Commentary

The Legal Response to COVID-19: Legal Pathways to a More Effective and Equitable Response

Scott Burris, JD; Sarah de Guia, JD; Lance Gable, JD, MPH; Donna Levin, JD; Wendy E. Parmet, JD; Nicolas P. Terry, LLM

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COVID-19 is the new disease this country had been preparing to take on for decades.[1] So far, the response has been a failure, with huge human and economic costs. While peer countries have managed to get the pandemic under a degree of control, the United States seems pathologically unable or unwilling to prevent rising cases and deaths. This is not a failure of resources: although decades of cutting health agency budgets is a big part of our problem,[2] we remain a country rich in money and expertise. This is not a failure of individual courage; from health care workers through transport workers to people who produce and deliver food supplies, essential workers have shown up and done their jobs at significant personal risk. This has been, first and foremost, a failure of leadership and the development or implementation of an effective response.

The law is integral to effective emergency preparedness and response.[3] It sets out the powers and duties of officers and agencies, creates standards of conduct and performance, channels resources to individuals and institutions, and sets limits on arbitrary or discriminatory exercise of authority in times of crisis.[4] Law is also an important factor in the background: as a pervasive force in social life, law both contributes to and is a means of reducing health inequities and their effects.[5]

The story of American pandemic response is sweeping and complicated. Crucially, the COVID-19 failure has, in important ways, also been a legal one. This failure occurred across multiple dimensions. Fundamental tenets of the US constitutional system and its customary functioning have been openly challenged by a federal administration that abstained from leadership and encouraged a Darwinian competition among states for scarce resources. Decades of pandemic preparation focused too much on plans and laws on paper, while ignoring the devastating effects of budget cuts and political interference on the operational readiness of our local, state, and national health agencies. The politicization of public health, from mask-wearing to the favored status enjoyed by some states, is a powerful exhibit in any evaluation of the continued health of the rule of law. Both inside and outside of the public health domain, our laws and the policies they are built on have failed to prevent racial and economic disparities in the pandemic's toll and, indeed have aggravated them. COVID-19 has exposed too many empty promises of equal justice under law.

COVID-19 has shed a brutal, unforgiving light on the weakness of many of the key structures that are meant to ensure the health and safety of our fellow citizens. Fundamental laws and policies, from policing to health care to privacy that have been ignored or band-aided over the years, have been exposed as totally inadequate. There has been a massive failure in legal implementation. Ample legal authority has not been used consistently, properly, or transparently as executive leadership has failed in many states and cities. In some states, governors or legislatures have reacted to COVID-19 with laws that reflected bad or inadequate policies, delaying state action and interfering with better-advised local measures through preemptive laws and orders.

Author Affiliations: *Center for Public Health Law Research, Temple University Beasley School of Law, Philadelphia, Pennsylvania (Mr Burris); ChangeLab Solutions, Oakland, California (Ms de Guia); Wayne State University Law School, Detroit, Michigan (Mr Gable); Network for Public Health Law, Edina, Minnesota (Mr Levin); Center for Health Policy and Law, Northeastern University School of Law, Boston, Massachusetts (Mr Parmet); and Indiana University Robert H. McKinney School of Law, Indianapolis, Indiana (Mr Terry).*

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Correspondence: *Scott Burris, JD, Center for Public Health Law Research, Temple University Beasley School of Law, 1719 N Broad St, Philadelphia, PA 19122 (burris@temple.edu).*

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While the practical results of these failures are plain to see, their exact causes and what is required to reverse these legal failures are less obvious. This commentary summarizes key findings and recommendations from a collection of 36 topical legal assessments written by more than 50 independent legal experts.[6] The authors have issued more than 100 specific legal recommendations for the president and Congress, governors and state legislatures, and mayors and city councilors across the country. The editors have organized them, and present them here, in 6 priority areas: Using Government Powers to Control the Pandemic; Fulfilling Governmental Responsibilities in a Federal System; Financing and Delivering Health Care; Assuring Access to Medicines and Medical Supplies; Protecting Workers and Families; and Taking on Disparities and Protecting Equal Rights. We begin with a description of the assessment process.

