

Federalism, Leadership, and COVID-19

Evolving Lessons for the Public's Health

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I INTRODUCTION

The first year of the COVID-19 pandemic distinguished the United States as having the “worst outbreak in the world,” with more Americans dying than in World War II, the Korean War, and the Vietnam War combined.¹ By October 2021, COVID-19 deaths exceeded those caused by the former deadliest pandemic, the 1918 influenza virus.² Prominent commentators framed the turbulent early pandemic response as a failure of leadership, but this assessment does not tell the complete story.³ There are structural explanations for the complicated response of the United States too. In particular, a fundamental feature of the American approach to public health – the national governance structure known as federalism – is at least partially responsible for weaknesses in the country’s response to the pandemic.

Federalism divides power, responsibility, and capacity for health policies across multiple levels of government, most often between federal and state governments. Though federalism is the default choice for structuring health laws, often it is not a constitutionally required one.⁴ States are invited through federal laws to participate in national policies with the promise of money and regulatory guardrails but also policy flexibility. Proponents claim the vertical division of authority between governments fosters tailored policies for local populations, experimentation, and innovation.

¹ Noah Higgins Dunn, ‘The U.S. Has the Worst Coronavirus Outbreak in the World: ‘The Numbers Don’t Lie,’ Dr. Fauci Says, CNBC (Aug. 5, 2020), www.cnbc.com/2020/08/05/dr-fauci-agrees-the-us-has-the-worst-coronavirus-outbreak-in-the-world-the-numbers-dont-lie.html.

² Farida B. Ahmad, Jodi A. Cisewski, and Robert N. Anderson, Provisional Mortality Data — United States, 2021, CDC Morbidity and Mortality Weekly Report (April 29, 2022), www.cdc.gov/mmwr/volumes/71/wr/pdfs/mm7117e1-H.pdf.

³ The Editors, Dying in a Leadership Vacuum, 383 *New Eng. J. Med.* 1479 (Oct. 7, 2020), 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 (Jan. 15, 2021), www.commonwealthfund.org/publications/podcast/2021/jan/us-is-missing-key-opportunities-end-covid-19-pandemic.

⁴ Abbe R. Gluck & Nicole Huberfeld, What Is Federalism in Healthcare for?, 70 *Stan. L. Rev.* 1689, 1719–24 (2018).

Yet divided authority also requires more coordination between government officials, which increases complexity in a public health emergency, requiring each leader to act in the right way at the right time and leaving more room for error when they do not.

In public health governance, authority is divided even further, between the federal government and more than 2,800 state, local, and tribal governments. Congress generally must draft emergency and disaster relief bills around state and local efforts; so, under existing laws, an emergency response always builds on the foundation of states' policy choices and is likely to intensify states' preexisting health and economic conditions, which in turn heightens the inequitable impact of an event such as a pandemic.

This is what has happened with the novel coronavirus. Decisions made by leaders at every level, but especially state officials, directly impacted infection and death rates and stymied relief efforts. Early in the pandemic, some state leaders filled the void when expected federal support was not supplied. But throughout the pandemic and especially as it evolved in 2021, state choices regarding containment measures and vaccination rollout decisions, as well as uptake and distribution of federal relief funds and challenges to federal vaccine rules, exacerbated the public health emergency and increased inequitable impacts. Populations already experiencing persistent health disparities, such as Black, Hispanic, Indigenous, and other people of color, as well as low-income and rural populations, suffered greater rates of infection and death.

In short, federalism increases the need for a coordinated response in emergency and disaster relief efforts. In the case of COVID-19, public health federalism quickly complicated dealing with the pandemic in the face of weak early federal leadership, long-underfunded state public health systems and resistance to health reform, and other emergency response policy choices that teed up the "worst outbreak." To reduce unnecessary risk when the next emergency occurs, COVID-19's legacy will need to include building a better governance structure to increase the resilience of individuals, populations, and public health systems.

II FEDERAL AUTHORITY AND EMERGENCY RESPONSE

A public health emergency (PHE) prompts a suite of federal actions, especially if it involves a multi-state or nationwide event. Congress, the President, and multiple federal agencies all must exercise authority under a set of federal laws that address the need for swift reaction in an emergency or disaster. Congress typically addresses national emergencies through legislation designed to assist those harmed on a short-term basis, using "relief bills" to deliver economic and other aid. Congress first responded to the COVID-19 PHE with two relief bills enacted in March 2020: the Coronavirus Aid, Relief, and Economic Security Act (CARES Act);⁵ and the Family First Coronavirus Response Act (Families First Act).⁶ Both followed prior relief bill

⁵ Pub. L. No. 116-136, 134 Stat. 281 (2020).

⁶ Pub. L. No. 116-127, 134 Stat. 177 (2020).

blueprints by providing loans to struggling businesses, increasing federal funding to cover Medicaid enrollment spikes, and enhancing unemployment insurance benefits. Recognizing Medicaid's countercyclical nature and states' immediate need for support given their balanced budget requirements, the bills offered states and private actors short-term monetary and deregulation measures.

