POLICY BRIEF

Temple University
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Center for Public Health Law Research

Sentinel Surveillance of Emerging Laws Limiting Public Health Emergency Orders

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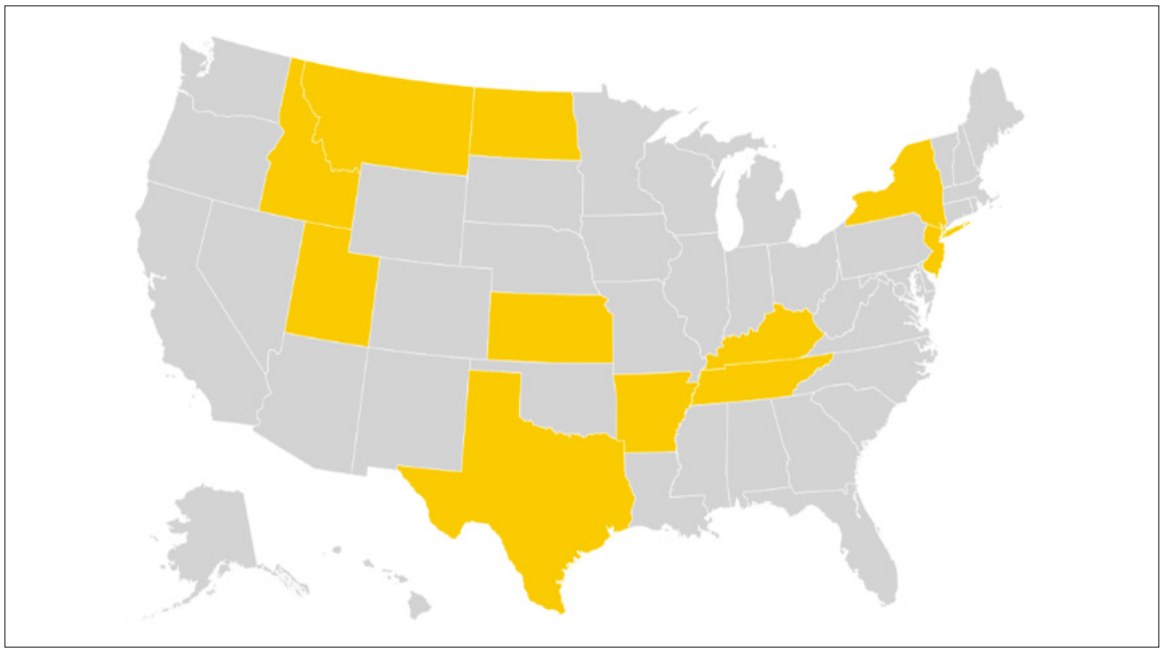
Introduction

During the COVID-19 pandemic, legislators in almost every state introduced bills that would limit state executive authority to respond to the current pandemic or future public health emergencies.[1] Between January 1, 2021 and June 17, 2021, these bills were enacted into law and became effective in eleven states.[2] Some of these laws prohibit governors or state health officials from taking action to enact measures to protect the public from the spread of deadly disease, including mandating the use of masks, requiring vaccination, or closing businesses, among others. Laws that restrict the authority of governors, state health officials and/or local health officials to act in times of emergency could significantly impact public health by limiting their ability to take actions necessary to respond to or mitigate crises in a swift and flexible way.[3] Based on history, expertise, and existing research — which, as described below, is not yet conclusive or complete — there is reason to believe that laws limiting reasonable and expert public health authority may pose a preventable threat to life and health.

While these laws are dangerous for all people living in the United States, they are likely to have a particularly harsh effect on Black, Indigenous and other communities of color. COVID-19 has disproportionately impacted Black, Latinx, Indigenous, and Pacific Islander populations in the



As of June 17, 2021, 11 states have a law in effect that was passed since January 1, 2021, that limits state executive authority regarding public health orders. These are Arkansas, Idaho, Kansas, Kentucky, Montana, New Jersey, New York, North Dakota, Tennessee, Texas, and Utah.

United States, both in terms of their health and economic well-being.[4,5] These disparities arose because of historic and systemic racial injustices, with much broader impacts than those related to COVID-19.[6] Laws that hinder the ability of state and local officials to respond to a public health crisis will likely have a disparate effect, particularly among the communities already facing disparate impacts on their health and equity.

