

The Roles of the State and Federal Governments in a Pandemic

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INTRODUCTION

In the early days of the COVID-19 pandemic, President Trump considered imposing a “quarantine” on parts of New York, New Jersey, and Connecticut.¹ While the Twitter-verse frantically debated the constitutionality of such a move, New York Governor Andrew Cuomo equated it to “a declaration of war on the states.”² Just two weeks later, as state officials around the country began to consider waking the nation from the economic equivalent of the medically induced coma that it had been in for several weeks, the President claimed for himself the authority to determine when states should “reopen” their economies, asserting that, local leaders “can’t do anything without the approval of the president of the United States.... When somebody is the president of the United States, the authority is total. And that’s the way it’s got to be. It’s total.”³ Doubling down on this position, Vice President Mike Pence declared that “the authority of the president of the United States during national emergencies is unquestionably plenary.”⁴ Even the country’s most pro-executive-power legal scholars rejected these statements,⁵ with Governor Cuomo once again providing the most quotable response: “We don’t have a king in this country.”⁶

These presidential claims of power, as well as Attorney General William Barr’s pronouncement that the Justice Department would “monitor state and local policies ‘and, if necessary, take action to correct’” any that potentially infringed on Americans’ constitutional rights,⁷ ensured that the division of powers and responsibilities between the state and federal governments would be among the many topics of debate surrounding the United States’ response to the novel coronavirus. Perhaps unsurprisingly, the reality is more complicated than either statements by President Trump or Governor Cuomo suggest.

As a public health matter, the primary responsibility for pandemic response lies with the states. At the same time, multiple laws, policies, and the numerous pandemic-response plans that the federal government has developed make plain that a successful fight against an outbreak of the

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¹ See Victoria Bekiempis & Richard Luscombe, *Cuomo and Trump Clash Over Talk of New York ‘Quarantine,’* THE GUARDIAN (Mar. 28, 2020, 9:27 PM), <https://perma.cc/F53C-YUJW>.

² *Id.*

³ See Meagan Flynn & Allyson Chiu, *Trump Says His ‘Authority is Total.’ Constitutional Experts Have ‘No Idea’ Where He Got That.,* WASH. POST (Apr. 14, 2020, 6:36 AM), <https://perma.cc/VDV2-QYMB>.

⁴ *Id.*

⁵ See Charlie Savage, *Trump’s Claim of Total Authority in Crisis Is Rejected Across Ideological Lines,* N.Y. TIMES (Apr. 14, 2020), <https://perma.cc/D7JT-TV9T>.

⁶ *Id.*

⁷ See Lisa Lerer & Kenneth P. Vogel, *Trump Administration Signals Support for Allies’ Fight Against Virus Orders,* N.Y. TIMES (Apr. 29, 2020), <https://perma.cc/3PVF-DKAR>.

scale and severity of COVID-19 requires a national response, with significant responsibilities necessarily falling on the federal government.

And indeed, numerous authorities relevant to pandemic response—some specific to public health, others more general emergency tools—rest with federal officials. By many accounts, however, the federal government has not been too heavy-handed—as President Trump’s statements cited above may suggest—but rather the opposite. State leaders have consistently pleaded for more active federal leadership—more policy guidance, more material resources, more national coordination. It thus appears that President Trump has been quick to claim power rhetorically—sometimes powers beyond those that he actually possesses, but often reluctant to exercise it.

This paper will explore the ways in which existing law and policy envision distinct pandemic-response roles for the state and federal governments, and distinct powers to fulfill those roles. It will then turn to the United States’ coronavirus response and argue that the federal government failed to bring the full range of its powers to bear—and indeed, that it continues to do so—in ways that have undermined the states’ ability to mount an effective response.

I. THE STATE GOVERNMENTS

As Ed Richards’ contribution to this special issue shows, under our federal constitutional system, the states enjoy inherent police power to regulate in the service of the public health, safety, and welfare of their people.⁸ States thus retain a general authority to regulate that has no federal analogue. The many pandemic-response plans developed at the national level recognize that the primary responsibility for addressing domestic health emergencies rests with states and localities.⁹ The exact contours of state pandemic-response authorities, as well as whether primary responsibility for wielding them lies with statewide or local officials, vary by state.¹⁰ Nevertheless, each state possesses multiple tools to wield against infectious-disease outbreaks.

Even outside the emergency context, states regularly enforce mandatory screening and vaccination rules; conduct health inspections of places of business such as restaurants and nail salons; and engage in surveillance, tracing, treatment, and notification of individuals who have been exposed to infectious diseases such as tuberculosis or HIV.¹¹ The routine exercise of these authorities fails to attract the attention devoted to pandemics like COVID-19, but they illustrate the nature of responsibilities carried out by local public health services across the country.

⁸ Edward P. Richards, *A Historical Review of the State Police Powers and Their Relevance to the COVID-19 Pandemic of 2020*, *infra*.

⁹ See, e.g., HOMELAND SEC. COUNCIL, NAT’L STRATEGY FOR PANDEMIC INFLUENZA, 8-9 (2006), <https://perma.cc/2DCB-WY2C>.

¹⁰ See Benjamin Della Rocca et al., *State Emergency Authorities to Address COVID-19*, LAWFARE BLOG (May 4, 2020, 3:03 PM), <https://perma.cc/V58Z-ZELW>; Samantha Fry et al., *Quarantine and Isolation Authorities in States Affected by COVID-19*, LAWFARE BLOG (Mar. 6, 2020, 12:40 PM), <https://perma.cc/6FZ9-6DX7>.

¹¹ See Kristen Underhill, *Public Health Law Tools: A Brief Guide in LAW IN THE TIME OF COVID-19*, 64 (2020), <https://perma.cc/GE56-JWRC>.

As the COVID-19 experience has demonstrated, pandemic conditions prompt states to utilize these authorities in more intrusive ways, many of which we saw rolled out across the nation in the spring and early summer months of 2020—social distancing requirements, curfews, business closures, travel restrictions, limits on assembly, quarantines of people or places exposed to the disease, and isolation of infected individuals. All fifty states have declared COVID-19 a public health emergency, a step that can augment the powers of governors or local officials, often authorizing them to impose such measures by fiat. Should the medical community succeed in developing a vaccine for the virus, we can expect many states to require inoculation, as they do in the case of other infectious diseases such as measles. The Emergency Management Assistance Compact, which all states have implemented through legislation, also permits states to assist in emergency response efforts across state borders—for example by sending personnel or equipment to their neighbors.¹²

To be sure, the states’ powers are not absolute. Mandatory quarantines or isolation of individuals, for example, are generally permissible only if government officials have reason to believe that an individual actually has been exposed to an infectious disease, and the decision to quarantine or isolate is subject to procedural due process protections.¹³ At the same time, while the emergency public-health measures imposing constraints on individual liberties, such as the freedom of assembly, the right to travel, and the right to free exercise of religious practices have faced multiple legal challenges, the courts—including the Supreme Court¹⁴—have extended state officials significant leeway in determining what is required to address public-health risks.¹⁵ There is no doubt that state, local, and tribal authorities are entitled to take aggressive measures necessary to protect public health.

Thus, state governments are on the front lines in the fight against COVID-19, and it is with the states that the broadest public health authorities reside. That said, state resources alone are inadequate to meet public health emergencies of the magnitude of COVID-19, which endanger innumerable lives, transcend both state and national borders, and inevitably overwhelm resources available at the state and local level. The federal government therefore also has its own multi-faceted pandemic-response toolkit.

II. THE FEDERAL GOVERNMENT

¹² The Compact has been ratified by Congress and is law in “all 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands and the Northern Mariana Islands.” See Emergency Mgmt. Assistance Compact, Pub. L. No. 104-321, 110 Stat. 3877 (1996); see also EMERGENCY MGMT. ASSISTANCE COMPACT, THE ALL HAZARDS NAT’L MUT. AID SYS., <https://perma.cc/R8QE-3YMX>.

¹³ See Underhill, *supra* note 11, at 64-65

¹⁴ See John Kurzel, *Supreme Court Declines to Lift Pennsylvania COVID-19 Health Order*, THE HILL (May 6, 2020, 3:45 PM), <https://perma.cc/24AR-5ZH9>.

¹⁵ See *Jacobson v. Massachusetts*, 197 U.S. 11 (1905) (upholding mandatory smallpox inoculation law despite risks the vaccine posed to some individuals); *Friends of Danny DeVito v. Wolf*, 227 A.3d 872 (Pa. 2020) (rejecting constitutional challenges to Pennsylvania governor’s executive order compelling the closure of all non-life-sustaining businesses).