The Families First Act, in Section 6008, provided an enhanced federal Medicaid match during the PHE, along with a requirement of "maintenance of effort" (MOE) so states could not decrease enrollment or eligibility while accepting enhanced federal funds. The Families First Act also allowed states to cover COVID-19 testing and related services for uninsured people through Medicaid with a 100 percent federal match. When the PHE ends, states lose emergency flexibilities, and the Families First Act enhanced match expires. With every state accepting the enhanced federal match, the two relief bills supported a 13.9 percent increase in Medicaid enrollment from the pandemic's beginning in February 2020 through January 2021.⁷

A national emergency also triggers unique presidential power and the need for coordinated action among the President, federal agencies, and state and local officials. Both the President and the Secretary of the Department of Health and Human Services (HHS) must declare an emergency to invoke the full range of federal aid available during a PHE. Under the Stafford Act, the President facilitates disaster and emergency aid by issuing major disaster declarations to individual states, usually after a governor's request, although President Trump also issued a national emergency declaration for COVID-19.⁸ A disaster declaration initiates help from agencies such as the Department of Homeland Security and its sub-agency, the Federal Emergency Management Agency,⁹ and triggers federal assistance that coordinates relief to states; provides technical and advisory support to state and local governments, including public health information and data; helps state and local officials with the distribution of food, medicine, and other supplies; and provides direct support to "save lives."¹⁰ The President can provide additional federal assistance if the response is deemed "inadequate ... to save lives, protect property and public health and safety, and lessen or avert the threat of a catastrophe."¹¹ The President also has authority to declare a national emergency under the National Emergencies Act, which triggers other flexibilities, including

⁷ Ctrs. for Medicare & Medicaid Servs., Press Release: New Medicaid and CHIP Enrollment Snapshot Shows Almost 10 Million Americans Enrolled in Coverage During the COVID-19 Public Health Emergency (June 21, 2021), www.cms.gov/newsroom/press-releases/new-medicare-and-chip-enrollment-snapshot-shows-almost-10-million-americans-enrolled-coverage-during.

⁸ Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. § 5191; Cong. Rsch. Serv., The Stafford Act Emergency Declaration for COVID-19 (Mar. 13, 2020), <https://crsreports.congress.gov/product/pdf/IN/IN11251>.

⁹ 42 U.S.C. §§ 5122, 5191–92.

¹⁰ 42 U.S.C. §§ 5121, 5192(a).

¹¹ 42 U.S.C. § 5192(b).

actions under the Defense Production Act.¹² The national emergency and PHE are relatively short-term declarations and must be renewed if an emergency continues; disaster declarations are open-ended.

The HHS Secretary's declaration of a PHE under the Public Health Service Act prompts regulatory, financial, and other relief that facilitates state emergency response.¹³ Using this suite of emergency powers, HHS and other federal agencies issue guidance for dealing with an emergency, deploy federal workers to assist state and local officials, and relax certain rules for Medicaid/Children's Health Insurance Program, Medicare, and some Health Insurance Portability and Accountability Act privacy standards. This labyrinth of emergency authority laws builds federal/state collaboration into a national emergency response. Because state officials can operationalize federal funding and policy guidance on the ground, pragmatically, both executive and legislative emergency actions rely on states and localities to partner in addressing emergencies and disasters.

Though HHS Secretary Alex Azar declared a PHE on January 31, 2020, the President waited to declare a national emergency, with the first declaration effective March 1, 2020; as such, states such as Washington and California facing the pandemic in January and February were responding to a new disease outbreak without the full range of federal assistance.¹⁴ Despite the enhanced executive powers that become available upon declaring a national emergency, President Trump was widely reported to have chosen not to exercise such powers, with the exceptions of imposing international travel restrictions and supporting rapid vaccine development. The kinds of actions President Biden commenced upon entering office provide examples of the authority that went unexercised: mask-wearing requirements on federal property; evidence-based manufacturing enhancements and distribution of personal protective equipment (PPE); opening and promoting a special enrollment period on the federal health insurance exchange ("marketplace") under the Affordable Care Act (ACA) to assist people who had lost jobs in obtaining insurance coverage; and clear vaccine distribution standards, to name a few.

Each presidential decision that reflected an anti-science stance, or that resulted in inaction, increased risks associated with COVID-19, a decidedly anti-public health approach to a PHE. Such choices included the President flouting state and local disease containment rules by ignoring mask-wearing orders during public events,¹⁵ and other noncompliant behavior,¹⁶ leading to his COVID-19 infection

¹² National Emergencies Act, 50 U.S.C. §§ 1601–51.

¹³ 42 U.S.C. § 247d.

¹⁴ 85 Fed. Reg. 15,337 (Mar. 18, 2020).

