Public Health Law Tools: A Brief Guide

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The COVID-19 pandemic offers a threat with few precedents in modern times and tests the tools of modern surveillance and public health law. The goal of this chapter is to provide a brief overview of the types of measures that state and federal governments can invoke to treat and prevent the spread of infectious disease. The following sections will provide an orientation to domestic public health law followed by the types of measures available to state and federal public health authorities.

Although this chapter does not consider international institutions, treaties, or norms that affect public health, these are also essential to the overall pandemic response. (See here for a helpful overview of the structure of global health law.)

Old and New Public Health Law

Public health law is sometimes divided into "old public health" and "new public health." Old public health law refers to the classic functions of government to limit the transmission of infectious disease and environmental hazards: these are measures like quarantines, vaccination, public sanitation, and food safety. These government policies pose "tragedy of the commons" issues: they require collective action or infrastructure that is unlikely or impossible without central coordination. COVID-19 and the person-to-person spread of the virus that causes it (SARS-Cov-2) meet this definition precisely. For any given individual, the costs of protective measures (like quarantine or self-isolation) may be greater than the risks posed by continuing ordinary life. But for the population as a whole, continuing life as usual will result in a large number of infections and/or deaths. As we have learned from past epidemics, these infections and deaths are often more concentrated in groups with preexisting vulnerabilities, including

people who are poor, ill, disabled, elderly, experiencing discrimination, or living in communities with poor infrastructure.

By contrast, "new" public health refers to governmental efforts to reduce risk factors leading to morbidity and mortality that are not infectious or transmitted by environmental hazards. Those risk factors include mental health problems, substance use disorders, and chronic noncommunicable conditions such as heart disease and cancer. These human problems may also benefit from centralized coordination, particularly in addressing social determinants of health (e.g., socioeconomic inequality). But "new" public health problems have more complex causes, and although government action can influence predictors of chronic and noncommunicable disease, these efforts are different in kind from efforts to limit agents of infectious or environmental disease.

Government policies that address "old" public health threats can be broad and sometimes coercive, including invasive interventions into daily life. But these actions rest on a solid foundation of case law that recognizes the unique capacity of government—particularly state government—to play a coordinating role in times when individual actions pose society-wide risks. Where there is a visceral threat to society as a whole, governments have wide latitude to protect the population. By contrast, efforts to address "new" public health problems tend to be perceived as less urgent and therefore draw greater opposition on the basis of personal autonomy. In the US context, some people also perceive new public health problems to be caused by irresponsible individual behaviors (e.g., lack of exercise or alcohol use) instead of being driven social determinants. This view tends to characterize government actions as paternalistic and detrimental to personal responsibility, and so appeals to solidarity may be less effective than in the infectious disease context.

Public Health Law Interventions in the US

In the US legal system, states have primary authority to address infectious public health threats as part of what is known as the "police power"—plenary authority to provide for the well-being of state citizens. The federal government can also address infectious disease but within a more

limited remit of actions that affect interstate commerce and/or the spread to the United States of infections transferred from other nations. The federal government, for example, can quarantine and test international travelers (including US citizens; see here for a sample quarantine order) and goods, limit entry by sea at US ports, bar air travel by infected people, and bar noncitizens from entering the country. The federal government has authority, through the Surgeon General, to "make and enforce such regulations as in his judgment are necessary" to prevent the interstate spread of infectious diseases (including testing people "reasonably believed to be infected" and isolating people actually infected). An executive order specifies the infections that qualify for federal quarantine; these include "severe acute respiratory syndromes" and the virus causing COVID-19. Federal quarantine authority has been used rarely, however, as the threat of infectious disease declined and as the federal government invested fewer resources in enforcement throughout the 20th century. The most recent use of widespread federal isolation and quarantine measures was during the Spanish flu pandemic a century ago. Restrictions at the federal level are more tenuous when applied to activities and corporations that act only in one state. In modern practice, the federal government assumes broad responsibility for limiting the risks of infection spread by the international movement of goods and people while states take the lead in responding to threats internal to the US.

