Date: **July 5, 2020**

To: **Commissioner Tim Berg, Chair, Scope and Program Committee**

From: **Diane Boyer, Chair, Study Committee on Public Health Emergency Authorities**

Re: **Report from Study Committee**

Introduction:

The memorandum constitutes the final report of the Study Committee on Public Health Emergency Authorities. The Committee was charged by the Executive Committee of the Uniform Law Commission (ULC) with "addressing the authority of state governments to respond to epidemics, pandemics and other health emergencies," and to consider:

1) The authority of state governments to order individual and area quarantines, isolation, social distancing, and other restrictions on travel and gatherings and the enforcement of such powers;
2) The authority of states to order the closure of non-essential business, and the criteria for determining which businesses are essential;
3) State government acquisition of critical resources through collective purchasing mechanisms (including the need to comply with federal antitrust law) or through commandeering private property; and
4) Rules for medical practice, including crisis standards of care, licensure reciprocity, and information sharing.

The Committee met four times via Zoom between May 15, 2020 and June 26, 2020. In addition to the Commissioners and the Reporter, Professor Wendy E. Parmet, representatives from the American Bar Association, the National Association of City and County Health Officials, the Council of State Governments, and Professors Polly Price and James Hodge attended one or more meetings.

In the initial meeting on May 15, the Committee decided to organize its research and discussion into three large areas:

1) The authority of state governments to order social distancing orders, and other emergency restrictions (such as requiring individuals to wear masks and closing non-essential businesses);
2) State purchasing cooperative and price gouging laws; and
3) State emergency laws relating to the health care system.

The Committee further decided in its initial meeting not to conduct further research or discuss isolation and quarantine laws because our initial research indicated that all states had statutes relating to such powers. In addition, isolation and quarantine provisions were included in both the 2001 Model State

Emergency Health Powers Act (MSHEPA) and the 2003 Model State Public Health Act. In its initial meeting, the Committee also decided not to explore crisis standards of care because a review of this issue would touch upon important bioethical issues and require the input from stakeholders who were not available to the Committee. Several commissioners also noted that full consideration of crisis standards of care would force us to discuss tort reform (as legislation about crisis standards tends to be coupled with immunity provisions) that was outside the scope of the Committee. Finally, the Committee decided not to discuss license reciprocity because the Uniform Emergency Volunteer Health Practitioners Act largely covers this issue.

Recommendation:

The Committee unanimously agreed upon the following recommendations:

- **Not** to recommend sending the following issues to a drafting committee:
    - Collective purchasing agreements;
    - Price gouging legislation;
    - State allocation of health services; and
    - Laws relating to the stockpiling of critical medical resources.
- To request **further time to monitor and study**, and report back by July 2021 on the following issues:
    - The full array of social distancing and mask laws (including their disparate impact); and
    - Laws designating essential and non-essential medical services.

The remainder of this memo reviews the law and describes the Committee's reasoning as to the items listed above in the manner and order in which we organized our discussions.

I. **Collective Purchasing Agreements & Price Gouging Laws**

Our research showed that states currently have ample authority to enter into collective purchasing agreements to attain critical supplies, and that these agreements do not raise either constitutional or antitrust concerns.

Under Article I of the U.S. Constitution, certain interstate compacts must be approved by Congress. Congressional approval is required when the compacts alter the balance of power between the states and the federal government or intrude upon a power reserved to Congress. Previous state-led purchasing agreements have not been considered to require Congressional approval, and there is little reason to believe that future purchasing agreements to procure pandemic-related supplies would be so considered.

Even if such compacts did require Congressional approval, the existing Emergency Management Assistance Compact (EMAC), which has received Congressional consent, would appear to provide authorization. All 50 states and the U.S territories have adopted the EMAC, and states have utilized it in

response to a range of disasters, including floods, hurricanes, and the 9/11 terrorist attacks. Several states have shared resources under the EMAC in response to COVID-19.