¹⁵ Teo Armus, *A GOP County Chair Asked Trump to Wear a Mask to His Rally. Instead, Trump Mocked Pandemic Restrictions*, Wash. Post (Sept. 9, 2020), www.washingtonpost.com/nation/2020/09/09/trump-rally-masks-nc/.

¹⁶ 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*, Bos. Globe (Oct. 4, 2020), www.bostonglobe.com/2020/10/04/nation/trumps-positive-covid-test-doesnt-change-views-some-supporters-wearing-masks/.

in October 2020.¹⁷ By law, the federal government is responsible for disseminating stockpiled supplies,¹⁸ yet President Trump told governors “we’re not a shipping clerk” and shifted to states the work of purchasing and distributing PPE.¹⁹ The White House interfered with information disseminated through key agencies, such as the Centers for Disease Control and Prevention (CDC), to downplay the magnitude of the outbreak.²⁰ As the pandemic progressed, White House communications were inconsistent and often undermined scientific evidence while simultaneously encouraging rebellion against state and local containment orders – while also pressuring states to curb the outbreak.²¹

This chaotic approach forced states to act alone and to compete with one another and the federal government for PPE. The devolution of executive responsibility tasked states with actions that centralized, coordinated action should have done and would have addressed better.²² This very situation was meant to be avoided by federal laws that centralize disaster resources, such as by creating a stockpile and enabling emergency authority under the Defense Production Act to ramp up production of necessary supplies.²³

The “Operation Warp Speed” vaccine development effort both contrasts with and evidences questionable leadership choices in the first year’s response. This effort supplied substantial federal funding for researchers and was deemed successful in generating vaccines worthy of Food and Drug Administration (FDA) emergency use approval by the end of 2020.²⁴ Vaccine distribution, on the other hand, suffered from many of the same flaws as other aspects of the pandemic response. No federal law currently mandates, tracks, or otherwise governs the distribution of adult vaccines in a consolidated fashion. The CDC largely relies on state and local health

¹⁷ Michael. C. Bender & Rebecca Ballhaus, Trump Didn’t Disclose First Positive COVID-19 Test While Awaiting a Second Test on Thursday, Wall St. J. (Oct. 4, 2020), www.wsj.com/articles/trump-didnt-disclose-first-positive-covid-19-test-while-awaiting-a-second-test-on-thursday-11601844813.

¹⁸ Fed. Emergency Mgmt. Agency, Bringing Resources to State, Local, Tribal & Territorial Governments, www.fema.gov/disasters/coronavirus/governments.

¹⁹ Quint Forgey, ‘We’re Not a Shipping Clerk’: Trump Tells Governors to Step up Efforts to Get Medical Supplies, Politico (Mar. 19, 2020), www.politico.com/news/2020/03/19/trump-governors-coronavirus-medical-supplies-137658; 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>.

²⁰ Aaron Rupar, Dr. Fauci and Dr. Birx Detail How Trump’s Coronavirus Response Was Even Worse Than We Thought, Vox (Jan. 25, 2021), www.vox.com/2021/1/25/22249050/fauci-birx-interviews-trump-coronavirus-response.

²¹ Lauren de Valle, Man Pleads Guilty in Plot to Kidnap Michigan Gov. Gretchen Whitmer, CNN (Jan. 27, 2021), www.cnn.com/2021/01/27/politics/gretchen-whitmer-kidnapping-plot/index.html.

²² Michael D. Shear et al., Inside Trump’s Failure: The Rush to Abandon Leadership Role on the Virus, NY Times (Sept. 15, 2020), www.nytimes.com/2020/07/18/us/politics/trump-coronavirus-response-failure-leadership.html.

²³ 50 U.S.C. § 4502.

²⁴ Dan Diamond, The Crash Landing of ‘Operation Warp Speed,’ Politico (Jan. 17, 2021), www.politico.com/news/2021/01/17/crash-landing-of-operation-warp-speed-459892.

departments and health care providers to supply data; yet the Trump Administration stopped hospitals from reporting directly to the CDC.²⁵ The lack of centralized decision-making, combined with stymied data collection and skeletal CDC guidance to state and local public health officials for dissemination, meant that vaccine distribution started fitfully, with high variability from state to state, a situation which continued throughout 2021.²⁶ The incoming Biden Administration found inconsistent information regarding how many vaccine doses existed, and many states had not collected any data regarding their vaccination efforts.²⁷ Some states implemented vaccine guidelines so strict that doses went to waste (e.g., New York), while others were so lax that a sort of vaccine tourism popped up (e.g., Florida, Utah).