Various federal government entities, as well as at least one Blue Ribbon committee, have developed emergency-response plans designed to guide pandemic response should the need arise. Some, such as the Department of Health and Human Services' (HHS) Pandemic Influenza Plan, originally issued in 2005 and updated most recently in 2017; the Homeland Security Council's National Strategy for Pandemic Influenza and its Implementation Plan; the Defense Department's Global Campaign Plan for Pandemic Influenza; and the National Security Council's (NSC) infectious disease Playbook, are pandemic-specific.¹⁶ Others, like the National Blueprint for Biodefense, which is the product of a bipartisan commission made up of former lawmakers, executive-branch officials, and experts; the Department of Homeland Security's (DHS) National Response Framework; and HHS's National Health Security Strategy and Implementation Plan, cover a range of possible emergency scenarios that would include pandemics.¹⁷ Finally, there is a U.S. Government Pandemic Crisis Action Plan (PanCAP) adapted specifically to respond to COVID-19.¹⁸ As the foregoing lists demonstrates, there is no shortage of plans issued by different entities during different presidential administrations. How those plans fit together, if at all, is less clear.¹⁹

Yet there are some elements common to all of them. Without exception, each of these plans envisions an energetic role for the federal government in meeting challenges such as the one we currently face. To fulfill this role, the government can employ two different sets of tools. The first are coercive—authorities empowering the federal government to require or prohibit particular actions, such as barring individuals suspected of carrying infectious diseases from entering the country. Just as important, however, are federal agencies' numerous non-coercive tools—powers that enable federal actions to support preparedness and response efforts, such as coordinating among government entities, vaccine and treatment research, public education efforts, and management of resources.

A. *The Federal Government's Role*

The federal government's part in pandemic response begins long before a novel virus like COVID-19 emerges. In the wake of lessons learned through the experiences of 9/11 and the

¹⁶ See CTRS. FOR DISEASE CONTROL AND PREVENTION, NATIONAL PANDEMIC INFLUENZA PLANS, <https://perma.cc/Y7HE-X555>; HOMELAND SEC. COUNCIL, *supra* note 9; DEP'T OF DEF., GLOBAL CAMPAIGN PLAN FOR PANDEMIC INFLUENZA AND INFECTIOUS DISEASE, 3551-13 (Oct. 15, 2013); EXEC. OFFICE OF THE PRESIDENT OF THE U.S., PLAYBOOK FOR RESPONSE TO HIGH-CONSEQUENCE EMERGING INFECTIOUS DISEASE THREATS & BIOLOGICAL INCIDENTS, <https://perma.cc/7S4G-4CR2>.

¹⁷ Blue Ribbon Study Panel on Biodefense, *A National Blueprint for Biodefense: Leadership and Major Reform Needed to Optimize Efforts—Report of the Bipartisan Commission on Biodefense*, HUDSON INSTITUTE (Oct. 28, 2015), <https://perma.cc/68LC-8QXV>; DEP'T OF HOMELAND SEC., NAT'L RESPONSE FRAMEWORK (4th ed. 2019), <https://perma.cc/8N9T-5FR5>; DEP'T OF HEALTH & HUMAN SERVS., NAT'L HEALTH SEC. STRATEGY 2019-2022, <https://perma.cc/QR25-38UN>.

¹⁸ DEP'T OF HEALTH & HUMAN SERVS., U.S. GOV'T COVID - 19 RESPONSE PLAN (Mar. 13, 2020), <https://perma.cc/67BH-WVZD>.

¹⁹ See Judge Glock, *When Crisis Planning Doesn't Work*, CITY J. (Apr. 27, 2020), <https://perma.cc/CZK6-HFRH> (arguing that having so many plans “ensures that there is not clear plan—and no accountability”).

subsequent anthrax attacks, as well as later disasters such as Hurricane Katrina, the 2005 H5N1 flu outbreak, and the Ebola outbreak of 2014, the federal government undertook to enhance the United States' emergency preparedness—including pandemic preparedness—at the global, federal, and local level. Globally, the United States joined with other nations, international organizations, and private-sector actors around the world to create the Global Health Security Agenda in 2014, with the goal of improving international capacity for identifying quickly and fighting emerging infectious diseases, so as to stop them before they spread to the United States.²⁰ In this international context, the federal government is the relevant actor, and the Centers for Disease Control and Prevention (CDC) has been a leading participant in the initiative, partnering with numerous nations to help improve their infectious disease detection, prevention, and response capacity.

Recognizing that global efforts will not always be successful in preventing public-health threats from reaching American shores, the federal government has also invested in domestic preparedness planning. These plans envision two distinct roles for the federal government. One role is to help build the capacity of local public-health authorities—the actors with primary responsibility for responding to infectious diseases—to detect and respond to outbreaks. Many state, local, tribal, and territorial governments have worked with the CDC to develop and exercise their own pandemic preparedness plans.²¹

At the same time, the states cannot do it all.²² So in addition to helping to put local public health departments on more solid footing, preparedness efforts at the federal level have also included stockpiling supplies such as vaccines, antiviral drugs, and other medical equipment; engaging in and funding medical research for vaccines and antivirals, testing and diagnostic development, and innovations in respirator and ventilator design; honing public-education strategies; developing surveillance networks; and generating forecasting and modeling tools to help public-health experts estimate how a pandemic virus will spread and what its impact will be.²³

Preparedness efforts, however, can only go so far. When it comes to actually responding to outbreaks of infectious disease, there are again distinct roles for different levels of government. As noted above, state and local public-health departments and other first responders will pull the laboring oar. Federal pandemic policy is meant to ensure that, when a widespread public-health emergency with the scope and severity of Covid-19 overwhelms states' response capacity, the

²⁰ GLOBAL HEALTH SEC. AGENDA, <https://perma.cc/QCN6-TU6R>.

²¹ See CTRS. FOR DISEASE CONTROL AND PREVENTION, PUBLIC HEALTH EMERGENCY PREPAREDNESS (PHEP) COOPERATIVE AGREEMENT, <https://perma.cc/6UWS-PKUW> (“Preparedness activities funded by the PHEP cooperative agreement specifically targeted the development of emergency-ready public health departments that are flexible and adaptable.”).

²² *E.g.*, DEP'T OF HEALTH & HUMAN SERVS., TERRORISM AND OTHER PUBLIC HEALTH EMERGENCIES: A REFERENCE GUIDE FOR MEDIA 6 (Sept. 2005), <https://perma.cc/Q9LV-CNVR>; DEP'T OF HEALTH & HUMAN SERVS., HHS PANDEMIC INFLUENZA PLAN 6 (Nov. 2005), <https://perma.cc/6A3Z-9QVL> (“Preparedness will require coordination among federal, state, and local government and partners in the private sector.”).

²³ See *e.g.*, NATIONAL STRATEGY FOR PANDEMIC INFLUENZA, *supra* note 16; DEP'T OF HEALTH & HUMAN SERVS., PANDEMIC INFLUENZA PLAN, 2017 UPDATE, <https://perma.cc/D8AD-2CAT>.

federal government will be able to deploy the expertise and resources it has stored as part of its preparedness efforts to bolster the local response.

One crucial responsibility that pandemic policies assign to the federal government is coordination. As the NSC Playbook recognizes, “[w]hile States hold significant power and responsibility related to public health response,” when a deadly pandemic hits, “the American public will look to the U.S. Government for action.”²⁴ The goal is to employ the full spectrum of federal medical and public-health capabilities to support state and local authorities.²⁵ This requires orchestrating a unified national response that includes multiple federal agencies as well as state and local health departments, the private sector, and academia.²⁶ HHS is the designated leader for federal responses—though in the Covid-19 context that leadership role was transferred to the Vice President on February 28²⁷—headed up by a presidentially appointed Assistant Secretary for Preparedness and Response (ASPR). The ASPR is statutorily assigned the responsibility to coordinate across federal agencies as well as with state, local, and tribal health and emergency management systems to ensure effective integration of government efforts.²⁸ This structure designates HHS and the CDC as leaders of the public-health response and DHS, including the Federal Emergency Management Agency (FEMA), as the coordinators of other forms of federal support, with an eye toward providing “the right resources to the right places at the right time.”²⁹

In addition to its coordinating function, the federal government’s role during an outbreak includes substantive responsibilities, such as engaging in epidemiologic studies to inform pandemic response efforts; developing necessary medical tools, such as vaccines, therapeutics, and diagnostics; determining the need for development or procurement of medical countermeasures; maintaining supply chains and stockpiling supplies; and monitoring demand for and distribution of those supplies by engaging with private sector partners and local governments.³⁰ Supply chain management includes not only directing critical resources to where they are most needed, but also employing tools available uniquely to the federal government such as the Strategic National Stockpile and authorities under the Defense Production Act—both discussed in more detail

²⁴ PLAYBOOK FOR EARLY RESPONSE TO HIGH-CONSEQUENCE EMERGING INFECTIOUS DISEASE THREATS AND BIOLOGICAL INCIDENTS, *supra* note 16, at 31.

