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## **American Public Health Federalism and the Response to the COVID-19 Pandemic**

Nicole Huberfeld, Sarah H. Gordon, David K. Jones

We dedicate this chapter to David K. Jones, our dear friend and coauthor who suffered an untimely death on 11 September 11 2021. We co-authored the article but completed revisions after his passing, honoring the thoughtfulness and precision he brought to all of our multidisciplinary projects. David cared deeply about health equity and social justice, and this work carries the imprint of his recent research in a particularly disadvantaged place, the Mississippi Delta. David's research in the Delta on the health inequities experienced by Black and other historically oppressed populations provides an important backdrop for understanding the ways in which the novel coronavirus pandemic exacerbated challenges faced by poor people of color in the U.S. More broadly, David's scholarship considered how U.S. federalist structures shape health inequities and can impact the objectives of public health. This chapter serves as a testament to David's commitment to these studies.

### **Abstract**

Benefits of American federalism are said to include flexibility to customize health policies to local preferences, maintain limited state budgets, and implement innovative health care delivery models. However, in the context of the novel coronavirus pandemic, the federalism structure of the U.S. public health system has hindered emergency response, contributed to greater rates of infection, increased the death toll, and exacerbated negative economic impacts. The power to enact disease containment measures largely rests with state and local authorities, contributing to wide variation in state responses. But early federal leadership inconsistencies pushed states officials to the frontline and slowed response times, fostering variability where common standards would have been more effective, and exacerbating health and economic inequalities. At the same time, early federal leadership often undermined efforts to contain the pandemic. This lack of oversight combined with a poorly-coordinated and fragmented response has reinforced existing geographic health inequities and exacerbated health disparities by race, ethnicity, and socioeconomic status. The pandemic has also spotlighted challenges for the U.S. health care safety net, including the Medicaid program and safety net hospitals. In short, COVID-19 highlights that federalism, despite being a deeply held American value, creates too much room for error in the face of a national public health emergency. Bolstering resiliency ahead of the next pandemic requires enacting a national floor with respect to public health preparedness and social welfare programs, including policy changes to streamline and coordinate the provision of personal protective equipment, standardize data collection, enhance support for safety net programs, and provide consistent access to affordable insurance for all Americans.

### **1. Introduction**

For the first year of the SARS-CoV-2 pandemic, the United States had the dubious distinction of being the global frontrunner in infection and mortality rates.<sup>1</sup> By January of 2021, COVID-19

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<sup>1</sup> Scottie Andrew, "The US has 4% of the world's population but 25% of its coronavirus cases," *CNN*, June 30, 2020, <https://www.cnn.com/2020/06/30/health/us-coronavirus-toll-in-numbers-june-trnd/index.html>.

became the number one cause of death in the U.S., with more Americans dying of COVID than World War II, the Vietnam War, and the Korean War combined. Many commentators blamed leadership failures for the lack of a coordinated response.<sup>2</sup> However, fundamental features of the American public health system complicated the launch of an effective and expedient response to the pandemic, interacting with both short and long-term leadership failures to result in more than 33 million COVID-19 infections and over 589,000 excess deaths.<sup>3</sup> One key feature is federalism, the governance structure common to public health laws that divides responsibility for given policies between federal and state governments.

Federalism has commonly cited benefits such as tailoring of policies to local populations and experimenting through the smaller “laboratories of democracy” of states and localities. But the weaknesses of public health federalism came into sharp focus in the face of a global infectious disease outbreak. Federalism significantly increases the need for coordination between government officials and necessitates dependable leadership, increasing complexity and variability by relying on fifty-one governments rather than one and increasing risk by creating more room for error.

Leadership and federalism were intertwined in the U.S. response to the novel coronavirus pandemic. Federal laws rely on both federal and state participation in implementation of national goals in a public health emergency. The federal government can issue guidance and direct funding, but day-to-day public health measures are operationalized by over 2,000 state and local health departments. If each official does not play their role at every level, relief efforts can fail to materialize or generate inequitable responses across states and localities. In addition, emergency response builds on historical policy choices that created vulnerabilities in the public health system, such that preexisting health and economic conditions were intensified by a public health emergency. During the novel coronavirus pandemic, a disproportionately high number of infections and deaths occurred within the populations of Black, Hispanic, indigenous, and other people of color.<sup>4</sup> The communities hit hardest by novel coronavirus also faced exacerbation of existing income, housing, education, and other inequities, reflecting in part that health is a function of location.

This chapter briefly provides an overview of the American public health emergency framework and highlights key leadership challenges that occurred at federal and state levels throughout the first year of the pandemic. Then the chapter examines decentralized responsibility in American social programs and states’ prior policy choices to understand how long-term choices affected

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<sup>2</sup> The Editors, “Dying in a Leadership Vacuum,” *New Eng. J. Med.*, October 7, 2020, <https://www.nejm.org/doi/full/10.1056/NEJMe2029812?query=TOC>; “The U.S. Is Missing Key Opportunities to End the COVID-19 Pandemic,” *The Dose — Commonwealth Fund*, January 15, 2021, <https://www.commonwealthfund.org/publications/podcast/2021/jan/us-is-missing-key-opportunities-end-covid-19-pandemic>.

<sup>3</sup> “COVID-19 Dashboard by the Center for Systems Science and Engineering (CSSE),” Johns Hopkins University, <https://coronavirus.jhu.edu/map.html>; Centers for Disease Control and Prevention, “United States COVID-19 Cases, Deaths, and Laboratory Testing (NAATs) by State, Territory, and Jurisdiction,” [https://covid.cdc.gov/covid-data-tracker/#cases\\_totaldeaths](https://covid.cdc.gov/covid-data-tracker/#cases_totaldeaths), visited May 28, 2021.

<sup>4</sup> “The COVID Racial Data Tracker,” <https://covidtracking.com/race> (reporting “Nationwide, Black people are dying at 2.362 times the rate of white people.”).

short-term emergency response. Finally, the chapter explores long-term ramifications and solutions to the governance difficulties the pandemic has highlighted.

## **2. Public Health Emergency Authority**

An emergency or other disaster prompts federal executive and legislative actions, especially when a multi-state or nationwide event is involved. A declaration of a public health emergency (PHE) triggers both presidential power unique to a crisis and coordinated action between the President, Congress, federal agencies, states and localities. Each governmental player must participate with precision, engaging in certain actions in a specific order and at the right moment to address an emergency effectively.

### **2.1 Federal Actions**

A patchwork of long-standing federal laws provides the President, Congress, and federal agencies with authority for federal emergency response, which are often enhanced by “relief bills” that Congress may enact to deliver short-term economic and other aid to people and states harmed by an emergency. Most federal legislative action involves indirect action through providing guidance and money to assist state and local efforts. Most direct actions occur at the state or local level; yet, federal response is necessary to emergency and disaster response.