In addition, since the start of the pandemic, many governors have entered into a range of informal understandings to increase their market power and coordinate purchasing of ventilators, personal protective equipment (PPE), and other medical equipment. These informal understandings do not appear to raise any constitutional issues as they are not interstate compacts and would almost certainly not run afoul of the Compacts Clause in Article I of the Constitution. Moreover, the existence of these loose agreements, plus the states' reliance on the EMAC, show that governors appear to have sufficient existing authority to enter into formal or informal collective purchasing agreements.

The Committee also looked at whether state collective purchasing agreements would raise antitrust issues. Our research indicated that they would not. Under settled law, the Sherman Act does not apply to state action. The market participation exception should not apply under these circumstances.

During a pandemic, as during any emergency, price gouging becomes a major problem. However, 34 states plus the District of Columbia already have statutes that prohibit price gouging upon the declaration of a state of emergency. In addition, other states can rely on existing state consumer protection law to police price gouging practices.

Despite the existence of these laws, the pandemic has exposed gaps in existing legislation. Most critical is the fact that state laws cannot reach out-of-state products. This points to the need for federal legislation, which would likely completely or partially preempt state law were it enacted.

For these reasons, the Committee concluded not to recommend either price gouging or collective purchasing agreements to a drafting committee.

2. Social Distancing & Mask Laws

Since the start of the pandemic, governors, state health commissioners, and local officials have instituted a wide range of emergency orders designed to retard the transmission of SARS-COV-2, the virus that causes COVID-19. These measures include isolation and quarantine orders, requirements for contact tracing, shelter-in-place orders, intra and inter-state travel restrictions, closures or limitations on businesses, restrictions on public gatherings, and orders requiring the wearing of masks. For purposes of discussion, the Committee has referred to all such orders as "social distancing measures." In addition, because another Study Committee has been charged with looking at the division of authority between states and local governments with respect to pandemic response, this Committee did not consider that issue.

The Committee's discussion of social distancing measures was informed by extensive research (available on the Committee's workspace on the ULC website) conducted by the staff, interns, and law student research assistants. The research reviewed a wide range of state orders, the statutory authority for such measures, as well as court decisions raising statutory and constitutional claims. Given the wide array of issues, and the dynamic nature of developments in this area, this memo only seeks to highlight key

points to explain why the Committee believes it should be given more time to further monitor developments and more fully discuss whether the issues should be sent to a drafting committee.

First, all states have some provisions that permit the governor or another state official (usually the health commissioner/secretary) to declare an emergency and exercise emergency powers. What is particularly interesting to note is that to a large degree, during the pandemic, governors and other executive branch officials relied on their general emergency powers, rather than specific public health emergency laws. State laws also vary significantly as to the duration of emergency orders, and the circumstances and procedures through which they may be extended. Indeed, because state emergency laws were often drafted with natural disasters in mind, the legislatures most likely did not contemplate that they would be used throughout the state for months or years on end to combat a long-term pandemic.

Second, with the exception of isolation and quarantine laws (which often do not depend on the declaration of an emergency) most state public health laws provide little specificity with respect to many of the measures that have been instituted during the current crisis. For example, few states have statutes that expressly authorize the closing of business, though many states appear to authorize executive officials to control the movement of persons and the occupancy of premises during an emergency.

Explicit statutory authorization is also lacking for many other measures that have been instituted during the pandemic. At least one-fifth of the states expressly authorize restrictions on gatherings. No statutes explicitly authorized shelter-in-place orders, though once again general emergency power to control the movement of individuals could be interpreted to provide the requisite authority. We also could not find any pre-COVID law authorizing the executive to require individuals to wear masks.

The 2001 MSEHPA does grant governors broad power during a public health emergency. Section 601 requires public health authorities to "use every available means to prevent the transmission" of an infectious disease. It also provides specific authority for closing of any facility and limiting travel into and out of affected areas. However, even the MSEHPA does not contemplate the full range and wide scale of the measures we have seen instituted in response to COVID-19. Moreover, as noted above, many states have not relied on their public health laws; instead, they have relied on general emergency laws.

