



Proposed Limits on Public Health Authority: Dangerous for Public Health

May 2021



Table of Contents

- I. [History of Public Health Authority](#)
- II. [Efforts to Undermine Public Health Authority](#)
- III. [Legislation to Limit Public Health Authority: Proposed and Adopted](#)
- IV. [The Role of ALEC](#)
- V. [Conclusions](#)

Executive Summary

In recent months, at least 15 state legislatures have passed or are considering measures to limit severely the legal authority of public health agencies to protect the public from serious illness, injury, and death. Other states may consider such legislation in the future. It is foreseeable that these laws will lead to preventable tragedies.

Specifically, this report finds that dissatisfaction and anger at perceived overreaches by governors and public health officials in response to the COVID-19 pandemic has led to an onslaught of legislative proposals to eliminate or limit the emergency powers and public health authority used by these officials. Public health officials are also being threatened personally.

The report provides a brief history of public health authority and an overview of the forces seeking to limit public health authority. It offers examples of specific laws that would limit public health authority, and key arguments to counter proposed legislation. It is intended as a resource for public health officials, advocates, and policymakers.

The report provides examples of laws that would:

- **Prohibit requiring masks in any situation, including cases of active tuberculosis.** In **North Dakota**, a new law would remove the authority of the state health office to require face masks or covering.
- **Block the closure of businesses necessary to prevent the spread of disease, allowing for super spreader venues.** In **Kansas**, a new law removes the Governor's ability to close businesses during a public health emergency.
- **Ban the use of quarantine.** In **Montana**, a new law prohibits local board of health emergency orders from separating those individuals who are not yet ill, but reasonably believed to be infected or exposed. Prohibition of quarantine orders undermines the basis of infection control and would make it impossible to stop outbreaks of deadly diseases that are spread by individuals who are not yet symptomatic.
- **Block state hospitals and universities from requiring vaccinations for employees and students in dormitories to protect state residents.** In **Arizona**, a new law prohibits requirements that a person receive a vaccination, except in K-12 school settings and creates criminal penalties for violating the ban.
- **Strip local governments, including local health agencies, of the ability to respond to local conditions in an emergency.** In **Texas**, a proposed bill would preempt local emergency action to the extent that it is inconsistent with orders of the Governor or state health department.

- 
- **Set arbitrary time limit for emergency orders.** In **Florida**, a new law provides for automatic expiration of local orders after seven days with a majority vote of the local governing body required for an extension, limits the total duration of local orders to 42 days, and prevents the issuance of a substantially similar order for the same emergency if a previous order has expired.
 - **Give unilateral power to legislatures to stop public health actions.** In **Ohio**, a new law will allow the Legislature alone to rescind any order or action by the state health department or director of health to control the spread of contagious or infectious disease. The Governor, who vetoed the law, issued a statement saying that the law “strikes at the heart of local health departments’ ability to move quickly to protect the public from the most serious emergencies Ohio could face.” The Governor’s veto was overridden by the Legislature and the law will take effect June 23, 2021.

The report also finds that many state attempts to undermine public health authority are the result of a well-organized national campaign coordinated by the American Legislative Exchange Council (ALEC). ALEC is seeking to curtail emergency powers of executive branch state and local government officials and public health agencies and shift emergency and public health authority to the legislative branch, including state legislatures and local legislative entities such as county commissioners.

The report reaches four conclusions:

1. Legislation to block reasonable public health measures like mask wearing, social distancing, and quarantine poses an immediate threat to life and health.
2. Legislation to stop expert public health agencies from leading the response to health emergencies creates unforeseen, serious risks to life and health.
3. Legislation that strips authority from public health agencies and the executive branch infringes on the constitutional separation of powers and undermines effective government response.
4. These laws could make it harder to advance health equity during a pandemic that has disproportionately sickened and killed Black, Hispanic and Latino, and Indigenous Americans.

I. History of Public Health Authority

The authority of public health agencies has emerged over time to prevent serious illness, injury, and the loss of life. As part of the executive branch, public health agencies must act within the scope of authority provided by the legislature. Public health agencies are expected to have the expertise and long-range perspective necessary to address health risks in areas that are often highly complex. Public health agencies are also able to act more quickly than the legislature in responding to public health emergencies. Safeguards such as due process requirements provide protections against public health authority misuse, as does judicial review of agency actions.