²⁵ U.S. GOVERNMENT COVID-19 RESPONSE PLAN., *supra* note 18, at 5 (stating that “pandemic response[s] require short-notice federal asset coordination and a national response that is scalable to the severity of the incident and the needs of the affected jurisdictions,” for example, state and local critical infrastructure and government).

²⁶ NATIONAL HEALTH SECURITY STRATEGY 2019–22, *supra* note 17, at 1–2; PANDEMIC INFLUENZA PLAN: 2017 UPDATE, *supra* note 23, at 36 (“The NRF [National Response Framework] also allows for the coordination of multiple federal agencies and emergency support functions involved in a response in support of state and local efforts in a consistent, national approach integrating all critical stakeholders, including public and private partners.”); *id.* at 40 (“HHS’s success in responding to and containing a potential pandemic relies on collaborations across federal departments and agencies but the role of nonfederal partners is critical.”).

²⁷ U.S. GOVERNMENT COVID-19 RESPONSE PLAN., *supra* note 18.

²⁸ Pandemic and All Hazards Preparedness Act of 2006, Pub. L. No. 109-417, § 2811, 120 Stat 2831 (2006).

²⁹ DEP’T OF HOMELAND SEC., CORONAVIRUS (COVID-19), COORDINATING THE FEDERAL RESPONSE (July 22, 2020), <https://perma.cc/7SPY-HSWN>.

³⁰ PANDEMIC INFLUENZA PLAN: 2017 UPDATE, *supra* note 22; PLAYBOOK FOR EARLY RESPONSE TO HIGH-CONSEQUENCE EMERGING INFECTIOUS DISEASE THREATS, *supra* note 16.

below—to prepare for and respond to shortages of critical medical supplies, such as medications, ventilators, and personal protective equipment (PPE).³¹

The federal government’s job during major pandemic outbreaks is therefore twofold. First, it must coordinate a national response that draws on and synthesizes the capabilities and expertise of numerous federal agencies into a coherent whole. Second, it must undertake both to develop or procure and to distribute the relevant information, treatments, or other necessary supplies to the front-line responders at the state and local level.

B. The Federal Government’s Powers

Some federal authorities confer coercive pandemic-response powers on the federal government, such as authority to impose international or interstate travel restrictions, to quarantine or isolate individuals seeking to enter the country, or to require private industry to prioritize government contracts. Others are more akin to soft-power tools, enabling coordination of efforts within the federal government, between the federal government and the states, and among governmental and non-governmental actors. What follows identifies both the coercive and non-coercive authorities that the federal government may bring to bear against pandemic disease. It also briefly assesses the lawfulness of some of the most sweeping claims of power made by President Trump and Attorney General Barr during the current crisis.

1. Federal Powers Available for Pandemic Response

Beginning with its coercive powers, the federal government has a great deal of authority to regulate people and things crossing borders, whether they are U.S. borders or state borders. One important source of federal power in this area is the Public Health Service Act (PHSA), enacted in 1944 pursuant to Congress’s Commerce Clause powers.³² The Act authorizes the HHS Secretary to take measures to prevent the entry and spread of communicable diseases from foreign countries into the United States and between states. Such measures can extend to the inspection and destruction of animals or cargo as well as to restriction the liberty of individuals who carry certain communicable diseases—a category that includes viruses that have the potential to cause a pandemic.³³ In addition, the President retains broad powers to regulate entry of non-citizens under the Immigration and Nationality Act.³⁴ President Trump availed himself of this authority to temporarily bar travelers from regions hard-hit by Covid-19 in the early days of the outbreak—such as China, Iran, Brazil, and parts of Europe—from entry into the United States.³⁵

³¹ U.S. GOVERNMENT COVID-19 RESPONSE PLAN, *supra* note 18, at 14.

³² Public Health Serv. Act, Pub. L. No. 78–410, 58 Stat. 682 (1944).

³³ 42 U.S.C. § 264.

³⁴ *See* 8 U.S.C. § 1182(f).

³⁵ *Travelers Prohibited from Entry to the United States*, CTRS. FOR DISEASE CONTROL AND PREVENTION (June 15, 2020), <https://perma.cc/JN6P-AMCZ>.

Despite its broad language, it is not entirely clear whether the PHSA confers on the President the power to declare a quarantine³⁶ for entire states or regions.³⁷ As an initial matter, the statute itself specifies that in order to apprehend and examine an individual, the government must (1) “reasonably believe[]” that the individual is infected, (2) that s/he is in a “qualifying stage”³⁸ of a communicable disease and (3) is “moving or about to move from” one state to another or is “a probable source of infection” to someone who will be doing so.³⁹ Only if such an individual is “found to be infected” may that person be detained “for such time and in such manner as may be reasonably necessary.”⁴⁰ The statutory language therefore seems to give the federal government the power to examine an individual upon a reasonable belief of infection, defined as “specific articulable facts upon which a public health officer could reasonably draw the inference” that the individual “may be harboring” a “quarantinable communicable disease” due to, for example, “contact with an infected person . . . , a contaminated environment,⁴¹ or through an intermediate host or vector.”⁴² Such a reasonable belief “will generally be based on . . . clinical and epidemiologic factors” specific to the disease at issue.⁴³ The statute then sets a higher bar for restrictions on liberty—only those individuals actually found to be infected can be detained.⁴⁴

The regulations promulgated under the statute apply the “reasonable belief” standard not only to decisions to apprehend or examine individuals, but also to orders to quarantine, isolate, or conditionally release.⁴⁵ This provision raises the question whether such orders constitute a “detention”—a term the statute does not define—or whether those measures are restrictions on liberty that fall short of detention. If the quarantine contemplated is a form of detention, then imposing quarantine orders on anyone in the absence of actual infection would exceed the executive’s statutory authority. This almost certainly eliminates the possibility of a lawful region or state-wide quarantine order.

If, however, a quarantine order is a deprivation of liberty that falls short of detention, then the statute is silent on the subject and two further questions arise. The first is whether it is a reasonable interpretation of the PHSA under the *Chevron* doctrine to conclude that the statute permits the

³⁶ One regulatory definition of quarantine is “the separation or restriction of movement of an individual or group reasonably believed to have been exposed to a quarantinable communicable disease, but who are not yet ill, from others who have not been so exposed.” 42 C.F.R. § 70.1; *see also* 82 Fed. Reg. 6890, 6905 (2017). Whether this is the sense in which the President used the term is not clear. *See supra* text at note 1.

³⁷ *But see* Miriam Jamshidi, *The Federal Government Probably Can’t Order Statewide Quarantines*, U. OF CHI. L. REV. ONLINE (Apr. 20, 2020) (so arguing), <https://perma.cc/Y7XS-9QMY>.

³⁸ 42 U.S.C. §264(d)(1). An individual is in a “qualifying stage” when he or she is in the communicable or precommunicable stage of a disease. 42 C.F.R. § 70.1.

³⁹ 42 U.S.C. § 264(d)(1).

⁴⁰ *Id.*

⁴¹ “Contaminated environment means the presence of an infectious agent on a surface, including on inanimate articles, or in a substance, including food, water, or in the air.” 42 C.F.R. § 70.1.

⁴² *Id.*

⁴³ 82 Fed. Reg. 6890, 6906 (2017).

⁴⁴ 42 U.S.C. § 264(d)(1).

⁴⁵ 42 C.F.R. § 70.6(a).

imposition of quarantines based on reasonable belief of infection.⁴⁶ On the one hand, the statute seems to contemplate a great deal of discretion to take necessary public health measures, and quarantine is a well-established tool of public health policy. So perhaps it is not unreasonable to conclude that Congress intended to leave the choice of means for preventing the spread of infectious disease short of detention to the public health experts in the executive branch. On the other hand, as some scholars have argued, the statute clearly differentiates between non-intrusive diagnostic measures—apprehension and examination—and a more coercive infringement on liberty—detention,⁴⁷ and as quarantine is unequivocally an infringement of liberty, perhaps it is unreasonable to apply the same standard to quarantines as to apprehension and examination. Suffice it to say here that there are plausible arguments on both sides of this question.