Third, since late March, there has been a plethora of litigation raising statutory and constitutional claims against state social distancing measures. Two important state cases focused on state statutory issues. Both cases arose out of disputes between the governor and the legislature and raised significant separation of powers issues.

In *Wisconsin v. Palm*, 391 Wis. 2d 497 (2020), the Wisconsin Supreme Court agreed with the Wisconsin legislature that the Secretary of Health's social distancing orders were rules that should have been instituted via notice and comment rulemaking. The court also found that the Secretary's statutory authority to prevent the spread of communicable diseases did not authorize the range of measures that she had imposed in response to COVID-19.

In *Kelly v. Legislative Coordinating Council*, 460 P.3d 832 (2020), the Kansas Supreme Court sided with the Governor, rejecting the Council's claim that it had authority to block the Governor's social distancing orders.

Many more courts have reviewed constitutional challenges of social distancing measures. Claims have been brought based on freedom of speech, the right to petition and assembly, free exercise of religion, substantive and procedural due process, the right to travel, the Second Amendment, and the takings clause. For the most part, courts have refused requests to enjoin state orders, relying on the Supreme Court's 1905 decision of *Jacobson v. Massachusetts*, 197 U.S. 11 (1905), to hold that courts should ordinarily be deferential to state officials during a public health emergency. Perhaps the most notable decision to reject a temporary restraining order was by the United States Supreme Court in *South Bay United Pentecostal Church v. Newsom*, No. 19A1044, 2020 WL 2813056 (U.S. May 29, 2020). In this case, the Court by a 5-4 vote rejected a church's emergency request for the Court to block California Governor Newsom's ban of in-person religious services. The majority of the Court did not issue an opinion, but in a concurring opinion, Chief Justice Roberts emphasized that courts should provide deference to state officials, and that the plaintiffs were unlikely to succeed on their first amendment claim because the order did not discriminate against religious services, as comparable secular activities were also barred. He also noted that the burden was on the plaintiffs in their attempt to seek an emergency order pending an appeal. In a dissent joined by Justices Gorsuch and Thomas, Justice Kavanaugh stated that the plaintiffs were likely to succeed in their free exercise claim.

Although a minority, several lower courts have enjoined state orders banning religious services. In contrast to Chief Justice Roberts, these courts have found that the particular order at issue discriminated against religious services usually by explicitly referencing religious services and by not designating them as an essential service. At least one court has also raised concerns, without blocking, a state law requiring out-of-staters to quarantine for 14 days. *Bayley's Campground v. Mills*, 2020 WL 2791797 (D. Me. May 29, 2020). Given the pace of litigation, the Committee expects that many more cases will be decided in the next few months (especially if states re-impose social distancing measures as cases of COVID-19 surge) based both on state structural/statutory grounds and constitutional claims. These cases may well provide greater clarity on the constitutional and structural constraints on state social distancing measures. Drafting a uniform law before the litigation on these structural and constitutional issues develops more fully seems premature.

Fourth, preliminary public health research indicates that both COVID-19 as well as the social distancing measures that have been used to control it have disproportionately impacted racial and ethnic minorities.[1] Racial and ethnic minorities, as well as low wage workers, are also disproportionately

[1] Centers for Disease Control and Prevention, COVID-19 in Racial and Ethnic Minorities (June 25, 2020), https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html#:~:text=Among%20some%20racial%20and%20ethnic,among%20non%2DHispanic%20white%20persons.

impacted by social distancing measures.[2] These inequities point to an important point that was raised by the ABA Advisors to the Committee: social distancing laws are more likely to be effective if they are coupled with measures that provide people with the means to comply.

