

Innovative Laws and Policies for a Post-Pandemic Public Health System

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Introduction

The mission of public health is to protect and improve the health of the population as a whole. Healthy communities are the bedrock for a thriving and just society. Creating them is a shared responsibility. In recent years, the COVID-19 pandemic, longstanding racial inequality, and a host of other public health threats have put the physical and mental health of people living in the United States in peril. Frequently, efforts to respond to these public health challenges have garnered quiet support but engendered loud concern from [vocal critics](#).¹ Even during the height of the backlash against governmental public health during the pandemic, and the exercise of public health authority specifically (detailed in [these reports](#) from [the Network](#) and these [resources](#) from the [Center for Public Health Law Research](#) and [Public Health Law Watch](#)²), public health officials, legislators, governors, and community advocates in a variety of jurisdictions have adapted and developed [innovative legal and policy strategies](#) to preserve governmental authority to protect communities and strengthen public health.

Public health departments require a full range of legal tools to fulfill their duty to protect public health so that individuals and communities can flourish. At the same time, the exercise of governmental public health authority must be accountable in ways that are both inclusive and supportive of the priorities and needs of disenfranchised communities and that respect necessary checks and balances on that power.

Public health law is one means of collective action to “[assure the conditions in which people can be healthy](#).” Regulation — such as by inspecting restaurants, requiring vaccinations, and excluding

students or closing schools during an outbreak of disease — is a core part of public health law. For example, mask requirements were an effective and less restrictive alternative to closing schools and other gathering places altogether in order to contain the spread of COVID. In addition to direct regulation, public health law offers [many other tools](#) — tools like ensuring information is available to the public, providing social and economic supports, and [changing the places](#) in which we live, learn, work, and play to provide a healthier environment. This report, inspired by questions raised by practitioners at the front lines of the public health response, as well as by efforts such as those undertaken by the [Bipartisan Policy Center](#), the [CDC Foundation](#), and the [Commonwealth Fund](#), casts a wide net in order to provide real-world examples of the modernization of public health which is already underway.

This report collects and categorizes policies that strengthen public health. It is neither a comprehensive policy surveillance exercise nor a legal epidemiology analysis; rather, it is meant to be a collection of meaningful categories—governance, funding, health equity, infrastructure, workforce, and public health

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interventions—and examples that point toward the possibilities of a stronger, more equitable, and more effective public health system.

The focus of this report, and the bulk of examples shared, are enacted state laws. However, examples may also include enacted federal and local laws, as well as proposed laws from every level of government. Legal arguments or advocacy strategies which contribute to the defeat of proposed legislation that is likely to be less protective of public health are also critically important, but they are not the focus of this report. Finally, in the many states which have enacted laws that are less protective of public health, promising legal innovations may take the form of government policies and implementation strategies which reduce the harm or mitigate the impact of the newly enacted, less protective, law, or take affirmative steps to increase understanding of public health or reduce health disparities. A few of these examples, showcasing governor's executive orders, memoranda of understanding between public health and elected officials, and criteria and contracts for program funding, are included as well.

Tribal Sovereignty Tribal Nations have [exercised their sovereignty](#) in many ways that mitigated the effects of the pandemic and continue to support the health of their citizens, as well as the health of people in surrounding communities. Tribes have sought to [increase their access to vital public health data](#) and [broadband internet service](#) through independent action and coordination with the U.S. and state governments. While the focus of this report is on legal innovations at the state level, Tribal sovereign authority provides unique opportunities and considerations for Indigenous communities and neighboring jurisdictions.

Most policies discussed in this report are laws enacted in 2020 or later. The goal of these new laws is to ensure that governments have the resources needed to carry out their duties and protect and improve health in their communities, along with appropriate safeguards and accountability. Legal innovation may on occasion take place rapidly, especially when spurred by an emergency. However, it may take longer for innovations to spread. The wide variety of political, cultural, social, and economic environments in the jurisdictions where these innovative laws originate and are adopted is striking.

Choosing Among Innovative Laws and Policies

The adoption and successful implementation of new laws is facilitated by a number of factors, which are sometimes referred to as the [five essential public health law services](#). It is frequently helpful if the law is carefully crafted to comply with the existing laws and legal framework in the jurisdiction, or to [correct deficiencies and fill in gaps](#). This can help to secure passage and to withstand any legal challenges. It is also helpful if the approach is selected with an eye toward achieving a cultural, political, and economic fit with the jurisdiction. To that end, normative and [ethical factors](#) are critical guides in determining which potential legal innovations to prioritize and support.

Public Health Accreditation Board standards and measures require accredited health departments to develop processes for policy development and strategies for resolving ethical issues. As a result, a growing number of health departments have established ethics committees, which may include health department staff, community members, and attorneys. These ethics committees may provide a venue, or serve as a model, for discussing and attempting to resolve tradeoffs among policy alternatives and resolving ethical dilemmas through application of public health ethics frameworks.

Achieving clarity with respect to public health values and goals is essential to identifying innovative laws and policies worthy of adopting and spreading. In conversations hosted by the Network for Public Health Law in September 2021 and April 2022, public health officials and practitioners, attorneys, researchers, advocates, and others interested in the public health law field discussed the values and goals of public health. This informed the criteria for inclusion in this report. The examples in this report have been selected based upon three core public health values:

1. Taking Evidence-Based Action to Promote Health and Well-being and Prevent Death, Disease, and Injury

Public health interventions and legal approaches should be firmly grounded in science and the best available evidence and expertise. This includes evidence of effectiveness in improving physical and mental health outcomes and preventing death, disease, and injury across the population. Particularly when facing novel threats, this value recognizes the imperative to test new approaches based on emerging evidence, including expert opinion, and lived experience in the affected communities.

2. Good Governance

Public health and other governmental leaders must be empowered to act in a nimble, adaptive, and flexible manner during an emergency. At the same time, public health should be accountable for striking a delicate but appropriate balance between advancing the common good and recognizing individual liberties. Public health decision-making and governance should demonstrate competence, be communicated clearly and transparently, and inspire confidence and trust. Effective governance ensures that public health has access to sufficient resources, including staffing, training, funding, data, systems, processes, tools, and infrastructure.

3. Equity and Fairness

Legal and policy innovations that strengthen the public health system should be equitable, anti-racist, and fair. As demonstrated by epidemiologic data time and again, including during the COVID pandemic, health outcomes are consistently worse among people of color and communities with lower average incomes. This often leads to conceptualizing equity as simply a long-term outcomes-oriented goal of eliminating health disparities, but this report recognizes there are also more immediate, process-oriented changes that demonstrate a commitment to equity and fairness. For example, public health can move toward greater equity and fairness by reducing economic and other barriers to compliance with public health orders; collecting data to identify where the toll of death, disease, and injury are greatest; allocating benefits and burdens fairly based on the data; and providing meaningful opportunities for community insights and lived experience to inform decision-making.

Governance refers to the structures and processes for making and implementing decisions, and for holding decision-makers and other leaders accountable. In the context of public health, governance is the system under which public health entities and other government officials operate when making [public health decisions](#). It is also the system through which any limitations upon their actions function.

Public health governance became a flash point early in the COVID-19 pandemic, after governors and public health officials exercised public health and emergency powers to keep their communities healthy and safe. The authority to do so had long existed in statute but had been seldom exercised. Some expressed concerns regarding the authority to issue executive orders and public health emergency orders with no fixed end time and with little opportunity for review, oversight, or checks and balances. These concerns were matched by concerns regarding excessive deference to individual liberties that impeded effective governmental action to promote the common good and protect the most adversely affected populations and vulnerable individuals, including people who were immunocompromised. Moreover, in their stated efforts to contain the potential for abuse of governmental power by the executive branch, many state legislatures, with respect to shifting executive branch authority to themselves, entertained and sometimes passed [measures whose own constitutionality were doubtful at best](#).

The jurisdictions below may be [early forerunners](#) of new paradigms for public health governance that strive to resolve these tensions. They include examples of modernizing public health, recognizing local authority and home rule, creating task forces and commissions to consider potential reforms outside the politicized atmosphere of a legislative session, increasing transparency when emergency and public health orders are issued, assessing the anticipated effects on racial health equity of proposed laws, shielding public health officials from being appointed, disciplined, or terminated for political reasons, and strategies for navigating a changed legal environment following passage of public-health-authority-limiting legislation.

