

# State Laws Limiting Public Health Protections: Hazardous for Our Health

October 2022

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# Introduction

Our goal in public health has always been to ensure everyone in our cities, suburbs, rural areas, and the entire country has what they need to stay healthy. The arrival of COVID-19 at the beginning of 2020 was devastating to our health and economy and further exacerbated health inequities across the nation. Public health jumped right in with effective interventions for the novel disease early on, and people responded to the call to protect each other enthusiastically: those who were able to stay home did so to protect frontline workers, respected distancing measures at grocery stores and other public spaces and wore masks indoors to protect themselves and others around them. However, the need to modify public health interventions to be effective with the smallest impact on people's daily lives and activities as more was learned about COVID-19 transmission was used by some political and business leaders for political or economic gain. Consequently, the mixture of misinformation and disinformation with public health guidance sometimes resulted in confusion and affected the credibility of public health measures and authority.

Government protections [provide](#) people with the freedom to live healthy lives. Thoughtful and informed discussion about public health interventions should focus on reasonable questions about the proper authority of executive and legislative branches to act on behalf of the wellbeing of our communities in an ongoing emergency; the appropriate level of government to lead the response; and the ability to implement measures that protect the greater good as well as the health of individuals in our communities. In many states, this was not the case. Through the efforts of the American Legislative Exchange Council and others, there has been a [coordinated backlash](#) aimed at public health authority and advancing a deregulatory agenda.

Against this backdrop, widespread economic insecurity, rampant misinformation, a deeply divided political climate, and dissatisfaction with and lack of understanding of public health measures resulted in the filing of over 1,500 bills in legislatures across the nation to limit the options and tools necessary for public health officials to protect their communities from illness and death.

While the majority of these bills failed to pass, many states did enact laws that will make it difficult, if not impossible, for public health agencies and officials to continue to protect the public's health and safety. These laws restricting public health authority were passed in haste, without the adequate understanding and consideration necessary to avoid constitutional infirmities and unintended consequences. As a result, the provisions in many of these laws will significantly weaken our collective ability to respond effectively in future pandemics and other public health emergencies and to carry out day-to-day public health activities.

# Introduction

When public health authority is at issue, it is essential to ensure that any new or revised laws are enacted after careful, informed consideration to ensure the future protection of the public’s health. In contrast to the reactive, piecemeal legislative enactments that are the focus of this report, a thoughtful, comprehensive approach is possible, and has the potential to better protect the health of communities, address stakeholder concerns, and protect everyone’s freedom to live healthy lives. Informed by these legislative developments, public health advocates will be better prepared to mount a strong defense against laws that threaten future health and safety, and to promote and support laws to advance the public health system and the public’s health (as will be discussed in a forthcoming brief).

## State Laws Limiting Public Health Protections: Snapshot of Categories

**185 Total Laws Enacted**  
**January 1, 2021 - May 20, 2022**

<p><b>10</b></p> <p><b>Laws that address mask requirements</b> state-wide or in schools</p> <p><a href="#">(See Section I)</a></p>	<p><b>60</b></p> <p><b>Laws that address vaccines</b> some of which prohibit vaccine mandates and passports and as a pre-condition for employment or school attendance</p> <p><a href="#">(See Section II)</a></p>	<p><b>61</b></p> <p><b>Laws that impact authority</b> of a governor, state health official, or local health official to use emergency orders by imposing restrictions on one or more of the following: issuance, scope, duration, or allowing termination by the legislature</p> <p><a href="#">(See Section III)</a></p>	<p><b>7</b></p> <p><b>Laws that shift public health authority</b> between local and state public health authorities, or between executive and legislative branches</p> <p><a href="#">(See Section III)</a></p>	<p><b>37</b></p> <p><b>Laws that address public health emergency measures</b> in one or more public places – businesses, places of worship, and schools (Described throughout)</p>
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Interactive maps displaying these laws—which will be accompanied by citations, full text of the bills, and numerical data for download in an Excel file—will be available on [LawAtlas.org](http://LawAtlas.org) once published. The data can be sorted by jurisdiction or category. The data will be longitudinal, showing changes in legislation between January 1, 2021, and May 20, 2022.