The Assessment: Why and How

For the public health law community, the seriousness of the COVID-19 threat was recognized and discussed as early as January and initial legal analyses began appearing the next month.[7,8] Few of us predicted the extent of the failure of leadership and implementation that unfolded over the next few months, but nearly all of us saw that equity in intervention and disparities in impact would require legal attention and that there would be important legal questions to resolve in many specific domains such as housing, workplace safety, and vaccine development and procurement. In late March, a group of lawyers associated with the George Consortium (a network of public health law scholars and practitioners[9]) and the informal public health law network of Robert Wood Johnson Foundation grantees—all of them experiencing a surge in demand for legal information from the press, health agencies, advocacy groups, and individual practitioners—worked together to launch "COVID-Law Briefings" on Twitter, YouTube, and the "The Week in Health Law" podcast. The group eventually produced 30 briefings over the next 2 months, discussing pressing issues such as emergency powers, prisoner's rights, and rules for rationing care.[10]

As the scale of the problem and the demand for legal guidance became clear, the group moved to the idea of a comprehensive, written assessment. An editorial committee was formed, and a list of important issues that had already emerged or seemed to be looming was circulated as an initial table of contents. Working through the George Consortium, experts were approached and asked to take on (and refine) topics on the list. Chapters were produced on a tight schedule of just 6 weeks for a first draft. Drafts were reviewed by 1 or more members of the editorial committee, and public health leaders including Joshua Sharfstein, Howard Koh, Brian Castrucci, and Daliah Heller read 1 or more chapters in their areas of expertise. The editors and authors are actively soliciting feedback on the report to inform a final, expanded version planned for the end of the year. Each chapter and its recommendations remain the work of the author (Table).

Equity was a primary concern of this assessment. Law and policy play an important role in limiting or exacerbating health disparities and health inequities. Health disparities are differences in health outcomes that people of different demographic backgrounds experience. Health disparities were all too common in the United States before COVID-19 and have been unmistakable during the pandemic. As Patricia Williams pointed out in her powerful closing reflections on the report, these disparities do not arise from bad individual choices or biological differences between races but the social factors that shape people's lives every day "in the ghettoized geographies that have become such petri dishes of contagion."

These disparities are not inevitable. We as a society have created them. Centuries of oppression through policies, norms, and institutional practices shape individual experience and over time have created the inequitable society we inhabit. Laws and policies too often reinforce health inequities by making resources scarce for many or creating unhealthy environments, especially in poor communities and communities of color. But the tools of law and policy can also be the deliberate intervention to change the fundamental drivers of inequity and increase health equity. We and our authors saw not only inequities throughout the pandemic legal response but also the moral and practical demand—we might even say craving—for cooperation, mutual aid, and solidarity. As Professor Williams concludes, "We can divide ourselves up into races and castes and neighborhoods and nations all we like, but to the virus—if not, alas, to us—we are one glorious, shimmering, and singular species."

Using Government Powers to Control the Pandemic

Decades of attention to "legal preparedness" have largely ensured that federal, state, local, and Tribal governments possess significant legal authority to intervene and respond to the challenges faced by communities across the country due to COVID-19. When the pandemic arrived, however, governments were slow to use that authority. Federal government leadership, coordination, and even unprecedented levels of congressional spending have been insufficient to meet

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TABLE
Assessing Legal Responses to COVID-19 Assessments and Authors[a]

