

Different Responses to COVID-19 in Four US States: Washington, New York, Missouri, and Alabama

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See also Erwin et al., p. 540, and the Fixing US Health Policy section, pp. 620–657.

In the United States, public health is largely the responsibility of state governments' implementing authority specified in their constitutions or reserved to states under the 10th Amendment to the US Constitution. The public health–related powers granted to the federal government are substantially less and derive primarily from the Commerce Clause (Article 1, Section 8) of the US Constitution. In public health emergencies over the past several decades, however, the Centers for Disease Control and Prevention (CDC) has played a major role in providing guidance, resources, and other support to state and local public health departments, for example, in large foodborne disease outbreaks, in response to major natural disasters, and especially in response to large-scale infectious disease

threats (e.g., West Nile virus, severe acute respiratory syndrome, and H1N1 influenza).¹

The CDC's role in response to COVID-19 has been atypical relative to its historical role in large-scale outbreaks, leaving states and cities to take much more prominent roles. As has been well documented, instead of the CDC leading, the federal response has been ineffectively managed directly from the White House (for a good summary, see Gostin²). We explore state responses to COVID-19 through brief examples from four states—Washington, New York, Missouri, and Alabama—to better understand the timing, range, breadth, and depth of state actions. We selected these states for several reasons, including differing timelines for when COVID-19 first appeared; geographic,

demographic, and political diversity; the scope of the policy responses; and apparently different patterns in case numbers, hospitalizations, and deaths. Although we hope these cases will illuminate the range of experiences, we make no claim about generalizability to all 50 states. Important milestones in the COVID-19 experience for each state are listed in Table 1, for data through November 4, 2020. We include additional state-specific information in the subsequent sections. All dates are for the year 2020, unless otherwise noted.

WASHINGTON

The first confirmed case of COVID-19 in the United States occurred in Washington State in a 35-year-old man who had returned from Wuhan, China, on January 15, went to an urgent care center on January 19, and was tested and confirmed positive on January 20. The first state-level action took place on February 29, when Governor Jay Inslee (D) declared a state of emergency after the first US death attributable to COVID-19 occurred in Washington State.³ After peaking in early April, daily new cases of COVID-19 began to decline and then plateaued in May. On May 1, Governor Inslee announced a four-phased plan (Safe Start Washington) to reopen the state based on a set of well-defined metrics, with county-level applications reviewed and approved by the secretary of health for the Washington State Department of Health.⁷

The four phases began with limited reopening in phase 1 to greater and greater lifting of restrictions to essentially pre-COVID-19 status for phase 4. By late June, because of a surge in COVID-19 cases, the governor suspended the movement of counties from

TABLE 1— Timeline of Important Milestones in the COVID-19 Pandemic: Washington State, New York State, Missouri, and Alabama, 2020

Milestone	Washington ³	New York ⁴	Missouri ⁵	Alabama ⁶
First confirmed COVID-19 case reported	Jan 20	Mar 1	Mar 6	Mar 13
First COVID-19 death	Feb 29	Mar 14	Mar 18	Mar 18
School closure	Mar 12	Mar 12 ^a and Mar 15 ^b	Mar 19	Mar 13
Business closures	Mar 15	Mar 22	Ap 6	Mar 27
Lifting restrictions and closures	May 1	May 15	May 4	Ap 30
Mask mandate ^c	Jun 26	Apr 15	none	Jul 15
Reported cumulative case rate (as of November 4) ²	1518/100 000	2665/100 000	3230/100 000	3996/100 000
Reported positivity rate (as of November 4), ^{d,6} %	6.0	1.6	12.1	18.9
Shape of the “epi curve” of reported cases	Peaks in spring, summer, and fall	One peak in Apr–May, rising again in late fall	Increasing numbers since Jun	Peaks in the summer and fall

^aState University of New York campuses.

^bNew York City Schools.

^cMask mandates that were statewide.

^dPercentage of tests performed that were positive.

phases 3 and 4, and on July 28, extended the pause indefinitely in counties moving ahead in the Safe Start Washington plan. By that time, five counties had achieved phase 1 reopening, 17 were in phase 2, and 17 in phase 3; no county has yet achieved phase 4 reopening. As of November 4, there was an average of 949 cases per day over the previous week, with a total of 115 608 cases (1518/100 000) and 2507 deaths in Washington State since the beginning of the pandemic, according to the *New York Times* database.⁸

NEW YORK

The COVID-19 experience in New York State was driven by the early high numbers of cases and hospitalizations occurring in New York City. On March 8, Governor Andrew Cuomo (D) announced guidelines for commuting—asking sick individuals to stay off the public transportation system and encouraging citizens to stay away from densely populated transportation.⁴ The

governor established the first containment zone on March 10, ordering public gatherings stopped within one mile of a New Rochelle synagogue in Westchester County because of a cluster of COVID-19 cases.⁴ The governor signed an executive order for New York residents to wear face masks or coverings in public places when they are unable to socially distance, effective April 17, making New York State one of the earliest states to have a statewide mask mandate (the first had been in New Jersey on April 8).⁹