This division of responsibility explains why infectious disease responses like vaccination and quarantine mandates are set by states (and, in some states, county or municipal governments), and why the US response to COVID-19 has varied so much across state lines. There are nonetheless many actions available to the federal government in pandemic times. These include providing services, funds, expertise, equipment, and resources (including, for example, compulsory licensing of patented drugs or requiring businesses to accept contracts to produce goods such as masks and ventilators); purchasing and distributing essential goods; enforcing laws that prohibit epidemic responses that discriminate against protected groups; enforcing statutes that bar hoarding or price gouging of designated goods; supporting surveillance and research; supporting the enforcement of state-ordered quarantines; coordinating state actions; providing direct messaging to the public; and taking actions that affect national markets and the social safety net. Federal actions that respond to COVID-19 are collated here.

State governments have a number of tools to reduce the transmission of infectious disease and they have used many of these during the COVID-19 epidemic. State power is at its strongest in laws that seek to protect public health against serious contagious disease. When state authorities reasonably believe that there is a threat of disease, courts tend to uphold state actions that are not shown to be abusive, in bad faith, or a pretext for discrimination. This is true even when state actions are later found to be erroneous. Individual health officers, members of state and local boards of health, and municipalities themselves are not liable for errors of judgment as long as they act in good faith and take only the actions within their authority.

In some states, state legislation has delegated authority to local governments to take some or all of these actions—culminating in a national response that involves the participation of more than 2,600 state, local, and tribal authorities. The need to coordinate these governmental units can severely complicate the rapid response needed to contain a fast-moving epidemic, as COVID-19 has illustrated.

The following public health measures are available at the state level for an infectious disease response, and many are used continuously for the monitoring and control of endemic infectious diseases.

State Spending and Legislation. States can (and must) spend funds or forgo income to support the response to an epidemic, including direct financing of public insurance, public health surveillance activities, grants to public and private hospitals and clinics, and the purchase of equipment (e.g., ventilators and masks). State efforts to shore up public safety nets, including health insurance coverage, nutritional assistance, unemployment benefits, and housing assistance also require public spending and may be an essential part of enabling people to comply safely with more restrictive measures such as quarantines. State legislation can also reduce individuals' exposure to the financial costs of the epidemic by requiring health insurance coverage for infection-related expense. These actions apply to insurance plans that are not subject to federal regulation under the Affordable Care Act. Lifting sanctions for criminal laws can also enable fuller compliance by populations who may fear contact with governmental institutions.

State Public Health Activities. State and municipal departments of public health conduct essential activities directly. These include providing centralized counts of infections and tracking of infection spread, engaging in contact tracing, notifying people who may have been exposed, and enforcing more invasive measures such as vaccination requirements and quarantines. These activities demand increased resources during pandemics, requiring further spending, borrowing, and perhaps taxing by states and cities.

State Speech and Regulation of Speech. States always have authority to warn and educate the public directly about infectious disease, modes of transmission, and preventive measures. States in pandemic times may also consider measures such as restricting erroneous or dangerous speech (e.g., prosecuting hoaxes and fraudulent claims about possible cures), or requiring speech by private parties (e.g., mandating posted warnings in hospitals or grocery stores). Any speech restrictions or compulsory speech are subject to constitutional limitations.

State Regulation and Control of the Built Environment. States can use the levers of licenses, permits, zoning laws, and building codes to require structural changes that may be needed to reduce infectious disease. States and cities can also make some changes to the environment directly, such as practices for cleaning, opening, and maintaining public facilities (e.g., transit systems, schools, parks, and public buildings).

State Courts. State court systems can also shape some areas of pandemic response such as by providing a functioning tort system that shapes medical practice (e.g., through medical malpractice claims that recognize standards of care), consumer protection (e.g., through products liability law and penalties for fraud and misrepresentation), and sometimes the direct transmission of infection (e.g., through tort penalties for people who negligently or purposely expose others to infectious disease). The tort system is slow-moving and relies on litigation by private parties, making it a cumbersome tool for the rapid response needed in a pandemic. Courts also provide a forum for individuals or groups to challenge public health regulations that are burdensome to individuals or corporations or that may be designed or implemented in a way that discriminates against protected classes. Lawsuits alleging that states have overstepped in their response to COVID-19 are already underway. Under some state laws, courts must issue

emergency orders to allow other uses of state power, such as quarantines. Courts are also central to modifying terms or conditions of imprisonment in order to lessen the threats of infectious disease in detention settings.