Public Health Modernization

For the past ten years, a growing number of states have sought to modernize and transform public health. Most recently, these states have been convened by the Public Health National Center for Innovations (PHNCI) at the Public Health Accreditation Board (PHAB) in a [21st Century Learning Community](#). States in the Learning Community have developed a shared understanding of [foundational public health services](#), which are the skills, programs, and activities that should be available from every health department, to every resident in their jurisdiction. [Modernization initiatives](#) have typically been paired with a push to stabilize public health funding throughout a state, which highlights the interconnected nature of the categories discussed in this report. States which have participated in the 21st Century Learning Community, or which have otherwise taken steps toward public health modernization, include [Washington, Oregon, Ohio, Kentucky, North Carolina, Massachusetts, and Indiana](#), among others. The [National Academy for State Health Policy recently](#) convened a learning collaborative of cross-sector teams from [Arkansas, Indiana, Michigan, and Rhode Island](#) to focus on public health modernization.

In 2018 and 2019, with support from the PHNCI, [Ohio](#) identified deficiencies in the state's foundational services and determined the level of support needed to close those gaps. This analysis indicated that

current funding levels limit the ability of local health departments to fully protect all their residents. In response to the analysis, many small jurisdictions [expressed interest](#) in sharing public health services across jurisdictions, and the state provided funds to assist. Similarly in **Massachusetts**, a [State Action for Public Health Excellence](#) program provides funding and technical assistance to support collaboration and shared services among local health departments. In **Kentucky**, a crisis in the state pension system provided the catalyst for [public health transformation](#) intended to balance the budget, improve health outcomes, and recalibrate the balance of decision-making authority and duties between state and local health departments.

Home Rule and Local Public Health Authority

One important aspect of public health law is the interplay between laws at different levels of government — such as the relationship between federal and state law, and between state and local law. [Home rule](#) is a legal concept which empowers local governments (typically cities or counties) to adopt laws that meet the needs of their community. Home rule can be a tool to ensure that local decisionmakers are able to implement policies consistent with the needs of their residents. While coordination between federal, state, and local public health authorities is important, [localities are often best positioned](#) to respond to rapidly evolving local conditions.

[Shifts in authority](#) away from the local level to the state level were one strategy used by critics to limit the use of public health emergency powers during the COVID-19 pandemic. Laws that [preempt](#), or prohibit, state or local action have long been an [obstacle](#) to effective public health initiatives such as commercial tobacco control and efforts to promote healthy food environments, and they were prominent during the pandemic with 12 states enacting 30 laws that [limited localities in implementing pandemic protective measures](#) such as requiring closures of public gathering places, capacity limits in restaurants, and mask requirements.

Nonetheless, some jurisdictions enacted laws which recognized the value of preserving and promoting authority at the local level in order to respond to local conditions. For example, the **Vermont** legislature enacted [Senate Bill 1](#) in 2021, which explicitly granted municipalities temporary authority to adopt indoor mask mandates (except on school grounds, which remained under school board authority). In **North Dakota**, [House Bill 1323](#) (2021) was amended to protect local control, allowing for political subdivisions of the state to require the use of face coverings. As originally filed, the bill would have prohibited not only state officials from mandating mask measures but also local jurisdictions. Meanwhile, **Colorado** [repealed preemptive state laws](#) related to [firearms regulations](#) and [minimum wage requirements](#).

Task Forces and Commissions

Since the pandemic began, several states have formed public health commissions or task forces that provide the opportunity for a comprehensive, evidence-informed dialogue among stakeholders in the public health system. With fewer political and time pressures than a legislative session, these statewide commissions and task forces have reviewed the powers and duties of public health agencies and are beginning to issue recommendations for consideration in their state legislatures.

Indiana established the Governor's Public Health Commission by [Executive Order 21-21](#) on August 18,

2021. It included representatives from public health entities, local government, the Minority Health Coalition, and health care associations as well as a citizen advisor. To gather public input, the Commission sought comment through its website, hosted seven public meetings across the state, and conducted more than 30 meetings with relevant groups. The Commission issued a [final report and recommendations](#) in just under a year on August 1, 2022. The governor incorporated some of the recommendations into his budget and legislative proposal for 2023. Indiana enacted [Senate Bill 4](#) during the 2023 legislative session, adopting a focus upon the delivery of “core public health services” and specifying the respective roles of the state and local governments, and setting forth metrics by which to assess performance at the local level. Indiana also passed [House Bill 1001](#), which substantially increased state funding for the expanded set of core public health services. (For more information on the Indiana Governor’s Public Health Commission, see [Funding Section](#) of this report.)

New Mexico formed a task force in 2021 (authorized by [New Mexico HM002](#)) which issued a [draft report](#) in July 2022, with 12 recommendations, including recommendations focused on health equity and climate change.

The University of **Oklahoma** led an initiative aimed at [Achieving a Healthy Oklahoma](#) which issued a [report and recommendations](#) in the summer of 2022.

Transparency

One key learning of the COVID pandemic for many public health leaders is the importance of [effective communication](#). Effective communication can help public health departments increase public trust, confidence, and understanding, as well as secure increased compliance with public health orders. In 2020, **Colorado** passed [House Bill 1426](#), requiring the governor to provide regular updates and respond to questions from the legislature during a public health emergency. Ongoing updates by the governor will likely strengthen public health communications, decision-making, and accountability by creating an expectation to provide information, including epidemiological data, to the legislature, which can be shared readily with the public.

Racial Equity Impact Assessments

A number of states, including **Colorado, Illinois, Maryland, and Virginia**, have recently adopted [laws requiring racial equity impact assessments](#). Similar to health impact assessments, these analyses identify whether a proposed law is likely to increase or reduce racial disparities in health outcomes in order to inform the policy-making process. **Colorado**, in particular, has completed a number of [demographic notes](#) on bills as required by [House Bill 19-1184](#) since the 2020 legislative session. The **District of Columbia** completed a racial equity impact assessment of a proposed [flavored tobacco law](#). See [the Health Equity Section](#) for more information on legal innovations to advance health equity.

Appointment, Oversight, and Termination of Health Officers and Boards of Health

Public health and other executive branch leaders must put the health of the public first by taking necessary actions in order to respond to a public health emergency, in spite of political pressures. In these instances, a legal system which provides a buffer between government officials and politically motivated reactions could be protective of public health.³ At the federal level, the **Federal Deposit Insurance Commission, the**

Federal Reserve System, the Federal Trade Commission, and the National Labor Relations Board all have enjoyed substantial independence for about a century.⁴ Aspects of their independence include leadership by boards of qualified experts, who may be removed during their terms only for cause.⁵

Research for this report revealed a few recent examples of legal innovations at the state level to protect public health decision-makers from politically-motivated reactions, perhaps because an approach which strikes an appropriate balance between deference to agency expertise and appropriate accountability and limitations upon potential poor judgment, errors, and negligence or recklessness in the executive branch has been difficult to craft.

Nonetheless, some jurisdictions have longstanding statutory provisions which provide some protection for the exercise of expert judgment from political interference. For example, the state health officer in **Mississippi** is appointed by the state board of health, rather than the governor, which made it feasible for the state health officer to issue evidence-based public health orders, even as the governor issued statements critical of those orders.

Navigating a Changed Legal Environment

In states where laws limiting public health powers have been enacted, a variety of innovative strategies can mitigate the impact of these laws by allowing public health departments to continue to protect the health of their communities in an emergency. For example, after the **Montana** legislature reduced the ability of local health officials to issue public health orders, the Montana Public Health Institute developed a toolkit to facilitate dialogue between local health officials and local elected officials and policy-makers regarding statutory duties and powers related to public health, and to establish clear understandings about how those duties could be fulfilled. The understanding reached could be memorialized in an interlocal agreement or memorandum of understanding, as in Missoula, Montana.

Many state statutory schemes feature a certain amount of redundancy, such that more than one government actor has authority to act to address a public health emergency. Such redundancy is desirable where political or other circumstances may prevent a particular government actor from taking needed steps. In **Ohio**, in 2021, Senate Bill 22 reduced the ability of local health officials to quarantine individuals exposed to a disease before a medical test confirms that they have contracted it, but local health officials worked with school officials to ensure that the school officials understood their own independent authority to prevent the outbreak of disease in schools, by requiring students to stay out of school when ill. Local health officials also worked to provide the necessary epidemiological information for the school officials to make informed decisions about the exercise of the exclusion power.

Sustained increases in public health funding are essential in order to achieve a stronger, more equitable public health system. Additionally, many public health leaders and decision-makers have concluded that increased amounts and stability of public health funding will have the greatest impact if paired with other systematic improvements to governance and infrastructure.