In March 2020, Congress enacted two major relief bills, the *Coronavirus Aid, Relief and Economic Security Act (CARES Act)*<sup>5</sup> and the *Family First Coronavirus Response Act (Families First Act)*.<sup>6</sup> These laws offered loans to businesses, increased federal funding to states for Medicaid, and enhanced unemployment insurance benefits. Another, smaller relief bill passed in December 2020 offered a variety of economic boosts such as stimulus checks, rent relief, enhanced unemployment benefits, education funding, aid to small businesses, and vaccine funding.<sup>7</sup>

In an emergency, many people become eligible for Medicaid, a program that provides public health insurance to low-income people, including those who lose their jobs. The program is governed by federal law but is funded by both the federal and state governments. The state portion of Medicaid costs is related to the state economy, ranging from about 46% in wealthier states like California and New York to about 15% in Mississippi.<sup>8</sup> At the same moment that state tax revenue declines and states often need to cut budgets, Medicaid enrollment spikes; so, Congress often increases its share of Medicaid funding during emergencies and disasters. The health and economic emergency brought on by the pandemic led Congress to include enhanced federal Medicaid funding to states in the *CARES Act* and the *Families First Act*, but these relief bills also required state “maintenance of effort” so enrollment could not be decreased or eligibility cut while states accept the extra money.

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<sup>5</sup> Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116-136 (2020).

<sup>6</sup> Families First Coronavirus Response Act, Pub. L. No. 116-127 (2020).

<sup>7</sup> Consolidated Appropriations Act, 2021, Pub. L. No. 116-260 (2020).

<sup>8</sup> Kaiser Family Foundation. “Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier.” (2021), <https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22FMAP%20Percentage%22,%22sort%22:%22desc%22%7D>.

During a PHE, multiple federal agencies have distinct responsibilities, an approach that can work with strong leadership and good communication but that risks a fragmented response even in the best of circumstances. The *Public Health Service Act of 1944* authorizes direct action by the Secretary of the Department of Health and Human Services (HHS) to prevent the entry and spread of communicable diseases from foreign countries and between states.<sup>9</sup> The Centers for Disease Control and Prevention (CDC), a sub-agency of HHS, is authorized to detain, examine, and release individuals crossing U.S. borders and traveling between states who may carry communicable diseases.<sup>10</sup> The Department of Homeland Security, the Federal Emergency Management Agency (FEMA), and the Transportation Security Administration also are responsible for federal response to emergencies and disasters.

Notably, the President and the HHS Secretary must both formally declare an emergency to produce the full range of federal aid. The President declares a National Emergency under the *National Emergencies Act* or issues major disaster declarations for states under the *Stafford Act* usually at a state governor's request.<sup>11</sup> When the President declares a National Emergency, federal assistance and coordinated relief can flow to affected areas, including public health information and data; assistance with distribution of food, medicine, and other supplies; and direct support to "save lives" as needed.<sup>12</sup> The President's National Emergency declaration prompts action from agencies like FEMA and HHS.<sup>13</sup> In addition, the HHS Secretary's public health emergency declaration facilitates regulatory relief that makes state response actions easier.<sup>14</sup> Both National Emergency and PHE declarations must be renewed regularly if an emergency continues. Disaster declarations can last longer.

Early in the pandemic response, the Trump administration moved to enact international travel restrictions and to provide funding and resources for "Operation Warp Speed" vaccine development efforts. However, on the whole, President Trump did not readily exercise the special power federal laws give the President to address emergencies, creating a leadership vacuum that other officials had to fill. The President waited to declare a national emergency, despite knowing the novel coronavirus pierced U.S. borders—his first declaration was issued on 13 March 2020 and effective as of March 1 – so West Coast states contending with early outbreaks had little federal assistance at the time they began to address novel coronavirus. The President's messaging to the public regarding the severity of COVID-19 and the effectiveness of mitigation efforts was inconsistent and at times inaccurate. President Trump made fabulist claims such as sunlight and injected bleach could kill the virus and ignored mask-wearing and other state or local rules during

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<sup>9</sup> Public Health Service Act Section 361; 42 U.S.C. § 264.

<sup>10</sup> 42 C.F.R. Parts 70 & 71.

<sup>11</sup> Robert T. Stafford Disaster Relief and Emergency Assistance Act, Public Law 100-707 (November 23, 1988) amending the Disaster Relief Act of 1974, Public Law 93-288 (codified in scattered sections of title 42 of the U.S. Code); National Emergencies Act, Pub. L. 94-412 (1976), codified at 50 U.S.C. §§ 1601-1651.

<sup>12</sup> 42 U.S.C. § 5121, 5192(a).

<sup>13</sup> 42 U.S.C. §§ 5122, 5191, 5192.

<sup>14</sup> 42 U.S.C. § 247d.

public events,<sup>15</sup> modeling noncompliance with state and local containment efforts.<sup>16</sup> The White House also obstructed dissemination of scientific information.<sup>17</sup> The President was hospitalized with COVID-19 in October 2020.<sup>18</sup> The President refused to authorize the provision of stockpiled supplies like personal protective equipment (PPE) to states, although the federal government is responsible for doing so,<sup>19</sup> forcing states to purchase and distribute PPE in competition with both FEMA and other states.<sup>20</sup> And, the President opposed the Obama-era health reform law called the *Patient Protection and Affordable Care Act* (ACA), so he refused to open a special enrollment period on the federal health insurance exchange (or, the “Marketplace”) to make it possible for more people to buy commercial insurance coverage with federal tax credits outside of the annual enrollment period that occurs only at year-end.<sup>21</sup> As the pandemic progressed, the White House undermined evidence and downplayed containment orders but pressured states to curb the outbreak.<sup>22</sup> These actions increased risks associated with novel coronavirus and forced state officials to act in ways meant to be avoided by federal laws that centralize disaster resources, such as having a national stockpile and emergency authority under the *Defense Production Act* to ramp up production of necessary supplies.<sup>23</sup>

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<sup>15</sup> Timothy Bella, “‘Shameful, dangerous and irresponsible’: Nevada governor blasts Trump for indoor rally against state rules,” *Washington Post*, September 14, 2020, <https://www.washingtonpost.com/nation/2020/09/14/trump-nevada-rally-coronavirus-sisolak/>; Teo Armus, “A GOP county chair asked Trump to wear a mask to his rally. Instead, Trump mocked pandemic restrictions,” *Washington Post*, September 9, 2020, <https://www.washingtonpost.com/nation/2020/09/09/trump-rally-masks-nc/>.

<sup>16</sup> Jess Bidgood, “‘If he believes he doesn’t need a mask, good for him’: Despite Trump’s illness, supporters still aren’t sure about masks,” *Boston Globe*, October 4, 2020, <https://www.bostonglobe.com/2020/10/04/nation/trumps-positive-covid-test-doesnt-change-views-some-supporters-wearing-masks/>.

<sup>17</sup> Alexis Madrigal, “Fauci to a Meddling HHS Official: ‘Take a Hike,’” *The Atlantic*, September 23, 2020, <https://www.theatlantic.com/health/archive/2020/09/fauci-caputo-alexander-cdc-fda/616436/>; Aaron Rugar, “Dr. Fauci and Dr. Birx detail how Trump’s coronavirus response was even worse than we thought,” *Vox*, January 25, 2021, <https://www.vox.com/2021/1/25/22249050/fauci-birx-interviews-trump-coronavirus-response>.

