions about administrability and enforceability remain. In 2021 and beyond, federal regulatory and legislative reforms could put equitable and effective pandemic response on firmer footing or, alternatively, erode preparedness for future emergencies.

**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 12), 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, subject to constitutional constraints that protect individual rights. 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.

Although state governments bear primary responsibility for public health in our federalist system, pre-pandemic plans recognized that the federal government must play a key role in ensuring a nationally funded and coordinated response. In most cases, state, Tribal, and local governments are in the best position to provide on-the-ground implementation of community mitigation (e.g., quarantine and isolation, restrictions on businesses and personal movement, and mask wearing) and medical countermeasures (e.g., testing, treatment, and vaccination) tailored to local conditions. But only the federal government has the deficit-spending ability and inter-jurisdictional coordinating authority necessary to support and harmonize public health activities and ensure equity during a nation-wide emergency.

Recognizing the substantial resources and interstate and international coordinating authority an effective public health emergency response requires, Congress has granted the federal administration a wide range of authorities and resources that it may use to support states (Katz et al., 2017). Federal officials are authorized — but not legally 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 authority to provide critical supplies and financial resources using existing federal funds. In some areas — including approval of laboratories, medical tests,
In 2020, the president, Department of Health and Human Services (HHS) Secretary, and other officials frequently blamed, rather than partnered with states. Federal agencies could have relied on programs created by Congress in the aftermath of the 2001 terror attacks, the 2003 SARS outbreak, the failed response to Hurricane Katrina, and amid concerns about the potential for an influenza pandemic to provide financial support for and clear communication to states and other stakeholders (Katz et al., 2017). In addition, planning and guidance documents created by past administrations should have equipped the Trump administration to coordinate response efforts at the national level. But these legislative authorizations and administrative plans did not impose legally binding obligations on executive branch officials. When federal officials failed to exercise the responsibilities preparedness plans assumed they would, there was no legal mechanism for affected stakeholders to seek court orders requiring them to do so. Congress has not issued clear directives to the administration mandating action in response to emergencies, even when state and local resources and authorities are overwhelmed.

For more information on federal-state conflicts over regulatory authorizations, business regulations, controls on personal movement, financial support, and coordination of supply chains in the first half of 2020, please see Chapter 8 in Assessing Legal Responses to COVID-19: Volume I. This follow-up Chapter briefly discusses the balance between federal and state authorities to secure equitable access to medical countermeasures (e.g., testing, treatment, and vaccination), and support community mitigation (e.g., quarantine and isolation, restrictions on businesses and personal movement, and mask wearing). It then offers an extended examination of the September 2020 CDC eviction moratorium order and two federal district court opinions declining to enjoin it. These decisions could lay the groundwork for a more active federal role in directly regulating businesses and individuals as part of pandemic response efforts — in the Biden administration and well into the future.

**Federal Authority to Ensure Access to Medical Countermeasures**

Throughout 2020, the Trump administration and Senate leadership repeatedly disclaimed federal responsibility for ensuring access to personal protective equipment, testing, treatment, and vaccination based on equitable and public health criteria. Federal statutes, including the Public Health Service Act and the Defense Production Act (see Chapter 24) provide authorities and resources the administration could have used to secure supply chains and provide guidance and surveillance capabilities to support state efforts. Congress and the Trump administration invested billions in federal funding to support development and purchase of new tests, vaccines, and treatments. After providing initial public health, health care, and stimulus funding in March 2020, Congress failed to act again for several months.

Even as state and local health departments issued increasingly urgent calls for resources to support widespread testing and to initiate planning and infrastructure development for an unprecedented vaccination campaign, Congress failed to respond (NACCHO, 2020). Investments to secure the “last mile” of distribution, which are critical to ensure equitable access to medical countermeasures and their effective deployment as public health tools, were delayed until late December. Amid reports of logistical failures that predictably marred the early months of the vaccination campaign, some governors blamed federal guidelines for the allocation of scarce vaccines that were based on public health goals and equity. Some abandoned federal guidelines and announced that they would open up access to vaccines for age-based groups that vastly exceed the number of doses available at the time. They did so without ensuring adequate resources and coordination to do so equitably or efficiently, resulting in distribution of scarce vaccines based on connections to private hospital systems that received initial doses and the ability to spend hours navigating unpredictable and inaccessible systems (Blackstock & Blackstock, 2021).