The second question raised by the regulation is whether an order to quarantine justified by a reasonable belief of infection would exceed constitutional limits imposed by either the Fourth Amendment’s prohibition on unreasonable seizures or the Due Process Clause’s substantive or procedural limits on non-punitive deprivations of liberty. The answer in the Fourth Amendment context may turn on the particular requirements of the quarantine. Under the Fourth Amendment, both the border-search doctrine⁴⁸ and the special-needs doctrine⁴⁹ permit at least some involuntary detention of individuals based on a “reasonable suspicion” standard. Any Fifth Amendment procedural concerns are likely satisfied by the regulations themselves, which require federal quarantine orders to be in writing, include the identity of the individual or group subject to it, the location of the quarantine, a statement of the factual basis underlying the reasonable belief that the individual is in a qualifying stage of a communicable disease, and that he or she poses an interstate risk.⁵⁰ In addition, the order must be reassessed after 72 hours, at which time the subject of the order may present witnesses and testimony, request a medical review, and be represented by a personal advocate.⁵¹ When it comes to the Fifth Amendment’s substantive due process protections, it is well established that non-punitive deprivations of liberty must be justified as a necessary means of averting a danger to the individual or the community.⁵²

Efforts to prevent the spread of communicable diseases such as COVID-19 certainly present a circumstance requiring investigation that would qualify as a special need under the Fourth Amendment and that pose a danger to the community that might satisfy the Fifth Amendment. At the same time, the Supreme Court has indicated that at some point under the Fourth Amendment,

⁴⁶ *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837 (1984) (holding that courts will defer to an agency’s interpretation of an ambiguous statute so long as that interpretation is “reasonable”).

⁴⁷ See Michael R. Ulrich & Wendy K. Mariner, *Quarantine and the Federal Role in Epidemics*, 71 S.M.U. L. REV. 391, 400-02 (2018).

⁴⁸ See *United States v. Montoya de Hernandez*, 473 U.S. 531 (1985).

⁴⁹ See *Michigan Dep’t of State Police v. Sitz*, 496 U.S. 444 (1990) (upholding a drunk driving checkpoint and indicating that a showing of individualized suspicion would be necessary to subject motorists to something beyond being stopped for preliminary testing and observation); *Skinner v. Railway Labor Executives’ Ass’n*, 489 U.S. 602 (1989).

⁵⁰ 42 C.F.R. § 70.14(a).

⁵¹ *Id.*

⁵² See, e.g., *Youngberg v. Romeo*, 457 U.S. 307, 319 (1982); *Kansas v. Hendricks*, 521 U.S. 346 (1997); Ulrich & Mariner, *supra* note 46, at 405-09.

detentions at the border or under the special-needs doctrine may become so intrusive—such as strip searches or involuntary x-rays—that the government might need to meet a standard higher than reasonable suspicion. Similarly, in the Fifth Amendment context, there is a question of what measures are “necessary” to address the very real threat the coronavirus poses.

What does all of this tell us about the President’s ability to impose a “quarantine” on, for example, New York City or the tri-state area more broadly? It might depend on what he means by quarantine and what type of information public-health officials use to decide who is eligible for such measures. As for the quarantine itself, screening travelers for symptoms of COVID-19 before they leave or enter the region looks very different from simply barring all travel into or out of the region, which in turn looks very different from requiring all residents of the region to confine themselves to their homes. Somewhere along this spectrum the measure might become sufficiently intrusive to require something more than a reasonable belief under the Fourth Amendment or be deemed more restrictive than necessary under the Fifth Amendment. Similarly, the level of individualization employed in determining whether the “reasonable belief” standard is met could also vary. The government suggests that under certain circumstances, one public health order could apply to every individual on an “affected interstate or international flight.”⁵³ Could that type of mass authority extend to entire geographic regions consistent with the Fourth Amendment’s individualized suspicion standard? If exposure to the pathogen alone is sufficient to satisfy the reasonable belief standard in the regulation, the question becomes one of determining when an entire state or region’s population can be considered exposed. At the same time, HHS and the CDC have indicated that determinations of which individuals pose a public health risk include consideration of such factors as “clinical manifestations; signs and symptoms consistent with those of a quarantinable disease; known or suspected contact with cases;” and “epidemiologic information/evidence (travel history or exposure to animals).”⁵⁴ While this more particularized inquiry is more clearly consistent with both the regulatory language and constitutional requirements, it is hard to imagine a scenario in which government officials have this type of granular information for every individual in a particular state or region. In short, the PHSA does extend to the federal government broad authority to impede the international or interstate spread of contagious disease. What exactly is definitively encompassed within that authority in the abstract is a difficult question to answer on the regulatory, statutory, and constitutional level.

One additional regulation promulgated under the PHSA bears mentioning. Entitled “Measure in Event of Inadequate Local Control,” it empowers the CDC Director “to take such measures to prevent” the spread of a communicable disease as he finds reasonably necessary for public health if he determines that the measures taken by local health authorities are inadequate to prevent the disease’s spread.⁵⁵ This provision seems to grant significant discretion to the CDC to second-guess all manner of state and local disease-control measures and to upend the traditional relationship between state and federal actors in this sphere. Commerce Clause jurisprudence, the Tenth

⁵³ See 82 Fed. Reg. 6890, 6912-13 (2017).

⁵⁴ See *Id.* at 6907.

⁵⁵ 42 C.F.R. § 70.2.

Amendment, and the text of the Public Health Service Act all suggest that this seemingly sweeping authority would necessarily be limited to interstate measures, but like the power to impose broad federal quarantines, it has not been invoked to date, so its scope, too, is unclear.

Congress has conferred another set of authorities on the executive through the Defense Production Act (DPA), which gives the President the power to mobilize domestic industry to “to expedite and expand the supply of resources from the U.S. industrial base” to support emergency preparedness.⁵⁶ As Jamie Baker’s article elsewhere in this anthology explains, there are three categories of DPA authorities most relevant to pandemic response. First, the President may require private industry to prioritize and accept government contracts and direct the allocation and distribution of materials.⁵⁷ Second, the President can provide economic incentives, through loans, purchases, or other means, to “create, maintain, protect, expand, or restore domestic industrial base capabilities.”⁵⁸ And third, the President can establish agreements with private industry as well as identify a voluntary pool of industry executives to enlist in promoting the national defense, the statutory definition of which includes threats from infectious disease.⁵⁹ In other words, the DPA allows the government to harness the resources of the private sector so as to maximize its capacity through allowing for federal coordination, financial incentives, and encouraging cooperation within usually competitive markets.⁶⁰

In addition to the powers already mentioned, a number of federal emergency response provisions enable the federal government to better support and supplement states’ front-line efforts. Many of these authorities stem from one or more emergency framework statutes—statutes that make available to the executive branch certain authorities during declared emergencies or natural disasters. The Public Health Emergencies Act, for example, unlocks specific federal powers when the HHS Secretary determines that a significant outbreak of infectious disease exists.⁶¹ Presidential declarations of national states of emergency made pursuant to the National Emergencies Act⁶² or the Robert T. Stafford Disaster Relief and Emergency Assistance Act (the Stafford Act),⁶³ whose purpose is to assist state and local efforts in “the rendering of aid, assistance, and emergency services,” also trigger powers relevant to the COVID-19 response.⁶⁴ Both the President and the HHS Secretary have issued relevant emergency declarations regarding the COVID-19 outbreak.

One authority triggered by a declared public health emergency is the power to suspend or waive certain regulatory requirements. Two types of waivers have been particularly relevant in the fight

⁵⁶ 42 U.S.C. § 5195(a)(3); Defense Production Act Authorities, FED. EMERGENCY MGMT. AGENCY (Aug. 13, 2018 1:43 PM), <https://perma.cc/M9MH-5L7P>.

⁵⁷ Defense Production Act of 1950, 50 U.S.C. §§ 4511-18; CONG. RSCH SERV., R43767, THE DEFENSE PRODUCTION ACT OF 1950, 5-9 (2020).

⁵⁸ 50 U.S.C. §§ 4531-34; CONG. RSCH SERV., *supra* note 57, at 9-14.