<sup>18</sup> Whether the President tested positive before October 2, 2020, when his COVID status was reported, is uncertain, as the White House issued differing timelines regarding positive status for the President and his advisors. Michael C. Bender and Rebecca Ballhaus, “Trump Didn’t Disclose First Positive Covid-19 Test While Awaiting a Second Test on Thursday,” *Wall Street Journal*, October 4, 2020, <https://www.wsj.com/articles/trump-didnt-disclose-first-positive-covid-19-test-while-awaiting-a-second-test-on-thursday-11601844813>.

<sup>19</sup> Federal Emergency Management Agency, “Bringing Resources to State, Local, Tribal & Territorial Governments,” <https://www.fema.gov/disasters/coronavirus/governments>.

<sup>20</sup> Quint Forgey, “‘We’re not a shipping clerk’: Trump tells governors to step up efforts to get medical supplies,” *Politico*, March 19, 2020, <https://www.politico.com/news/2020/03/19/trump-governors-coronavirus-medical-supplies-137658>; Jordan Fabian, “Trump Told Governors to Buy Own Virus Supplies, Then Outbid Them,” *Bloomberg*, March 19, 2020, <https://www.bloomberg.com/news/articles/2020-03-19/trump-told-governors-to-buy-own-virus-supplies-then-outbid-them>; Olivia Ruben, et al., “Despite Trump claim, 13 states say some orders for coronavirus supplies still unfilled,” *abc News*, July 23, 2020, <https://abcnews.go.com/Health/trump-claim-12-states-orders-coronavirus-supplies-unfilled/story?id=71946598>.

<sup>21</sup> Susannah Luthi, “Trump rejects Obamacare special enrollment period amid pandemic,” *Politico*, March 31, 2020, <https://www.politico.com/news/2020/03/31/trump-obamacare-coronavirus-157788>.

<sup>22</sup> President Trump tweeted “liberate Michigan,” which inspired a plot to kidnap the governor. Lauren de Valle, “Man pleads guilty in plot to kidnap Michigan Gov. Gretchen Whitmer,” *CNN*, January 27, 2021, <https://www.cnn.com/2021/01/27/politics/gretchen-whitmer-kidnapping-plot/index.html>.

<sup>23</sup> Defense Production Reauthorization Act of 2009, Pub. L. 111-67 (reauthorizing and amending Defense Production Act of 1950).

The Operation Warp Speed vaccine development effort led by the White House both contrasts with and evidences leadership challenges. This program supplied substantial federal support for vaccine researchers and was deemed a success for generating vaccines ready for FDA emergency approval within calendar year 2020.<sup>24</sup> Vaccine distribution, on the other hand, suffered from many of the same flaws as other aspects of the pandemic response, such as a lack of centralized decision-making and marginal guidance to state public health officials. Vaccine distribution began with high variability across states, though little data was collected by most states so precise numbers are hard to come by.<sup>25</sup>

Overall, HHS exercised its emergency powers in a more predictable manner. HHS Secretary Alex Azar declared a PHE effective on 27 January 2020, shortly after SARS-CoV-2 reached U.S. borders.<sup>26</sup> This activated HHS's special authority to issue grants responding to the PHE, enter into contracts, access emergency funds, and temporarily increase state regulatory flexibility.<sup>27</sup> Once the President declared an emergency, the national emergency and PHE declarations together permitted the Secretary to issue emergency-related waivers to states. These waivers allowed certain Medicaid rules to be modified so officials could secure health care access, for example, waiving licensure requirements for out of state health care providers. Secretary Azar renewed the PHE declaration throughout 2020, issuing his last declaration on 7 January 2021 so the PHE continued through the start of the Biden administration.

The President's avoidance of emergency authority and responsibility unexpectedly thwarted longstanding national public health emergency architecture. Federal laws assume a federalism governance structure will work for emergencies – and in normal times – and do not address the possibility that the President would not take up special power to enact public health protections or that governors would follow his lead in failing to take action. Yet, both occurred throughout 2020 and into 2021 after the Biden administration took office facing the ongoing emergency of the pandemic. President Biden ran a campaign that promised an effective, coordinated approach to combatting COVID-19, and the common account is that President Biden's election reflected dissatisfaction and distrust with the Trump administration's erratic pandemic response.<sup>28</sup>

## 2.2. State Response

As previously noted, at the national level, CDC performs research, data collection, and surveillance, and can influence state and local actions with policy guidance and money but has little authority to compel uniform state or local action. As such, short-term federal emergency response builds on states' public health capacity. In other words, because state and local public

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<sup>24</sup> Dan Diamond, "The crash landing of 'Operation Warp Speed'," *Politico*, January 17, 2021, <https://www.politico.com/news/2021/01/17/crash-landing-of-operation-warp-speed-459892>.

<sup>25</sup> Alejandro de la Garza and Chris Wilson, "Many States Don't Know Who's Getting COVID-19 Vaccines. That's a Huge Problem for Equity," *Time*, January 28, 2021, <https://time.com/5934095/covid-vaccine-data/>.

<sup>26</sup> Secretary Alex M. Azar II, "Determination that a Public Health Emergency Exists," <https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx>.

<sup>27</sup> 42 U.S.C. § 247d(a).

<sup>28</sup> Ashley Parker et al., "How Trump's erratic behavior and failure on coronavirus doomed his reelection," *Washington Post*, November 7, 2020, <https://www.washingtonpost.com/elections/interactive/2020/trump-pandemic-coronavirus-election/>.

health departments are frontline actors in day-to-day public health activities,<sup>29</sup> and state health policies impact neighbor states' and national public health efforts, state and local public health choices affect response to a national or global PHE.<sup>30</sup>

The pandemic hit within the context that states had consistently reduced public health spending over the last decade.<sup>31</sup> Such reductions diminished public health departments' ability to respond to public health events, and staffing dropped correspondingly. Defunded health departments faced a colossal containment task and vaccine rollout effort without staff or other resources adequate for such work.<sup>32</sup> States historically were responsible for and regulated public health, safety, and welfare by exercising their plenary police power; but, over time, federal power and responsibility have grown significantly, responding in part to state and local public health programs relying heavily on federal funding.