While recognizing the importance of states providing support for compliance, the Committee was worried about recommending measures that would have a significant fiscal impact. As an alternative, the Committee discussed ways to ensure that states remain attuned to the impact of emergency social distancing laws across populations. One possibility would be to require governors (or health officials) who impose such measures to establish an advisory board specifically charged with advising on the impact of social distancing measures on minority and other vulnerable communities. During the present pandemic, almost all governors established an advisory board. Twelve states (including D.C.) established some type of disparate impact task force or advisory board. In some states, for example, Michigan, the Executive Order establishing the board required that its membership be diverse and representative of the state's population.[3]

The Committee also looked into whether states were reporting racial and other demographic data related to COVID-19. Our research showed that although most states have made public certain demographic information such as age, gender, ethnicity, and race for those who are diagnosed or die from COVID-19, no state has provided specific socio-economic data for those affected.[4] In addition, at least at this point in the pandemic, serious gaps exist with respect to many data sources, including particularly from health care facilities. For the most part, health care facilities have not been required to report demographic data. To address this gap, New Jersey, recently passed a law which "requires hospitals to report demographic data including age, ethnicity, gender, and race of individuals who have

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[2] *E.g.,* Samantha Artiga et. al., *Communities of Color at Higher Risk for Health and Economic Challenges due to COVID-19*, KAISER FAMILY FOUNDATION (Apr. 7, 2020), *available at* https://www.kff.org/coronavirus-covid-19/issue-brief/communities-of-color-at-higher-risk-for-health-and-economic-challenges-due-to-covid-19/view/footnotes/#footnote-458389-6 (pending KFF review).

[3] MI Exec. Order No. 2020-55 (Apr. 20, 2020), https://www.michigan.gov/whitmer/0,9309,7-387-90499_90705-526476--,00.html; Bryce Huffman, *Lt. Gov. Gilchrist to head COVID-19 racial disparities task force*, MICHIGAN RADIO (Apr. 10, 2020) https://www.michiganradio.org/post/lt-gov-gilchrist-head-covid-19-racial-disparities-task-force; Press Release, OFFICE OF THE GOVERNOR, STATE OF MICHIGAN, GOVERNOR WHITMER SIGNS EXECUTIVE ORDER CREATING THE MICHIGAN CORONAVIRUS TASK FORCE ON RACIAL DISPARITIES (Apr. 20, 2020), https://www.michigan.gov/whitmer/0,9309,7-387-90499-526478--,00.html,

[4] *See generally* ALABAMA DEPARTMENT OF PUBLIC HEALTH, ALABAMA'S COVID-19 DATA AND SURVEILLANCE DASHBOARD, https://alpublichealth.maps.arcgis.com/apps/opsdashboard/index.html#/6d2771faa9da4a2786a509d82c8cf0f7 (Accessed Jun. 2, 2020). States do not include general socio-economic detriments as part of their reporting requirements. *See* Table A (highlighting state-level information on COVID-19 available to the public). Instead state and university researchers use demographic information in conjunction with available census-track data to highlight socio-economic disparities. JOHNS HOPKINS UNIV., MALONE RESEARCHERS PUBLISH SOCIOECONOMIC DATASET FOR PREDICTIVE MODELING OF COVID-19 (Mar. 27, 2020), https://malonecenter.jhu.edu/malone-researchers-publish-socioeconomic-dataset-for-predictive-modeling-of-covid-19/.

tested positive for COVID-19, who have died from COVID-19, and who have tried to get testing but have been turned away."[5]

After a robust discussion about all of these issues over the course of several meetings, the Study Committee concluded that it required more time to monitor, study, and discuss these issues. One critical reason for this conclusion was the belief that even if a drafting committee were formed, a uniform law could not be completed and presented to the states, never mind enacted, in the next several months. Given that limitation, it seemed advisable to the Committee that it be given more time to follow developments, including legislation, litigation, and public health findings, and to have the opportunity to more fully discuss these complex and nuanced issues before issuing a final recommendation. More time would also allow the Committee to more fully explore the question of what constitutes an emergency, and whether governors should be permitted to continue to rely on broad powers, or whether more specific statutory directives would be advisable. The Committee also seeks time to further consider whether there are specific reasons why a uniform law might be helpful in this context.

In addition, the Committee felt that in light of the extensive research done for the Committee, and the productive conversations the Commissioners had during Committee meetings, it made more sense for the present Committee to continue rather than have another committee appointed at a later date. The Committee believes that it should be able to file a final report on social distancing issues by July 2021.