⁵⁹ 50 U.S.C. §§ 4551-68; CONG. RSCH SERV., *supra* note 57, at 14-16.

⁶⁰ Jane Chong, *How to Actually Use the Defense Production Act*, THE ATLANTIC (Apr. 6, 2020), <https://perma.cc/C4MP-2BX7>; *see also* James E. Baker, *From Shortages to Stockpiles*, elsewhere in this anthology.

⁶¹ 42 U.S.C. § 247d.

⁶² 50 U.S.C. §§ 1601-1651.

⁶³ 42 U.S.C. §§ 5121-5207.

⁶⁴ 42 U.S.C. § 5121(a), (b).

against COVID-19. First, public health emergencies empower HHS to modify provision of public insurance programs, such as Medicare, Medicaid, and the Child’s Health Insurance Program, as well as HIPPA—often referred to as Section 1135 waivers.⁶⁵ Waivers of this type issued in response to COVID-19 have enabled expanded access to telehealth services, permitted health care workers to provide services in states outside ones in which they are licensed, expanded hospital capacity, and reduced administrative burdens on health care workers, hospitals, and insurance providers.⁶⁶ Second, public health emergencies allow the Food and Drug Administration to relax regulations normally applicable to medications and medical devices, allowing emergency use of products that have not been approved according to normal regulatory rules.⁶⁷ COVID-19-era Emergency Use Authorizations (EUAs) have been issued to permit the use of new diagnostic tests and testing equipment, additional forms of personal protective equipment, such as re-sterilized used N95 respirator masks, innovative means of converting devices into ventilators, and novel therapeutics, such as remdesivir.⁶⁸ HHS Secretary Azar has also invoked the Public Readiness and Emergency Preparedness Act, which provides immunity from liability for losses that might result from certain efforts to fight COVID-19.⁶⁹

In addition to these waivers of usually applicable laws and regulations, a declared public health emergency makes additional federal resources available. One such resource is the Public Health Emergency Fund, the purposes of which include efforts to “facilitate coordination between and among” all levels of government as well as public and private health care entities, and to “facilitate and accelerate” the development of diagnostics, mitigation measures, and treatments.⁷⁰ Another such resource is the Strategic National Stockpile (SNS). Established in 2002 pursuant to the Federal Public Health Security and Bioterrorism Preparedness and Response Act,⁷¹ the SNS is under the remit of the HHS Assistant Secretary for Preparedness and Response and holds a multi-billion-dollar inventory of medical supplies, such as drugs, vaccines, medical devices, personal protective equipment, supplies required for the administration of drugs, vaccines and other biological products, medical devices, and diagnostic tests.⁷² Recognizing that “[e]mergencies can overwhelm state and local medical resources even with the best preparation,”⁷³ the SNS is designed to be used “in a public health emergency severe enough to cause local supplies to run

⁶⁵ See 42 U.S.C.A. § 1320b-5.

⁶⁶ For a list of Covid-19-related waivers, visit *Coronavirus Waivers & Flexibilities*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://perma.cc/6483-AWLB>.

⁶⁷ 21 U.S.C. § 360bbb-3.

⁶⁸ For a list of Covid-19-related EUAs, visit *Emergency Use Authorizations for Medical Devices*, FOOD & DRUG ADMIN., <https://perma.cc/BQ2L-AKLE>.

⁶⁹ 42 U.S.C. 247d-6d.

⁷⁰ 42 U.S.C. § 247d(b)(1).

⁷¹ Pub. L. No. 107-188, § 121.

⁷² 42 U.S.C. § 247d-6b(a).

⁷³ Greg Burel et al., *The Evolution of the Strategic National Stockpile*, ASPR BLOG, DEP’T OF HEALTH & HUMAN SERVS. (Aug. 21, 2019, 10:02 AM), <https://perma.cc/7AUD-Y8R6>.

out,” ensuring that when “state, local, tribal, and territorial responders request federal assistance to support their response efforts,” the necessary supplies “get to those who need them most.”⁷⁴

The Stafford Act also makes federal assistance available when there is a disaster “of such severity and magnitude” that it exceeds the capabilities of local government to respond effectively.⁷⁵ A presidential emergency declaration pursuant to the Stafford Act triggers financial and physical assistance through FEMA, which can draw on the Disaster Relief Fund appropriated by Congress. FEMA embedded a team within HHS as part of its coronavirus response in order to coordinate with and avoid duplication of HHS’s efforts.⁷⁶ When either HHS has issued a public health emergency declaration or the President has declared an emergency under the Stafford Act, the Department of Defense may serve as a supporting agency to provide health services in conjunction with HHS or with state or local governments.⁷⁷

Existing statutes and regulations confer the foregoing powers on the executive branch of the federal government. Should a perceived need to augment these powers arise, Congress could do so. Congress has already exercised its legislative authority to mitigate the financial impact of the pandemic several times.⁷⁸ But it could also use its constitutionally enumerated powers to confer additional authorities on the executive—or impose additional requirements on the states—by employing either its commerce or spending powers. Indeed, President Trump has suggested that Congress should condition financial assistance for states on those states’ willingness to enforce federal immigration policies.⁷⁹ While this particular use of the spending power might run afoul of doctrine laid down in *South Dakota v. Dole*⁸⁰ and *NFIB v. Sebelius*,⁸¹ particularly the requirement that there be a nexus between the spending condition and the federal program the funding supports, Congress certainly could decide to impose conditions on how COVID-19-related assistance is used to address the current emergency.

So the federal government currently has a menu of options available to it in crafting a response to a pandemic. Some of them bring the federal government’s coercive powers to bear, while others provide opportunities for federal agencies to coordinate, support, and supplement state and local efforts. Where do President Trump’s claimed authorities fit, if at all, within this regime?

⁷⁴ See Quint Forgey, *Strategic National Stockpile Description Altered Online After Kushner’s Remarks*, POLITICO (Apr. 3, 2020, 02:48 PM), <https://perma.cc/V5LB-GK4X> (quoting original description on HHS website and noting changes to that definition).

⁷⁵ 42 U.S.C. § 5170.

⁷⁶ DEP’T OF HEALTH & HUMAN SERVS., *supra* note 17, at 8.

⁷⁷ See U.S. GOV’T ACCOUNTABILITY OFF., GAO-18-47, DEFENSE CIVIL SUPPORT: DOD NEEDS TO ADDRESS CYBER INCIDENT TRAINING REQUIREMENTS (2017).

⁷⁸ See Kelsey Snell, *Here’s How Much Congress Has Approved for Coronavirus Relief so Far and What It’s For*, NPR (May 15, 2020, 01:53 PM), <https://perma.cc/CNZ2-84LB>.

⁷⁹ See Justin Wise, *Trump Suggests Coronavirus Funding for State Could be Tied to Sanctuary City Policies*, THE HILL (Apr. 28, 2020, 08:34 PM), <https://perma.cc/QMQ5-8WKW>.

⁸⁰ 483 U.S. 203 (1987).

⁸¹ 567 U.S. 519 (2012).

2. Assessing the Trump Administration’s Assertions of Federal Power

While the authorities that are available to the federal government during public health emergencies are not insignificant—and, as discussed previously, the question whether they include the power to impose state-wide or regional quarantines is a difficult one—nothing confers on the President the authority to dictate to the states what their individual responses will look like. While the President has a great deal of leeway both at the nation’s borders and in the context of interstate activity, none of those powers reaches purely intra-state public health decisions made pursuant to a state’s police power. Thus, contrary to President Trump’s assertion, he cannot dictate to a state when it will exercise its police powers to limit commercial activity—or when it will lift such limits. The Commerce Clause does provide the basis for a creative—though ultimately unconvincing—argument supporting President Trump’s assertion of “total authority” over the states’ COVID-19 response. The argument goes like this: the economic impact of a state official’s order imposing mandatory closure of all non-essential commercial activity in the state has such significant effects on the interstate economy that it renders that order a violation of the so-called “dormant commerce clause”—the idea that some state commercial regulations improperly infringe on the federal government’s power to regulate interstate commerce, even when there is no explicit conflict between state and federal law.⁸² This may be the theory that Attorney General Barr had in mind when he told conservative pundit Hugh Hewitt that governors cannot impinge on the “national commerce.”⁸³

While Barr’s assertion is no doubt true as a general matter, the dormant commerce clause is offended only when state regulations either discriminate against other states or impose a burden on interstate commerce clearly excessive in relation to the purpose of the rule.⁸⁴ None of the states’ COVID-19-related orders treats out-of-state businesses differently from local businesses, so there is no discrimination concern. And when faced with the question whether a state measure impermissibly burdens interstate commerce, courts engage in a balancing test—asking whether the state’s interest in the regulation outweighs the regulation’s impact on commerce. To be sure, mandatory business closures and stay-at-home orders have had an enormous, negative impact on the interstate economy. At the same time, the state interest in public health is at least as compelling. As time goes by, this balance could change, but while the need to “flatten the curve” in order to prevent exponential growth of cases and deaths and to ensure that health care facilities are not overwhelmed, the balance favors the state orders.⁸⁵

Attorney General Barr also invoked a much more plausible means the federal government has of influencing state anti-COVID-19 measures—the authority to investigate and potentially challenge in court state rules that “could be violating the constitutional rights and civil liberties of

⁸² See *Pike v. Bruce Church, Inc.*, 397 U.S. 137, 142 (1970).