Yet, the vacuum of federal leadership boosted state responsibility for a disease outbreak greater than any public health challenge in recent history. Unsurprisingly, without more centralized federal direction, and political tensions running high, state leaders responded to the pandemic in a highly irregular fashion. Governors found themselves on the frontline, and many used emergency authority to swiftly contain the outbreak. But, some governors followed President Trump's model in resisting stringent containment measures recommended by CDC or other federal public health experts, which then left containment to mayors, education leaders, and other local officials.<sup>33</sup> In some states, such as Mississippi<sup>34</sup> and South Carolina<sup>35</sup>, governors superseded or limited local officials' stay-at-home and related containment orders and undermined their authority for issuing such rules, adding a micro-federalism dimension of intra-state conflict.<sup>36</sup> In 2021, a handful of state legislatures have enacted limits on gubernatorial emergency powers, which often parallel

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<sup>29</sup> Centers for Disease Control and Prevention, "Health Department Governance: State and Local Health Department Governance Classification Map," <https://www.cdc.gov/publichealthgateway/sitesgovernance/index.html> (last visited 10/5/2020); Wendy M. Mariner et al., *Public Health Law* 18-20, 63-194 (3d ed. 2019).

<sup>30</sup> David Holtz et al., *Interdependence and the Cost of Uncoordinated Responses to COVID-19*, May 22, 2020, <https://osf.io/b9psy/>.

<sup>31</sup> Jennifer Haberkorn, "The Prevention and Public Health Fund Policy Brief," *Health Affairs* (2012), [https://www.healthaffairs.org/doi/10.1377/hpb20120223.98342/full/healthpolicybrief\\_63.pdf](https://www.healthaffairs.org/doi/10.1377/hpb20120223.98342/full/healthpolicybrief_63.pdf); "Hollowed-Out Public Health System Faces More Cuts Amid Virus," *Kaiser Health News* (July 1, 2020), <https://khn.org/news/us-public-health-system-underfunded-under-threat-faces-more-cuts-amid-covid-pandemic/>.

<sup>32</sup> President Trump's appointees reportedly resisted giving more money to states for vaccine rollout. Nicholas Florko, "Trump officials actively lobbied to deny states money for vaccine rollout last fall," *STAT News*, February 1, 2021, [https://www.statnews.com/2021/01/31/trump-officials-lobbied-to-deny-states-money-for-vaccine-rollout/?utm\\_source=STAT+Newsletters&utm\\_campaign=a94a277bf9-MR\\_COPY\\_14&utm\\_medium=email&utm\\_term=0\\_8cab1d7961-a94a277bf9-150488781](https://www.statnews.com/2021/01/31/trump-officials-lobbied-to-deny-states-money-for-vaccine-rollout/?utm_source=STAT+Newsletters&utm_campaign=a94a277bf9-MR_COPY_14&utm_medium=email&utm_term=0_8cab1d7961-a94a277bf9-150488781).

<sup>33</sup> Jim Salter, "Missouri's COVID-19 Response in Spotlight at Governor Forum," *U.S. News*, October 9, 2020, <https://www.usnews.com/news/best-states/missouri/articles/2020-10-09/missouris-covid-19-response-in-spotlight-at-governor-forum>.

<sup>34</sup> Mississippi Governor Tate Reeves Exec. Order 1463 (March 24, 2020).

<sup>35</sup> Laurel Mallory, "S.C. attorney general says local governments cannot issue stay-at-home orders," *wbtv.com*, March 27, 2020, <https://www.wbtv.com/2020/03/27/sc-attorney-general-says-local-governments-cannot-issue-stay-at-home-orders/>.

<sup>36</sup> Adam Gabbatt, "Which states have done the least to contain coronavirus?," *The Guardian*, April 3, 2020, <https://www.theguardian.com/world/2020/apr/03/coronavirus-states-response-who-has-done-least-alabama-oklahoma-missouri>.



presidential emergency powers but are more extensive, in response to more stringent containment actions.<sup>37</sup> For example, Idaho enacted a law limiting gubernatorial power during emergencies, increasing legislative oversight of emergencies, and limiting the containment measures that can be implemented in emergencies.<sup>38</sup> Arkansas enacted a law limiting containment measures but then experienced severe Delta variant outbreaks in 2021, leading the governor to publicly express regret for signing the law.

Non-pharmaceutical interventions (NPI) were the primary tool for controlling the spread of novel coronavirus throughout 2020 and into early 2021.<sup>39</sup> CDC's NPI recommendations included mask-wearing, frequent hand and surface sanitizing, community measures such as physical distance and restricted occupancy in public spaces, limited gathering size, stay in place orders (SIP), and business, church, and school closures. Some states swiftly implemented stringent NPIs, like Washington and California, while others like Texas responded in a more relaxed fashion, reopening quickly from the March/April SIP orders and resisting additional containment measures. South Dakota had a particularly serious outbreak after resisting NPI and then allowing an unmasked motorcycle rally that led to outbreaks that bypassed state borders.<sup>40</sup> Texas continued the pattern when Governor Abbott decided to end executive orders requiring mask wearing and other NPI in the first week of March 2021, which Mississippi also did, despite President Biden's warnings to the contrary.<sup>41</sup>

Testing was not widely or consistently available in many places, and the federal government did not respond reliably to governor's requests for PPE, testing materials, and other supplies to deal with the pandemic due to political motivations combined with shortages in the federal stockpile of supplies. Data collection on infections, hospitalizations, and deaths due to COVID-19 was unreliable, even though states are obligated to collect certain kinds of demographic data within the Medicaid program that could have been extended to the pandemic context.

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<sup>37</sup> David A. Lieb, "State lawmakers are pushing to curb governors' virus powers," *Associated Press*, January 28, 2021, [https://apnews.com/article/state-lawmakers-governor-coronavirus-7d5710f2d8aa4e659c0ec68400ad3d3c?utm\\_source=Sailthru&utm\\_medium=email&utm\\_campaign=AP%20Mornning%20Wire&utm\\_term=Morning%20Wire%20Subscribers](https://apnews.com/article/state-lawmakers-governor-coronavirus-7d5710f2d8aa4e659c0ec68400ad3d3c?utm_source=Sailthru&utm_medium=email&utm_campaign=AP%20Mornning%20Wire&utm_term=Morning%20Wire%20Subscribers); "Legislative Oversight of Emergency Executive Powers", National Conference of State Legislatures (2021), <https://www.ncsl.org/research/about-state-legislatures/legislative-oversight-of-executive-orders.aspx#Emergency%20Powers%20Bills>.

<sup>38</sup> Idaho S.B. 1217, enacted May 10, 2021, available at [https://custom.statenet.com/public/resources.cgi?id=ID:bill:ID2021000S1217&ciq=ncsl&client\\_md=2763280a02f529e8c9506c252a005b41&mode=current\\_text](https://custom.statenet.com/public/resources.cgi?id=ID:bill:ID2021000S1217&ciq=ncsl&client_md=2763280a02f529e8c9506c252a005b41&mode=current_text).

<sup>39</sup> FDA Press Release, "FDA Takes Key Action in Fight Against COVID-19 by Issuing Emergency Use Authorization for First COVID-19 Vaccine," December 11, 2021, <https://www.fda.gov/news-events/press-announcements/fda-takes-key-action-fight-against-covid-19-issuing-emergency-use-authorization-first-covid-19>.