Topics	Authors
A Chronological Overview of the Federal, State, and Local Response to COVID-19	Lindsay K. Cloud, JD; Katie Moran-McCabe, JD; Elizabeth Platt, JD, MA; Nadya Prood, MPH
Is Law Working? A Brief Look at the Legal Epidemiology of COVID-19	Evan Anderson, JD, PhD; Scott Burris, JD
Tracing, Intrastate and Interstate Quarantine, and Isolation	Ross D. Silverman, JD, MPH
Mass Movement, Business, and Property Control Measures	Lance Gable, JD, MPH
Surveillance, Privacy, and App Tracking	Jennifer D. Oliva, JD, MBA
Conducting Elections During a Pandemic	David J. Becker, JD
Executive Decision Making for COVID-19: Public Health Science Through a Political Lens	Peter D. Jacobson, JD, MPH; Denise Chrysler, JD; Jessica Bresler, JD
Federalism in Pandemic Prevention and Response	Lindsay F. Wiley, JD, MPH
Preemption, Public Health, and Equity in the Time of COVID-19	Kim Haddow, BA; Derek Carr, JD; Benjamin D. Winig, JD, MPA; Sabrina Adler, JD
Upholding Tribal Sovereignty and Promoting Tribal Public Health Capacity During the COVID-19	Aila Hoss, JD; Heather Tanana, JD, MPH
US Withdrawal From the World Health Organization: Unconstitutional and Unhealthy	Sarah Wetter, JD, MPH; Eric A. Friedman, JD
Private Insurance Limits and Responses	Elizabeth Weeks, JD
Medicaid's Vital Role in Addressing Health and Economic Emergencies	Nicole Huberfeld, JD; Sidney Watson, JD
Caring for the Uninsured in a Pandemic Era	Sara Rosenbaum, JD; Morgan Handley, JD
Assuring Access to Abortion	Rachel Rebouché, JD, LLM
Telehealth in the COVID-19 Pandemic	Cason D. Schmit et al
Access to Treatment for Individuals With Opioid Use Disorder	Corey S. Davis, JD, MSPH; Amy Judd Lieberman, JD
Legal Strategies for Promoting Mental Health and Well-being in the COVID-19 Pandemic	Jill Krueger, JD
Implementation and Enforcement of Quality and Safety in Long-Term Care	Tara Sklar, JD
COVID-19: State and Local Responses to PPE Shortages	Michael S. Sinha, MD, JD, MPH
Expanding Access to Patents for COVID-19	Jorge L. Contreras, JD
Drug and Vaccine Development and Access	Patricia J. Zettler, JD; Micah L. Berman, JD; Efthimios Parasidis, JD, MBE
Assuring Essential Medical Supplies During a Pandemic: Using Federal Law to Measure Need, Stimulate Production, and Coordinate Distribution	Evan Anderson, JD, PhD; Scott Burris, JD
Allocation of Scarce Medical Resources and Crisis Standards of Care	Lance Gable, JD, MPH
A Pandemic Meets a Housing Crisis	Courtney Lauren Anderson, JD, LLM
Protecting Workers that Provide Essential Services	Ruqaiijah Yearby, JD, MPH
Liability and Liability Shields	Nicolas P. Terry, LLM
Protecting Workers' Jobs and Income During COVID-19	Sharon Terman, JD
Using SNAP to Address Food Insecurity During the COVID-19 Pandemic	Mathew Swinburne, JD
COVID-19 Illustrates Need to Close the Digital Divide	Betsy Lawton, JD
COVID-19, Incarceration, and the Criminal Legal System	Jessica Bresler, JD; Leo Beletsky, JD, MPH
Supporting LGBT Communities in the COVID Pandemic	Craig J. Konnoth, JD, MPhil
Immigration Law's Adverse Impact on COVID-19	Wendy E. Parmet, JD
Protecting the Rights of People With Disabilities	Elizabeth Pendo, JD
Fostering the Civil Rights of Health	Angela Harris, JD; Aysha Pamukcu, JD
Closing Reflection: The Endless Looping of Public Health and Scientific Racism	Patricia Williams, JD

Abbreviation: PPE, personal protective equipment.
[a] *Individual chapters and full report available at https://www.publichealthlawwatch.org/covid19-policy-playbook.*

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the national need. Authors saw too much political interference and too little competent coordination and regulatory enforcement.

The federal failure to respect and deploy expertise was front and center. It is difficult to imagine a successful federal response that does not put the Centers for Disease Control and Prevention (CDC) in the lead, but to lead the CDC needs the independence and resources to work with other relevant federal agencies to develop rigorous, scientifically grounded, and apolitical guidance. Similarly, incidents such as the issuance of Emergency Use Authorizations (EUAs) for chloroquine phosphate and hydroxychloroquine sulfate after an errant presidential endorsement, and the looming conflict of interest arising from an election campaign coinciding with vaccine development, raise real questions about decision making at the Food and Drug Administration (FDA).