⁸³ See Chris Strohm, *Barr Threatens Legal Action Against Governors Over Lockdowns*, BLOOMBERG, (Apr. 21, 2020, 12:24 PM), <https://perma.cc/Q8XG-LCGL>.

⁸⁴ See *Pike*, 397 U.S. at 142.

⁸⁵ See, e.g., Bobby Chesney, *Can the Federal Government Override State Government Rules on Social Distancing to Promote the Economy?*, LAWFARE BLOG (Mar. 24, 2020, 5:16 PM), <https://perma.cc/Z6BG-8SSH>.

individual citizens.”⁸⁶ If state or local public-health measures impose unconstitutional limitations on rights such as freedom of assembly or religious exercise, the Justice Department can bring enforcement actions in federal court to challenge those measures, or intervene on behalf of other litigants who do so. DOJ took the latter route in a case in Mississippi in which congregants were each fined \$500 for attending religious services in their cars in a parking lot, while drive-in restaurants were permitted to continue operating, arguing that this unconstitutionally singled out religious exercise for restriction.⁸⁷ Rules with indications of discriminatory intent will be vulnerable to such challenges. As noted above, however, courts are likely to be deferential to reasonable public health measures undertaken by the states, even if they have an incidental impact on certain constitutional liberties.

Even if the federal government succeeds in limiting a state’s ability to impose lockdown orders, however, there is no federal power—or state power, for that matter—available to force businesses to open or to force customers back to stores, movie theaters, or restaurants. To be sure, the President retains the “bully pulpit,” and we have seen that his pronouncements both generate pressure for state officials from his own party to fall in line and prompt a significant slice of the American public to adopt his position. And individuals have followed the President’s lead in insisting on reopening businesses even in the face of mandatory requirements to the contrary.⁸⁸ At the same time, non-mandatory guidelines or recommendations issued by state or local leaders also will significantly influence decisions of businesses and customers alike with respect to whether to maintain lockdowns or social distancing even in the absence of mandatory requirements. Polls suggest that most of the American people have significantly more confidence in local leaders’ views on this matter than they do in those of federal political figures.⁸⁹ Thus, state-level pronouncements might actually have a larger impact—at least with some Americans—than those of the President.

III. THE GOVERNMENT’S FEDERAL COVID-19 RESPONSE

The federal government enjoys an array of pandemic-response tools that it can bring to bear. While President Trump likes to say that nobody could have seen the novel coronavirus coming, many government planning documents, as well as warnings from experts both inside and outside of government agencies, belie the accuracy of that assertion.⁹⁰ In 2019, the current HHS Secretary Alex Azar told a group of bio-threat experts that, when asked what kept him up most at night, the

⁸⁶ Matt Zapotsky, *Barr Tells Prosecutors to “Be on the Lookout” for State, Local Coronavirus Orders that May Violate Constitution*, WASH. POST (Apr. 27, 2020, 5:00 PM), <https://perma.cc/T69F-U2Q7>.

⁸⁷ Igor Derysh, *William Bar Intervenes After Mississippi Mayor Restricts Easter Church Service Due to Coronavirus*, SALON (Apr. 15, 2020, 3:57 PM), <https://perma.cc/ZK6C-7ACW>.

⁸⁸ See, e.g., Manny Fernandez & David Montgomery, *Businesses Chafing Under Covid-19 Lockdowns Turn to Armed Defiance*, N.Y. TIMES (May 13, 2020), <https://perma.cc/Q2AH-7QNK>.

⁸⁹ See Dhrumil Mehta, *Most Americans Like How Their Governor is Handling the Coronavirus*, FIFTYTHREE (Apr. 10, 2020, 5:58 AM), <https://perma.cc/66Y5-JTTP>.

⁹⁰ See, e.g., Aaron Blake, *Trump Keeps Saying Nobody Could Have Foreseen Coronavirus. We Keep Finding Out About New Warning Signs*, WASH. POST (Mar. 19, 2020), <https://perma.cc/7CND-L7PS>.

answer was, “Pandemic flu, of course,” adding that “everyone in this room probably shares that concern.”⁹¹ In addition, the Office of the Director of National Intelligence’s *2019 World Threat Assessment* identified a “large scale outbreak of a contagious disease” with high “rates of death and disability,” and a severe resulting effect “on the world economy,” as a persistent threat to the United States.⁹² Obama Administration officials viewed a severe pandemic as so likely that, when handing off the government to the incoming Trump Administration, they convened a pandemic simulation for the incoming officials, led by President Obama’s Homeland Security and Counterterrorism Advisor.⁹³ So while the timing was uncertain, the arrival of a COVID-19-like pandemic has long been viewed as nearly inescapable. Why, then, has the United States fared so poorly when compared to other countries, such as Germany, South Korea, Taiwan, and New Zealand, whose rates of contagion and death per capita are dwarfed by those of the United States?

There is, of course, no one answer to this question, but the federal government’s lackluster efforts to fulfill the pandemic-response role envisioned for it have certainly contributed. Some shortcomings stem from decisions to downgrade—at least as a budgeting matter—pandemic preparedness made long before reports about a novel coronavirus began emerging from Wuhan, China. While South Korea, Singapore, and Taiwan’s coronavirus response relied heavily on tools they developed after SARS and MERS,⁹⁴ the United States had taken a large step backward in its pandemic preparedness in recent years. Funding for CDC prevention efforts had been cut for three years running,⁹⁵ and the last remaining CDC officials posted in China were recalled in July 2019, “leaving an intelligence vacuum when Covid-19 began to emerge.”⁹⁶ Congress never appropriated the funds necessary to fully replenish the Strategic National Stockpile after it was partially depleted during responses to the 2009 H1N1 pandemic, the Ebola and Zika viruses, and hurricanes Alex, Irene, Isaac, and Sandy.⁹⁷ When the Obama Administration’s experience with Ebola in 2014 drove home the gravity and immediacy of pandemic threats, it established a Directorate for Global Health Security and Biodefense on the National Security Council (NSC), so that a permanent cadre of experts could both plan for and implement a response to emergencies such as the one we currently face.⁹⁸ That office was either abolished or “folded into another” NSC office, depending on whom

⁹¹ *Remarks to the National Biodefense Summit*, Alex M. Azar II, DEP’T OF HEALTH & HUMAN SERVS. (Apr. 17, 2019), <https://perma.cc/9S5A-E47Z>.

⁹² OFFICE DIR. NAT’L INTELLIGENCE, *WORLDWIDE THREAT ASSESSMENT OF THE U.S. INTELLIGENCE COMMUNITY* (2019), <https://perma.cc/HCB3-8CGE>.

⁹³ See Lisa Monaco, *Pandemic Disease Is a Threat to National Security*, FOREIGN AFFAIRS (Mar. 3, 2020), <https://perma.cc/4QVS-U7L5>.

⁹⁴ Crystal Watson et. al., *National Plan to Enable Comprehensive COVID-19 Case-Finding and Contact-Tracing in the U.S.*, JOHNS HOPKINS CTR. FOR HEALTH SEC. 5 (Apr. 10, 2020), <https://perma.cc/L2UJ-86LX>.

⁹⁵ See Laurie Garrett, *Trump Has Sabotaged America’s Coronavirus Response*, FOREIGN POLICY (Jan. 31, 2020, 11:07 AM), <https://perma.cc/69QX-78EK>; Lena H. Sun, *CDC to Cut by 80 Percent Efforts to Prevent Global Disease Outbreak*, WASH. POST (Feb. 1, 2018, 1:53 PM), <https://perma.cc/7JFQ-RFJD>.