Public health powers date back to the start of our nation. Even before the Constitution was ratified, state and local governments imposed quarantines, abated nuisances, and mandated other actions aimed at halting the devastating epidemics of smallpox and yellow fever that were a common feature of colonial life.

Initially, public health control measures were largely reactive. When an outbreak occurred, local leaders would empower a committee to issue orders and take steps to control the threat. This approach was inefficient, deadly, and costly to commerce, which suffered as epidemics raged. To ensure a more rapid and effective response, and support preventative measures, states began to authorize standing boards of health. In 1799, Massachusetts established the first municipal board of health for the City of Boston.



In 1832, New York State granted local boards of health the power to institute quarantines and issue “all such other regulations as they shall think necessary and proper for the preservation of public health.”

Evolution of Boards of Health

As the science surrounding epidemics developed, and the field of public health became more professionalized, states began to establish professionalized boards of health. Historians credit the New York Metropolitan Board of Health, created in 1866, with improving sanitation and helping to control cholera.

The boards of health that were established in the nineteenth and twentieth centuries were granted broad general powers, as well as more specific authorities relating to common diseases (such as tuberculosis) or interventions (such as quarantine). The breadth of their authority allowed them to respond quickly to new, potentially unforeseeable situations, while also carrying out the everyday work necessary to protect the public from unsafe conditions and significant health hazards.

State Public Health Authority

During and after the 1918 influenza epidemic, state and local boards of health sometimes clashed over their respective jurisdictions. In response, many states began to move more public health powers to statewide officials. This trend accelerated during the Cold War, as states enacted new disaster management or civil defense acts. These emergency power acts often granted Governors broad emergency powers that could be triggered upon the issuance of an emergency declaration. Although Governors have generally used these powers in response to natural disasters – hurricanes, wildfires, snowstorms – the statutory language is usually broad enough to apply to epidemics. Importantly, while the grant of authority granted under state emergency acts is sometimes more extensive than what is available under traditional public health laws, emergency powers acts are usually time limited, which is not ordinarily the case with traditional public health statutes.

After September 11, 2001, many states enacted specific public health emergency statutes. In many states, these laws do not provide clear authority to impose shutdown orders and community-wide social distancing measures, which have been used widely since the start of the COVID-19 pandemic. For that reason, most Governors have relied in large measure on their general emergency powers during the COVID pandemic.

Modern Public Health Functions and Successes

In the twentieth century, public health interventions helped to increase life expectancy among U.S. residents by 62%, from 47.3 years in 1900 to 76.8 in 2000.¹ In this timeframe, the most notable achievements in public health, assisted by the efforts of public health agencies across the country, include:

- Vaccination
- Motor-vehicle safety
- Safer workplaces
- Control of infectious diseases
- Decline in deaths from coronary heart disease and stroke
- Safer and healthier foods
- Healthier mothers and babies
- Family planning
- Fluoridation of drinking water
- Recognition of tobacco use as a health hazard²

Modern public health agencies use their authority for more than preventing epidemics and tracking, investigating and stopping the spread of disease and other health threats (e.g. foodborne illness, HIV/AIDS, measles). These agencies serve many other critical functions, such as preventing injuries; promoting and encouraging healthy behaviors such as diet and exercise; preventing chronic diseases, including cancer and diabetes; planning for and responding to disasters and assisting communities in



recovery; protecting against environmental hazards; assuring the quality and accessibility of services, and advancing health equity. Public health agencies inspect restaurants; enforce smoke-free air laws; and test children for lead exposure. They also collect data on how diseases and conditions affect the populations they serve, and implement programs to ensure that people who are disproportionately impacted can have equitable health outcomes.