The following analysis discusses examples of several types of laws enacted that impact the effectiveness of public health response now and for the future. These laws include those that limited requirements for masks and vaccinations, shifted authority, and limited emergency orders. Many of these laws impacted various places including businesses, schools, and places of worship. Also included is a brief discussion of laws that placed the protection of individual liberties, sometimes without limitation, over compliance with measures to protect the community at large.

## I. PROHIBITIONS ON MASK REQUIREMENTS

As COVID-19 is a highly infectious disease which spreads through airborne particles and droplets, masks provide critical protection from illness. Despite strong evidence that masks are effective in reducing transmission, some newly enacted laws prevent state and local governments, private businesses, houses of worship, and schools from imposing mask requirements that are responsive to current conditions, such as increased COVID-19 cases, hospitalizations, and deaths in the community. Additionally, some of these laws prevent governments from making public health decisions based on science, such as the emergence of new and more contagious variants.

**Implications:** These restrictions put all of us at greater risk despite ample evidence that universal mask wearing is an effective way to mitigate the spread of COVID-19, and to significantly reduce the risk of infection, hospitalization, and long-term health issues for people who are immunocompromised or unvaccinated. Looking to the future, these laws can act to normalize prohibitions on masking and serve as models for similar laws addressing other future communicable diseases – significantly undermining a key, effective public health intervention.

### Examples:

**Iowa [HF 847](#)** bars **school districts** and accredited nonpublic schools from adopting, enforcing, or implementing policies requiring employees, students, or members of the public to wear a face covering when on school property, unless necessary for an extracurricular or instructional purpose or otherwise required by law. The law also prohibits a county or city government from requiring owners of real property to implement policies requiring facial coverings that are more stringent than requirements imposed by the state.

**Oklahoma [SB 658](#)** prohibits **education agencies and education authorities** from requiring vaccination against COVID-19 as a condition of attendance, or implementing mask requirements for students who are not vaccinated against COVID-19. This law allows mask mandates to be implemented only when there is a governor-declared state of emergency; Oklahoma's state of emergency expired on May 4, 2021.

**Tennessee [SB 9014](#), [2021 Tenn. Pub. Acts. Ch. 6](#)**, prohibits **government entities** from requiring a person to wear a face covering as a condition of accessing the business or entity's premises or to receive services. It also prohibits **government employers** from

requiring an employee to wear a face covering as a term or condition of employment or from taking an adverse action against an employee for failing to wear a face covering. This law allows face covering requirements only if “severe conditions”<sup>\*</sup> exist, and the requirements last for no more than 14 days unless the severe conditions persist. It also provides an exemption for persons with documentation from a healthcare provider that wearing a face covering is contraindicated, or if the person has a sincerely held religious belief.

The law also prohibits **schools, governing bodies of schools, and publicly operated childcare agencies** from requiring a person to wear a face covering while on school property unless severe conditions exist; the requirement is in effect for no more than 14 days (subject to renewal if severe conditions continue); and the school provides N95 face masks for persons over 12 years of age, and appropriate face coverings for persons aged 5-12. Further, it provides that the Commissioner of Education can withhold funds from a local education agency if state funds were used to mandate or require students to wear face coverings.

<sup>\*</sup>While the law allows for mask requirements under “severe conditions,” this requires a governor-declared state of emergency for COVID-19 and a rolling 14-day COVID-19 infection rate of at least 1,000 new infections per 100,000 residents. For reference, the CDC and the Tennessee COVID-19 Dashboard currently publish 7-day moving averages. At the peak of Omicron, which resulted in the highest number of cases per day during the pandemic, the 7-day case rate per 100,000 was 1,702. However, the 7-day case rate per 100,000 for the two prior peaks was under 1,000. This law creates a standard that is incredibly difficult to meet, effectively prohibiting mask requirements entirely.