⁹⁶ Editorial, *Reviving the U.S. CDC*, LANCET (May 16, 2020), <https://perma.cc/C7NK-37SY>.

⁹⁷ See Matthew Brown, *Fact Check: Did the Obama Administration Deplete the Federal Stockpile of N95 Masks?*, USA TODAY (Apr. 3, 2020, 3:31 PM), <https://perma.cc/VA7E-Z6AN>.

⁹⁸ See Monaco, *supra* note 93.

you ask, in 2018.⁹⁹ And of course state, local, and tribal public health services are chronically underfunded and overextended. As a result, the nation was less well prepared than it could have been when COVID-19 struck. To be sure, it is impossible to predict when any one of the numerous threats that we face will materialize, and it is easy in hindsight to criticize all levels of government for not doing more to prepare for the one that actually did come about. At the same time, the blaring alarm bells that both experts and high-level government officials have been ringing for years regarding the risk of pandemic make the federal government's decisions to scale back investment in preparedness seem particularly problematic.

The extent to which government agencies may have been underprepared for the coronavirus outbreak, however, is far from the full story. Anyone who has considered pandemic preparedness has emphasized the need for a “single, comprehensive, and harmonized strategy” orchestrated by a “single leader to control, prioritize, coordinate, and hold agencies accountable.”¹⁰⁰ Even with capable individuals overseeing the relevant departments and agencies, the absence of “strong centralized leadership at the highest level of government” can undermine response efforts.¹⁰¹ First HHS Secretary Azar and then Vice President Pence nominally took on this role during the coronavirus response. Any chance that either of them could succeed in developing a comprehensive, unified strategy, however, was undermined by mixed messages from the President himself. Presidential statements disclaiming responsibility for coordinating a national effort to secure needed supplies and testing capacity,¹⁰² encouraging citizens to defy local stay-at-home orders,¹⁰³ and encouraging governors to defy the White House's own guidelines regarding when mitigation measures could be eased¹⁰⁴ left the clear impression that the President had no interest in bringing the federal government's powers to bear in executing the basic blocking and tackling needed for a successful response. Worse, statements and policy preferences emanating from the White House often appeared motivated not by public-health imperatives but by economic or political concerns.¹⁰⁵

The result was a leadership vacuum that led to an absence of a truly coordinated anti-COVID-19 effort led by the federal government. This leadership vacuum may have resulted from a reluctance to recognize or acknowledge the severity of the threat. Had the United States mobilized early to plan and carry out an aggressive, nationwide testing and tracing regime, it might have been

⁹⁹ See Glenn Kessler & Meg Kelly, *Was the White House Office for Global Pandemics Eliminated?*, WASH. POST (Mar. 20, 2020, 3:00 AM), <https://perma.cc/U95E-DUGE>.

¹⁰⁰ Blue Ribbon Study Panel on Biodefense, *supra* note 17, at iv; see also *National Strategy for Pandemic Influenza and the HHS Pandemic Influenza Plan: Thoughts and Comments*, 3 BIOSECURITY AND BIOTERRORISM: BIODEFENSE STRATEGY, PRACTICE, AND SCIENCE 292 (2005).

¹⁰¹ Blue Ribbon Study Panel on Biodefense, *supra* note 17, at iv.

¹⁰² See Aaron Blake, *Trump's Continually Strange Comments on Possibly 'Overrated' Coronavirus Testing*, WASH. POST (May 15, 2020, 10:16 AM), <https://perma.cc/7AGA-5782>.

¹⁰³ See Michael D. Shear & Sarah Mervosh, *Trump Encourages Protest Against Governors Who Have Imposed Virus Restrictions*, N.Y. TIMES (Apr. 17, 2020), <https://perma.cc/8DBF-LBFZ>.

¹⁰⁴ See Toluse Olorunnipa et al., *Trump Cheers on Governors Even as They Ignore White House Coronavirus Guidelines in Race to Reopen*, WASH. POST (May 4, 2020, 10:10 PM), <https://perma.cc/6FH6-PLND>.

¹⁰⁵ Eric Lipton et al., *He Could Have Seen What Was Coming: Behind Trump's Failure on the Virus*, N.Y. TIMES (Apr. 11, 2020), <https://perma.cc/9552-3PAJ>.

able to contain the virus.¹⁰⁶ Even after containment was impossible, early adoption of a uniform federal plan that acknowledged the severity of the crisis and provided mitigation guidelines for state public-health officials and ordinary citizens might have lessened the virus's impact.¹⁰⁷ Rather than embrace this responsibility, however, it seems the President ignored multiple warnings throughout the months of January and February, insisted repeatedly that the virus was under control and would soon be defeated entirely, and threatened to fire the CDC official who tried to sound a public alarm.¹⁰⁸ While some states, like Ohio, took the initiative and implemented their own mitigation measures relatively early,¹⁰⁹ many others were hindered either by the "chaotic and often dysfunctional federal response"¹¹⁰ or by waiting to follow the President's lead.¹¹¹

Once the pandemic was undeniably in full swing, the federal government not only continued to decline to formulate a coherent national plan, but also left the more concrete tools at its disposal underutilized. One persistent problem at the height of the pandemic was a shortage of necessary equipment, including "severe shortages" of testing supplies and "widespread shortages" of masks and other equipment, such as ventilators, at hospitals.¹¹² This is one area where pandemic-response plans call for active federal coordination, to manage supply chains and ensure that supplies are distributed to locations where they are most needed. As many critics were quick to point out, the President could have ameliorated the situation by invoking his powers under the DPA to spur additional production of scarce medical supplies and centralized their procurement and distribution. Instead, the President rejected the statute as heavy-handed "nationalizing" of private business and sought to rely on voluntary actions by the private sector. As a result, governors and hospital administrators were often left to fend for themselves and to compete with other states as well as the federal government to purchase scarce supplies. The states and even individual hospitals found themselves scouring the Internet for suppliers or even relying on ad hoc networks of private citizens, struggling to determine whether the PPE or testing supplies on offer were the genuine article or even existed at all.¹¹³ As New York Governor Andrew Cuomo famously quipped, "it's like being on eBay with 50 other states, bidding on a ventilator."¹¹⁴ Under pressure

¹⁰⁶ See Michael D. Shear et al., *The Lost Month: How a Failure to Test Blinded the U.S. to Covid-19*, N.Y. TIMES (Mar. 28, 2020), <https://perma.cc/D8BR-2QAT>.

¹⁰⁷ See James Glanz & Campbell Robertson, *Lockdown Delays Cost at Least 36,000 Lives, Data Show*, N.Y. TIMES (May 20, 2020), <https://perma.cc/US5G-Y4MH>.

¹⁰⁸ See *id.*

¹⁰⁹ Lenny Bernstein, *Did Ohio Get the Coronavirus Right?*, WASH. POST (Apr. 9, 2020, 4:23 PM), <https://perma.cc/H5KF-4C8C>.

¹¹⁰ J. David Goodman, *How Delays and Unheeded Warning Hindered New York's Virus Fight*, N.Y. TIMES (Apr. 9, 2020), <https://perma.cc/3MA9-X8PD>.

¹¹¹ Katherine Faulders et al., *After Talk with Trump, Florida Reverses Course on Coronavirus Stay-at-Home Order*, ABC NEWS (Apr. 1, 2020, 7:00-10:00 AM), <https://perma.cc/AXK5-G29B>.

¹¹² DEP'T OF HEALTH AND HUMAN SERVS., OFF. OF INSPECTOR GEN., OEI-06-20-00300, HOSPITAL EXPERIENCES RESPONDING TO THE COVID-19 PANDEMIC: RESULTS OF A NATIONAL PULSE SURVEY MARCH 23–27, 2020 (2020), <https://perma.cc/33Q4-JJ5X>.

¹¹³ Anna Russell, *The Underground Efforts to Get Masks to Doctors*, NEW YORKER (May 7, 2020), <https://perma.cc/QJE8-NQPV>.