Early in the pandemic, in the face of an unprecedented emergency, the federal government responded by providing unprecedented levels of funding to facilitate compliance with emergency orders and soften the economic impact upon individuals, communities, and sectors of the economy. As the pandemic continued, the federal government approved several large appropriations bills to support efforts to rebuild public health infrastructure and workforce, among other goals. While this funding was crucial to protecting the nation's health, government agencies need sufficient infrastructure to absorb these infusions of cash before, during, and after an emergency. Such infrastructure includes flexible and sustained funding to hire, onboard, and retain skilled staff.

The 21st Century Learning Community of states focused on public health modernization discussed in the [Governance section](#) makes steady, increased public health funding one of its principal goals, together with assessing and modernizing public health systems and identifying and delivering foundational public health services. Predictable funding facilitates long-term planning, which is a hallmark of effective public health systems.

In addition to using government funding to support individuals, families, businesses, and communities in weathering the challenges of the pandemic and complying with pandemic restrictions, and to strengthen public health infrastructure and workforce development, some jurisdictions have begun to explore the use of government funding to support stronger community engagement and invest in community partnerships.

Federal COVID Relief Legislation

In the early days of the pandemic, Congress passed several pieces of landmark legislation to support compliance with public health emergency orders, to provide economic support for paid sick leave, for unemployment benefits, and for parents to take time off to supervise children during remote learning, whether or not any member of the family had COVID. These bills included the [Coronavirus Aid, Relief, and Economic Security \(CARES\) Act](#) and the [Families First Coronavirus Response Act \(FFCRA\)](#). These laws marked an important recognition of the critical role of government in providing [economic and social support for compliance](#) with public health orders.

As the pandemic continued, Congress passed the [Coronavirus Relief and Response Supplemental Appropriations Act](#), the [American Rescue Plan Act](#), the [Infrastructure and Jobs Act](#), and the [Inflation Reduction Act](#). These latter bills authorized the expenditure of substantial federal funds on an expanded set of public health concerns, including the public health workforce, community mental health services, water infrastructure, climate change, pollution reduction, and the transition away from fossil fuels to renewable energy.

State Public Health Modernization/ Transformation

As a result of multi-year campaigns, two of the original member states of the 21st Century Learning Community — [Washington](#) and [Oregon](#) — have achieved successes in increasing statewide funding for

public health, though with notable differences in approach and emphasis. **Kentucky, Massachusetts,** and **Indiana** have also recently substantially increased baseline funding for public health. These funding allocations are critically important as examples of ongoing, rather than emergency, funding for state public health systems.

In a number of states, sustained advocacy has been critical to creating support for a new vision and increased funding for public health. For example, the Washington Department of Health, Washington State Public Health Association and Washington State Association of Public Health Officials engaged in a nearly 10-year effort to build understanding and support among legislators. The state of **Washington**, conducted a [baseline assessment](#) in 2018 to determine the capacity of local and state health systems to provide foundational public health services. This assessment identified major deficiencies and [calculated](#) the need for \$225 million in additional public health funding each year. The focus upon providing unique governmental public health services to every resident of the state ensured an approach that could appeal to rural, urban, and suburban legislators and contributed to passage of [House Bill 1497](#) in 2019.

While this Washington bill predates the pandemic, the bill, together with [steps to implement](#) a shift to enhanced, stable funding in order to provide foundational public health services to every resident of the state, provides a powerful example for other states. Importantly, the initial list of 55 foundational public health services is not enshrined in state statute and will be easier to update and amend as a result. The initial investment [resulted](#) in a small but measurable increase in the system's capacity. In 2021, the legislature [recommitted](#) to strengthening foundational public health services with hundreds of millions of dollars in additional investments.

Neighboring **Oregon** also focused on public health modernization and foundational public health services, but took a slightly different approach, including acknowledging that collaborating with community partners may achieve better outcomes than acting alone. The Oregon legislature and Oregon Health Authority have prioritized collaboration with community stakeholders, including providing grants to nearly 200 community-based organizations through a braided funding approach in eight areas, including community health education, mass vaccination, climate planning, and commercial tobacco control. Oregon's investment in the state and local public health systems has increased steadily since 2017, and includes investment by the state legislature in comprehensive third party [after action reports](#) and evaluative activities.

The Indiana Governor's Public Health Commission was established by [Executive Order 21-21](#). Based in part upon recommendations made in the Commission's 2022 report, the governor's budget request in 2023 [asked the state legislature](#) for \$120 million in fiscal year 2024 and another \$227 million in fiscal year 2025 to support the provision of core public health services across the state. Indiana passed [House Bill 1001](#), which [increased state funding for local public health](#) programs from \$7 million to \$225 million, in the 2023 session.

Kentucky chose to engage in [public health transformation](#) in part to address financial concerns arising from the operation of the state pension fund. Like Indiana, **Kentucky** was also spurred to act by comparatively poor public health outcomes. The state legislature adopted [House Bill 129](#) in 2020 categorizing core public health programs and required foundational public health services, and

distinguishing them from optional public health services which may be assessed and prioritized for funding by local governments.

Pursuant to [action taken by the legislature in 2016](#), **Massachusetts** established a Special Commission on Local and Regional Public Health in order to make recommendations on how to improve the delivery of public health services and preventive measures across the state. In 2019, the Commission released its final report, [Blueprint for Public Health Excellence: Recommendations for Improved Effectiveness and Efficiency of Local Public Health Protections](#). Then in 2020, the legislature passed the [State Action for Public Health Excellence Act](#), which authorized a grant program for increased funding for shared public health services at the local and regional level, and provided for technical assistance from the state.

Equitable Engagement Compensation Programs

A distinguishing feature of public health modernization efforts in **Oregon** is a drive to change how public health decisions are made and [how public health activities are funded and carried out](#). The Oregon Health Authority acknowledges the role of structural racism in public health and is pivoting to focus more on the strengths of community-based organizations in reaching and serving their constituencies. This approach is not confined to the “traditional” public health sector, as the Oregon Department of Transportation created an [Equitable Engagement Compensation Policy](#) in 2021. The Oregon DOT policy sets forth funding mechanisms aimed at providing (1) financial incentives for individual participation in decision-making, (2) stipends for community members who engage in government decision-making in a more sustained way (such as participation in task forces and commissions where individuals participating in their official capacity would generally be compensated for their time and effort through their salaries), and (3) contracts for community-based organizations that partner with the agency to deliver transportation programs and achieve transportation goals.

While Oregon is notable for its comprehensive state-wide approach to a more inclusive process for governmental decision-making and programming, other state and local governments have also taken steps to [improve community engagement](#), including by compensating both individuals and community-based organizations for their contributions to governmental decision-making and program design and delivery. For example, numerous states, including **Michigan** and **Wisconsin**, adopted initiatives and funding priorities to overcome vaccine hesitancy and increase vaccine equity in communities of color by partnering with trusted organizations in those communities. **Alaska and Missouri** adopted practices and contract provisions requiring compensation for youth who accepted leadership roles in public health initiatives. Local governments, including **Richmond, Virginia**; **Minneapolis, Minnesota**; and **King County, Washington** adopted approaches to compensate community members for sharing their experiences to inform program design and implementation of government projects and initiatives.

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Long-standing systemic inequities have resulted in disparate health outcomes, mostly impacting communities of color, rural communities, people with disabilities, individuals with lower incomes, and under-resourced communities. The COVID-19 pandemic exacerbated health inequities experienced by these same groups, which given the prolonged nature of the pandemic, has forced renewed attention to the many social and structural barriers that impede the advancement of health equity. In other words, health disparities are the consequence of policymakers' decisions, which too often, have caused trauma and adverse experiences, including adverse health outcomes. Health

disparities are neither natural nor inevitable; if policymakers change their decision-making, changes in health outcomes will follow. Each section of this report includes an example of law and policy that advances health equity because achieving health equity must be a [goal embedded in the public health system](#). However, this section — divided into two primary categories — stands on its own to recognize that post-COVID-19 equitable public health authority must encompass more than just getting back to business as usual. The laws and policies highlighted throughout this report serve as explicit examples of re-orienting public health to advance equity.

Declarations of Racism as a Public Health Crisis

Amid racial justice protests following the murder of George Floyd in May 2020, and [worsening disparities](#) in COVID-19 cases, hospitalizations, and deaths, jurisdictions across the country began issuing statements declaring racism a public health crisis. While most statements were issued as proclamations or resolutions without the force of law, some jurisdictions issued more formal executive orders and enacted legislation.⁷ The more than 200 state and local declarations⁸ varied in scope, and this report highlights both examples of declarations that take a necessary first step to recognize inequities faced by people of color and examples of declarations that take a step further to include legally enforceable commitments.