## II. PROHIBITIONS ON PROOF OF VACCINATION AND VACCINE MANDATES

The evidence is overwhelming: vaccines save lives. According to a [report from the Commonwealth Fund](#), vaccines prevented 1.1 million additional COVID-19 deaths and more than 10.3 million additional COVID-19 hospitalizations in the U.S. through the end of November 2021. Yet many states enacted provisions limiting or forbidding COVID-19 vaccination requirements, such as prohibitions on:

- government agencies issuing vaccine mandates or passports;
- vaccination as a condition of receiving governmental services and benefits;
- vaccination as a condition for private business services or employment; and
- vaccination as a condition for school attendance.

The status of vaccine exemptions (primarily for school attendance) has varied across the states, with all states allowing medical exemptions and the majority of states also allowing for religious exemptions. A minority of states allow for philosophical exemptions. During the COVID-19 pandemic some states have passed COVID-19-specific laws allowing individuals to refuse COVID-19 vaccinations based on personal or other grounds in addition to religious and medical exemptions. One state (Wyoming) enacted a law stating that public entities will not enforce COVID-19 vaccine requirements issued

by the Centers for Medicare and Medicaid Services (CMS) and the Occupational Safety and Health Administration (OSHA) COVID-19, and authorizing the state attorney general to challenge federal vaccination requirements.

**Implications:** Even when vaccinations are an effective and necessary way for state residents to protect themselves, their families, and their neighbors, state leaders enacting these laws send the opposite message to the community. These laws undermine governmental authority to require vaccines other than COVID-19, despite their effectiveness and ease of use. It is [well established](#) that the risk of disease outbreaks of vaccine preventable diseases increases when there are lower vaccination rates. The prohibitions in these laws have and will continue to result in lower vaccination rates, resulting in higher numbers of preventable deaths and disease in our communities.

### Examples:

**Alaska [HB 76](#)** authorizes **individuals** to refuse COVID-19 vaccination based on “religious, medical, or other grounds” and prohibits requirements for documentation or other justification supporting decisions not to vaccinate. It contains comprehensive liability protections for Alaska **businesses** from harm to employees and patrons, although it establishes presumptive workers’ compensation for certain employees who contracted COVID-19.

**Arizona [HB 2498](#)** prohibits **government entities** from requiring a resident of the state to receive a vaccination for COVID-19. This law preempts **counties and local governments** from continuing or instituting vaccine requirements, except for health care institutions run by a government entity. For example, with the passage of this law, [Pima County](#) could no longer require any county employee to be vaccinated against COVID-19 except for those employees delivering clinical care in government health care facilities.

**Arkansas [HB 1547](#)** prohibits the **state** from mandating a vaccine or immunization for COVID-19. The law also requires **state owned medical facilities** to receive Legislative Council approval for vaccination requirements, and prohibits the state/state entities from “discriminating against or coercing” receipt of a vaccine, although it allows incentives for vaccination.

**Montana [HB 702](#)** prohibits discrimination based upon vaccination status or possession of an immunity passport by a **person, employer, governmental entity, or public accommodation**. The law does provide exceptions for vaccine requirements imposed by schools, day care facilities, and in accordance with CMS regulations for nursing homes, long-term care facilities, and assisted living facilities.

**Tennessee [SB 9014](#), [2021 Tenn. Pub. Acts. Ch. 6](#)**, as amended by [SB 1823 \(2022\)](#), [Tenn. Pub. Ch. 644](#), prohibits a **government, school, or local education agency** from establishing requirements for vaccination against COVID-19 and from mandating that a private business or school require proof of vaccination to access business or school premises or to receive services. A private business, governmental entity, school, or local

education agency is prohibited from requiring proof of vaccination or taking adverse action against a person for objecting to receipt of a vaccine. As amended, the law requires employers previously not subject to the prohibition against a mandatory COVID-19 vaccination policy to grant an exemption for a person who provides a statement signed by a licensed healthcare provider or claims to have a religious belief that prevents compliance. In addition, the law establishes guidelines for the exemption process and penalties for violation of these guidelines. The law also applies to previously exempt federally regulated employees, including healthcare providers regulated by CMS, and federal contractors and grant recipients.