With the executive failure in mind, more than one of the authors advised Congress to urgently consider reorganizing the CDC and the FDA as independent agencies along the lines of the Federal Reserve, enhancing their capacity and rendering them less susceptible to political influence. Congress is well advised to amend the Public Health Services Act to add transparency and accountability mechanisms that require the HHS secretary and CDC director to provide scientific support for guidance and orders responding to the pandemic. In the face of executive failure or deliberate suppression of information, it is urgent for Congress to mandate and fund efforts to ensure the collection and dissemination of accurate data. To clear the way for better use of modern information technology in disease control, Congress would do well to enact legislation that safeguards individuals from privacy and discrimination risks that arise from digital contact tracing and surveillance.

The state response has been hampered in some places by interbranch and state-local fights over authority. State legislators, where necessary, should clarify the scope and authority of state executive officials to implement disease surveillance and data collection, testing and contact tracing, and physical distancing measures. State health departments should deploy these measures to protect the public's health and include transparent supporting scientific information with emergency orders implementing these measures.

A more effective response to COVID-19 would have deployed widespread testing, contact tracing, and quarantine and isolation where necessary to track and interrupt the spread of the disease. State powers to implement these disease control measures were ample on paper but were used sparingly and limited by lack of testing and contact tracing capacity. Absent the information and resources to impose targeted quarantine and isolation restrictions, state and local officials relied instead on widespread stay-at-home orders, business closures, and gathering restrictions to achieve physical distancing.

State legislatures should fund expansion of testing and tracing capacity and engage community-based organizations to facilitate connections with diverse local communities through multilingual and culturally sensitive outreach efforts. State legislation or executive orders also should provide incentives, funding, programmatic support, and legal protections to assist people with employment, housing, food access, physical and mental health care, social services, and income support, which will allow people to comply with public health guidance as well as mitigating economic and social harm. State health departments should collect detailed demographic data to enhance targeted COVID-19 response efforts and should provide privacy and antidiscrimination protection for data collected through surveillance or digital contact tracing.

Fulfilling Governmental Responsibilities in a Federal System

The division of authority among federal, state, local, and Tribal governments—and between executives, legislatures, and courts—is a strength of American governance. However, COVID-19 also exposed its weaknesses. There is room for creativity and responsiveness to local needs and values but also high risk of confusion, infighting, and the breakdown of essential coordination. Leadership and the explicit delineation of roles and responsibility make the difference in a crisis. For the last century at least, the federal government has provided broad expertise, clear guidelines, and essential resources to state, Tribal, and local governments, which have served as the frontline responders.

Under the Constitution, the president of the United States has primary responsibility for ensuring that federal agencies respond effectively and amplifying and modeling compliance with federal advice. Given the manifest failure of the Trump administration, many of our authors called for changes in the organization and operation of the federal government. To help ensure that we are better prepared for the next pandemic, Congress and the president should jointly convene an independent commission of inquiry to investigate pandemic preparedness and the nation's response to COVID-19. Because the pandemic is global in a world where the United States should be a positive force, Congress should also pass a joint resolution to reverse the president's decision to withdraw the United States from the World Health

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Organization and continue funding that organization. Congress must also honor the federal government's trust responsibility and provide funding directly to American Indian and Native Alaskan Tribes, while sufficiently funding the Indian Health Service and Urban Indian Health Centers, as well as other Indian health programs.

There are also recommendations for state and local governments. They, too, must be guided, to the extent possible, by science. State orders should provide clarity as to the scientific basis that underlies them. State orders should also incorporate equity considerations. In addition, states should not preempt local laws that provide greater protection against the pandemic or that enhance economic security or civil rights. States should also strengthen home rule, and local governments should advocate for state legislation or ballot initiatives that do so. States should enact laws that require them to consult with Tribes within their boundaries and work with Tribal governments to enter into data sharing and mutual aid agreements, while respecting Tribal authority and jurisdiction to promote the health and welfare of their communities.