Connecticut enacted a law in 2021, which declared racism a continuing public health crisis until “at least a [70%] reduction in ... racial disparities [indicators regarding education, health care utilization and outcomes, criminal justice, and economic justice]” ([Senate Bill 1](#)). To meet this ambitious goal, the legislation set forth several new requirements, including:

- the collection of health care or public health data “in a manner that allows for aggregation and disaggregation,” the importance of which is discussed in the [Infrastructure section](#);
- the creation of a cross-sector Commission on Racial Equity in Public Health empowered to study how racism impacts diverse groups of the state’s population and importantly for accountability, to create and periodically update a comprehensive strategic plan to eliminate health disparities and inequities across sectors;

- a diversity of community member engagement by the Commission to inform its recommendations; and
- the submission of [biannual reports](#) to the Secretary of the Office of Policy and Management and General Assembly standing committees related to public health.

In August of 2020, the governor of **Michigan** signed [Executive Directive 2020-9](#) recognizing and addressing racism as a public health crisis. The executive order directed the Department of Health Human and Services (DHHS) “to work in partnership with all state departments and agencies” to address the health inequities caused by racism in the following areas: data and analysis; policy and planning; and engagement, communication, and advocacy. It also required regular implicit bias training for state employees and that state departments and agencies “take all necessary steps to implement the directive, including through the allocation of funding and other resources in a manner consistent with applicable law.”

Milwaukee County, Wisconsin adopted an [ordinance](#) declaring racism a public health crisis in May 2020, which built on efforts that began with a National Public Health Week [announcement](#) in April 2019 and a passed resolution shortly thereafter. The ordinance codified the County’s commitment to “achieving racial equity by identifying and eliminating any racism in its institutional policies, procedures, practices, and power structures for black and brown individuals and communities so everyone in Milwaukee County can thrive.” More specifically, the County is now legally accountable for achieving the objectives detailed in the ordinance, including building a diverse and inclusive workforce that represents the demographics of the communities served, prioritizing customer-centered design and evaluation of County services, securing additional revenue, and implementing fiscal mechanisms to make strategic investments aligned with its racial equity priorities. In addition to an explicit statement that the County “will be held accountable by external partners and community members,” the ordinance also established an 11-member Strategic Plan Advisory Council to provide input and monitor the County’s progress.

Health Equity Task Forces

The establishment of [health equity working groups](#) was an important pandemic policy tool used by 25 states and a handful of localities to inform the COVID-19 response, direct resources to communities most in need, and develop longer-term strategies to address health inequities.⁹ The [source of authority](#) for most equity task forces was administrative (i.e. initiated by the governor or state health department), but some committees were created legislatively or through non-governmental organizations. Approaches to task force membership and access to funds to carry out committee duties varied widely, but [most task forces](#) shared both the general goal of increasing short- and long-term equitable outcomes and common duties around assessing data and its collection, engaging and including community, designing communication strategies, providing access to and provision of health care, addressing social determinants of health, and recommending implementation strategies necessary to overcome institutional barriers to achieving equity. Three state examples are included below, and additional examples can be found in an [article](#) published in the Saint Louis University Journal of Health Law and Policy and a National Governors Association [report](#) detailing key accomplishments and lessons learned for 10 states (Delaware, Illinois, Louisiana, Michigan, New Mexico, North Carolina, Pennsylvania, Rhode Island, Virginia and Washington).

The 16-member **Massachusetts** Health Equity Task Force was created in June 2020 by [An Act Addressing COVID-19 Data Collection and Disparities in Treatment](#). The task force’s mandate was “to study and make

recommendations to the [legislature] that address health disparities for underserved or underrepresented populations based on culture, race, ethnicity, language, disability, gender identify, sexual orientation, geographic location ... and age in the commonwealth during the COVID-19 pandemic.” Over 10 months, and following 17 public meetings and three public hearings to obtain feedback from the public, it issued an [Interim Report](#) in October 2020 focused on key time-sensitive priorities for the state budget and a [Final Report](#) in July 2021 with key recommendations for strengthening the local and state public health system, using an equity lens in investing federal ARPA funds, and creating a Cabinet level equity leader. The final report also set forth three community-driven guiding principles as an equity “north star” for decision making: (1) communities are partners that should have a voice at all the tables (i.e. planning, implementation, evaluation, etc.); (2) data must be complete, actionable, and transparent (i.e. available to the public, stratified and disaggregated by race, ethnicity, language, ability, sexual orientation, gender identity, age, and geographic location); and (3) a return to the pre-pandemic “normal” is not success because that is what created inequitable conditions.

Virginia enacted a law in 2021, which codified Virginia's [COVID-19 Equity Leadership Task Force \(Senate Bill 1296\)](#). The task force is required to “include experts from (i) the Governor's Office of Diversity, Equity, and Inclusion and other state agencies; (ii) the public at large; and (iii) the private sector who have expertise related to at-risk and vulnerable populations and the threats faced by such populations during a disaster.” The task force directs the work of the Health Equity Work Group, which was created in 2020 by the Commissioner of Health during the initial formation of the COVID-19 Unified Command. The task force and work group have engaged in capacity building through partnership between state agencies and community organizations, equitable resource allocation, adopting a data-driven equity lens, and embedding equity into the language of emergency management plans and grants. These approaches were key to Virginia's COVID-19 response where PPE and vaccination distribution efforts involved an equity analysis that considered accessibility factors, income, race and ethnicity, comorbidities, housing factors and language accessibility to determine the placement and resources needed at sites.

In **Utah**, the governor convened a [Multicultural Advisory Committee](#) for the state’s COVID-19 response in May 2020. The committee worked in collaboration with diverse cross-sector groups representing state agencies, community advocates, healthcare partners, faith-based organizations, and the private sector to prioritize filling gaps in existing efforts surrounding language access, food and housing security, and equitable distribution of state resources (e.g. tests, masks and vaccines). One outcome from the committee’s cross-sector participation was the creation of [two new grant programs](#) (1) the Racial Equity & Inclusion Fund, which after two different appropriations totaling \$4 million and an additional \$1 million private donation, dispensed over \$4.8 million to 126 front-line community-based organizations providing emergency assistance to communities disproportionately impacted by the pandemic, and (2) the [Multicultural Rural Mental Health Grant](#), which was made possible with funds from a healthcare partner, and invested over \$1 million over two years across 17 CBOs serving the mental and behavioral health needs of multicultural communities in rural Utah.

The ability of the public health system to be successful is only as strong as the infrastructure that supports it. Public health infrastructure can mean many different things, including as [outlined](#) by the National Network of Public Health Institutes, “the foundation for planning, delivering, evaluating, and improving public health, [which depends] on basic infrastructure such as up-to-date information systems, health professionals who are competent in cross-cutting and technical skills, and public health organizations with the capacity to assess and respond to community health needs.”¹⁰ In this section, [we focus on modernization of laboratories, data and IT systems including data disaggregation and emergency stockpiles](#). These facets of public health infrastructure are necessary to support an effective, equitable response to expected and unexpected challenges to the public’s health. We acknowledge other critical aspects of public health infrastructure in the [Governance](#), [Funding](#), and [Workforce](#) sections of this report.

Modernization of Public Health Laboratories

Every state, territory and the District of Columbia has a central public health laboratory, and many states have local laboratories that range in size and specialty area depending on the region or community that they serve.¹¹ Public health laboratories “perform limited diagnostic testing, reference testing, and disease surveillance. They also provide emergency response support, perform applied research, and offer training for laboratory personnel in other laboratories.”¹² Working in collaboration with federal agencies, including the Centers for Disease Control and Prevention, Food and Drug Administration, Environmental Protection Agency, the Federal Bureau of Investigation, and Department of Homeland Security, they are, collectively, “the backbone of a national laboratory network on alert 24/7 to respond to novel strains of disease, natural disasters, chemical spills, foodborne outbreaks, and other health emergencies.”¹³

Modernization of public health laboratories is necessary to support best practices to diagnose and screen for infectious diseases — both during pandemics like COVID-19 and those that pose a threat of sickness and death to communities in non-emergency times. However, the COVID-19 response revealed the [chronic underfunding](#) of public health laboratories and the gaps and deficiencies in their capacity to perform the operations necessary to protect the public health. Up-to-date technology, appropriate and sufficient supplies, and adequate information systems, including upgraded data entry systems for data management and analysis, and data sharing between public health departments and health care entities as well as Tribal public health authorities are the baseline for effective functioning of public health laboratories (see Data Modernization, below).