**Utah [SB 2004](#)** allows **employers** to require proof of COVID-19 vaccinations, but provides exemptions for conflicts with employees' sincerely held personal beliefs in addition to medical and religious exemptions. No exemptions are required for an employer with less than 15 employees who establishes a nexus between the vaccine requirement and the employees' assigned duties and responsibilities. The law prohibits employers from taking adverse action against employees based on non-vaccination status or from keeping a copy of their vaccine card unless otherwise required by law or standard business practice, and requires employers to pay for COVID-19 testing.

**West Virginia [HB 4012](#)** prohibits a **state or local government official or entity, hospital, or state institution of higher education** from requiring proof of vaccination as a condition of entering the premises.

**Wyoming [HB 1002](#)** provides that public entities in Wyoming will not enforce **federal vaccine requirements** under CMS and OSHA upon employers, and authorizes the state attorney general, with the direction and consent of the governor, to participate in litigation to challenge federal vaccination requirements.

### III. SHIFTS IN AUTHORITY AND LIMITATIONS ON PUBLIC HEALTH ORDERS

#### State Executive to State Legislature

In addition to enacting laws that specifically limit effective public health measures including mask and vaccination requirements, a number of states also enacted laws that shift public health authority to the legislature. These laws remove authority from the chief executive and public health agencies to exercise their expertise and the flexibility needed for day-to-day public health protection and emergency response. These laws give this authority to those with less knowledge and expertise to make health decisions that impact entire communities. Among other provisions, these laws impose time limits on emergency orders and establish new legislative authority to limit public health protective measures, including guidelines on public gatherings, and to extend, change, terminate, and oversee implementation and enforcement of emergency orders. Laws in Kentucky and Ohio are examples of the transfer of authority from the state governor



and public health department to the legislature with associated implications for the public's health, which are specifically discussed below.

**Kentucky SB 1, KRS § 39A.090**, limits an executive emergency order issued by the governor to 30 days if the order restricts in-person meetings or puts restrictions on the functioning of schools, businesses, local governments, and places of worship, or if it imposes any isolation or quarantine requirements, unless the legislature approves an extension. The law allows the legislature to terminate a declaration of emergency at any time and shifts authority from the governor to the legislature to extend, change, or terminate an emergency order.

The law reduces the governor's use of other emergency powers by prohibiting an extension or implementation of an emergency declaration without prior approval of the legislature. The law also deletes the statutory provision which allowed the governor to perform and exercise "other functions, powers, and duties deemed necessary to promote and secure the safety and protection of the civilian population" during an emergency.

**Implications:** Instead of public health professionals leading the effort to prevent the spread of disease, the state legislature will determine policy in future health emergencies, undermining and disregarding the years of expertise and knowledge that public health professionals bring to the table. Legislative action will require a majority vote and/or a special session during an evolving crisis. Requiring prior legislative approval for the exercise of emergency authority from the governor and executive branch public health officials will politicize response to future health crises and result in delay and inadequate response at a time when quick, definitive action is necessary based on the threat to health and life posed by the situation.

**Kentucky SB 2, 2021**, delegates authority for administrative review of emergency administrative rules to a legislative commission that has the authority to amend the rules, or find an emergency regulation defective and have it withdrawn. The law includes a heightened emergency justification demonstrated by documentary evidence and notice and comment requirements for emergency administrative regulations. Further, the law places a limit of 30 days on the effective period for emergency regulations for the control of contagion and active spread of disease if the regulations contain restrictions on in-person meetings and the functioning of schools, businesses, local governments, and places of worship or imposes any isolation or quarantine requirements.