Legal Challenges to Public Health Authority

The judicial branch provides a check on the exercise of public health authority. Prior to COVID-19, courts usually upheld delegations of authority under public health powers and emergency powers, at least with respect to communicable disease control. For example, in 1905, in *Jacobson v. Massachusetts*, the U.S. Supreme Court stated:

“The authority to determine for all what ought to be done in such an emergency must have been lodged somewhere or in some body; and surely it was appropriate for the legislature to refer that question, in the first instance, to a board of health composed of persons residing in the locality affected, and appointed, presumably, because of their fitness to determine such questions.”

The Court in that case also made clear that courts should defer to reasonable orders issued by public health authorities. In recent decades, courts have followed this important guidance and, until COVID-19, they continued to grant public health agencies substantial deference to impose requirements intended to limit the spread of diseases, such as mandatory measles vaccinations.

During the COVID-19 pandemic, most courts have continued to grant deference to public health orders. However, the Supreme Court has made clear that public health orders that restrict the exercise of religion more strictly than comparable secular activities will be subject to strict scrutiny,³ and some state courts have looked closely to ensure that public health orders that comply with emergency acts do not violate separation of powers.⁴

II. Efforts to Undermine Public Health Authority

Anger and opposition to public health measures imposed during the COVID-19 pandemic has taken numerous forms, including threats to public officials and legislative proposals to strip agencies of their ability to take action to protect the public. It is entirely reasonable that an event of the magnitude and attendant controversy of the COVID-19 pandemic would cause state legislators to revisit laws governing state emergency powers and public health authority. The most helpful process would include a comprehensive and nonpartisan assessment of the response, with after action reports and input from public health and executive branch officials who are no longer fully engaged in response efforts.

However, nationwide, state and local public health officials working to protect the public from COVID-19 are on the receiving end of threatening and harassing conduct for simply fulfilling their duty to protect the public health. This threatening conduct has interfered with a health officer or department fulfilling their duties and placed health officials and their staff in reasonable fear for their safety and that of their families.

The Network for Public Health Law examined whether states have laws that protect public health officials. As of January 2021, 35 states and Washington, D.C. have laws that protect public health officials generally, criminalize the behavior of those who impede public health officials' duties, or have language that is broad enough to include public health officials (or, in the case of three states, could be broadened to include public health officials). The remaining 15 states either do not have a law protecting government officials in these circumstances or do not have one protecting public health officials. Additional information is available in this [chart](#).

For example, so-called protestors have appeared at health officials' workplaces or homes with firearms, hanging effigies, and blaring loudspeakers. This conduct has caused public health officials to leave their jobs and may dissuade others from stepping into the public health field, creating a workforce challenge.

Additionally, dissatisfaction and anger at perceived overreaches by Governors and public health officials has led to an onslaught of legislative proposals to eliminate or limit the emergency powers and public health authority utilized by Governors and public health officials throughout the course of the response to the COVID-19 pandemic. An effective legislative response demands less haste, more deliberation, more nuance, and more evidence that it has taken the knowledge and perspectives of public health and executive branch officials into account.

III. Legislation to Limit Public Health Authority: Proposed and Adopted

At least 15 states have passed or have considered measures to drastically undermine the authority of public health agencies to save lives. These legislative proposals would change the nature and allocation of emergency powers and public health authority among the executive, legislative, and judicial branches of state and local governments.

The following summary of bills illustrates the types of laws designed to limit or shift the authority to protect the public's health and their potential consequences. Many of the proposed bills would impede effective governmental response to public health emergencies as well as the essential day-to-day work of protecting, promoting and improving public health.

Among the hundreds of bills introduced, a subset had been enacted by mid-May, some are still pending, and others were defeated but could return in the next legislative session. Examples of all of these are instructive and included. Other states may consider such legislation in the future.

Shift of General or Emergency Public Health Authority

- **Local Public Health Agency to Another Local Entity**
- **Local Public Health Agency to State Public Health Agency or State Legislature**
- **State Public Health Agency to Governor or State Legislature**
- **State Executive to State Legislature**
- **Prohibition of Certain Types of State or Local Public Health Orders**

● **Arizona [House Bill 2190](#) (proposed):** This bill is intended to prevent large-scale vaccine mandates. The bill would prohibit Arizona's state, county, and local governments, as well as state officials, from: (1) requiring a person to receive a vaccination, except in K-12 school settings; (2) conditioning receipt of government benefits, financial benefits, services, licenses, permits, certifications, public building entrance, or public transportation use on receipt of vaccination; or (3) offering special privileges, financial benefits, or other incentives for vaccination. Violations would constitute a Class 5 felony. Businesses may not refuse to provide services, products, admission or transportation on the grounds that a person has not been vaccinated. State courts can order suspension of violators' state or local business licenses for 30 days to one year.