After struggling with an outdated laboratory during the pandemic, [Rhode Island](#) is building a new \$81.7 million public health laboratory with funds from an Epidemiology and Laboratory Capacity Grant from the CDC. [Rhode Island](#) is one of [seven jurisdictions](#) to receive construction awards to [expand and modernize](#) infectious disease laboratory facilities. In 2022, the [South Dakota](#) legislature approved a nearly \$70 million appropriation in federal fund expenditure authority for the construction of a new state public health laboratory and the renovation of the existing laboratory ([Senate Bill 58](#)).

Data Modernization Initiatives

“A robust, modern, interoperable, and secure public health information system delivers real-time, accurate, and actionable data to help public health officials detect new or growing threats, identify groups that may be at risk, and respond quickly with tailored policy, practice, and program interventions. Public health departments also translate and share data with policymakers and other stakeholders in a timely manner.”¹⁴

The [CDC-led data modernization initiative](#) began in 2020 and received its first large influx of funds under the Coronavirus Aid, Relief, and Economic Security (CARES) Act, which provided \$500 million for public health data modernization. It has since received an additional [\\$825 million](#) from Congress. The initiative “bring[s] together state, tribal, local, and territorial ... public health jurisdictions and [other] private and public sector partners to create modern, interoperable, and real-time public health data and surveillance systems.”¹⁵ One example of the initiative’s impact was the launch of a free web application developed by CDC and one of its technology partners in [Alaska](#) in 2021. This tool automated COVID-19 case reporting, allowing non-traditional testing locations in the state that had previously relied on calls, faxes, and spreadsheets to report cases more efficiently to the state.

Another aspect of data modernization involves health information exchanges (HIEs), which enable healthcare providers to share patient data with treatment providers across different healthcare and electronic health record systems. Two examples of improvements to state HIEs noted by [ASTHO](#) include:

[Maryland](#) enacted two laws to improve the Chesapeake Regional Information System for our Patients, Inc. (CRISP). These statutes authorized data exchange between the state health department and CRISP and require real-time data exchange between the two entities. More specifically, the [first law](#) established that privacy and security requirements do not prohibit sharing health data (1) required under federal law, (2) for purposes important to public health, or (3) for payment purposes. The [second law](#) designated CRISP a “health data utility.” Health data utilities (HDUs) emphasize multi-stakeholder organizational and data governance and are usually designated non-profit organizations or independent state agencies. They leverage existing infrastructure for clinical data exchange, such as regional and statewide HIEs.

In 2022, the Maryland Health Care Commission partnered with [Civitas Networks for Health](#) to host an HDU roundtable series and develop an [HDU Framework implementation guide](#) to serve as a guide to assist Maryland and other states, HIEs, and community partners in developing and implementing HDUs.

[Oklahoma](#) and several other states, including [Nebraska](#), [Rhode Island](#), and [Vermont](#), have also begun to formalize their HIEs by [shifting to the HDU model](#). In 2021, Oklahoma passed a law [creating](#) the Office of the State Coordinator for Health Information Exchange within the state’s Medicaid agency, the Oklahoma

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Health Care Authority ([Senate Bill 1369](#)). With the law's enactment, all healthcare providers in the state must use the state-designated HIE and report data to it.

Several counties are also investing in data modernization with specific funding authorized by the Coronavirus State and Local Fiscal Recovery Fund in the American Rescue Plan Act (ARPA). Counties undertaking these improvements featured in a recent [report](#) by the National Association of Counties include:

Camden County, New Jersey; Genesee County, Michigan; and Hidalgo County, Texas, which are expanding, implementing, or updating electronic health record systems.

Hamilton County, Ohio, which is investing in both the creation of public health data systems, including for emergency surveillance, and improved access to medical and social support services through a mobile tech bus.

Maricopa County, Arizona, which is using funds for a “vaccine management system that will provide access to real-time information and improve data-driven strategies to help guide immunization and outreach activities.”

Disaggregation of Data

[Disaggregation of data by race, ethnicity, language](#) and other demographic information, including sexual orientation and gender identity, is necessary to support health equity, disease control and high-quality patient care. It is impossible to accurately identify or meaningfully measure progress without [detailed data](#) to inform public health efforts. Importantly, while [legal concerns are often cited as a limitation](#) to collecting and disseminating disaggregated data, the [law is generally not a barrier](#). That said, laws that clarify legal authority or require data disaggregation are highlighted in this report.

Colorado passed a law in 2022 that requires the health department to collect data on race, ethnicity, disability, sexual orientation, and gender identity ([House Bill 1157](#)). The department's Office of Health Equity must establish “appropriate methods to collect and disaggregate” the data “for inclusion in data reports documenting health disparities,” and it is expected to use the data for strategic planning.

Oregon passed a law in 2021 clarifying and expanding upon existing state requirements for specified health care providers to collect race, ethnicity, preferred language, disability (REALD), sexual orientation, and gender identity information for patients and to report this data to the Oregon Health Authority annually ([House Bill 3159](#)). The bill also directed the Oregon Health Authority to establish a data system to collect the information.

In 2021, **Nevada** enacted a law which requires any governmental agency that requests from a person information related to the person's race or ethnicity to also request information related to sexual orientation and gender identity. ([Senate Bill 109](#)).

Strategic State Stockpiles

In a recent [report](#), the Congressional Research Service reviewed the performance of the strategic national stockpile (SNS), “which consists of drugs, vaccines, medical products, and ancillary supplies that can be deployed at the request of state, local, tribal and territorial health jurisdictions in response to a threat to public health.” Although there is no current requirement for state, local, tribal, or territorial governments to maintain their own stockpiles, these jurisdictions have the option to maintain supplies to prepare for and respond to a health emergency, and some grant funding has been available for this purpose. Some states have taken steps to plan for, establish, or strengthen state-based strategic stockpiles; for example:

California requires that employers in hospital settings maintain a three-month stockpile of new, unexpired and unused personal protective equipment (PPE) and provide them to employees (Assembly Bill 2537, enacted in September 2020). The law also created a PPE advisory committee to guide the creation of a California stockpile of PPE and guidelines for procurement to ensure a 90-day pandemic-level supply for all essential workers.

In 2022, **Colorado** passed a law which required the procurement and maintenance of a stockpile of essential materials for use following the Governor’s declaration of a disaster emergency ([HB22-1352](#)). The law further specified that the current authority of the state board of health to adopt rules and establish standards to assure preparedness by health agencies and providers included the authority to do so with respect to the maintenance of an adequate stockpile of PPE.

Public health powers and duties to keep our communities healthy and safe cannot be exercised and fulfilled without a robust workforce, which makes workforce policy innovation one of the key elements of a stronger public health system. However, recruiting, retaining, and [promoting the well-being](#) of skilled public health personnel became [even more challenging](#) during the COVID-19 pandemic. Increased demands on the public health workforce clashed with [several other factors](#), including planned retirements, chronic underfunding of the public health system, and unexpected threats and harassment. The latter necessitated an entirely new body of [research](#) to both assess the impact of workplace violence perpetrated against public health officials and identify potential solutions to the problem. Legal protections for the public health workforce are on the books¹⁶ and the passage of new laws that explicitly protected the personal information of public health workers in some jurisdictions (such as [Colorado House Bill 21-1107](#)) offered hope in the face of significant workforce safety concerns. It is also clear that [workforce policy innovation](#) must include longer-term investments to strengthen public health system capacities, such as preparing leaders to respond to political conflict more effectively, providing training on how to engage with law and policy more strategically, and developing additional [public health workforce networks](#) for [mutual support](#). This section includes legal and policy workforce innovations that were prompted by the pandemic, some of which may also benefit workers in their usual, day-to-day, non-emergency lives.

Hazard Pay

The pandemic brought into focus the role that frontline, essential workers played in providing services and goods to communities that was not only crucial to the well-being of communities but also placed these workers at increased risk of illness. These workers were predominantly low-wage earners who were [less likely to be able to work from home](#) and avoid exposure to COVID-19. Consequently, dedicated federal funding was appropriated for hazard pay for these workers under the 2020 CARES Act and the American Rescue Plan Act (ARPA). Notably, state and county workers, including those working in public health, received hazard pay in some jurisdictions.

[Missouri provided \\$73 million in premium pay](#) to more than 18,000 state employees in 2021 using CARES Act funds. Additionally, in 2023, the state enacted [House Bill 14](#), which provided an 8.7 percent cost-of-living pay increase for all state employees.

[Santa Clara County, California](#) granted nearly all 22,000 county employees [“hero pay”](#) — a one-time bonus of \$2,500 – in late 2021, which was funded from \$187.2 million in ARPA funds and totaled just over \$76 million.