3. The Determination of Essential Health Services and the Allocation and Stockpiling of Health Resources.

In its final meeting, the Committee discussed several issues related to health services. First, the Committee looked into the question of whether states have sufficient authority to stockpile medical supplies and health services.

At least 26 states have statutes that address the procurement and distribution of medical supplies during a pandemic. In addition, the MSEHPA addresses the issue. Under Section 505, if there is a shortage of medical supplies during an emergency, the health authority may "control, restrict and regulate" the distribution of supplies. Several state laws use similar language. Given the existence of these state laws and the model provided by Section 505, the Committee did not feel there was a need for a uniform law on this subject.

The Committee also looked at the states' power to allocate health care services between facilities during a pandemic. This can be important to prevent overcrowding at some hospitals (or hospital systems) while others (which may primarily treat higher-income patients) have excess capacity. Our research

[5] Press Release, Office of the Governor, State of New Jersey, Governor Murphy Announces Actions to Require Reporting of COVID-19 Demographic Data (Apr. 4, 2020), https://nj.gov/governor/news/news/562020/approved/20200422b.shtml (announcing the Governor signing law a statute which would mandate hospitals report demographic data to state).

indicates that 12 states already have laws that address this issue. In addition, Section 502 of the MSEHPA grants the public health authority, during a public health emergency, authority to "require a health care facility to provide services or the use of its facility if such services or use are reasonable and necessary to respond to the public health emergency."

The allocation of health care facilities can also present issues of federal law. During the present pandemic, the Centers for Medicare and Medicaid Services (CMS) has issued several blanket waivers that have relaxed Medicare and Medicaid requirements on health care facilities, allowing them to create surge capacity and extend their use of telehealth.

Given the model offered by the MSEHPA, as well as existing state laws, the Committee concluded that this issue should not be forwarded to a drafting committee.

Early in the pandemic, CMS recommended delaying elective surgeries, and non-essential medical and dental procedures. In its guidance, CMS stated that the determination of what services were essential would "remain the responsibility of local healthcare delivery systems, including state and local officials, and those clinicians who have direct responsibility for their patients."[6]

Although no state statute speaks specifically to this issue (nor does the MSEHPA), governors in 36 states and the District of Columbia used their general emergency powers to issue guidance or orders recommending or ordering the postponement of non-essential health services.[7] Some state legislatures also took up the issue. On May 4, 2020, North Carolina enacted Senate Bill 704 which required the formation of a task force to study the impact of postponing elective procedures during the pandemic.

The decision by several states to treat abortions, including medication abortions, as non-essential, and therefore banned during the emergency, has been especially controversial. These decisions were challenged in several cases, and have led to conflicting opinions by the Courts of Appeals.[8]

The Committee quickly decided that it did not want to focus on or discuss the abortion cases, which raise distinct and divisive constitutional issues. Commissioners also felt that a uniform law should not try to decide which services are essential, as such decisions are ultimately medical. However, because of the absence of any specific state statutes on this issue, and because it is not addressed by the MSEHPA, the Committee felt that it would benefit from more time to study the issue, and speak with other stakeholders (including representatives of the medical profession) before determining whether it should recommend that a drafting committee should take up the questions of how states should decide what medical care is essential, and what process should be used to make the determination.

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[6] CENTERS FOR MEDICARE & SERVICES, NON-EMERGENT MEDICAL SERVICES, AND TREATMENT RECOMMENDATIONS (Apr. 7, 2020), htpss:www.cms.gov/files/document/cms-non-emergent-eletive-medical-recommendations.pdf.
[7] State Guidance on Elective Surgeries: AMBULATORY SURGERY CENTER ASSOC. (Apr.20, 2020), https://ascassociation.org/asca/resourcecenter/latestnewsresourcecenter/covid-19/covid-19-state.
[8] *E.g.* In re Abbott, 954 F.3d 772 (5th Cir. 2020)(refusing TRO of order blocking abortions); Robinson v. Att'y Gen., No. 2:19cv365-MHT, 2020 WL 1847128 (M.D. Ala. Apr. 12, 2020)(upholding preliminary injunction in part).