Implications: This bill effectively takes governmental vaccine mandates off the table as a viable option in Arizona except in K-12 schools, as well as certain mandates by business entities,

which could limit the ability to reach herd immunity quickly in the state and result in unnecessary and dangerous spread of and morbidity or mortality from communicable diseases.

 **Florida [Senate Bill 2006](#) (enacted April, 2021):** This law grants the Legislature new authority to unilaterally terminate orders or directives issued by the Governor under a state of emergency. It also allows for automatic expiration of local orders after seven days with a majority vote of the local governing body required for an extension, limits the total duration of local orders to 42 days, and prevents the issuance of a substantially similar order for the same emergency if a previous order has expired. This law authorizes the Governor or Legislature to invalidate any local measure that “unnecessarily restricts” individual rights or liberties, without defining what constitutes an unnecessary restriction or otherwise providing a process for evaluating what may be restricted. It also prevents a business or government entity or educational institution from requiring proof of COVID-19 vaccination to access services.

Implications: This law allows the Legislature to “veto” any orders or directives issued under a declared emergency, and it severely limits the ability of local governments to respond to a public health emergency by placing restrictions and standards on local orders and expanding the Governor’s authority to invalidate those orders. Altogether, the changes in this law could severely delay, limit, and impair public health response.

 **Indiana [Senate Bill 5](#) (enacted May, 2021):** This law prevents local health officers from imposing emergency disease prevention measures on individuals and businesses that are more stringent than those issued by the governor. Enacted following an override of Governor Eric Holcomb's veto, the law requires that the local governing body overseeing a county or city health officer approve any health order with provisions that go beyond state requirements during an emergency.

Implications: In his veto message, Governor Holcomb stated: “Critical to [Indiana’s] success has been the ability during the emergency to allow local health officers to use localized data to tailor their actions to their community’s needs. It is hard to express the rapidity needed in the early days of the pandemic - particularly on the local level. One reason Indiana has weathered the storm so well is due to coordination with local health experts and the flexibility in law to be fast, nimble, and targeted. Also, the knowledge that local health officials were able to exercise this discretionary authority greatly informed the state’s own day-by-day, sometimes hour-by-hour, emergency response.”

 **Kansas [House Bill 2016](#) (enacted June, 2020); [Senate Bill 40](#) (enacted March, 2021):** House Bill 2016 designates the board of county commissioners as the local board of health, and limits the ability of local health officers to issue orders without the board’s approval. The law also enables the elected board of county commissioners to opt out of the Governor’s public health orders and limits public health efforts in contact tracing. Senate Bill 40 removes the Governor’s ability to close businesses during a public health emergency, requires legislative approval to extend a Governor’s emergency order, specifies that only local school boards can limit in-person attendance during COVID-19, and allows any aggrieved individual to file a civil action and receive a hearing opposing the Governor’s emergency orders within 72 hours.

Implications: Shifting responsibility from state and local health departments to elected officials marginalizes public health experience; limits the departments’ pandemic preparedness and the ability to respond to and effectively mitigate infectious disease outbreaks; and may also adversely affect routine public health activities through delays and limitations on the types of remedies available.

/// **● Maryland [Senate Bill 920/House Bill 1083](#) (Inactive/may return next session):** These cross-filed bills would create an oversight board within each county in addition to existing boards of health and local legislative bodies. Requirements for inspections are subject to approval by the oversight board, including when and how county health officials could inspect businesses suspected of violating health standards. The oversight board would also serve as an appeal board for any citation issued by a county health official, and review potential misconduct by a local health officer and make referrals for enforcement. The oversight board must include at least one owner of a business licensed in the county but the bill provides no other detail on composition or terms for membership.