Capacity, Recruitment, and Retention

The [outsized loss](#) of state and local public health staff in 2021 coincided with the enactment of the American Rescue Plan Act, from which the CDC, in 2022, [awarded \\$3 billion](#) over five years to help U.S. state, local, and territorial jurisdictions strengthen their public health workforce. [These grants](#) support health departments in all U.S. states, territories, freely associated states, and Washington, D.C., as well as 48 large cities.

Community Health Workers

The American Public Health Association [defines](#) “community health workers” (CHWs) as “frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. This trusting relationship enables CHWs to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHWs also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.” Even within challenging legal frameworks and reimbursement models, [CHWs](#) have long been working to [serve as a bridge](#) between the healthcare system and communities experiencing health inequities. Between the federal [CARES Act](#) (\$300 million) and [ARPA](#) (\$200 million), nearly half a billion dollars were invested in strengthening the CHW workforce through 2025. The surge of CHWs has been vital to combatting COVID-19 misinformation and mistrust by educating, connecting, and assisting those most at risk, including by meeting diverse language and messaging needs necessary to promote masking, testing, and vaccination.¹⁷ While these cash infusions have temporarily improved funding to scale up the [evidence-based CHW model](#), short-term funding is not a sustainable solution.

The opportunity to build on the influx of federal pandemic funding was seized by **California** in 2022 when it [added CHW services](#) as a covered Medicaid (known as Medi-Cal) benefit. The state legislature then enacted a law enshrining the benefit in state statute that also required Medi-Cal managed care plans to promote the benefit to enrollees and ensured front-line CHWs remain actively engaged in efforts shaping the new benefit ([Assembly Bill 2697](#)). While this legal innovation may not be possible in all states or [cover the full scope of CHWs](#), it serves as one example of [the many ways](#) states are working to recognize CHWs as a fundamental component of the public health workforce.¹⁸

Loan Forgiveness

One significant obstacle faced by new health department hires is that they cannot afford relatively low governmental public health wages because their specialized education left them with student loan debt. The [median debt](#) of a master’s level public health graduate hovers just over \$50,000. A federal public health loan repayment program has now been authorized three times—first in the [Pandemic and All](#)

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[Hazards Preparedness Act](#) (2006), the [Patient Protection and Affordable Care Act](#) (2010), and most recently in the [Consolidated Appropriations Act of 2023](#)—but the program has yet to secure funding. Efforts remain underway by the [National Alliance of Public Health Students & Alums](#) to actualize public health student loan forgiveness.

Building Public Health Workforce Capacity Related to Law and Policy

The COVID-19 pandemic highlighted the need for legal and policy acumen among public health leaders and practitioners. In 2021, the Public Health Foundation revised the [Core Competencies](#) for public health, and in 2022, the Public Health Accreditation Board released a revised set of [accreditation standards and measures](#) for excellence in public health department practices. Taken together, both of these voluntary standards provide guidance for individual and organizational public health workforce development. Both the Core Competencies and the Accreditation Standards include policy development among their domains, and highlight skills and practices such as establishing, maintaining, implementing, enforcing, evaluating, and improving policies, as well as strategic planning, including community health improvement. These are [not new priorities](#) for public health and the public health workforce, though recent years saw the development of new tools and supports for building public health workforce capacity related to law and policy, frequently with an elevated focus on health equity.

Promising efforts to support health departments’ understanding and use of law effectively include:

NACCHO has worked with the CDC’s Public Health Law Program to examine different kinds of partnerships between Local Health Departments (LHDs) and public health attorneys hired by the state health agency or the county attorney’s office. This effort, titled “[Lawyer Up to Level Up: Legal Stories from the Field](#)” highlighted several examples of ways in which local health departments access the services of lawyers with public health expertise. One successful model can be found in [South Carolina](#), where LHDs work directly with dedicated public health attorneys employed by the state health agency. Four of the 18 dedicated public health attorneys provide support solely for public health programs, including the state’s 46 LHDs.

The CDC’s Public Health Law Program and ChangeLab Solutions’ launching of the new [Public Health Law Fellowship](#), which is designed not just for law students and recent law graduates and other graduate students and recent graduates (e.g. MPH, DrPH, MPA, PhD) interested in on-the-job training for a career in public health law or policy. The [Public Health Law Academy](#) offers free, online training about the legal system and the use of law and policy for improving health outcomes.

Collaborative efforts of public health lawyers, public health legal organizations, and partner organizations to support the field, by providing legal resources, legal training, and legal technical assistance. Examples include [Act 4 Public Health](#), [the Collaborative for Anti-Racism and Equity](#), the [COVID-19 Policy Playbook](#), and [Fighting 4 Public Health](#).

The growing use of [legal epidemiology](#) and policy [surveillance](#) to systematically study and determine the role law plays as a determinant of health, including evaluating which laws work to improve the public’s health, is also an important and powerful policy tool. For example, the [Local Policy Surveillance Project](#)

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[of 2018](#) built capacity in local health departments to monitor and assess local policies related to public health goals.

Most [public health authority legislation](#) introduced in 2021 and 2022 related to [regulating public health measures](#), such as vaccination requirements or mask mandates (of the [1531 bills total](#), 1197 were intervention bills). Among the bills that addressed public health authority that were actually enacted by states between January 2021 and May 2022, many [significantly weakened](#) the ability of public health to respond quickly and effectively in future emergencies and to carry out day-to-day public health activities. Yet even as most bills and laws restricted state or local authority, some facilitated the adoption of important mitigation measures [meant to slow the transmission of COVID-19](#). Some of these measures, such as explicitly or implicitly allowing local governments to implement requirements to wear a mask in public gathering spaces or requiring government officials to transparently set forth the evidence and reasoning in support of public health orders, are discussed elsewhere in this report, such as in the [Governance section](#).

Two larger efforts focused on seeking to identify regulatory approaches to infectious disease control that may represent either a post-COVID consensus or a jurisdiction-specific assessment of regulatory best practices are taking place under the auspices of the Uniform Law Commission and the CDC, respectively. The [Uniform Law Commission](#) is composed of law professors and attorneys who tackle thorny legal issues and develop proposed legislation, and then seek its passage in every state. A committee of the Uniform Law Commission is in the process of developing a [proposed Model Public Health Emergency Authority Act](#) intended to clarify the authority of governors to declare public health emergencies and issue orders related to the declaration, as well as to hold the governor accountable to the legislature and the public. If the model act is endorsed by the Uniform Law Commission as a whole, public health practitioners and advocates should prepare for its introduction in their state in the coming years. The [Prevention Measures Law Assessment Tool](#) is a collaborative effort of the CDC, the Association of State and Territorial Health Officials (ASTHO), and the Network for Public Health Law to update a tool for assessing legal measures to control the spread of infectious disease and increase access to vaccines ([formerly known](#) as the [Social Distancing Law Project](#)), which is currently undergoing pilot testing. The updated tool includes background legal information, a template questionnaire and suggested protocols for a legal consultation meeting and tabletop exercise. The tool can be used to generate a jurisdiction-specific report and recommended action steps.

This section of the report highlights examples of several types of laws enacted to enable state and local officials to use not only direct regulation, but also other legal tools, to protect the public's health, especially in emergency situations. Measures that alter the [socioeconomic environment](#) are included here because they address important upstream determinants of health, including the ability to comply with public health orders and requirements. These socioeconomic measures mitigate the unequal burden experienced most often by disenfranchised communities due to long-standing systemic inequities and the prolonged nature of the COVID-19 epidemic.

Expanded and More Equitable Access to Preventive Care and Treatment

[States followed a number of different legislative and policy paths](#) in order to increase access to health care, including both prevention and treatment, among those who wanted it but who had encountered

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barriers to access. Some measures sought to increase access to vaccines, whether specifically for COVID or more broadly. These measures included approaches such as requiring private insurance to cover COVID testing, vaccines, and treatment to the extent not covered by the federal government, expanding coverage for vaccines for adults under the federal Medicare and Medicaid programs, choosing COVID vaccine distribution sites and partnering with community organizations in order to provide equitable access to vaccines in communities of color and communities with lower incomes, and amending state scope of practice laws so that health care providers such as pharmacists were authorized to administer COVID vaccines. One public health intervention with ramifications well beyond the pandemic is the decision in several states to expand Medicaid coverage during the pandemic, either by legislative enactment or by popular referendum.

Medicaid Expansion

As of March 27, 2023, 41 states (including the District of Columbia) have opted to expand Medicaid. Among those recently expanding coverage as reported by [Kaiser Family Foundation Health News](#) are **Missouri, North Carolina, Oklahoma** and **South Dakota**.