<sup>40</sup> Rosalind J. Carter, et al., CDC COVID-19 Response Team, "Widespread Severe Acute Respiratory Syndrome Coronavirus 2 Transmission Among Attendees at a Large Motorcycle Rally and their Contacts, 30 US Jurisdictions, August–September, 2020," *73 Clinical Infectious Diseases*, S106–S109, Issue Supplement\_1, July 15, 2021; Melanie J. Firestone, et al., "COVID-19 Outbreak Associated with a 10-Day Motorcycle Rally in a Neighboring State — Minnesota, August–September 2020," *69 Morb. Mortal. Wkly. Report* 1771, November 27, 2020, <https://www.cdc.gov/mmwr/volumes/69/wr/mm6947e1.htm>.

<sup>41</sup> Marissa Martinez, "Texas no longer has a statewide mask mandate. But face coverings are still required in some businesses and public places." *The Texas Tribune*, March 10, 2021, <https://www.texastribune.org/2021/03/10/texas-mask-mandate-coronavirus-restrictions/>.

Studies show these heterogeneous containment policies affected infection and mortality rates, contributing to disproportionate health and economic impacts across states. Researchers at Oxford University studied state containment policy differences, including types of NPI measures, stringency of rules, and duration of implementation. They have accumulated evidence with systematic data collection showing that more stringent state-level COVID-19 containment policies have correlated to lower outbreak severity.<sup>42</sup>

The novel coronavirus pandemic developed in parallel with the intensification of the Black Lives Matter movement in the wake of George Floyd's murder by a Minneapolis police officer on 25 May 2020. This spotlighted the fact that Black, Hispanic, and other populations of color were disproportionately infected and dying during the pandemic. Federalism in the United States historically has been more than a technical question of which level of government is best suited to perform certain functions but rather a compromise allowing states to maintain slavery, segregation, and other legal structures that explicitly or implicitly restrict access to resources for non-white populations.<sup>43</sup> Electoral systems in some states such as Mississippi and Alabama were designed so that the officials making policy decisions do not reflect or represent the populations they serve.<sup>44</sup> These approaches have continued even today, for example with Texas enacting a law in September 2021 that will make voting more difficult for low-income people, people of color, and people with disabilities.<sup>45</sup> Further, several states do not require state legislatures to implement laws that are passed by a majority of voters via ballot initiative. In states like Utah and Missouri, this feature delayed the implementation of Medicaid expansion.

National death rates from COVID-19 among Black, Hispanic, and Indigenous patients were 2-2.4 times higher than among White patients.<sup>46</sup> Studies indicate that people of color who are low income and face high-exposure suffered the most in every state,<sup>47</sup> but especially in states with less stringent NPI and low vaccination rates, many of which also are resistant to the full implementation of social

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<sup>42</sup> Coronavirus Government Response Tracker, University of Oxford Blavatnik School of Government, <https://www.bsg.ox.ac.uk/research/research-projects/coronavirus-government-response-tracker>; "Variation in US states' responses to COVID-19," Version 2.0 published December 2020, [https://www.bsg.ox.ac.uk/sites/default/files/2020-12/BSG-WP-2020-034-v2\\_0.pdf](https://www.bsg.ox.ac.uk/sites/default/files/2020-12/BSG-WP-2020-034-v2_0.pdf).

<sup>43</sup> Daniel E. Dawes, *The Political Determinants of Health* (Johns Hopkins Press, Baltimore, 2020), 21; John A. Ferejohn & Barry R. Weingast, "Introduction," *The New Federalism: Can the States Be Trusted?* (Stanford: Stanford University Press, 1997), ix.

<sup>44</sup> David. K. Jones, "Political Participation in the Least Healthy Place in America: Examining the Political Determinants of Health in the Mississippi Delta." 44(3) *Journal of Health Politics, Policy and Law* (2019): 505-531.

<sup>45</sup> Texas Senate Bill 1 (September 7, 2021), <https://capitol.texas.gov/BillLookup/History.aspx?LegSess=872&Bill=SB1>.

<sup>46</sup> U.S. Centers for Disease Control and Prevention, "COVID-19 cases, data, and surveillance: hospitalization and death by race/ethnicity" (accessed October 12, 2020), <https://www-cdc-gov.ezproxy.bu.edu/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html>.

<sup>47</sup> Erin K. Stokes, et al., "Coronavirus Disease 2019 Case Surveillance — United States, January 22–May 30, 2020," 69 *Morb. Mortal. Wkly. Rep.* 759 (2020); Marie E. Killerby, et al., "Characteristics Associated with Hospitalization Among Patients with COVID-19 — Metropolitan Atlanta, Georgia, March–April 2020," *Morb. Mortal. Wkly. Rep. ePub*: 17 June 2020; Sebastian D. Romano et al., "Trends in Racial and Ethnic Disparities in COVID-19 Hospitalizations, by Region — United States, March–December 2020," 70 *Morb. Mortal. Wkly. Rep.* 560, April 16, 2021.

welfare programs.<sup>48</sup> These states' short-term PHE response exacerbated long-term patterns of health disparities by race, ethnicity, and income.

### 3. Federalism, Health Care, and Social Programs

COVID-19 has tested the limits of federalism in health care and social welfare programs, which, like public health systems, operate within a federalist governance structure. An example of this dynamic exists in Medicaid, the primary source of health insurance for low-income Americans and a federal program that provides money and rules to states, which have considerable flexibility within the program through exercising statutory options and seeking federal waivers to further the purpose of the program in new ways. Medicaid is not only an important source of public health insurance, it is also a key tool in public health emergencies. Like Medicaid, other social programs such as housing support, unemployment benefits, minimum hourly wage standards, and food assistance all vary at the state level within federal rules. Also, given that nursing homes were a primary source of COVID-19 infections and deaths, it is notable that the responsibility for quality assurance in nursing homes is shared between the federal government and states. The federal government issues standards related to the safety and quality of care delivered in nursing homes but regular inspection activities are conducted by local authorities. Here, Medicaid provides an example of the importance of long-term state choices in a short-term emergency response.

Congress enacted the ACA to improve access to health care by crafting near-universal health insurance coverage cobbled together through commercial and public insurance mechanisms.<sup>49</sup> The ACA offered federal money to states to establish health insurance exchanges (“Exchanges” or “Marketplaces”) to sell “qualified health plans.” HHS runs a national Exchange if states have not established their own, ensuring that an exchange exists in every state regardless of state leadership choices. However, if a state does not expand Medicaid eligibility under the ACA, a key feature of the ACA’s expansion of insurance coverage, no federal backup exists. In Medicaid non-expansion states, people earning less than 100% of the federal poverty level do not qualify for insurance subsidies on the Exchange and cannot enroll in Medicaid, creating a coverage gap for over 2 million people that is concentrated in Deep South and central Midwestern states.<sup>50</sup> Approximately 28 million individuals were uninsured when novel coronavirus emerged, almost half of whom are eligible for Medicaid or for federal tax subsidies to purchase insurance on an Exchange.<sup>51</sup> Some

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<sup>48</sup> Health Equity Considerations and Racial and Ethnic Minority Groups. Centers for Disease Control and Prevention. 2021. <https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html>.