**Federal Authority to Support Community Mitigation**

In 2020, the Trump administration failed to adopt clear guidelines to coordinate community mitigation efforts across jurisdictions. 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. 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, federalism constraints allowed state and local governments to adopt and maintain health measures the president clearly opposed. Regardless of whether tighter or looser restrictions and mandates would have been a better approach, inconsistent messaging from federal, state, 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 did.

Even more critically for equity, Congress failed to provide desperately needed funding to support the ability of businesses and households to comply with public health recommendations and legal protections for disempowered front-line workers and tenants at risk of eviction. 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, unemployment insurance, and rental assistance), legal protections (e.g., paid family, medical, and quarantine leave and a short-term extension of a federal eviction moratorium), 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. Americans waited months between the March 2020 and December 2020 relief bills. Many state and local governments took steps to freeze evictions and utility shut-offs and provide nutrition support, but without more federal financial assistance, these efforts were largely stop-gaps.

Judicial Decisions Defining the Boundaries of Federal Authority to Regulate Businesses and Individuals

From the earliest days of the pandemic, commentators speculated about whether the Trump administration could issue nationwide public health orders like those implemented in many other countries — or, alternatively, whether he could interfere with state orders by loosening or lifting them. 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, most legal experts assumed the president did not have authority to interfere with state social distancing or face covering orders. The combination of federalism constraints and uncertain statutory authority has caused both the Trump and Biden administrations to be appropriately hesitant to embrace a strong federal role in ordering business restrictions or mask requirements.

The primary source of authority for federal executive action to mandate and support social distancing and face covering is Section 361(a) of the Public Health Services Act (PHSA), 42 U.S.C. § 264. The key text, which dates to the original PHSA of 1944, authorizes the HHS Secretary “to make and enforce such regulations as in his judgment are necessary to prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the States or possessions, or from one State or possession into any other State or possession.” The statute refers to the Surgeon General, subject to the approval of the HHS Secretary, but following administrative reorganizations, it is now read to refer to the secretary directly, who has in turn delegated authority to the CDC Director and U.S. Food and Drug Administration (FDA) Administrator. A CDC regulation interpreting this authority states:

Whenever the Director of the Centers for Disease Control and Prevention determines that the measures taken by health authorities of any State or possession (including political subdivisions thereof) are insufficient to prevent the spread of any of the communicable diseases from such State or possession to any other State or possession, he/she may take such measures to prevent such spread of the diseases as he/she deems reasonably necessary, including inspection, fumigation, disinfection, sanitation, pest extermination, and destruction of animals or articles believed to be sources of infection (42 C.F.R. § 70.2).

A September 2020 CDC order halting evictions through the end of the calendar year pushed the boundaries that experts previously assumed applied to federal executive authority (CDC, 2020; Wiley, 2020). This was the agency’s first attempt to test the outer limits of its authority under Section 361 and Section 70.2. The order temporarily halted evictions of covered tenants from residential properties. Covered tenants were required to make a sworn declaration that they met income-based eligibility requirements and had exhausted available government assistance programs and that eviction would lead to homelessness living in “close quarters in a new congregate or shared living setting,” among other requirements. Interest groups argued that while the order could buy time for at-risk tenants by delaying evictions, it fell short of the rent-relief and other financial assistance needed to address the housing crisis and associated exacerbation of disease transmission (see Anderson, 2020).

The CDC eviction order was challenged by landlords on the grounds that it exceeded the agency’s statutory and regulatory authority, was not a proper exercise of federal power to regulate interstate commerce, inappropriately infringed on matters of state governance, and violated the landlords’ constitutionally protected rights.

In 2020, two federal district courts issued opinions refusing to enjoin the CDC eviction order: the Northern District of Georgia in Brown v. Azar, 2020 (Oct. 29, 2020) and the Western District of Louisiana in Chambless Enterprises v. Redfield, 2020 (Dec. 22, 2020). Both courts easily disposed of the individual rights challenges. They also readily rejected the federalism challenges, based on precedents interpreting the interstate commerce power broadly.

Both courts offered an extended analysis of the statutory and regulatory interpretation issue, describing the outer boundaries of the federal agencies authority to regulate businesses (and, by implication, individuals who are not reasonably suspected of being infected or exposed).