Financing and Delivering Health Care

The US health care system continues to critically underperform across multiple primary dimensions including access, financing, delivery, and the integration of technology. COVID-19 both emphasized these existing failings and highlighted some second-level problems. The pandemic and its impact on employment demonstrated the overreliance of health care access and financing on the employer model: as millions of jobs were lost, the ranks of the uninsured swelled. Alternate public or private financing systems were unable to cope. Those without health insurance before COVID-19 suffered even more. The health of the disadvantaged, whether because of poverty, race, substance use, or congregate living, declined still further as the virus further exposed the inadequacy of the country's safety net. Even for the insured, not all policies covered the tests and treatments necessary to combat COVID-19.

Medicaid is the key to solving many of the COVID-19 health care problems. Experts in the report urge Congress and the administration to step up with an enhanced Medicaid funding match during COVID-19 and its economic turmoil and also provide additional incentives to persuade holdout states to finally expand Medicaid. For those who remain or wish to remain in private health insurance markets, our authors recommend that Congress should authorize COBRA subsidies to help workers and their families to maintain comprehensive coverage. Similarly, both the federal and state governments should ease access to their individual markets with Special Enrollment Periods and extended end dates.

Federal legislation is urgently required to address deficiencies in health care coverage and costs relating to COVID-19 testing and treatment, including cost sharing, balance billing, and other impediments to care delivery. The federal government should increase its support for health care safety net providers by better targeting federal emergency provider grants, giving states greater Medicaid flexibility to help safety net providers, and helping uninsured patients gain access to the Provider Uninsured Claims Fund. The federal government should recognize that increased regulation and improved enforcement are necessary to protect nursing home residents and staff; yet, there is no justification for exceptional rules that, for example, deny women their reproductive health during the pandemic or those in the lesbian, gay, bisexual, and transgender (LGBT) communities access to HIV medication and gender confirmation services.

State governments should be aggressive in pursuing Medicaid waivers and other avenues to streamline application and enrollment processes and to increase eligibility and services. States should prioritize assistance to state safety net providers, expand their funding of telehealth programs, and use their own budgets to extend coverage to noncitizens. State legislators and governors should be conscious of the possibility that the Affordable Care Act (ACA) will be invalidated in a case currently before the Supreme Court[11] and make overdue changes to the affordability of their insurance markets by introducing a "public option" and stabilizing their insurance risk pools.

Local governments are, for the most part, observers in the health care funding debate, but they can do important things to make health care more accessible. For example, they can remove barriers to effective care for substance use disorder by modifying zoning and licensing laws that create barriers to the establishment of and access to methadone treatment facilities.

Assuring Access to Medicines and Medical Supplies

The United States was unprepared for the surge in demand for basic medical equipment for testing, infection control, and care. From the outset, there was a shortage of personal protective equipment such as masks and gowns and fears that ventilators would be next. Soon after, there were shortages in swabs, reagents, pipettes, and other supplies for testing. Between long-term cuts in federal staffing, poor leadership, and political posturing, the federal

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government proved to be unready for shortages it had itself long predicted, and slow, ineffective, or even derelict in using its robust legal power to ramp up supplies. States, cities, and health care providers, all of whom had trusted too much in federal preparation and taken too little responsibility for their own predictable needs, were left to scramble in an increasingly pricey competition with each other and the federal government.

The best long-term solution for future emergencies is to be better prepared for the short-term need. As the COVID-19 emergency eases, Congress should fund and require HHS to hire and manage the long-term staff and infrastructure to monitor, track, and proactively address deficiencies in the supply chain for essential medical supplies. When the next virus hits, we should have complete, up-to-date information on the supply chain, an ample Strategic National Stockpile, new technologies, and a real plan to meet the surge in demand.