**Implications:**

- The law makes it more difficult for the governor and executive branch administrative agencies, including the Kentucky Cabinet for Health and Family Services, to respond quickly and efficiently with effective public health measures during an emergency. The additional requirements imposed by this law may delay or prevent implementation of these measures resulting in the

lack of timely public health response to the spread of disease, and associated morbidity and mortality.

- The law provides a large amount of discretion to a legislative committee of politicians, not public health experts, to amend or invalidate emergency regulations. The public health consequences are significant, putting people in harm's way, particularly in delaying the restriction of public gatherings during an infectious epidemic, reducing authority over school operations and religious gatherings, and restricting local health departments from issuing isolation and quarantine orders.

**Ohio [S.B. 22, 134<sup>th</sup> General Assembly](#)**, limits the duration of the governor's-declared state of emergency to 90 days unless the legislature extends it, and allows the legislature to terminate the order after 30 days. It also permits the legislature to rescind or invalidate orders, rules, or actions issued or taken by the Ohio Department of Health (ODH) or its director to control and suppress the cause of disease or illness, including contagious, infectious, epidemic, pandemic, or endemic conditions.

In addition, the law provides that the legislature may act through a concurrent resolution, which bypasses the governor's ability to veto the action taken by the legislature. It also establishes a Health Oversight and Advisory Committee within the legislature to oversee ODH actions taken to prevent or investigate the spread of disease, with the authority to issue subpoenas for individuals to testify and to provide documents (*duces tecum*).

### Implications:

- By allowing the legislature to intervene through a concurrent resolution, the legislature effectively negates the governor's ability to control the response to a pandemic. Flexibility and speed of action based on science are essential in mitigating the effects of a quickly evolving pandemic. The legislature would have difficulty issuing, monitoring, and enforcing emergency orders in real time.
- The legislature lacks the skills and knowledge to deal with a rapidly evolving pandemic. Although the Oversight and Advisory Committee could provide a venue for offering suggestions that the ODH director could consider, the authority to issue subpoenas would not only result in delay but could also have a chilling effect on public health practitioners' efforts to protect the public's health.

### Local Public Health Authority to the State or to Local Legislatures

Laws passed in Florida, Indiana, Ohio, and West Virginia shift authority from local jurisdictions to the state, or from local public health officials to local legislatures. These laws invoke the authority of the state to "preempt" or mandate what local governments and their public health agencies can and cannot do to respond to conditions that may be specific to their communities. These laws impact the length of local emergency orders as well as the use of protective public health measures such as isolation and quarantine, and closures. They also shift the ability to hire and remove public health officials from

public health agencies to legislative bodies. The particular implications for these various laws are discussed below.

[Indiana Public Law 219 of 2021 \(SB 5\) SB0005.06.ENRH.pdf \(in.gov\)](#) **Indiana SB 5, Public Law 219 of 2021** provides that if the governor has declared an emergency and a local order addresses any aspect that is not addressed by the executive order, or if a local order addresses an aspect of a declared emergency more stringently than an executive order, then the local order may not take effect, or remain in effect, unless approved by the applicable local legislative body (i.e., county legislative body, city legislative body, etc.)

The law further prohibits a local board of health or local health officer from filing an action to enforce an order, citation, or administrative notice unless the appropriate legislative body has authorized it to file the action. The law creates a new right to appeal directly to the local legislative body to challenge public health enforcement actions in response to either (i) a declared local public health emergency or (ii) a disaster emergency declared by the governor.

The law requires that the appointment of a local health officer be approved by the legislative body or bodies (in the case of a multi-county board of health). If the appropriate legislative body or bodies do not approve the appointment on two separate occasions, the individual is barred from further consideration for the position. Further, it provides that a health officer may be removed for “other good cause,” which is not defined. Previously, removal of a health officer had to relate to failure to perform statutory duties or enforce the rules of the state department.