<sup>49</sup> Paul Starr, *Remedy and Reaction: The Peculiar American Struggle over Health Care Reform* (New Haven: Yale University Press, 2011).

<sup>50</sup> Medicaid non-expansion states are Texas, Tennessee, Florida, Georgia, South Carolina, North Carolina, Wyoming, Wisconsin, Alabama, Kansas, Mississippi, and South Dakota. Oklahoma and Missouri each had a successful ballot initiative to expand Medicaid in the summer of 2020, but expansion has not begun. Rachel Garfield et al., “The Coverage Gap,” *Kaiser Family Foundation*, January 2020, <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.

<sup>51</sup> Munira Z. Gunja and Sara R. Collins, “Who Are the Remaining Uninsured, and Why Do They Lack Coverage?,” *Commonwealth Fund*, August 28, 2019, <https://www.commonwealthfund.org/publications/issue-briefs/2019/aug/who-are-remaining-uninsured-and-why-do-they-lack-coverage>.

four million people became eligible for Medicaid in 2020 due to recession-related job loss and other financial hardships accompanying the pandemic, a 6.2% increase.<sup>52</sup>

Before the pandemic reordered political priorities, the Trump administration was hostile to the ACA, directing federal agencies by Executive Order to avoid implementing and enforcing the law.<sup>53</sup> The administration took many actions to undermine the ACA when Congress did not repeal it, such as blocking federal payments to insurance companies for high-cost insurance subscribers,<sup>54</sup> ending cost-sharing reduction payments for low-income subscribers,<sup>55</sup> and reducing Marketplace outreach funding and open enrollment periods that help people find and enroll in coverage. To undercut Medicaid expansion, the administration crafted novel policies that required beneficiaries to work or engage in work-related activities to maintain Medicaid coverage,<sup>56</sup> which were never approved by Congress and no prior administration allowed. These policies had the predictable effect of disenrolling Medicaid beneficiaries by creating confusing paperwork and other administrative burdens.<sup>57</sup> Insurance rates declined due to these policies, with un-insurance rates especially high in non-expansion states. Ninety percent of people in the coverage gap lived in the eight Southern states that did not expand Medicaid, with Texas, Florida, and Georgia accounting for three-quarters of the uninsured.<sup>58</sup> These states' choices were crucial for people of color, who were disproportionately infected and dying from COVID-19, especially if they were also low income and in high-exposure jobs.<sup>59</sup>

Fourteen states had not implemented the ACA's Medicaid eligibility expansion by the time the pandemic began, to the detriment of low-income residents, health care providers, and state budgets. Non-expansion states already experienced economic inequality, parsimonious unemployment benefits, lower rates of employer-sponsored insurance coverage, and higher chronic disease incidence. These states' leaders, largely for political reasons, ignored the evidence from more than 400 studies that Medicaid expansion produces positive outcomes for individual and public health, increasing health insurance coverage and reducing health disparities by increasing access for

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<sup>52</sup> Centers for Medicare & Medicaid Services, "CMS Releases Medicaid and CHIP Enrollment Trends Snapshot Showing COVID-19 Impact on Enrollment," September 30, 2020, [https://www.cms.gov/newsroom/press-releases/cms-releases-medicaid-and-chip-enrollment-trends-snapshot-showing-covid-19-impact-enrollment?utm\\_campaign=wp\\_the\\_health\\_202&utm\\_medium=email&utm\\_source=newsletter&wpisrc=nl\\_health202](https://www.cms.gov/newsroom/press-releases/cms-releases-medicaid-and-chip-enrollment-trends-snapshot-showing-covid-19-impact-enrollment?utm_campaign=wp_the_health_202&utm_medium=email&utm_source=newsletter&wpisrc=nl_health202).

<sup>53</sup> Executive Order No. 13765, 82 Federal Register 8351 (January 20, 2017).

<sup>54</sup> *Maine Community Health Options v. United States*, \_ U.S. \_, Docket No. 18-1023 (2020).

<sup>55</sup> *Sanford Health Plan v. United States*, 2019-1290, 2019-1302 (D.C. Circuit Court of Appeals, August 14, 2020); *Community Health Choice, Inc. v. United States*, 2019-1633 (D.C. Circuit Court of Appeals, August 14, 2020).

<sup>56</sup> Letter to State Medicaid Directors, SMD 18-002, Center for Medicare & Medicaid Services (January 11, 2018), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf>; Healthy Adult Opportunity Fact Sheet, Center for Medicare & Medicaid Services (January 30, 2020), <https://www.cms.gov/newsroom/fact-sheets/healthy-adult-opportunity-fact-sheet> (federal policy guidance inviting block grant proposals from states for expansion population).

<sup>57</sup> Ben Sommers et al., "Medicaid Work Requirements — Results from the First Year in Arkansas," 381 *New England Journal of Medicine* 1073 (2019).

<sup>58</sup> Rachel Garfield, Kendal Orgera and Anthony Damico, "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid," *Kaiser Family Foundation* (2020), <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.

<sup>59</sup> Richard A. Opiel, et al., "The Fullest Look Yet at the Racial Inequity of Coronavirus," *New York Times*, <https://www.nytimes.com/interactive/2020/07/05/us/coronavirus-latinos-african-americans-cdc-data.html>.

minority populations, individuals with low educational attainment, and low-income workers.<sup>60</sup> These studies demonstrate that Medicaid expansion is associated with higher rates of education, housing, food, transportation, and has helped increase income<sup>61</sup> and decreased medical debt and bankruptcies.<sup>62</sup> Medicaid expansion also increases voter registration and participation in elections.<sup>63</sup> Medicaid expansion has thus been important for rural areas and communities with high rates of un-insurance. For example, more than 100 rural hospitals have closed since 2010, but very few were located in Medicaid expansion states.<sup>64</sup> Also, states have experienced budgetary savings from shifting the cost of the expansion population to the federal government.<sup>65</sup>

States with generous social programs are better equipped to put federal aid to work because they have infrastructure that makes emergency assistance easier to administer and social programs that are generally simpler to navigate. States with meager safety nets often lack administrative capacity, experience higher leadership turnover in public health departments, and have longstanding health disparities that worsen the impact of an emergency. The “new federalism” movement that began with President Richard Nixon to counteract federal social programs created during the Civil Rights Era reflected desire to shrink government and culminated in policies that shifted safety-net responsibility to states.<sup>66</sup> Arguably, this began the trend of diminished public health capacity that left many states limited in their ability to respond to the pandemic. These dynamics highlight differences between states and elevate existing inequities in a public health emergency.

#### 4. Leadership Matters

The Institute of Medicine defined public health as “fulfilling society’s interest in assuring conditions in which people can be healthy” and argued for greater attention to public health needs more than thirty years ago.<sup>67</sup> Instead, public health was deprioritized both fiscally and as a policy matter for years before the pandemic.<sup>68</sup> A government that does not fund public health will not

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<sup>60</sup> Madeline Guth et al., “The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review,” *Kaiser Family Foundation*, March 20, 2020, <https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/>.