Governments and the law also have a role in supporting the development of new devices, treatments, and vaccines. The FDA should immediately beef up its guidance on alternative sources and reuse of scarce medical supplies. Even more important is for Congress to look closely at the substantial risk that social or political pressure—or just the overwhelming desire to do good—will influence the FDA to approve a vaccine too soon. While expediting the process is obviously vital, it is equally important to ensure that the final decision is made by scientists, not politicians facing an election. In particular, the FDA should resist pressure to issue an Expanded Use Authorization (EUA) for any new vaccine, and the time is now for Congress to consider banning EUAs for COVID-19 vaccines altogether. States can use their authority over the practice of medicine to prevent practitioners from prescribing untested and potentially dangerous drugs even if the FDA has given them its green light.

Protecting Workers and Families

Before COVID-19, it was obvious that the United States was failing to provide many low-income individuals and families safe and affordable housing, food security, job and income stability, and workplace safety. Indeed, changes in law and policy in the past few years have further limited health and safety protections and their enforcement.[12] While the pandemic has affected all families and workers, the most severe impact has been on those the system was already failing—people of color and low-income individuals, whose ranks include the majority of workers providing essential services and unable to shelter at home. Stable housing, safe working conditions, and food and income security are all essential to health, and COVID-19 has made matters worse. Employers—and our society through our government—have done too little to protect essential workers and our vulnerable neighbors.

Many of the recommendations that flow from this assessment aim to address these socioeconomic determinants of health. Federal, state, and local governments can all act to join our peer nations in providing universal, job-protected paid leave so that workers can afford to comply with quarantine and stay-at-home orders. The federal government can increase SNAP (food stamp) allotments and widen eligibility for help. All levels of government can increase funding and widen eligibility for housing assistance of all kinds and can maintain moratoria on evictions during and for a significant period of time after the COVID-19 crisis. The Occupational Safety and Health Administration (OSHA) can take more vigorous action, with congressional prodding if necessary, to make sure every workplace is safe from COVID-19 and future pandemics.

Taking on Disparities and Protecting Equal Rights

The COVID-19 pandemic has laid bare the life and death consequences of inadequate and discriminatory laws and policies such as unequal worker protections, inhumane immigration policies, and uneven access to health care, to name a few. Health and racial disparities are being compounded by the COVID-19 pandemic, the government's response (or lack thereof), and discrimination in the private sector. Existing gaps in legal protections, the lack of knowledge, and widespread noncompliance with current laws are also contributing to COVID-19's impact. In addition, the rollback of protections and access to services for immigrants and LGBT communities is contributing to the deepening of poverty, health disparities, and lack of opportunity among these groups and their families. It is no surprise then that Black, Latinx, LGBT, persons with disabilities, incarcerated persons, those suffering from substance use, and immigrants are disproportionately impacted by both the economic and health toll of the pandemic.

The federal government can take important steps to ensure that persistent health and racial disparities and inequities are not further exacerbated in the response to COVID-19 and beyond. These include shoring up civil rights protections and offering clear guidance on various legal requirements, addressing immigrant and criminal justice detention and enforcement issues to minimize the spread of COVID-19, and solidifying or expanding resources and partnerships

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for organizations serving communities that are most at risk. Federal agencies such as the US Department of Health and Human Services Office of Civil Rights should start by issuing clear, ongoing legal guidance on protections under the requirements of Title VI of the 1964 Civil Rights Act, Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and Section 1557 of the ACA, and other federal legislation protecting civil rights. Congress should ensure sufficient resources for federal agencies to assist with the outreach and enforcement of these protections as well as encourage coordination with civil rights organizations to monitor compliance. Congress should also convene a commission to study the causes of the racial and health disparities resulting from the COVID-19 pandemic to help assess future response policies.

To minimize additional risks of exposure to COVID-19, Congress and the federal administration should put an end to immigration detentions for nonviolent offenders and specifically reduce or suspend enforcement around schools and health care facilitates. To ensure these families are not deterred from accessing health care and other critical benefits, Congress or the federal administration should reverse the public charge rule to allow for access to critical food and health care services during this economic downturn. The federal administration or Congress should affirm and reinstate prohibitions on discrimination based on sexual orientation and gender identity in health care, housing, and other private settings. Finally, Congress should ensure that funding under the CARES Act or other federal emergency funding is available to community-based organizations serving racial/ethnic communities, immigrants, LGBT, incarcerated populations, persons with disabilities, and other underresourced and underserved communities.