Current Legal Landscape

Legislators in nearly all US states (46) have introduced bills in 2021 to limit governors' or health officials' authority during the COVID-19 pandemic or other emergencies, and many have been enacted, according to a legal scan conducted by the Center for Public Health Law Research.[7]

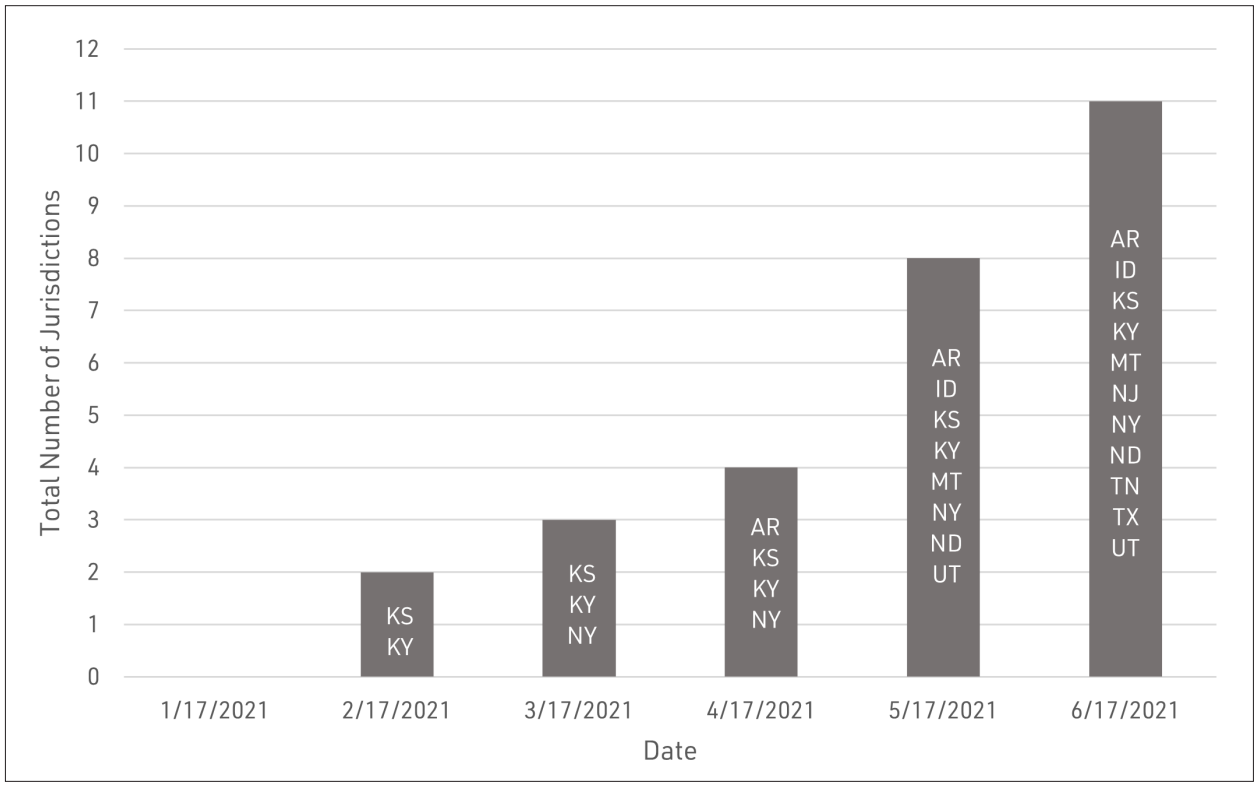
The scan shows that 11 states passed these laws in the first half of 2021.

States have taken a variety of approaches to curbing public health authority. As of June 17, 2021, 11 states have a law in effect that was passed since January 1, 2021, that limits state executive authority regarding public health orders. These are Arkansas, Idaho, Kansas, Kentucky, Montana, New Jersey, New York, North Dakota, Tennessee, Texas, and Utah.

Among the 11 states, nine have limited both the then-governor's authority and the authority of a state agency or official, with all those states limiting the scope of at least one type of order: Arkansas, Idaho, Kansas, Kentucky, Montana, New Jersey, North Dakota, Tennessee, and Utah.

Five states — Arkansas, Kansas, Montana, Tennessee, and Utah — limited the governor's authority, the authority of a state agency or official, and the authority of a local agency or official.

Some laws limit the duration of a state of emergency or limit emergency orders to a specific number of days (as in Arkansas for example). Others require elected officials to approve health officer actions (as in North Dakota), or prohibit the governor or health officials from requiring vaccination (as in Tennessee).



The progression of laws limiting public health authority has increased by 11 states from January 2021 through June 2021.

Kansas was the first state in 2021 to pass a law limiting public health emergency orders. Kansas is the only state to allow counties to issue a local order that is less stringent than a governor's order. The Kansas law also provides that such a local order will operate in the county in lieu of the governor's executive order.

Utah is the only state that limited both state and local health officials in all of the following areas: restricting the ability to issue emergency orders, limiting the duration of emergency orders, restricting the scope of emergency orders, and establishing that emergency orders may be terminated by legislature or another entity.