Implications: These bills would limit the ability of public health professionals to make real-time decisions necessary to preserve public health by creating interference in those processes by a poorly defined, unnecessary oversight board.

● Missouri [House Bill 75](#) (proposed): This bill limits the closure, partial closure, or restrictions on the access to or opening of schools, businesses, churches, or other places of public or private gathering for public health or safety reasons to 15 days with a single 15-day extension, if approved by the local governing entity's legislative body. The bill also limits subsequent extensions of closure orders to 10 days with a two-thirds vote. For six or more extensions, the bill requires a unanimous vote of the legislative body. The bill also requires a two-thirds vote of a governing entity's legislative body to enact a generally applicable rule or regulation related to public health.

Implications: This bill places onerous requirements on the issuance and renewal of public health orders that are intended to prevent the spread of infectious diseases by limiting contact between individuals in potentially high-risk settings. The proposed limits will delay or impair the public health response and could result in non-renewal of orders. This bill also restricts rulemaking authority related to public health, which could impair the legal framework guiding public health activities.

●● Montana [House Bill 121](#) (enacted April, 2021) [House Bill 257](#) (enacted May, 2021). House Bill 121 transfers authority to appoint a local health officer from local boards of health to the local governing body (county commissioners or the city council); authorizes the local governing body to change or rescind local board of health emergency orders; and requires approval from the local governing body for certain board of health regulations and fees. The law prohibits local board of health emergency orders from limiting physical attendance at religious worship, and prohibits quarantine of individuals who are not yet ill, but reasonably believed to be infected or exposed. House Bill 257 bars local ordinances from limiting access to the premises, goods, and services of businesses except in limited circumstances. House Bill 257 includes additional limits on public health authority.

Implications: House Bill 121 increases the risk of spread of communicable disease by allowing unlimited attendance for religious worship and prohibiting quarantine of persons who may have been exposed. The new requirements for adoption by the local governing body of certain non-emergency regulations including those related to sanitation, sewage and public nuisance, increases the risk of delay and politicization of basic health and safety standards. House Bill 257 bars business closures pending investigation. Differences in the two bills create confusion about public health authority in the state.

● North Dakota [House Bill 1323](#) (enacted following Governor's veto April, 2021): This law prohibits a statewide elected official or state health officer from requiring any individual in the state to wear a face mask, shield, or other type of face covering.

Implications: The law impedes a coordinated response to pandemics and other airborne threats that require face coverings as a mitigation measure. This law severely undercuts

statewide efforts to respond to pandemics or disasters by creating a piecemeal and uncoordinated system.

 **Ohio [Senate Bill 22](#) (enacted following Governor's veto March, 2021).** This law limits the duration of a public health emergency declaration to 90 days unless the Legislature extends it. The law allows the Ohio Legislature to unilaterally rescind “any order or rule for preventing the spread of contagious or infectious disease” issued by the Governor or the Ohio Department of Health (ODH). Other sections limit the ability of local boards of health to issue isolation and quarantine orders and allow ODH to override local decisions.

Implications: In response, Governor DeWine stated that “Senate Bill 22 jeopardizes the safety of every Ohioan. It goes well beyond the issues that have occurred during the COVID-19 pandemic. SB 22 strikes at the heart of local health departments’ ability to move quickly to protect the public from the most serious emergencies Ohio could face.”

 **Oklahoma [House Bill 2504](#) (Inactive/may return next session):** This bill gives the State Commissioner of Health authority over certain local actions related to city-county boards of health. It removes a city-appointed member of the city-county board of health and adds one appointed by the Commissioner; requires the board director to perform duties in consultation with the Commissioner to ensure administrative alignment; gives the Commissioner a role in appointing a new director if a vacancy exists; and allows the Commissioner to request the removal of a director, which can be approved by a two-thirds vote of the board. This bill also prevents local rules and regulations related to public health from being more stringent than any state laws, rules, or regulations.

Implications: This bill is an attempt to allow the state to exert control over the two largest city-county health departments, which have independent budgetary and decision-making authority from the state department of health. The bill would limit the ability of these health departments to respond to the needs of their particular communities and direct resources and activities to local needs and priorities, which may differ from other areas of the state.