The plaintiff-landlords argued that the courts should rely on canons of statutory construction that essentially boil down to a directive that the courts should assume Congress did not intend to authorize such a sweeping agency order unless the legislature did so with “a high degree of clarity” (Chambless v. Redfield, 2020). The two federal district courts analyzed each of these canons of construction in detail and ultimately found that “the plain text of the statute is unambiguous and evinces a legislative determination to defer to the judgment of public health authorities about what measures they deem necessary to prevent contagion. Congress’s use of the phrase such regulations as in his judgment are necessary shows that it intended to defer to agency expertise” (Chambless v. Redfield, 2020).

These two decisions could have far-reaching implications for the federal government’s role in responding to the coronavirus pandemic and for federal communicable disease control powers more broadly. As Ilya Somin argued, “If Congress can delegate the
power to suppress virtually any activity of any kind, so long as the CDC claims that doing so is ‘reasonably necessary’ to reduce the spread of disease, it is hard to see how any meaningful limits on delegation would remain’ (Somin, 2020).

There are, however, meaningful constraints imposed by Section 361 and Section 70.2. Unlike state and local leaders, federal officials are limited to the exercise of powers enumerated in the Constitution. Public health — particularly community mitigation efforts that rely on controlled movement and business restrictions to slow the spread of infection — is primarily governed at the state level. The typical federal role — which has largely been abdicated in this crisis — is to finance, support, guide, and inform state and local efforts. Section 361’s emphasis on preventing the interstate spread of infection reflects the gap-filling role the federal administration is intended to play. Section 70.2 of the CDC’s regulations implementing Section 361 arguably narrows the federal role further, by making CDC authority contingent upon a finding that state and local efforts are “insufficient to prevent the spread of communicable diseases” across state and territorial borders.

CDC could further strengthen regulatory guardrails for compulsory measures intended to increase social distance and mandate use of personal protective equipment (such as face masks). Individually enforceable regulatory rights to hearings, such as those adopted in the CDC’s 2017 amendments to federal regulations governing individually targeted quarantine and isolation orders are not a good fit for orders applicable to the general population. But Congress could amend the PHSA (or CDC could revise Section 70.2) to require the CDC Director to articulate the scientific basis for any guidance or orders issued pursuant to Section 361, including the nexus between the order and the interstate or international spread of disease, and the insufficiency of state and local efforts.

In the early days of the Biden administration, CDC used Section 361 to renew the CDC eviction order and impose a mask requirement for public transit. Notably, the transit mask order applies to modes of public transit that are entirely intra-state. The order may be challenged, but it is probably justifiable as a valid exercise of the federal power to regulate the channels and instrumentalities of interstate commerce and economic activities with substantial effects on interstate commerce. Whether the new administration will issue additional CDC orders imposing nation-wide, federally-imposed restrictions on personal movement and businesses to increase social distance and mandate face covering remains to be seen.

There are reasons to be wary of expanding the federal role in social distancing restrictions and face covering mandates. For one, local conditions vary from place to place and time to time throughout the course of the pandemic. Nationally uniform rules may not always be appropriate or desirable. For another, enforcement options are more limited at the federal level. Section 368(a) of the PHSA, 42 U.S.C. § 271(a), makes any violation of a regulation issued under Section 361 a crime; 42 CFR § 70.18 provides that violations are subject to steep fines and jail time. CDC’s eviction and transit mask orders have relied on these provisions to indicate that harsh criminal penalties may be available. But enforcement mechanisms and the administrability of criminal penalties for a violation of broadly applicable CDC disease control orders remain unclear. Many state and local governments have used licensing-based penalties, such as smaller fines and suspension of business licenses, to enforce restrictions without relying heavily on criminalization and community policing. But federal agencies have little involvement in licensing and thus fewer levers available to incentivize compliance without resorting to criminalization. Federal financial support is crucial, but federal restrictions should be adopted with caution.

**Recommendations for Action**

**Federal government:**

- To ensure that the federal executive branch provides adequate financial support, addresses shortages, bottlenecks, and interstate competition for scarce supplies in future public health emergencies, Congress should 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.
- CDC should amend 42 C.F.R. § 70.2, to add transparency and accountability mechanisms requiring the secretary of HHS and the CDC director 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, including the nexus between the order and the interstate or international spread of disease, and the insufficiency of state and local efforts.
About the Author


References