In **Missouri, Oklahoma** and **South Dakota** voters approved ballot measures to add Medicaid expansion to their respective state constitutions. Coverage in Missouri and Oklahoma was retroactive to July 1, 2021, and the effective date for implementation in South Dakota is July 1, 2023. Language in the ballot measures in each state prohibited additional burdens or restrictions on eligibility for the expansion population.

On March 27, 2023, the **North Carolina** governor signed a law passed by the legislature, directing the state to expand Medicaid, with implementation conditioned on available appropriations in the State Fiscal Year (SFY) 2023-2024 biennial budget ([House Bill 76](#)). The expansion is expected to provide health coverage to more than 600,000 North Carolinians and includes provisions increasing hospital assessments to fund the state share of expansion and increasing hospital reimbursement rates.

Expanded Medicare and Medicaid Coverage for Adult Vaccines

Under the Inflation Reduction Act of 2022, cost-sharing for all adult vaccines covered by Medicare and Medicaid was eliminated for [Advisory Committee on Immunization Practices](#)-approved vaccines. [Complete coverage](#) was provided for these preventative vaccines for Medicare as of January 1, 2023 and for Medicaid as of October 1, 2023. The elimination of cost-sharing and co-payments may increase vaccination rates in the adult population, where lack of insurance is one of a diverse set of barriers to low immunization uptake. An increase in affordability [may help to reduce existing racial and ethnic disparities](#) with respect to access to these vaccines. Additional [potential strategies](#) to enhance vaccine access and uptake for Medicaid enrollees are promising.

Equitable Vaccine Allocation and Distribution

Many states took steps to ensure that vaccine allocation programs, plans, and policies were informed by data which identified racial, ethnic, geographic, and other disparities, such as through the use of the [CDC's Social Vulnerability Index](#). As noted above in the Funding and Health Equity sections, states including **Michigan** and **Wisconsin** addressed vaccine equity through grant-making to facilitate partnerships with community-based organizations programs and other states, including **Virginia, Utah**, and **Massachusetts**, addressed vaccine equity in their state health equity task forces.

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Other examples of informal approaches to increase equitable vaccine access through programs, plans, and policy statements include:

New Hampshire and **Connecticut**, each of which vowed to [reserve 10% of their vaccine allocations](#) for communities “hard hit by the pandemic” and based on the social vulnerability index; and **North Carolina**, which publicly announced focusing additional vaccine allocation in communities with [“larger aged populations and historically marginalized populations.”](#)

Expanded Vaccine Access through Scope of Practice Laws for Health Care Providers

States also expanded the scope of practice for health care providers to increase access to care, especially vaccinations, in a variety of ways. Strategies employed by states included relying upon existing authority expand the ability of health-care providers licensed in other states to provide care, authorizing providers such as pharmacists, pharmacy technicians, or pharmacy students to administer COVID vaccines (this [document](#) from the National Alliance of State Pharmacy Associations analyzes the developing authority of pharmacists to administer COVID and other vaccines by state, age of the patient, and whether a prescription is required), and authorizing dentists to administer COVID and/or flu vaccines, sometimes with specified training requirements (for an example, see Wisconsin [Senate Bill 13](#)).

Regulation of Private Insurance

Several states implemented [novel insurance requirements](#) to increase equitable access to care:

In March, 2021, **Maine** enacted [S.P.29 - L.D. 1](#), An Act to Establish the 1 COVID-19 Patient Bill of Rights and To Amend the Governor’s Emergency Powers. This Act codified the Superintendent of Insurance’s orders relating to no-cost access to COVID-19 screening, testing and immunization that would remain in effect after the state of civil emergency expired.¹⁹

The **Alaska** Department of Commerce, Community and Economic Development, Division of Insurance, [Bulletin 20-11](#) (March 27, 2020) provided protections for employee coverage under group policies, including continued eligibility during decreased work hours and prohibited insurers from increasing premium rates or terminating a group policy based on a group’s decreased enrollment or participation due to COVID-19.”

Social and Economic Supports

As governments implemented far-reaching executive orders, public health emergency orders, and other regulations, social and economic disruptions were foreseeable, but governments employed [social and economic supports](#) to help soften the impact, particularly among the most economically vulnerable populations. These supports included eviction moratoria, paid sick leave, expanded unemployment benefits, food support, expanded insurance coverage for telehealth and expanded access and infrastructure for broadband to support remote learning and remote work. This section provides examples of eviction moratoria and related eviction protections and paid sick leave.

Eviction Moratoria and Other Eviction Protections

[Eviction moratoria](#) that allowed people to stay in their homes and adhere to shelter-in-place orders, and that prevented homelessness were common throughout states and territories at the beginning of the

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pandemic as courts shut down and jobs were lost. Most moratoria were enacted through court or executive orders. The CDC also issued an eviction moratorium that was eventually [overturned](#) by the Supreme Court. While most states and territories have restarted their eviction proceedings, some made lasting changes to their laws and procedures that aim to balance the protection of the most vulnerable tenants with the economic stability of landlords.

In **Washington, DC**, evictions authorized prior to March 11, 2020 but not executed were [put on hold](#) until July 25, 2021. Eviction filings were prohibited between March 11, 2020 and January 1, 2022, except in limited circumstances (*e.g.* for issues of public safety). Nonpayment of rent was not a [permissible exception](#) to the moratorium until October 12, 2021. Following the expiration of the Public Health Emergency and the Public Emergency, District Council voted to enact a limitation on landlords' eviction actions, prohibiting any eviction filings for rental arrears of \$600 or less. This pandemic-based policy became [District law](#) on May 18, 2022.

The New Mexico Supreme Court [issued orders](#) on March 24 and 26, 2020 which stayed eviction proceedings based on failure to pay rent. The [moratorium was lifted](#) on a pilot basis February 1, 2022 in a small number of counties. As the moratorium was lifted throughout the state, New Mexico launched the [Eviction Prevention and Diversion Program](#) that provided limited rental funding for applicants.

In 2020, the **New Jersey** Legislature [passed a law](#) explicitly granting the Governor the authority to issue Executive Orders declaring eviction moratoria. The Governor declared an [eviction moratorium](#) on the same day the law was signed. In August 2021, in advance of the moratorium's [January 1, 2022 expiration](#), [Senate Bill 3691](#) was enacted which codified permanent protections for renters whose incomes were below 120% of their county's area median income and who had experienced economic hardships during the pandemic. This law provided permanent protection from eviction or removal at any time for nonpayment of rent, habitual late payment of rent or failure to accept a rent increase that accrued from March 2020 through August 2021.

Kentucky issued an eviction moratorium during the pandemic that extended into 2021, consistent with the CDC's eviction moratorium. Following the end of the CDC's eviction order, Kentucky announced the [Healthy at Home Eviction Relief Fund](#) supported by federal funding that assisted renters who experienced "income reduction/loss or other economic hardship as a result of the COVID-19 pandemic" as long as funds remained available. Applications were closed as of [January 20, 2023](#). Concurrently, the Kentucky Supreme Court also announced an [eviction diversion pilot program](#) in Jefferson County Evidence suggests that higher eviction filing fees discourage landlords from treating eviction as a default option to address late and unpaid rent and encourage more collaborative strategies. **Minnesota** has adopted one of the highest eviction filing fees in the nation.²⁰

Paid Sick Leave

Congress passed the **Families First and Coronavirus Response Act (FFCRA)** in 2020 which provided employees of covered employers with paid sick leave. However, the law applied only to employers with fewer than 500 employees, and small businesses with fewer than 50 employees could request

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exemptions. While many individuals were covered by the Act, states were left to fill the gaps to the extent possible through law and policy.

Effective January 1, 2021, [Colorado](#) enacted a permanent requirement that employers with over 16 employees provide one hour of accrued paid leave per 30 hours worked, up to 48 hours per year, and has required all employers in Colorado to provide supplemental emergency leave.

- In addition to this permanent requirement, all employers in Colorado have been obligated to provide public health emergency leave since January 1, 2021 for the duration of a federal, state or local declaration of emergency. This supplemental emergency leave provides an 80-hour one-time benefit for full-time employees (with less for part-time employees).
- As of January 1, 2022, the [Colorado Healthy Families and Workplaces Act](#) provided that all employers regardless of number of employees must provide paid sick leave and accrued paid leave for time out on sick leave. The leave time provided under the Act expired when both the federal and Colorado declared public health emergencies were no longer in effect.