Generally, HHS made more predictable choices. When the coronavirus penetrated national borders, Secretary Azar declared a PHE effective January 27, 2020. The PHE activated the special authority of HHS to issue emergency grants, enter into contracts, access emergency funds, and increase regulatory flexibility. After the President declared a national emergency under the National Emergencies Act, the two declarations – national emergency and PHE – empowered the Secretary to issue emergency-related waivers under Section 1135 of the Social Security Act (SSA). Section 1135 permits modification of specific Medicaid requirements to ensure sufficient health care access during an emergency, for example, waiving licensure requirements for out-of-state providers. HHS made other emergency flexibilities available to states, including provisions to boost Medicaid capacity without legislative action, as the program is a crucial tool for emergency response. For example, states may make limited changes to Medicaid state plans to address access and coverage issues during a PHE and apply for waivers under SSA Section 1115 for temporary coronavirus-related demonstration projects.

HHS could have taken further actions to facilitate nationwide emergency response. If the President and Secretary Azar were not hostile to the ACA, natural choices would have been to encourage states to expand Medicaid eligibility and to open a special enrollment period on the federal exchange, or at least advertise the end-of-year open enrollment period more widely and extend it. Nevertheless, Secretary Azar renewed the PHE declaration throughout 2020, issuing his last declaration on January 7, 2021 (effective January 21, 2021), ensuring the PHE would continue through the first three months of the Biden Administration.

Congress enacted the American Rescue Plan Act of 2021 (ARPA) shortly after President Biden took office,²⁸ structuring it similarly to the first two relief bills but

²⁵ Sheryl Gay Stolberg, *Trump Administration Strips C.D.C. of Control of Coronavirus Data*, NY Times (July 15, 2020), www.nytimes.com/2020/07/14/us/politics/trump-cdc-coronavirus.html.

²⁶ Ctrs. for Disease Control & Prevention, *COVID-19 Vaccinations in the United States*, https://covid.cdc.gov/covid-data-tracker/#vaccinations_vacc-total-admin-rate-total.

²⁷ Alejandro de la Garza & Chris Wilson, *Many States Don't Know Who's Getting COVID-19 Vaccines. That's a Huge Problem for Equity*, Time (Jan. 28, 2021), <https://time.com/5934095/covid-vaccine-data/>.

²⁸ Pub. L. No. 117-2, 135 Stat. 3 (2021).

reflecting different priorities. The Biden Administration's early executive orders made use of available statutory authority, recentered scientific evidence, elevated health equity, and committed to vigorously implementing the ACA, including extending the special enrollment period on the federal exchange and maximizing Medicaid expansion.²⁹ ARPA reflected these leadership choices, for example, providing an enhanced federal match for states to expand Medicaid eligibility, increasing Supplemental Nutrition Assistance Program (SNAP) funding, enhancing emergency rental assistance, and offering money to get elementary and secondary students back to school.

ARPA also built on the federalist structure found in most American social programs, making state and local choices important even with stronger federal leadership and partnership. For example, Florida did not apply for the bump in SNAP funding for schoolchildren's 2021 summer break,³⁰ and did not submit a plan to the Department of Education to receive ARPA's school funding before the summer ended.³¹ All states distributed some portion of ARPA emergency rental assistance funds, yet as of September 2021 states had distributed just 25 percent of the available money. Eighteen states distributed less than 10 percent of available funds, including Florida, Indiana, Iowa, Montana, and Vermont at 9 percent; Alabama and Georgia at 6 percent; and South Dakota and Wyoming at 2 percent.³² Further, half of states ended ARPA's federally funded unemployment benefits early.³³ Even with federal money available, for administrative, political, or other reasons, some state officials did not perform their PHE implementation role.

III STATE RESPONSES

Public health officials are largely local and state actors, so historically public health in everyday and emergency circumstances has been addressed through a combination of state and local funding and operationalization, combined with federal guidance and money. This structure assumes states both have and use

²⁹ The Biden-Harris Plan to Beat COVID-19, White House, www.whitehouse.gov/priorities/covid-19/.

³⁰ Kate Santich, Florida Missing Out on Millions of Dollars in Federal Aid for Childhood Hunger, Orlando Sentinel (Aug. 24, 2021), www.orlandosentinel.com/news/os-ne-florida-missing-out-on-millions-for-childhood-snap-benefits-20210824-drldk44j5zd6pfp34ymcx3id5e-story.html.

³¹ ARP ESSER State Plans, Dep't of Educ. Off. of Elementary & Secondary Educ., <https://oese.ed.gov/offices/american-rescue-plan/american-rescue-plan-elementary-and-secondary-school-emergency-relief/stateplans/> (last visited Sept. 24, 2021).

³² Nat'l Low Income Hous. Coal., NLIHC Overview and Analysis of Latest Emergency Rental Assistance Spending Data (Sept. 24, 2021), <https://nlihc.org/news/nlihc-overview-and-analysis-latest-emergency-rental-assistance-spending-data>.