<sup>61</sup> Kevin Griffith et al., “The Affordable Care Act Reduced Socioeconomic Disparities in Health Care Access,” 36 *Health Affairs* (2017): 1503.

<sup>62</sup> Naomi Zewde and Christopher Wimer, “Antipoverty Impact of Medicaid Growing with State Expansions over Time,” 38 *Health Affairs* (2019): 132; LuoJia Hu et al., “The Effect of the Affordable Care Act Medicaid Expansions on Financial Wellbeing,” 163 *Journal of Public Economics* (2018): 99; Renuka Tipirneni et al., “Association of Medicaid Expansion with Enrollee Employment and Student Status in Michigan,” *JAMA Network Open*, January 2020, <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2759843>.

<sup>63</sup> Jake Haselswerdt and Jamila Michener, “Disenrolled: Retrenchment and Voting in Health Policy,” 44 *Journal of Health Politics, Policy & Law* 423, 426 (2019); Jake Haselswerdt, “Expanding Medicaid, Expanding the Electorate: The Affordable Care Act’s Short-Term Impact on Political Participation,” 42 *Journal of Health Politics, Policy & Law* 667 (2017).

<sup>64</sup> Nicole Huberfeld, “Rural Health, Universality, and Legislative Targeting,” 13 *Harvard Law & Policy Review* 241 (2018).

<sup>65</sup> Guth, 9-10.

<sup>66</sup> Dawes, 29-30, 32, 33.

<sup>67</sup> Committee for the Study of the Future of Public Health, “The Future of Public Health,” *Institute of Medicine*, 19 (1988).

<sup>68</sup> Karen B. DeSalvo et al., “Public Health 3.0: A Call to Action for Public Health to Meet the Challenges of the 21st Century,” *National Academy of Medicine* (2017), <https://nam.edu/public-health-3-0-call-action-public-health-meet-challenges-21st-century/>.

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have a healthy public, evidenced by declines in life expectancy even before COVID-19.<sup>69</sup> Decreased funding for public health, and decentralizing public health responsibility, have weakened the public's health in the U.S. and made already vulnerable populations less resilient in the face of an emergency, contributing to a 1.5 year decline in life expectancy in 2020.<sup>70</sup>

Public health federalism may operationalize a public health emergency response but also contributed to structural troubles that became so apparent during the PHE. Federalism in health laws occurs for a number of reasons. One is path dependence<sup>71</sup> combined with an instinct for incrementalism in health reform – public health emergency laws and the ACA both are examples of this tendency for past decisions to constrain the options that seem feasible in the future.<sup>72</sup> Another reason is that Congress may find it politically expedient to include states in public health laws so that the nationalization of state-based rules seems less threatening to state autonomy – health insurance exchange structure provides an example, where Congress invited states to continue using their decades of insurance regulation experience to guide a new insurance product. Sometimes, Congress decides states must adhere to new federal baselines because state policy choices have failed, as with expanding Medicaid eligibility to childless adults under the ACA. Sometimes Congress takes over, especially when states or markets have failed in a health policy function, as with Medicare or current proposals for a public option for health insurance,<sup>73</sup> but this is less common.<sup>74</sup>

A crisis that exposes deep health disparities may clarify the weaknesses of federalism as a health governance approach, especially in a public health emergency. So, what are the lessons we can draw from the first year of the pandemic when it comes to the challenges that federalism is currently facing?

National leadership matters. The Trump administration's coronavirus response created a leadership vacuum that included delaying the national emergency declaration, inconsistent communication regarding the severity of the outbreak to the public, funding and supply delays, uneven assistance to states, and insufficient and botched testing.<sup>75</sup> The vaccine development encouraged by Operation Warp Speed was important, but pharmaceutical companies had been

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<sup>69</sup> Sherry L. Murphy et al., "Mortality in the United States, 2017," *National Center for Health Statistics Data Brief No. 328*, November 2018, <https://www.cdc.gov/nchs/data/databriefs/db328-h.pdf>.

<sup>70</sup> Elizabeth Arias et al., "Provisional Life Expectancy Estimates for 2020," *NVSS Vital Statistics Rapid Release Report No. 015*, July 2021, <https://www.cdc.gov/nchs/data/vsrr/vsrr015-508.pdf>.

<sup>71</sup> "Path dependence" describes the idea that history may prescribe policy choices, making any given decision less deliberate than it might have been without the initial set of decisions, often attributed to Professor Paul David, who framed the idea within the example of the inefficient QWERTY keyboard. Paul A. David, "Clio and the Economics of QWERTY," *75 Am. Econ. Rev.* 332 (1985).

<sup>72</sup> Abbe R. Gluck and Nicole Huberfeld, "What Is Federalism in Healthcare For?," *70 Stanford Law Review* 1689 (2018): 1703-1719.

<sup>73</sup> Medicare X Choice Senate bill available at <https://www.bennet.senate.gov/public/index.cfm/press-releases?id=5D307D1A-B91B-465D-8D0B-6EE62C4E99D8>.

<sup>74</sup> See Gluck and Huberfeld, *supra* note 64, at 1716-19.

<sup>75</sup> "It Is Roiling Him": Reporter Maggie Haberman Unpacks Trump's Refusal To Admit He Lost," *Fresh Air*, December 10, 2020, <https://www.npr.org/2020/12/10/944935318/it-is-roiling-him-nyts-maggie-haberman-unpacks-trumps-refusal-to-admit-he-lost>; Michael Shear, Noah Weiland, Eric Lipton, Maggie Haberman & David E. Sanger, "Inside Trump's Failure: The Rush to Abandon Leadership Role on the Virus", *New York Times*, July 18, 2020, <https://www.nytimes.com/2020/07/18/us/politics/trump-coronavirus-response-failure-leadership.html>.

developing the technology for such mRNA vaccines for more than a decade before novel coronavirus. Many deaths were preventable and many people will be “long haulers” who face debilitating effects from COVID-19 for years to come. In constitutional law, the President has the most power when the Constitution and Congress agree that the President can act, which is the case in a PHE. This makes Trump’s reluctance to lead all the more confounding.

On the other hand, the Biden administration entered office prioritizing expedient policy action and effective management. Vaccine distribution, strengthening the health care safety net, appointing experienced government officials, deference to science and evidence, and health equity were all articulated through early executive orders and swift regulatory actions. The Biden administration used existing laws to change the federal government’s response to the pandemic. Leadership is important; but it is not the entire story, because state partnership and uptake of federal funding and guidance is still central to the public health system and especially a PHE.

The federal government is limited in its ability to mandate centralized action or to force states or localities to act, irrespective of leadership. The federal government typically is a backstop for states, though in the first year of the pandemic some states filled in the gaps and backed the federal government. History demonstrates that states cannot respond to a public health emergency alone. Public health emergencies require effective federal leadership and federal funding as well as coordinated state, local, and tribal implementation. Without coherent federal leadership, state policy heterogeneity made it so that state outbreaks were worse depending on short-term measures and so that millions of people were falling through preexisting holes in the safety net due to longer term state policy preferences.