### Implications:

- The law is likely to result in confusion and delay in getting critical information to community members since legislative approval of local health department orders is only required where the order goes further than the Governor’s order or addresses something not included in an executive order. Even if local legislative approval of an emergency local public health order is not required, the local health department is required to obtain legislative approval to initiate action to formally enforce its order. This requirement is very likely to slow the local health department’s ability to respond to dynamic public health crises.
- The law inserts politics into public health emergency response. Local legislators now have authority to approve or negate enforcement of local public health orders during emergencies, when public health expertise, discretion, and flexibility to determine appropriate action to protect the public in a dynamic environment are needed most.
- Local legislative bodies may not understand why certain public health actions are needed to protect the public’s health. Public health departments are better equipped to respond appropriately to public health threats or crises than local legislative bodies whose members have no expertise in public health and may not understand the local public health department’s authority.

- The law also injects politics into the hiring of local health officers. If a local legislative body does not approve of the philosophy or approach of a potential local public health officer (e.g., they took actions to address COVID-19 in another community that the legislative body disapproves of), then the local legislative body may block that individual's appointment. This removes necessary expertise and authority from a community's local board of health.

As mentioned above, [Ohio S.B. 22, 134<sup>th</sup> General Assembly](#), establishes the Ohio Health Oversight and Advisory Committee within the legislature to oversee actions taken by, and to consult with, the governor and the Ohio Department of Health. It also provides that local boards of health may only issue quarantine or isolation orders to individuals who have been medically diagnosed with the disease subject to the order, or to individuals who have come in direct contact with someone who has been medically diagnosed with the disease. In addition, the law removes the authority of local health departments to prohibit public gatherings and to close schools except in very limited circumstances. Further, it allows any person to challenge an emergency rule and recover attorney's fees if successful.

**Implications:** The law undermines the ability to mitigate a pandemic at the local level. The language regarding the authority of local health agencies to quarantine and isolate is so restrictive that it will block public health's ability to do its job to slow or stop the spread of a pandemic. Even if the pandemic is raging in one part of the state, the local health department would be prohibited from taking strong action to stop the spread of disease.

- Provisions requiring a medically diagnosed disease before issuing a quarantine or isolation order prevent the health department from taking effective steps at the disease's early stages.
- Prohibiting a health department from issuing blanket isolation or quarantine orders, and allowing only individual orders, significantly impairs the ability of a local health department to effectively manage disease prevention and protect the health of the community.

**West Virginia SB 12 (W. Va. Code §§ 16-2-2, 16-2-9, 16-2-11)** provides that if the Governor declares a statewide public health emergency, local health departments must comply with relevant policies and guidelines established by the state health officer. It also allows the county commission and/or municipality that authorized creation of a local board of health (the "appointing authority") to remove its appointed members of the local board of health. Previously, only members of the local board of health could make removals. (The state health officer retains the authority to remove members of the local board of health for failure or refusal to comply with applicable statutes.)

The law requires the Commissioner of the Bureau of Public Health, a state officer, to establish appeals procedures for local health department determinations for consistent interpretation of state rules. The law also subjects local health department rules to approval by the appointing authority. Although the law allows rules in an imminent public health emergency to become effective without prior approval, it requires the

appointing authority to approve or disapprove emergency rules within 30 days of their effective date.

**Implications:**

- The law limits the ability of local boards of health and health departments to protect the health of their communities by allowing state and county officials to remove appointed members and amend or reject local rules.
- The law also may impair the ability of local boards of health to respond to specific circumstances during health emergencies by authorizing the state to issue mandatory guidelines for local action.

## **IV. PROHIBITIONS ON MEASURES TO PROTECT THE COMMUNITY IN THE NAME OF INDIVIDUAL LIBERTIES**

During times of widespread challenges and emergencies, the American people have by and large accepted measures to support the common good, even if such measures meant that their own individual choices were not completely unfettered. Examples include evacuation orders in the face of impending natural disasters such as hurricanes and wildfires and food rations during World War II. Americans have understood that an individual choice not to evacuate may increase the threat to the community as a whole by diverting resources, as well as threatening the liberty and safety of individuals such as first responders and firefighters. Similarly, an individual choice to forego vaccination, social distancing, and mask usage, if practiced widely, may threaten community health and the health care systems by increasing the number, speed of spread, and severity of cases of infectious disease. It is important to note that the exercise of absolute individual rights by people gathering in places of worship, workplaces, or schools inevitably infringes upon the individual liberties of others, such as health care providers, other frontline workers, and immunocompromised students.