State Regulation of Individuals. In pandemic times, state and local actions that exert direct control over individuals and corporations are highly visible. States continuously and quietly engage in many of these actions in non-epidemic times, including the surveillance of infectious and chronic disease rates, enforcing mandates for screening and testing (e.g., mandatory testing in detention facilities), providing for (or sometimes mandating) the treatment of infectious diseases (e.g., tuberculosis), setting and enforcing vaccine schedules, tracing contacts and notifying possibly exposed persons, inspecting premises (e.g., restaurants), and enforcing other criminal and civil laws intended to minimize the spread of infectious disease (e.g., public nuisance laws). But in pandemic times, the use of more coercive measures can escalate, including business closures, social distancing and travel restrictions, limitations on gatherings (as long as such bans are content-neutral), curfews, quarantines for people visiting from out of state, isolation orders for infected individuals, and vaccination mandates. With the exception of vaccination (as no vaccine is yet available), a majority of states have now enacted some or all of these measures to respond to COVID-19. Although states may retain authority to create sanitary cordons—isolated geographic zones with bars on entry and exit—states have not yet taken this measure in the current pandemic.

All of these state approaches are bounded by the limits of the federal constitution as well as by the constitutions of individual states. Where states reasonably believe that there is a serious public health threat, however, courts tend to be deferential, as the state's interest in public health tends to outweigh individual freedoms. Penalties for individual violations of these mandates may include civil fines, criminal fines, or jail time, as long as these penalties are permitted under state legislation and set in advance. But notably, criminalization of infectious disease exposure (even intentional exposure) may undermine other state efforts to control infection (e.g., contact tracing, testing, and treatment), which may be illustrated by state efforts since the 1980s to criminalize HIV exposure. Several federal and state efforts to prosecute individuals for intentional coronavirus exposure are underway using charges such as assault, and

the federal government may prosecute these offenses under anti-terrorism laws (e.g., use of weapons of mass destruction).

Quarantine, Isolation, and Social Distancing

State laws enabling quarantines, isolation, and social distancing measures have been significant in the COVID-19 response. State quarantine laws vary greatly along lines such as the duration and location of quarantine, enforcement penalties, application to individuals and/or groups, additional authorities available after emergency declarations, and availability of administrative review. State quarantine laws are collated and searchable here.

Although quarantines, isolation, and other social distancing measures can interfere with many rights—including freedom of assembly, freedom of religion, freedom of contract, and the right to travel—courts usually find that states' interest in public health outweighs these freedoms. As a result, social distancing orders are usually upheld as long as they are reasonable in relation to the threat to public health. Judicial decisions in New Jersey and Maine pertaining to the same individual during the 2014 Ebola epidemic illustrate the court approaches. Although quarantines must not be a pretext for discrimination against any protected class, religious exemptions are not required. In order for quarantine regulations to survive judicial review, authorities must reasonably believe that the public is in danger of an epidemic and that quarantined people have been exposed; mere suspicion of infection or exposure is insufficient. Courts also agree that some procedural due process is needed; hearings, however, are usually limited to the question of whether authorities were reasonable in their belief that a quarantine was needed. State statutes structure the ways in which quarantines are enforced and federal law specifies that state and federal governments may (and should) support each other in quarantine enforcement.

Vaccination Laws

Although no vaccine is yet available for SARS-CoV-2, states' authority to mandate vaccination may apply to the COVID-19 response in the future. Should a vaccine be developed, states could

permissibly require individuals to receive the vaccine (enforceable by fines or even compulsorily required), as long as there are exemptions for people who are medically unable to be vaccinated. Multiple courts have found that Religious exemptions from state vaccination mandates are not required by the 14th Amendment. Courts are also wary of second-guessing state legislatures' belief that vaccination is sufficiently safe and needed as part of a pandemic response.

Emergency Declarations

Emergency declarations at the state and federal levels can allow states to access additional resources. Those declarations also expand the powers granted to the executive branch in times of a pandemic. The goal of such declarations—enabled by more than 100 federal laws—is to enable a nimbler and faster response to changing conditions without requiring the more cumbersome machinery of the legislature and courts. The White House and all 50 state governors have now declared COVID-19 to be a public health emergency and the White House has deemed it both a public health emergency under the Public Health Service Act and a "major disaster" qualifying under the terms of the Stafford Act.