³³ Sarah Chaney Cambon & Danny Dougherty, States that Cut Unemployment Benefits Saw Limited Impact on Job Growth, Wall St. J. (Sept. 1, 2021), www.wsj.com/articles/states-that-cut-unemployment-benefits-saw-limited-impact-on-job-growth-11630488601.

public health expertise and have the capacity to implement it, which sometimes is true. But as already described, states have not always chosen to respond to federal PHE measures.³⁴

Nevertheless, the early vacuum of presidential leadership boosted state responsibility – and power – to respond to a disease outbreak posing a greater challenge than any public health event in recent history. A solely state-based response could not have adequately addressed this level of disaster, making national containment measures even more important. Facing little federal assistance and contradictory guidance, it is unsurprising that states initially responded to the pandemic in a highly irregular fashion. Governors found themselves thrust onto the pandemic frontline but also sometimes in a bind. While governors have authority to respond quickly to an emergency, in some states, such as Missouri, they refused to adopt containment measures suggested by federal public health experts, such as Dr. Anthony Fauci, the Director of the National Institute of Allergy and Infectious Diseases, leaving decisions and implementation to local officials.³⁵ In other states, such as Mississippi, governors limited local authority to issue containment rules, contradicting evidence that such measures were critical to slowing disease spread.³⁶ With the pandemic raging on, some state legislatures in the 2021 session limited gubernatorial emergency powers, which could impair response to future PHE.³⁷ This shows how state responsibility for the pandemic reflects a particularly risky brew of short- and long-term policy choices driven by leadership successes and failures.

On the short-term policy front, non-pharmaceutical interventions (NPIs) were the primary tool for controlling the spread of COVID-19 in 2020 and remained important into 2021, even as the FDA's emergency use vaccine approvals began on December 11, 2020.³⁸ The NPIs recommended by the CDC included individual efforts such as mask-wearing and frequent sanitizing of hands and surfaces; public measures such as physical distance and restricted occupancy in public spaces; limitations on the size of gatherings; state and local stay-in-place orders (SIP); and

³⁴ Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2019, Pub. L. No. 116–22, 133 Stat. 905 (2019).

³⁵ Jim Salter, Missouri's COVID-19 Response in Spotlight at Governor Forum, US News (Oct. 9, 2020), www.usnews.com/news/best-states/missouri/articles/2020-10-09/missouris-covid-19-response-in-spotlight-at-governor-forum.

³⁶ Adam Gabbatt, Which States Have Done the Least to Contain Coronavirus?, Guardian (Apr. 3, 2020), www.theguardian.com/world/2020/apr/03/coronavirus-states-response-who-has-done-least-alabama-oklahoma-missouri.

³⁷ David A. Lieb, State Lawmakers Are Pushing to Curb Governors' Virus Powers, Associated Press (Jan. 28, 2021), https://apnews.com/article/state-lawmakers-governor-coronavirus-7d5710f2d8aa4e659c0ec68400ad3d3c?utm_source=Sailthru&utm_medium=email&utm_campaign=AP%20Mornin%20Wire&utm_term=Morning%20Wire%20Subscribers.

³⁸ Food & Drug Admin. Press Release, FDA Takes Key Action in Fight Against COVID-19 by Issuing Emergency Use Authorization for First COVID-19 Vaccine (Dec. 11, 2021), www.fda.gov/news-events/press-announcements/fda-takes-key-action-fight-against-covid-19-issuing-emergency-use-authorization-first-covid-19.

business, church, and school closures. Some state officials swiftly implemented NPIs and kept them in place when infection rates spiked, as in California, while others such as Texas responded minimally, reopening quickly after SIPs and resisting further containment. South Dakota and neighboring states had a particularly bad outbreak in the summer of 2020 after resisting most NPIs and allowing a major motorcycle rally to occur.³⁹

Indeed, data show that states with the weakest containment measures, such as Florida, Mississippi, Texas, and North Dakota, had the worst outbreaks. Studies have documented containment policy differences, including the kinds of measures, stringency, and duration of implementation, showing that policy heterogeneity and weak containment measures correlated to severity of outbreaks in each state.⁴⁰ In addition, temporal dissimilarities contributed to severity of outbreaks. State and local NPIs came in waves, with many states opting for near total lockdown, including closing schools and businesses, in March and April of 2020. But some states reopened with almost no containment measures as summer arrived. State containment laxity facilitated a late summer spike in infections across the Midwest and South, followed by a second wave of NPIs. A third wave of NPIs occurred after Thanksgiving outbreaks again flooded hospitals with COVID-19 cases into the end of 2020.⁴¹

In 2021, when vaccination promised some normalcy, states relaxed and even limited NPIs, going so far as to ban vaccine verification and indoor mask-wearing requirements. These choices fueled a spike in Delta variant cases in the summer months and as the 2021–22 school year began, especially in Southern states, which have had the lowest vaccination rates. As of September 2021, contrary to CDC guidance, nine states forbade school mask-wearing requirements, or required that families be able to opt out for any reason, some of which courts blocked and school boards ignored (Arizona, Arkansas, Florida, Iowa, Oklahoma, South Carolina, Tennessee, Texas, Utah); nineteen states (and also the District of Columbia) required mask-wearing; and the others left decisions to local officials.⁴² Many of the same states also banned vaccine mandates and vaccine verification requirements. These same

³⁹ 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 (July 15, 2021).