Long-term planning for future public health crises must recognize that federalism is often a choice rooted in history and policy preference and not always a constitutional requirement. Congress could enact health reform that is purely national, in the model of Medicare for example, and this would be constitutionally more straightforward than including states. Other nations have decentralized policymaking through a federalist structure, but American federalism is different for the degree to which states control policy even when the federal government has power to offer national solutions. State and local leaders who do not favor policies such as spending on public health often argue that states have the “right” to control these policies, not the federal government. The U.S. Supreme Court decided long ago that Congress has authority to create social programs that are purely national.<sup>76</sup> If federalism governance structures are not constitutionally required, then, using federalism for structuring social programs and policies raises important questions regarding whether, how, and when responses to national health needs should involve states. It also raises the question of whether states will predictably accept the invitation to engage.<sup>77</sup>

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<sup>76</sup> *United States v. South-Eastern Underwriters Association*, 322 U.S. 533 (1944) (Congress has commerce clause authority to regulate national insurance markets); *Helvering v. Davis*, 301 U.S. 619 (1937) (old age benefits) and *Steward Machine Co. v. Davis*, 301 U.S. 548 (1937) (unemployment insurance) (both part of the Social Security Act). The Supreme Court rejected arguments that providing welfare to the elderly was reserved for states. *Helvering*, 640-645.

<sup>77</sup> Robert F. Rich & William D. White, “Health Care Policy and the American States: Issues of Federalism,” in *Health Policy, Federalism, and the American States* (England: Urban Institute Press, 1997).

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Though federalism is not required in laws governing social and public health programs, it is enshrined in American policymaking. For this reason, complete centralization of public health policy is unlikely. Centralization of public health efforts also may not be the most efficient restructuring for response to public health crises. Federalism can be a rational policy choice, but public health federalism should be a purposeful choice that maximizes the nation's health with an understanding of the capacity that states and localities build or ignore within the federalist structure.

The evidence from novel coronavirus so far indicates that federalism's divided governance complicated the response to an infectious disease outbreak. Public health has largely been addressed at the whim of state budgets, politics, and policymaking, even when some uniform policy is more desirable, making states even less capable of responding to a public health emergency alone. Will we be ready for the next public health crisis? The system needs to be resilient enough to withstand an unpredictable leadership vacuum as well as the predictable variability of public health federalism.

The flexibility offered by public health federalism must have a floor, meaning federal rules for basic levels of support through social programs. Inequity is inherent to federalism's variability without such rules, which foreseeably results in different health outcomes that have been worse for vulnerable populations.

Increased spending is necessary for staffing public health at federal, state, tribal, and local levels. The Biden administration proposed creating a public health workforce in this regard, and that would be a fine start.<sup>78</sup> But the ACA promised public health funding to states, and Congress rolled it back. This policy idea should be renewed. A retrospective analysis of existing gaps and weaknesses in the public health infrastructure must occur to be prepared when the next emergency strikes.

Universal health insurance coverage must become the norm, whether building on the current patchwork or not. Eleven years after the ACA was enacted, millions of people remain in a coverage gap that left them and others unnecessarily exposed during an emergency. This would also help to improve other features of the safety net's infrastructure, such as community health centers and safety net hospitals, which rely heavily on Medicaid in their patient mix.

Consistent data collection is important for addressing the next public health emergency through better coordination and evidence-based action. State and local data collection is necessary given inconsistencies revealed during the pandemic that complicated the response to the emergency as well as the understanding of its impacts. Congress could choose to condition some portion of federal Medicaid spending on specific state health department data collection. A model for this already exists under ACA section 4302, which demands state and local collection and reporting of racial and ethnic data, and is a provision that could be enforced more consistently.<sup>79</sup> Data regarding

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<sup>78</sup> Fact Sheet: Biden-Harris Administration to Invest \$7 Billion from American Rescue Plan to Hire and Train Public Health Workers in Response to COVID-19, *The White House*, May 13, 2021, <https://www.whitehouse.gov/briefing-room/statements-releases/2021/05/13/fact-sheet-biden-harris-administration-to-invest-7-billion-from-american-rescue-plan-to-hire-and-train-public-health-workers-in-response-to-covid-19/>.

<sup>79</sup> Pub. L. No. 111-148 sec. 4302.



race, ethnicity, socio-economic status, and other key identifying characteristics should be prioritized.

If federalism is to remain in the public health picture – and it seems like it will – then, its policy heterogeneity must be recognized as both a possible challenge and a possible good. Federalism contributes to fragmentation in American public health and health care, even within laws that demand states meet federal requirements. Combined with underfunding of public health, previous policy choices, and a lack of coordination between federal and state leaders, it is no wonder that the U.S. had such poor results in addressing the pandemic.

## 5. Conclusion

American health care delivers shorter life expectancy, costs more than other wealthy nations, spends less on prevention, and perpetuates disparities for Black, indigenous, and people of color as well as low-income individuals within and across states.<sup>80</sup> All of these factors came into play as the pandemic hit U.S. soil.<sup>81</sup> Rather than focus on such long-term issues, many commentators have blamed leadership failures. While we believe this was an important factor in the failed U.S. response, we must also take a hard look at the governance choices that enabled such unnecessary disaster.<sup>82</sup>

Federalism is entrenched in the governance architecture of public health, reflecting historical, political, and policy choices, but not always constitutional requirements. The novel coronavirus pandemic highlighted the costs of this structure, paid in rates of infection and mortality, especially in places where the health and economic stability of people of color have long been disproportionately harmed by state policies. Pushing states and localities to the frontline slowed response times, fostered variability where commonality would have been more effective, and exacerbated existing health and economic inequalities. Bolstering resiliency ahead of the next pandemic requires enacting a national floor with respect to public health preparedness and social welfare programs so that when tested again, the flexibility of the federalist system bows but does not break.

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<sup>80</sup> Steven H. Woolf and Heidi Schoomaker, “Life Expectancy and Mortality Rates in the United States,” 1959-2017, 322 *JAMA* (2019): 1996, <https://jamanetwork.com/journals/jama/article-abstract/2756187>; Organization for Economic Cooperation & Development, “Health at a Glance 2019: OECD Indicators” (2019), <https://www.oecd-ilibrary.org/docserver/4dd50c09-en.pdf?expires=1589998199&id=id&accname=guest&checksum=AC4537397D75ACC7E8AC3F3DCC07B31B>.

<sup>81</sup> Brian M. Rosenthal, et al., “Why Surviving the Virus May Come Down to Which Hospital Admits You,” *New York Times*, July 1, 2020, <https://www.nytimes.com/2020/07/01/nyregion/Coronavirus-hospitals.html?referringSource=articleShare>.

<sup>82</sup> Michael D. Sparer and Lawrence D. Brown, “States and the Health Care Crisis: The Limits and Lessons of Laboratory Federalism,” in *Health Policy, Federalism, and the American States* (England: Urban Institute Press, 1997).