State governments have an important role in advancing equitable policies that can work toward eliminating or limiting health disparities at the local and state levels. State policy makers should incorporate equity considerations and address the needs of disenfranchised and underserved communities in COVID-19 response through state guidance to local and state agencies and departments. State agencies and attorneys general should clarify the rights and legal protections of people who experience discrimination under appropriate federal and state laws. As states roll out contact tracing applications and processes, they must ensure privacy protections, utilize best practices in reaching underserved communities, and include multilingual information and services. In addition, state governments must ensure adequate resources for state- and local-level community-based organizations serving racial/ethnic communities, immigrants, LGBT, incarcerated populations, persons with disabilities, and other underresourced and underserved communities. Furthermore, states should allocate additional funding or realign budget priorities to include resources that support preventive health services.

Next Steps

The many legal issues presented by COVID-19 have underscored the need for increased capacity to use law and policy to protect the public's health and achieve health equity. Public health agencies should have funding for, and access to, public health law expertise, whether embedded in the agency or dedicated to the agency at municipal, county, or state attorney general offices.

Learning legal lessons will help the nation better weather pandemics to come, but COVID-19 is here now and there is no time to waste in getting it under control. Everyone in America can help by maintaining physical distance, wearing a mask, and vocally supporting an effective response rooted in apolitical good judgment, scientific evidence, and public health expertise. Everyone in America can stand up for a response that is not just effective but also fair and generous to essential workers and the vulnerable among us. This country is still capable of great things, and the legal recommendations in *Assessing Legal Responses to COVID-19* offer a detailed roadmap to successful control of the pandemic and amelioration of its worst health, economic, and social effects.[6]

We cannot settle for less.

References

1. Savoia E, Lin L, Bernard D, Klein N, James LP, Guicciardi S. Public health system research in public health emergency preparedness in the United States (2009-2015): actionable knowledge base. *Am J Public Health*. 2017;107(S2):e1-e6.
2. Farberman RK, McKillop M, Lieberman DA, et al. *The Impact of Chronic Underfunding on America's Public Health System: Trends, Risks, and Recommendations, 2020*. Washington, DC: Trust for America's Health; 2020.
3. Jacobson PD, Wasserman J, Botoseneanu A, Silverstein A, Wu HW. The role of law in public health preparedness: opportunities and challenges. *J Health Polit Policy Law*. 2012;37(2):297-328.
4. Gostin LO, Wiley LF. *Public Health Law: Power, Duty, Restraint*. 3rd ed. Berkeley, CA: University of California Press; 2016.
5. Burris S, Kawachi I, Sarat A. Integrating law and social epidemiology. *J Law Med Ethics*. 2002;30:510-521.
6. Burris S, de Guia S, Gable L, Levin DE, Parmet WE, Terry NP, eds. *Assessing Legal Responses to COVID-19*. Boston, MA: Public Health Law Watch; 2020.
7. Gostin LO, Hodge JG Jr. US emergency legal responses to novel coronavirus: balancing public health and civil liberties. *JAMA*. 2020; 323(12):1131-1132.
8. Parmet WE, Sinha MS. COVID-19—the law and limits of quarantine. *N Engl J Med*. 2020;382(15):e28.

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9. Beletsky L, Parmet W, Burris S. *Advancing Public Health Through the Law: The Role of Legal Academics*. Boston, MA: Northeastern University School of Law Program on Health Policy and Law; 2012.
10. Public Health Law Watch. COVID law briefings. https://www.publichealthlawwatch.org/covid19-briefings. Published 2020. Accessed August 6, 2020.
11. *California, et al v. Texas, et al* (US 2020).
12. Brookings. Tracking deregulation in the Trump era. https://www.brookings.edu/interactives/tracking-deregulation-in-the-trump-era. Published 2020. Accessed August 11, 2020.

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