⁴⁰ Coronavirus Government Response Tracker, Univ. of Oxford Blavatnik Sch. of Gov't, www.bsg.ox.ac.uk/research/research-projects/coronavirus-government-response-tracker; Variation in US States' Responses to COVID-19, Version 2.0 (Dec. 2020), www.bsg.ox.ac.uk/sites/default/files/2020-12/BSG-WP-2020-034-v2_o.pdf.

⁴¹ Laura Hallas et al., Variation in US States' Responses to COVID-19 Version 3.0 (May 2021), www.bsg.ox.ac.uk/research/research-projects/coronavirus-government-response-tracker.

⁴² State COVID-19 Data and Policy Actions, Kaiser Fam. Found. (Sept. 28, 2021), www.kff.org/report-section/state-covid-19-data-and-policy-actions-policy-actions/#note-2-9; Stacey Decker, Which States Ban Mask Mandates in Schools, and Which Require Masks?, *Educ. Week* (Sept. 29, 2021), www.edweek.org/policy-politics/which-states-ban-mask-mandates-in-schools-and-which-require-masks/2021/08.

states experienced spikes in COVID-19 infections and deaths while the Delta variant became dominant and vaccine hesitancy took hold in the summer of 2021.⁴³ Arkansas' governor expressed regret for signing the bill banning mask-wearing as infection and death rates spiked in August 2021.⁴⁴ Governors and state attorneys general from these and other states also challenged federal vaccine requirements for federal contractors,⁴⁵ and health care providers,⁴⁶ issued in response to these state officials' reticence to promote or require vaccination, and federal courts have at least preliminarily agreed.⁴⁷ Such state choices limited federal vaccination efforts as the Omicron variant emerged in late 2021.

States' variable outcomes also reflect long-term policy choices; two key pre-pandemic examples demonstrate this. First, nearly all public health spending occurs at the state and local level, and most states have reduced public health spending over the last decade and more, with steep budget cuts initiated during the 2008 Great Recession never rebounding.⁴⁸ One study found that states spend less than 3 percent of their annual budgets on public health agencies, translating to \$100 per resident annually, but varying widely between states, from a high of \$263 per person in Delaware to a low of \$32 in Louisiana.⁴⁹ Another study estimates that public health spending accounts for less than two cents on every health dollar.⁵⁰ Florida has had one of the worst COVID-19 outbreaks and spends less than 2 percent of its budget on public health.⁵¹ Even Massachusetts, which increased public health spending over the last decade, had fewer staff relative to the number of residents.⁵² Reduced resources impacted state and local governments, increasing leadership turnover and decreasing the reach of short-staffed public health agencies, impacting, for example,

⁴³ Tracking Coronavirus Vaccinations and Outbreaks in the U.S., Reuters (Sept. 30, 2021), <https://graphics.reuters.com/HEALTH-CORONAVIRUS/USA-TRENDS/dgkvlgrkpb/>.

⁴⁴ Josie Fischels, Arkansas Governor Wants to Reverse a Law That Forbids Schools to Require Masks, NPR (Aug. 4, 2021), www.npr.org/2021/08/04/1024939859/arkansas-governor-reverse-law-let-schools-require-masks.

⁴⁵ Executive Order 14,042 (Sept. 9, 2021); *Georgia v. Biden*, Case No. 1:21-cv-00163-RSB-BKE, 2021 WL 5779939 (S.D. Ga. Dec. 7, 2021).

⁴⁶ *Ctrs. for Medicare & Medicaid Servs., Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination*, 86 Fed. Reg. 61,555-01 (Nov. 5, 2021).

⁴⁷ *Missouri v. Biden*, Case No. 4:21-cv-01329-MTS, 2021 WL 5564501 (E.D. Mo. Nov. 29, 2021); *Louisiana v. Becerra*, Case No. 3:21-CV-03970, 2021 WL 5609846 (Nov. 30, 2021).

⁴⁸ Y. Natalia Alfonso et al., Neglected: Flat or Declining Spending Left States Ill Equipped to Respond to COVID-19, 40 *Health Affs.* 664 (2021).

⁴⁹ Lauren Webber et al., Hollowed-Out Public Health System Faces More Cuts Amid Virus, Kaiser Health News & Associated Press (July 1, 2020).

⁵⁰ Jonathan P. Leider et al., Inaccuracy of Official Estimates of Public Health Spending in the United States, 2000–2018, 110 *Am. J. Pub. Health* 194 (2020), <https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2020.305709>.