 **Tennessee [House Bill 0035](#)/[Senate Bill 0467](#) (proposed):** These cross-filed bills would prevent the Governor, the executive head of a city or county, or a governmental entity of a city, county, or the state from placing limitations on the number of people “who may exercise their First Amendment right to peaceably assemble” at either a personal residence or a place of worship if the number of people congregating otherwise complies with the occupancy requirements set forth by the state fire marshal.

Implications: If enacted, these bills would limit the ability of state and local authorities to issue orders that may mitigate the spread of infectious diseases like COVID-19 by limiting contact between individuals and groups of individuals. In addition, because the changes are not limited to emergencies, they are a broader curb on public health authority and could have other implications for public health and safety.

 **Texas [House Bill 3](#)/[Senate Bill 1025](#) (proposed):** House Bill 3 bill would create the Pandemic Disaster Legislative Oversight Committee, comprised of legislative leaders and the Lieutenant Governor, that would have authority to terminate a pandemic declaration by the Governor and to change any parts of related gubernatorial orders and orders of local government when the Legislature is not in session. The proposal grants the Legislature review power of a gubernatorial business closure order that exceeds 30 days and would prohibit the Governor from renewing a pandemic declaration if terminated by the Legislature. The bill would prohibit local governments from issuing an order closing specific businesses or industries or an order that distinguishes between types of businesses or industries in limiting operation capacities. Senate Bill 1025 would limit the governor

and local authority during pandemics and also places exclusive power in the state Legislature to order business closures during any kind of disaster.

Implications: Unilateral legislative power to terminate or limit necessary measures in an ongoing emergency could politicize emergency response and jeopardize health and safety. Preemption of local response precludes authority to address different local situations.

●● **Utah [Senate Bill 195](#) (enacted March, 2021):** This law would allow the Legislature alone to terminate state health department orders issued in a public health emergency, including stay-at-home orders, and allow county legislative bodies to terminate local health department orders. The law also requires department public health emergency orders lasting longer than 30 days to provide notice of proposed action to the legislative emergency response committee at least 24 hours before issuing the order.

Implications: Legislative authority to terminate health department orders issued to address an emergency situation will jeopardize health and safety.

●● **West Virginia [Senate Bill 12](#) (enacted March, 2021):** This law requires local governing body approval of rules proposed by local health boards. However, if there is an imminent public health emergency, rules will go into effect immediately with approval or disapproval from the local governing body within 30 days. During a statewide public health emergency, local health departments must comply with state health officer emergency policies and guidelines.

Implications: Local governing body oversight will politicize decisions that were previously made by local boards of health based on science and the protection of the public's health, such as local tobacco control measures.

IV. The Role of ALEC

The attack on public health authority appears to be coordinated, in part, by the [American Legislative Exchange Council](#) (ALEC). For more than forty years, ALEC has been driving a strategic effort to limit local authority and policy making through state legislation to preempt or limit local actions through other statutory changes. Funded almost exclusively by corporations, trade organizations, and corporate foundations, ALEC claims one quarter of state legislators among its members.

ALEC is advocating a slate of policy initiatives and model bills crafted to limit the authority of public health agencies and weaken their ability to protect the public's health. ALEC's nationally coordinated campaign focuses on curtailing emergency powers of executive branch state and local government officials and public health agencies, and shifting emergency and public health authority to the legislative branch, including state legislatures and local legislative entities such as county commissioners.

Many of the bills that have been, or will be considered, in a majority of states are based on ALEC's model acts. Lawmakers in at least nine states — Arizona, Idaho, Kentucky, Montana, North Dakota, Pennsylvania, Utah, Virginia and Washington — have introduced legislation that appears to be modeled on ALEC's proposal. In some cases, the legislation uses language that is almost verbatim to ALEC's model bill.⁵

V. Conclusions

Reforms to emergency authority should be carefully crafted to ensure that public health officials retain the authority to act quickly to address future public health emergencies. Current legislation under consideration, however, does not meet this standard. These proposed and enacted laws would add a



level of bureaucracy and politics that undercut the flexibility and timeliness of local public health orders and make it harder for public health experts on the front lines to protect and respond to local communities.