The data were produced using a novel legal mapping technique called sentinel surveillance of emerging laws and policies (SSELP), developed by the Center for Public Health Law Research, to track laws faster so researchers may more quickly evaluate the impact of these laws and policies on health, well-being and equity.[8]

Evidence

No evaluations have been found examining laws limiting state executive authority regarding public health emergency orders. It is likely that evidence about the implementation and impact of these laws is lacking because of their recent enactment. There is some research indicating that the types of measures (e.g., mask mandates and business closures) restricted by these laws can be effective in slowing the spread of COVID-19,[9,10,11,12,13] and that early adoption of quarantine and other control measures could prevent large rises in cases or death rates.[14] However, existing research on the impacts of social distancing policies on COVID-19 outcomes is incomplete, and insufficient to know with certainty precisely which policies work, and to what degree.[15,16] One non-peer reviewed study examining the strength of evidence in the evaluation literature on COVID-19 policy impacts found that most studies failed to meet important design criteria for evidence rigorous enough to be actionable by policymakers.[17] It is still too early to definitively assess the effectiveness of specific mitigation measures, or to draw firm conclusions about the optimal division of emergency powers among the branches of government. However, strong emergency powers have been built into U.S. public health law for centuries, and both logic and experience suggest that rapid legal action is indispensable for an effective pandemic response.

Policy Recommendations

Legislative reforms are necessary to provide guidance and standards for protecting the public during future public health emergencies. However, these reforms should be the result of careful reflection, discussion, and collaboration among a range of stakeholders, including public health practitioners, lawyers, policymakers, and people from the business and healthcare industries. Legislative changes should allow for nuanced responses to public health emergencies that are based on evidence and the expertise of trained public health officials, and that balance mitigation measures with individual rights. It is also critical that emergency measures be taken promptly without delay caused by unnecessary bureaucratic requirements.

The nature of, and risks presented by, public health emergencies vary. The next emergency, and those that follow, could pose considerably different risks than COVID-19 did, and might disproportionately affect populations that the coronavirus did not. Legislative reforms should consider that future public health emergencies will not mirror COVID-19. Reforms must provide public health officials with the authority and flexibility to order protective measures, based on their expertise, that address the particular threat posed.

Lindsay Wiley offers six principles consistent with public health experience and such evidence as we have, which could be useful for guiding conversations on legislative reform in this area:

1. Transparency should be mandated by the statute.
2. Health officials' authorized actions should have time limits but be renewable.
3. Statutes should authorize a scaled response.

4. Statutory standards should promote neutral orders that do not discriminate based on religion.

5. Statutes should require provision of supports, legal protections, and accommodations of safer alternatives.

6. Criminal enforcement against individuals should be authorized only if it is established as the least restrictive alternative to achieve compliance with orders.[18]

States can also consider enacting laws to strengthen public health authority and infrastructure, following trends from some states during the COVID-19 pandemic. These could include establishing commissions or advisory bodies to make recommendations on emergency response efforts; strengthening local public health authority; and increasing transparency and accountability.[19]

Research Agenda

The Center for Public Health Law Research dataset provides a high-level overview of laws that limit state executive authority regarding public health emergency orders, but it does not capture many details of these laws. A more granular picture of the legal landscape, facilitated by policy surveillance, would support a broader understanding of these laws and how they impact health. This could include capturing the length of duration limits (e.g., 30 days), the types of provisions restricted in emergency orders (e.g., mask mandates are prohibited), and the process by which a legislature may terminate an emergency order. While this information is available in the legal text cited and linked in the dataset, these features of the laws are not included as legal variables that can be queried, easily identified, or converted into numerical data. Policy surveillance on this topic would also provide reliable legal data, facilitating the evaluation of the health impacts of these laws.

To fully comprehend the impact of this type of legislation on public health, policy surveillance research should include laws that limit state executive authority in other ways, or that limit local authority to respond to emergencies, which are outside the scope of this dataset. Further, research – initially a legal scan, potentially leading to policy surveillance and evaluation – should be conducted on laws that strengthen public health authority, which are referenced in the Policy Recommendations section above, to understand how the features of these laws may impact health.

More broadly, rigorous research is needed on the role of law in shaping the powers of public health agencies, and the emergency authority of governors, in order to evaluate the impact of these powers on public health.[20] Understanding whether varying levels and distributions of emergency power affect the timing or overall efficacy of responses to a public health crisis is critical to determining what changes should be made to laws governing public health authority.

Conclusion

Laws that limit state executive authority to respond to public health crises could have a significant negative impact on health. During the COVID-19 pandemic, most states introduced bills, many of which have been enacted, restricting the authority of a governor or state health official to act in a health emergency. These laws limit duration of emergency orders, prohibit mask requirements, and allow legislatures to terminate emergency public health orders, among imposing other restrictions. These laws impede the ability of a governor or state health official to respond to a health emergency in a quick and flexible manner. It is critical to know what the health impacts of these laws are, as well as what legislative reforms could be beneficial when it comes to executing public health authority in an emergency. This SSELP dataset provides a helpful overview of the policy landscape on this topic and lays a foundation for policy surveillance datasets that would create the legal data necessary to evaluate these impacts.

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