When it comes to mitigating health risks, those who push to strip away public health powers and duties to protect the community frame this effort as a defense of individual liberties, without acknowledging that dismantling governmental public health laws often favors certain individual liberties over others, or the liberties of certain individuals over those of others. During the COVID-19 pandemic, some politicians weaponized constitutional rights in state legislatures to push for limitations on public health measures that keep us healthy. Laws passed in 2021 and 2022 in states such as Florida, Idaho, Kansas, Kentucky, Montana, and New Hampshire claimed to protect individual constitutional rights generally, or sought to protect specific individual rights, including the right to free exercise of religion, to attend worship services in person, to peaceful assembly, and to bear arms.

While the drafters of some of these laws appear to concede that some infringement upon individual liberties may be “necessary” (see Florida SB 2006, described below), other hastily enacted laws appear to intend to create an absolute right to engage in the

constitutional right in question, without limitation. This is a departure from long-standing legal norms recognizing that in order to protect community health, the government may need to take actions that limit individual rights, for as long as is necessary and reasonable. Interestingly, even in cases challenging public health measures as an imposition on the free exercise of religion — the type of individual rights challenges where courts have been by far the most sympathetic to plaintiffs — the existing public health measures have been upheld in the majority of cases, according to analyses conducted in 2020 and 2021 by Wendy E. Parmet in [The COVID Cases: A Preliminary Assessment of Judicial Review of Public Health Powers During a Partisan and Polarized Pandemic](#).

Examples of these laws and the implications associated with them are discussed below.

**Idaho [HB 391](#)** provides that during a state of emergency, the governor, governmental agencies, and political subdivisions of the state may not limit or suspend any rights guaranteed by the U.S. or state Constitutions, including but not limited to the rights to lawful manufacture and use of firearms and ammunition, peaceable assembly, and free exercise of religion.

**Implications:** This law may substantially limit the government’s ability to protect community health during an emergency, since many such measures may have some limiting effect on individual rights. In barring limitations on the manufacture of firearms and ammunition, the law extends beyond the ostensible purpose of protecting the individual right to bear arms, to provide greater protection from government regulation for the firearms industry than for other manufacturing industries.

**Idaho [SB 1262](#) and [HB 705](#)** provide that during a state of disaster emergency, businesses engaged in sale, transfer of firearms and accessories, and training in the use of firearms are essential businesses. These laws further provide that neither the governor, nor a state agency, nor a political subdivision, may seize or confiscate privately owned firearms used in connection with otherwise lawful conduct during a declared state of emergency or an extreme disaster declaration.

**Kansas [SB 14](#)** prohibits, among other provisions, certain types of emergency actions, including limiting the sale of firearms.

**Implications:** These three laws single out businesses engaged in the sale, transfer, and training in the use of firearms as not subject to closure in a disaster or emergency. This may be a problem because an infectious disease can be spread when people gather in close proximity. These laws appear to go beyond simply prohibiting laws that discriminate against use of firearms, to prohibiting non-discriminatory limitations as well, which may make containment of infectious disease more difficult.

**Kentucky [SB 1](#), [KRS § 39A.090](#)** states that the emergency management law shall not be construed to allow restrictions on the rights to free speech, press, or assembly, or to rights to worship, worship in-person, or act in accordance with one’s religious beliefs.

**Florida [SB 2006](#)** provides that it is the intent of the legislature to minimize the negative effects of an emergency order issued by a political subdivision and that search orders must be limited in duration, applicability, and scope in order to reduce any infringement on individual rights or liberties to the greatest extent possible. The law also authorizes the Governor to invalidate any local measure that “unnecessarily restricts” individual rights or liberties.