¹¹⁴ Sarah Mervosh & Katie Rogers, *Governors Fight Back Against Coronavirus Chaos*, N.Y. TIMES (Mar. 31, 2020), <https://perma.cc/N8EK-AANP>.

from Congress to develop a national testing strategy, the White House did issue a “blueprint” for increasing testing capacity, but this skeletal document limited the federal role to “strategic direction and technical assistance,” as well as the ability to “align laboratory testing supplies and capacity with existing and anticipated laboratory needs,” but the federal government was described as the “supplier of last resort.”¹¹⁵

Indeed, rather than standing up the centralized procurement and distribution system that the preparedness documents envision, via the DPA or otherwise, President Trump demoted the official who had identified equipment shortages and allowed his son-in-law, Jared Kushner, to “exacerbate[e] chronic problems in procuring supplies” by establishing an operation outside the auspices of the official White House coronavirus task force staffed, at least in part, by unqualified individuals.¹¹⁶ And while Kushner’s team reportedly was successful in securing equipment for some of those in need, the resources seemed to be allocated according to who had his phone number, rather than who had the most critical shortfalls.¹¹⁷ President Trump did finally invoke various provisions of the DPA to get General Motors to prioritize the government’s requests for ventilators, to limit 3M’s exports of certain medical equipment, to require meatpacking plants to remain open, and to boost production of the swabs needed for coronavirus testing. These efforts, however, were scattershot, when what was needed was employing DPA authorities as part of the coordinated management of supply chains that various pandemic-planning documents describe.

The federal government has also eschewed taking the helm in establishing the type of testing and contact tracing that public-health experts unanimously agree are necessary to enable the country to emerge safely from the induced economic coma created by stay-at-home and social distancing orders.¹¹⁸ It has consistently declined to provide the guidance and coordination for which local officials, health experts, and ordinary citizens have clamored. The President himself has repeatedly stated both that “anyone who wants a test can get one”¹¹⁹—a demonstrably false assertion—and that increased testing capacity was not actually required.¹²⁰ And the White House’s “blueprint” for testing places the onus on the states not only to secure their own supplies, but also to develop their own plans and rapid-response programs.¹²¹

To be sure, there are countless people within the federal government who have worked tirelessly for months on the pandemic response, and often to good effect. The waivers that HHS and the FDA issued have enabled aggressive research and facilitated the rapid development of PPE

¹¹⁵ Mike DeBonis et al., *White House Issues Coronavirus Testing Guidance That Leaves States in Charge*, WASH. POST (Apr. 27, 2020, 9:00 PM), <https://perma.cc/3FNZ-P6MQ>.

¹¹⁶ See Yasmeen Abutaleb & Ashley Parker, *Kushner Coronavirus Effort Said to be Hampered by Inexperienced Volunteers*, WASH. POST (May 5, 2020, 3:49 PM), <https://perma.cc/E6VJ-QDZQ>.

¹¹⁷ See Andrea Bernstein, *He Went To Jared*, WNYC PODCAST (Apr. 22, 2020), <https://perma.cc/SHG6-3QLN>.

¹¹⁸ See Keith Humphreys, *Widespread Testing Might Not Work in America. We Love Our ‘Freedom’ Too Much.*, WASH. POST (May 14, 2020, 12:46 PM), <https://perma.cc/55CA-8TAW>.

¹¹⁹ See Miriam Valverde, *Donald Trump’s Wrong Claim that ‘Anybody’ Can Get Tested for Coronavirus*, POLITIFACT (Mar. 11, 2020), <https://perma.cc/P634-X39Z>.

¹²⁰ See Blake, *supra* note 102.

¹²¹ THE WHITE HOUSE, CTRS. FOR DISEASE CONTROL & PREVENTION, AND FOOD & DRUG ADMIN., *OPENING UP AMERICA AGAIN* (2020), <https://perma.cc/EP6D-RQWT>.

innovations—such as the ability to disinfect and re-use respirator masks—as well as treatments.¹²² And the FDA, while perhaps initially overeager to help solve the testing-supply shortage, has reconsidered its decision to allow unreviewed testing products to reach the market after discovering that many of them were inaccurate.¹²³ Moreover, the Trump administration assisted both California and New York to increase hospital capacity by providing U.S. Navy hospital ships and constructing temporary facilities.¹²⁴ And it has launched bold initiatives both to “replenish and modernize’ the government’s stores of masks, ventilators, and other essential pandemic-fighting medical equipment”¹²⁵ and to rapidly develop, manufacture, and distribute a vaccine and other treatments.¹²⁶

Yet as of this writing, in mid-summer 2020, despite a new spike in coronavirus cases in many states across the country,¹²⁷ and persistent shortages of PPE,¹²⁸ there remains no comprehensive national plan for assessing the need for and distributing PPE and other supplies or for developing the surveillance and testing capacities that experts insist are needed to keep the virus under control. Instead, President Trump continues to minimize the severity of the threat, the likelihood of a second wave of infections in the fall,¹²⁹ and the timeline for vaccine development.¹³⁰ Rather than employ federal agencies to amalgamate all of the extensive expertise both within the executive branch and at academic institutions, he persists in retaliating against truth-tellers¹³¹ and sidelining experts.¹³² And he still shies away from aggressive use of DPA authorities and federal capacity to

¹²² See FOOD & DRUG ADMIN., EMERGENCY USE AUTHORIZATION, <https://perma.cc/W8YV-QW8N>.

¹²³ See Thomas M. Burton, *FDA Sets Standards for Coronavirus Antibody Tests in Crackdown on Fraud*, WALL ST. J. (May 4, 2020, 8:24 PM), <https://perma.cc/M3YY-WL4D>; Matthew Perronne, *U.S. to Put Limits on Flood of COVID-19 Blood Tests After Lax Oversight*, ASSOC. PRESS (May 4, 2020, 11:57AM), <https://perma.cc/J5HM-7VVY>.

¹²⁴ See Geoff Ziezulewicz, *The U.S.N.S. Comfort is Now Taking Covis-19 Patients. Here’s What to Expect.*, N.Y. TIMES (Apr. 8, 2020), <https://perma.cc/PM5V-AXYL>.

¹²⁵ Amy Goldstein, *Trump Administration Plans to Expand Emergency Gear in National Stockpile*, WASH. POST (May 14, 2020, 5:55 PM), <https://perma.cc/8WQU-JF9C>.

¹²⁶ See Press Release, Dep’t of Health & Human Servs., *Trump Administration Announces Framework and Leadership for ‘Operation Warp Speed’* (May 15, 2020), <https://perma.cc/SY2A-PAWS>.

¹²⁷ See Chris Canipe & Lisa Shumaker, *New U.S. COVID-19 Cases Surge 25% Last Week; Arizona, Florida and Texas Set Records*, REUTERS (June 23, 2020, 7:12 AM), <https://perma.cc/U6W2-P3SA>.

¹²⁸ See, e.g., Andrew Jacobs, *Grave Shortage of Protective Gear Flare Again as Covid Cases Surge*, N.Y. TIMES (July 8, 2020), <https://perma.cc/M5VM-8F6Y>.

¹²⁹ See Brett Samuels, *Trump Says Coronavirus ‘May Not Comeback at All,’* THE HILL (Apr. 22, 2020, 6:56 PM), <https://perma.cc/V2V9-YZTE>.

¹³⁰ See David Smith, *Trump Unveils ‘Warp-Speed Effort to Create Coronavirus Vaccine by Year’s End*, THE GUARDIAN (May 16, 2020, 11:55 AM), <https://perma.cc/6ASC-WT75>.

¹³¹ See Editorial, *supra* note 96 (“In a press conference on February 25, Nancy Messonnier, director of the CDC’s National Center for Immunization and Respiratory Diseases, warned US citizens to prepare for major disruptions to movement and everyday life. Messonnier subsequently no longer appeared at White House briefings on COVID-19.”).

¹³² See Oliver Milman, *Where is the CDC? How Trump Sidelines the Public Health Agency in a Pandemic*, GUARDIAN (May 14, 2020, 3:00 AM), <https://perma.cc/XL6Q-WEP5>; Jason Dearen & Mike Stobbe, *Trump Administration Buries Detailed CDC Advice on Reopening*, ASSOC. PRESS (May 6, 2020), <https://perma.cc/8MUC-JN2G>; Ali Zaslav, *Schumer Fails to Pass Resolution to Release CDC Reopening Guidance*, CNN (May 13, 2020, 12:16 PM), <https://perma.cc/2DFS-J3ZD>.

coordinate nation-wide efforts. In short, his approach flies in the face of the role envisioned for the federal government by Congress and previous administrations in such circumstances.

CONCLUSION

To bring the discussion full circle, President Trump is correct when he asserts that the federal government has significant power at its disposal to address public health emergencies such as COVID-19. What a closer look at those authorities reveals, however, is that the relevant question is less about what the President has the *power* to do, and more about what the President—and the federal government as a whole—has the *responsibility* to do in support of state and local response efforts. What we have seen so far is an approach that is long on assertions of power and short on acceptance of responsibility.