⁵¹ *Id.*

⁵² The Impact of Chronic Underfunding on America's Public Health System: Trends, Risks, and Recommendations, 2021, Trust for America's Health (May 2021), www.tfah.org/wp-content/uploads/2021/05/2021_PHFunding_Fnl.pdf.

routine childhood vaccinations and contact-tracing for infections such as HIV, and reducing capacity to respond to a PHE.

State funding cuts should have been balanced by increased federal funding allocated in the ACA, but Congress decreased funding for the Prevention and Public Health Fund shortly after enacting the ACA. Funding for the CDC was flat for the last decade, and states rely on partnering with the CDC for both funding and expertise, producing layers of underfunded public health in the federalist public health structure.⁵³ In short, public health was underfunded and understaffed when COVID-19 arrived, demanding a massive containment effort and an extensive vaccine rollout without staff or other resources adequate to the tasks.⁵⁴ Long-term fiscal neglect increased the risks associated with a pandemic.

Second, states that expanded Medicaid eligibility under the ACA have more federal funding available than non-expansion states, which has administrative, structural, systemic, and population health implications for states' ability to address the pandemic. For example, expansion states drew down more federal money under the CARES Act: \$1,755 per resident compared with \$1,198 in non-expansion states.⁵⁵ Before the pandemic, expansion states experienced improvements in individual and public health as well as financial benefits for health care providers (especially hospitals) and state budgets.⁵⁶ Fourteen states did not expand Medicaid as of January 2020, and their populations have higher rates of chronic conditions and worse overall health;⁵⁷ their hospitals are less financially stable and have closed at higher rates;⁵⁸ and their budgets have not seen the stabilizing shift that comes with expansion funding.⁵⁹ All of these are factors contributing to higher COVID-19 infection and death rates.

⁵³ David Himmelstein & Steffie Woolhandler, Public Health's Falling Share of US Health Spending, 106 *Am. J. Pub. Health* 56–57 (2016), www.ncbi.nlm.nih.gov/pmc/articles/PMC4695931/; Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 § 4002 (2010).

⁵⁴ Nicholas Florko, Trump Officials Actively Lobbied to Deny States Money for Vaccine Rollout Last Fall, *STAT News* (Feb. 1, 2021), 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.

⁵⁵ Cindy Mann, The COVID-19 Crisis Is Giving States That Haven't Expanded Medicaid New Reasons to Reconsider, *Commonwealth Fund* (Apr. 15, 2020), www.commonwealthfund.org/blog/2020/covid-19-crisis-giving-states-havent-expanded-medicaid-new-reconsideration.

⁵⁶ Madeline Guth, Rachel Garfield & Robin Rudowitz, The Effects of Medicaid Expansion Under the ACA: Updated Findings from a Literature Review, *Kaiser Fam. Found.* (Mar. 2020), <http://files.kff.org/attachment/Report-The-Effects-of-Medicaid-Expansion-under-the-ACA-Updated-Findings-from-a-Literature-Review.pdf>.

⁵⁷ Jacob Goldin, Ithai Z. Lurie & Janet McCubbin, Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach (Nat'l Bureau of Econ. Rsch., Working Paper No. 26,533, 2019), www.nber.org/papers/w26533.

⁵⁸ Frederic Blavin & Christal Ramos, Medicaid Expansion: Effects on Hospital Finances and Implications for Hospitals Facing COVID-19 Challenges, 40 *Health Affs.* 82 (2021).

⁵⁹ Stan Dorn et al., The Effects of the Medicaid Expansion on State Budgets: An Early Look in Select States, *Kaiser Fam. Found.* (2015), www.kff.org/medicaid/issue-brief/the-effects-of-the-medicaid-expansion-on-state-budgets-an-early-look-in-select-states/.

ACA-resistant states made related long-term policy choices that deepened the crisis for people who lost jobs during the pandemic. For example, Georgia has not expanded Medicaid eligibility and relies on the federal exchange; however, it obtained a federal “Section 1332” waiver to disband the exchange, which HHS approved on November 1, 2020 as the severity of the pandemic was increasing.⁶⁰ In June 2021, the Biden Administration asked Georgia for data to support waiver continuation, and the waiver faces a court challenge.⁶¹ But Georgia’s approach made it harder for the pandemic’s newly jobless to find or renew coverage until the Biden Administration opened and advertised a special enrollment period and enlarged subsidies in ways that increased enrollment under ARPA. Many ACA-resistant states also limited access to social programs that address job loss, such as Temporary Assistance to Needy Families (cash assistance), SNAP/Special Supplemental Nutrition Program for Women, Infants, and Children (“food stamps”), and unemployment insurance, making the economic crisis accompanying the pandemic worse for many people.⁶² Many states, such as Florida, made the process of applying for unemployment insurance burdensome and the duration of benefits limited, while also not expanding Medicaid, creating a perfect storm of safety net failures when the emergency hit.⁶³

Yet every state used Medicaid’s temporary regulatory flexibilities to respond to the PHE, indicating that state leaders sometimes make policy choices that federal lawmakers anticipate. Also, every state claimed the Families First Act enhanced federal match, accepting the condition of meeting MOE requirements for the duration of the PHE: no limits or cuts to Medicaid eligibility, no increased premiums, no disenrollment of current or newly enrolled beneficiaries, and state-sponsored COVID-19 testing and treatment with no cost-sharing. MOE requirements prevented new barriers to coverage and enrollment, which had the effect of pausing waiver initiatives that hindered enrollment and destabilized eligibility, such as work requirements and frequent eligibility determinations. Some parts of the federal–state partnership worked, but many did not.