This report has four conclusions:

1. Legislation to block reasonable public health measures like mask wearing, social distancing, and quarantine poses an immediate threat to life and health.

- Legislation should not limit the flexibility public health officials need to act in response to specific threats.
- Prohibiting specific public health orders or providing exemptions for certain classes of businesses endangers the ability to respond to threats that are most readily transmitted in a particular setting and is dangerous for the greater community.

2. Legislation to stop expert public health agencies from leading the response to health emergencies creates unforeseen, serious risks to life and health.

- Public health officials have specific training and experience in developing policies that are evidence-based to address public health emergencies.
- Public health officials are best positioned to coordinate a statewide response to public health emergencies or one informed by expert assessment of local conditions.

3. Legislation that strips authority from public health agencies and the executive branch and transfers it to the legislature violates the constitutional separation of powers and undermines effective government response.

- Establishing an absolute and extremely short duration for emergency declarations can result in inaction, lack of legal status for funding, remove the necessary authority to act and reduce the ability to help citizens, businesses, and other entities to take needed public health measures.
- To save lives and prevent disease, public health emergencies require swift responses and nimble adjustments. Moving power to state legislatures will result in the inability to locally tailor orders and could lead to slowed and/or poorly informed responses.
- State legislatures are generally not in a position to respond quickly to a public health emergency. Legislative procedures are cumbersome and often require days or weeks to build consensus among large numbers of representatives with widely divergent political views. Elected legislative officials may be reluctant to take necessary, but unpopular, action.

4. If adopted, these bills would make it harder to advance health equity during a pandemic that has disproportionately sickened and killed Black, Hispanic and Latino, and Indigenous Americans.

- For example, communities across the country have wanted to direct COVID testing, contact tracing, vaccines, and personal protective equipment to hard hit communities, including communities of color, but have sometimes been blocked by states.
- Limiting emergency authority puts communities at risk by potentially limiting access to emergency funding intended to mitigate the effects of public health emergencies on affected communities. For example, CARES Act coronavirus relief funds have been used to provide grants to non-profits and other organizations working to address the disproportionate impact of COVID-19 on communities of color.



Resources and Acknowledgments

For additional information on any of the issues discussed in this fact sheet document or updates on bills, please contact your Network for Public Health Law (Network) [regional office](#) of the Network for Public Health Law. Support for the Network is provided by the Robert Wood Johnson Foundation.

The Network for Public Health Law would like to thank Leslie Zellers; Joshua Sharfstein; Beth Resnick; Wendy Parmet; Lindsay F. Wiley; [ChangeLab Solutions](#); and the [Local Solutions Support Center](#) for their input on and/or review of this document. NACCHO and the Network would like to acknowledge and thank the CDC Foundation for providing funding to support the development of this report.

¹ Centers for Disease Control and Prevention. Ten Great Public Health Achievements --- United States, 2001—2010. (2011). MMWR, 60(19);619-623. <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6019a5.htm>

² Centers for Disease Control and Prevention. Ten Great Public Health Achievements -- United States, 1900-1999. (1999). MMWR, 48(12);241-243. <https://www.cdc.gov/mmwr/preview/mmwrhtml/00056796.htm>

³ Tandon v. Newsom, 141 S.Ct. 1294 (2021) (per curiam); Roman Catholic Diocese v. Cuomo, 141 S.Ct. 63 (2020) (per curiam).

⁴ *E.g.*, Fabick v. Evers, 956 N.W. 856 (Wi. 2021); Wisconsin Legislature v. Palm, 391 Wisc.2d 497 (2020); Certified Questions From the United States Dist. Court v. Governor of Mich., No. 161492, 2020 BL 383749 at *24 (Mich. Oct. 02, 2020).

⁵ Waldron, T. (Feb. 5, 2021). A Powerful Conservative Coalition Is Fueling The State-Level Push To Hamper COVID-19 Restrictions. HuffPost. https://www.huffpost.com/entry/alec-republicans-governors-covid-pandemic-powers_n_601c6de4c5b66c385ef7ee12