[California](#) has required employers to [provide paid sick leave](#) since 2015. In April 2020, the Governor issued [Executive Order N-51-20](#) which provided supplemental paid sick leave for food sector workers. From 2020 through 2022, the governor and the legislature worked together to fill the gaps in the federal Families First and Coronavirus Response Act leave protections by passing a series of laws to:

- Extend paid sick days protections by including employers with over 500 employees nationwide and public and private employers of first responders and health care employees who opted not to cover their employees under federal law ([Assembly Bill 1867](#), 2020)
- Impose new obligations on employers to provide COVID-19 supplemental paid sick leave for employees who are unable to work or telework for certain qualifying reasons. [Senate Bill 95](#) (2021).
- [Extend supplemental leave](#) through September and subsequently through December 31, 2022. [Senate Bill 114](#) and [Assembly Bill 152](#) (2022).

Conclusion

If we are to face and overcome the public health threats of the present and the future, we must have systems that support quick, decisive, and collective action. The laws and policies that will most effectively create the conditions for people to be healthy are grounded in the best available evidence, with accountability for responsible, democratic decision-making, and crafted to advance justice and fairness and dismantle systems that consistently produce better conditions and outcomes for members of favored groups, particularly groups based upon race, ethnicity, national origin, and language.

To the extent that vocal critics resisted public health leadership and measures during the COVID-19 pandemic, many of their protests were focused on public health interventions implemented through direct regulation, including emergency orders. Regulation is a critical tool of public health law, whether in an emergency or when facing day-to-day public health challenges. However, throughout the past three years of the COVID-19 pandemic, governments at every jurisdictional level within the United States have implemented bold, creative new laws and policies to strengthen the ability of public health to fulfill its mission — not only by regulating behavior, but by changing the conditions in which individuals make their choices and live their lives. This report highlights numerous examples across six domains of the public health system: governance, funding, health equity, infrastructure, workforce, and public health interventions.

Innovative laws and policies for a post-pandemic public health system must be informed by science, law, and ethics. The best information available may include emerging evidence, expert opinion, and the lived experiences of the most affected communities. Laws and policies should be conceptualized, drafted, implemented, and enforced with legal skill; political, economic, and cultural sensitivity; and an orientation toward increasing fairness and health equity. The breadth and diversity of examples discussed in this report provide ample reason to hope that public health can emerge from the COVID-19 pandemic better prepared and equipped to fulfill its mission to protect and improve the health of the population as a whole in the years to come.

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¹ While criticism and legislative proposals to limit public health authority frequently appeared to be spontaneous and localized, entities such as the American Legislative Exchange Council (ALEC) played an organizing role.

² The focus of this report is on legislation, not litigation. Those seeking a detailed analysis of court opinions arising out of the COVID-19 pandemic may be interested in Wendy Parmet, *CONSTITUTIONAL CONTAGION: COVID, THE COURTS, AND PUBLIC HEALTH* (Cambridge University Press, 2023), available at <https://www.cambridge.org/core/books/constitutional-contagion/6BF9D06349549B35507967DEDB252301>.

³ Salwa, J., & Robertson, C. (2021). *Designing an Independent Public Health Agency*. *NEW ENGLAND JOURNAL OF MEDICINE*. See also Jacqueline Salwa and Christopher Robertson, *The Need for a Strong and Stable Federal Public Health Agency Independent from Politicians*, in *COVID Policy Playbook II*, Chapter 9 (2021).

⁴ Id.

⁵ Id.

⁶ The Collaborative for Anti-Racism and Equity (CARE), at <https://herenow.org/definitions/>. The Network is a co-founder of the Collaborative for Anti-Racism and Equity (CARE), a national group of partners working to understand and support the movement to address racism as a public health crisis.

⁷ For analysis of declarations from several regions of the United States, see e.g., Dawn Hunter, *State and Local Efforts to Declare Racism a Public Health Crisis: Southeastern Region Update*, available at <https://www.networkforphl.org/resources/state-and-local-efforts-to-declare-racism-a-public-health-crisis/> and Morgan Axtell Jones, *State and Local Efforts to Declare Racism a Public Health Crisis: Eastern Region Update*, available at <https://www.networkforphl.org/resources/state-and-local-efforts-to-declare-racism-a-public-health-crisis-eastern-region-update/>.

⁸ American Public Health Association, *Racism as a Public Health Crisis: From Declaration to Action*, available at <https://endingracism.apha.org/> and Cliff Despres, Update: 246 Cities, Counties, Leaders Declare Racism a Public Health Crisis! (September 1, 2021), available at <https://salud-america.org/rising-number-of-cities-counties-are-declaring-racism-a-public-health-crisis/> .

⁹ Dawn M. Hunter and Betsy Lawton, *Centering Racial Equity: Disparities Task Forces as a Strategy to Ensure an Equitable Pandemic Response*, SAINT LOUIS UNIVERSITY JOURNAL OF HEALTH LAW AND POLICY (2021), available at <https://scholarship.law.slu.edu/cgi/viewcontent.cgi?article=1260&context=jhlp>.

¹⁰ National Network of Public Health Institutes, Challenges and Opportunities for Strengthening the U.S. Public Health Infrastructure (2021) p.2, available at <https://nnphi.org/wp-content/uploads/2021/06/NNPHI-E2A-Kresge-Report-Web.pdf>.

¹¹ Denise Toney, et al., *Creating a Blueprint for the Future: Lessons Learned from Public Health Laboratories in the COVID-19 Response*, JOURNAL OF PUBLIC HEALTH MANAGEMENT AND PRACTICE (Jan./Feb. 2021), available at https://journals.lww.com/jphmp/Fulltext/2021/01001/Creating_a_Blueprint_for_the_Future_Lessons.17.aspx .

¹² *Id.*

¹³ *Id.*

¹⁴ Bipartisan Policy Center, *Public Health Forward: Modernizing the U.S. Public Health System* (2021), available at https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/12/BPC_Public-Health-Forward_R01_WEB.pdf.

¹⁵ Centers for Disease Control and Prevention, *Public Health Data Modernization Initiative*, fact sheet available at https://cdn.ymaws.com/www.cste.org/resource/resmgr/data_health/covid-19-data-modernization-.pdf.

¹⁶ Brooke Torton, *50 State Survey: Legal Protections for Public Health Officials* (Nov. 2020), available at <https://www.networkforphl.org/resources/legal-protections-for-public-health-officials/>; see also Stand with Public Health, *50 State Survey: Doxing – Legal Protections for Public Health Officials*, available at <https://standwithpublichealth.ihsph.edu/project/50-state-survey-doxing-legal-protections-for-public-health-officials/>; Stand with Public Health, *50 State Survey: Threats and Interfering with Government Operations – Legal Protections for Public Health Officials*, available at <https://standwithpublichealth.ihsph.edu/project/50-state-survey-threats-and-interfering-with-government-operations-legal-protections-for-public-health-officials/> .

¹⁷ National Association of Community Health Workers, *Recommendations for Federal and State COVID-19 Vaccine and Testing Equity*, available at <https://nachw.org/2022/10/12/recommendations-for-federal-and-state-covid-19-vaccine-and-testing-equity/>; Shelby Rowell, *A Grassroots Leader’s Vision for the Future Community Health Workforce* (August 10, 2022), available at <https://www.astho.org/communications/blog/grassroots-leaders-vision-for-future-community-health-workforce/>; Keith Allen et al., *Despite Being Crucial to Reducing Health Disparities, Culturally Relevant Health Care Programs Remain Poorly Funded*, available at <https://www.networkforphl.org/resources/despite-being-crucial-to-reducing-health-disparities-culturally-relevant-health-care-programs-remain-poorly-funded/> .

¹⁸ See e.g., Shelby Rowell, *Why Louisiana Doesn’t Certify Community Health Workers* (May 10, 2023), (telling Louisiana’s story of how, after an engaged process that included direct CHW input, it decided not to pursue CHW certification), available at <https://www.astho.org/communications/blog/why-louisiana-doesnt-certify-community-health-workers/> .

¹⁹ For an analysis of the far-reaching legal repercussions of the end of the national public health emergency, see Erica White et al., *Legal and Health Care Repercussions of the End of the National Public Health Emergency* (May 30, 2023), available at <https://www.networkforphl.org/resources/legal-and-health-care-repercussions-of-the-end-of-the-national-public-health-emergency/>. For an updated list of the current status of state public health emergency declarations, please see, Erica White, et al., *Guidance: State COVID-19 Emergency Declarations*, (June 1, 2023), available at <https://www.networkforphl.org/resources/guidance-state-covid-19-emergency-declarations/>.

²⁰ Minnesota Judicial Branch, District Court Fees, <https://www.mncourts.gov/Help-Topics/Court-Fees/District-Court-Fees.aspx>.