IV LESSONS LEARNED?

The Biden Administration took office and began pulling all the levers that were at President Trump’s disposal, seemingly to make up for a year’s worth of delay. During that year, more than 25 million Americans were infected with and more

⁶⁰ Ctrs. for Medicare & Medicaid Servs., Georgia: State Innovation Waiver Under Section 1332 of the PPACA (Nov. 1, 2020), www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers/1332-GA-Fact-Sheet.pdf.

⁶¹ Letter to Governor Brian P. Kemp from CMS Administrator Chiquita Brooks-LaSure (June 3, 2021), www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-Request-Updated-GA-Analysis-Letter.pdf.

⁶² 42 U.S.C. § 503.

⁶³ Pamela Herd & Donald Moynihan, How Administrative Burdens Can Harm Health, Health Aff. Health Pol’y Brief (Oct. 2020), www.healthaffairs.org/doi/10.1377/hpb20200904.405159/full/.

than 429,000 died from COVID-19.⁶⁴ Assessing the long-term implications for legal doctrine will be an ongoing project, but some lessons were emerging even as the pandemic continued.

The federalism structure within federal statutes varies from law to law and even within laws.⁶⁵ In the field of health law, the federalism structure of Medicaid is different from the decentralized structures within the Public Health Service Act, and these laws are different from the structure of grant-in-aid programs that offer federal money to states for focused purposes, such as family planning under Title X, or limited funding for states to create exchanges. These statutes sometimes provide a federal backup when states resist federal policies, but many do not, leaving gaps when state leaders reject or neglect federal funding, as some did with COVID-19 relief funds, and jeopardizing PHE response.

These laws also reflect congressional assumptions about states' desire to partner with the federal government that do not neatly align with the lived experience of the COVID-19 pandemic. State leaders' persistent anti-science policies during COVID-19, especially as the pandemic surged in 2021 while vaccine and NPI resistance swelled, should be a warning for those implementing future PHEs. Key laws such as the Stafford Act and the National Emergencies Act rely heavily on state and local cooperation and implementation, and these are no longer a given reaction.

If public health, emergency, and disaster laws are reexamined, major questions should arise: Do these laws make accurate assumptions about states' partnership and capacity to implement federal policy, and to what degree is centralized leadership and implementation necessary in addition to money and guidance? This inquiry is not the same as constitutional questions considered by the Supreme Court as to whether the federal government can "coerce" states with money; the issue is not what amount of money states need to implement national goals or whether states need that money, but rather who *should* and who *will* lead a policy effort.⁶⁶

Early state policy heterogeneity may have reflected improvisation and perhaps distrust borne of a lack of federal leadership in 2020. But state defiance of federal policy direction long predated the pandemic and should not be a surprise. States negotiate to get what they want from the federal government, observing how to bargain and lining up for concessions, as exemplified by the dynamic negotiations of Medicaid expansion waivers. Vigorous state negotiation may lead to greater variability and dynamism than Congress envisioned as a tradeoff for policy implementation, an important lesson for public health laws and for broader health reform efforts going forward. Though public health federalism structures provided early backup when state officials filled a federal leadership vacuum, the weaknesses of public health

⁶⁴ Ctrs. for Disease Control & Prevention, COVID-19 Mortality Overview, www.cdc.gov/nchs/covid19/mortality-overview.htm (last visited Feb. 24, 2021).

⁶⁵ Abbe R. Gluck, Intrastatutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond, 121 *Yale L. J.* 534 (2011).

⁶⁶ Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012).

federalism were brought into sharp relief as the pandemic continued. Inadequately funding public health, under-preparation for emergencies and disasters, long-term choices that weakened the social safety net, non-scientific decisions about containment measures and vaccinations necessary to containing a pandemic – these state choices weakened the US public health apparatus.

V CONCLUSION

The legacy of COVID-19 is more than the cost of leadership failures; the pandemic highlighted the costs of the federalist structure, paid in high rates of infection and mortality. The pandemic exposed the room for error that divided governance allows through fragmenting not only responsibility and power but also capacity. Between prior health policy choices, fiscal neglect, and lack of effective coordination between federal and state leaders, it is no wonder that the United States had the world's "worst outbreak."