Federal emergency preparations (see here and here for overviews) changed dramatically in the wake of the 9/11 attacks and the anthrax exposures in 2001 and subsequent legislation included the Federal Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (which established the National Disaster Medical System and the Strategic National Stockpile of medical supplies); the Project BioShield Act of 2004 (which allows the FDA to issue emergency use authorizations for drugs and devices); amendments to the Stafford Act; the National Emergencies Act; the Public Health Service Act, and the Pandemic and All-Hazards Preparedness Act (PAHPA). The Stafford Act declaration enables the Federal Emergency Management Agency to coordinate the national response to COVID-19 in affected states that request support and to certify that the emergency has overwhelmed state capacity. Each of these declarations enables federal executive actions that ease constraints on public health insurance (e.g., Medicaid § 1135 waivers or waivers of obligations under the Emergency Medical Treatment and Active Labor Act or HIPA), allow additional expenditures, grant increased authority to enact quarantines, alleviate

tort liability for products and persons involved in the response, and provide for the reallocation of resources and personnel. Federal emergency powers under the Defense Production Act also give the executive branch the authority to take control of industries and to require contractors to prioritize federal contracts. The federal government response to the COVID-19 epidemic has lagged but is increasingly scaling up to use these authorities. Congress can also grant agencies more powers in times of crisis (see, for example, the request by the Department of Justice for authority to extend statutes of limitation and detention periods for defendants with delayed trials).

States have their own emergency statutes, and a number of states adopted versions of the Model State Emergency Health Powers Act (MSEHPA) after its drafting in 2001. State definitions of emergency vary, with many states leaving the term undefined, but most states require an exigent situation, potential calamitous harm, and an inability to avoid the harm through ordinary measures. At the state level, declarations of a state emergency expand the powers of governors, health officers, and boards of health. These powers vary, but generally include the power to quarantine exposed people, isolate or treat infected people, vaccinate against infectious disease, institute distancing measures, ease licensure restrictions on clinicians from other states, educate the public, spend state funds, and engage in takings. (For a useful overview of state and federal emergency powers, see here.)

The expansive grants of federal and state executive power during emergencies can raise concerns that agencies, governors, or the President will misuse these temporary authorities to enact policy changes that were impermissible in normal times. But as the Congressional response to COVID-19 has shown, legislative action can also be too slow and unwieldy in times of crisis. Federal coordination is essential for responding to epidemics that cross domestic and international borders and that outmatch states' resources to respond. The COVID-19 emergency is one such epidemic, and both federal and state efforts will be crucial for an effective and durable response.

Additional Resources

General public health law related to COVID-19:

https://www.healthaffairs.org/do/10.1377/hblog20200319.757883/full/

https://jamanetwork.com/journals/jama/fullarticle/2764283

https://www.nejm.org/doi/full/10.1056/NEJMra1314094

https://www.ncsl.org/research/health/ncsl-coronavirus-covid-19-resources.aspx

https://www.nejm.org/doi/full/10.1056/NEJMp2006740

Emergency law:

https://www.train.org/cdctrain/training_plan/4120

https://law.emory.edu/elj/content/volume-67/issue-3/index.html

https://www.ncsl.org/research/health/public-health-chart.aspx

CDC and NIH resources:

https://www.cdc.gov/quarantine/aboutlawsregulationsquarantineisolation.html

https://www.cdc.gov/quarantine/pdf/Public-Health-Order_Generic_FINAL_02-13-2020-p.pdf

https://www.cdc.gov/quarantine/specificlawsregulations.html

Resources on state law:

https://www.ncsl.org/research/health/state-quarantine-and-isolation-statutes.aspx

https://www.ncsc.org/Newsroom/Public-health-emergency.aspx

https://www.ncsc.org/~/media/Files/PDF/Topics/Courthouse%20Facilities/State-Law-Pandemic-Response.ashx

https://www.kff.org/health-costs/issue-brief/state-data-and-policy-actions-to-address-coronavirus/

Resources on quarantine law:

https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3157182

https://www.theatlantic.com/ideas/archive/2020/02/coronavirus-quarantine-america-could-be-giant-legal-mess/606595/

https://dash.harvard.edu/bitstream/handle/1/8852098/vanderhook2.html?sequence=4

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5886825/

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6687239/