**New Hampshire [Chapter Law 11](#)** prohibits the suspension of civil liberties during a state of emergency.

**Implications:** The broad provisions prohibiting any restrictions on public gatherings and freedom of assembly will allow for further spread of a deadly disease during an infectious epidemic in school operations, in-person religious worship, and other public gatherings.

**Montana [HB 230](#)** provides that declaring a disaster or emergency does not grant the government authority to limit physical attendance at religious services or operation of religious organizations. Previously, Montana law did address attendance at religious services during an emergency or disaster (Montana Code Annotated 10-3-102). Consequently, prior to passage of HB 230, it was more likely that a government order requiring closures of businesses, schools, and places of worship would have been upheld as a content neutral measure to protect public health, as long as religious services were not singled out for worse or more restrictive treatment and were allowed to continue on the same terms as other gatherings, such as outdoors or remotely.

**Implications:** The law singles out religious services as not subject to closure by state, local, or inter-jurisdictional governmental authority in a disaster or emergency. This may be a problem because an infectious disease may be spread when people gather in close proximity for extended periods of time. The law appears to go beyond simply prohibiting laws that discriminate against religion, to prohibiting non-discriminatory limitations as well, which may make containment of infectious disease more difficult.

**Montana [SB 185](#)** prohibits the governor from suspending a statute that affects an individual’s exercise of constitutional rights during a disaster or emergency.

**Implications:** This law is similar to Montana HB 230, but with an even broader impact, since many statutes may affect an individual’s exercise of constitutional rights.

# Conclusion

The purpose of this report is to inform those in the public health field of the recent legislative trends that will limit future day-to-day and emergency public health response in the states that have enacted these laws and potentially the nation at large.

The report is also a wake-up call for the public health community. Continued efforts to understand the context for this legislative response to the approaches taken by public health authorities are necessary to gain better insight into those perspectives and reactions that drove the enactment of these laws, and to become better messengers and advocates for the public's health in the legislature and other arenas. There is a tremendous opportunity now to create and advocate for laws that protect and promote health and health equity.

One example, created by [executive order](#) of the governor of Indiana, is to form a public health commission to consider the public health system as a whole outside of the politically charged atmosphere of the state legislature. The public health commission in Indiana has produced a [report with recommendations](#). These recommendations will be subject to the legislative process, but the people of the state of Indiana will surely benefit from the careful consideration of many facets of the public health system, including the scientific, social, economic, environmental, and legal dimensions.

Laws that have been enacted in the absence of public health expertise will delay lifesaving information and interventions reaching the public, while advancing health-harming political calculations that override protective decisions and measures for the public's health. These laws have:

- imposed legislative limitations on executive branch public health agency decision-making and implementation and shifted executive branch authority to legislative bodies;
- banned or limited reasonable public health measures including vaccination, mask, isolation and quarantine and physical distancing requirements;
- established limits on the duration or renewal of emergency declarations and orders, and the ability of local public health agencies to tailor responses to the specific threats and needs of their communities, including health equity considerations; and
- elevated the protection of specific individual rights over that of the community and common good, including the right to free exercise of religion, to attend worship services in person, to peaceful assembly, and to bear arms.

The laws summarized in this report, and others like them, are the result of reactionary legislative actions that can have dire consequences for communities across the country, particularly historically disadvantaged communities. Understanding the type and range of limitations prescribed in these laws is valuable for those invested in protecting the public's health, for public health officials, policymakers, advocates, and researchers heading into upcoming legislative sessions.



# Act for Public Health

*An initiative of the Public Health Law Partnership*



ChangeLab Solutions



PUBLIC HEALTH  
LAW CENTER  
at Mitchell Hamline School of Law



The Network  
for Public Health Law



Temple  
University  
Beasley School of Law

Center for  
Public Health  
Law Research

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