A four-phase plan for reopening (New York Forward) was implemented on May 15, with each successive phase in two-week increments, automatically allowing more and more restrictions to be lifted.¹⁰ All regions of the state had achieved phase 4 reopening by late July. During the summer, Governor Cuomo imposed a 14-day quarantine on visitors to New York from states that were experiencing a 10% or higher test positivity rate. During the first week of November, this order was replaced by mandatory testing of travelers within three days of

departure from a state with 10% or higher test positivity rate.¹¹ As of November 4, there was an average of 2149 cases per day over the previous week, with a total of 518 431 cases (2665/100 000) and 33 198 deaths in New York State since the beginning of the pandemic.⁸

MISSOURI

Although in late March Governor Mike Parson (R) announced there would be no plans to issue a stay-at-home order, several days later he issued such an order that would be in effect for Missouri from April 6 through 24 (later until May 3).⁵ On April 22, Missouri attorney general Eric Schmitt filed a lawsuit in US federal court against the Chinese government for “causing a global pandemic that was unnecessary and preventable”; the lawsuit was the first of its kind⁵ (and as of November 4, Mississippi was the only other state to file suit¹²).

A two-phase plan for reopening began May 4, and no state-level restrictions

have been reimposed¹³; any restrictions have been left to cities and counties. There has been no state-level requirement for wearing a mask; instead, the state health officer has emphasized personal responsibility. On June 23, the governor was asked at a press briefing if he takes responsibility for COVID-19 deaths, and he responded, "That's no different than the flu virus or do I feel guilty because we have car accidents and people die every day? No, I don't feel guilty about that."¹⁴ New cases statewide began surging in late June. On September 23, the governor and his wife were both confirmed to be COVID-19-positive. As of November 4, there was an average of 2686 cases per day over the previous week, with a total of 198 252 cases (3230/100 000) and 3136 deaths in Missouri since the beginning of the pandemic.⁸

ALABAMA

Initial state-level actions began in early March, with the formation of the Alabama Coronavirus Task Force on March 6.⁶ One week later, after the first confirmed cases, Governor Kay Ivey (R) declared a state of emergency. On April 3, Governor Ivey issued a statewide stay-at-home order until April 30.¹⁵ Effective April 30, a Safer at Home statewide order allowed businesses to reopen with restrictions (e.g., retail stores reopened at 50% capacity), reopened Alabama's beaches, and allowed elective medical procedures to begin again.¹⁶

Educational institutions could open June 1 with proper social-distancing procedures. Beginning the second week of June, the seven-day average of new cases increased sharply, from approximately 400 per day to more than 1700 per day by mid-July.⁸ On July 15, Governor Ivey announced that face masks would be mandatory statewide in public

spaces; the order has been extended several times and is in place through January 22, 2021.⁶ As of November 4, there was an average of 1299 cases per day over the previous week, with a total of 195 929 cases (3996/100 000) and 2987 deaths in Alabama since the beginning of the pandemic.⁸

DIFFERENT SETTINGS, ACTIONS, AND EXPERIENCES

How do we make sense of these different responses and perceived different epidemiological patterns across these four states? First, it is clear that even in examining only four states, we see how differently states have reacted to and experienced the pandemic. Washington experienced the first cases in the United States, and after an initial first peak of cases in April, the epidemic curve remained relatively flat until a new wave of cases began being reported during the summer. New York experienced a massive outbreak in New York City but has seen a sharp decline to very low levels of daily new cases and one of the lowest positivity rates through the first week of November. After the initial outbreak, Missouri's reported cases plateaued until mid-July and then cases rose steeply. Alabama began experiencing a significant rise after the Memorial Day weekend (May 22–25), peaked in late July, and declined through August and September. All four states began experiencing an increase in cases after Labor Day weekend (September 4–7), continuing through October and into the first week of November, paralleling the surge in cases across the entire United States. By December, all four states had reached new records for daily cases, higher than at any previous time since the beginning of the pandemic.

Second, regarding subsequent policy enactment, governors in Washington and New York were early to mandate wearing a mask and limit businesses and were slow to reopen, whereas Missouri and Alabama reopened earlier, before meeting the White House gating criteria. Of the four states, Washington and New York have the most comprehensive, data-driven reopening plans. The positivity rates (percentage of COVID-19 tests that are positive) provide insights into the differential impact of planning and implementation: as of November 3, the seven-day average positivity rates were as follows: New York (1.6%), Washington (6.0%), Missouri (12.1%), and Alabama (18.9%).¹⁷

Third, policy responses to how the epidemic was evolving over time have differed. Although Washington State announced its four-phase reopening on May 1, in response to a surge in cases in June, the governor suspended the movement of counties from phase 3 and 4 and later extended the pause indefinitely. Although all regions in New York State achieved phase 4 reopening, an increase in cases in New York City in September and October led to new restrictions on schools and businesses in specific hotspots. The reopening of businesses and beaches in Alabama was followed by a surge in cases in June, but a statewide mandate to wear masks was not issued until mid-July. Despite a surge in cases in the summer with no sustained decline since, Missouri's governor has maintained that a statewide action such as a mask mandate could not be used in a state with diverse local-level COVID-19 experiences.

EXPERIENCES ACROSS ALL 50 STATES

Without suggesting these four states represent a typology of state responses but rather examples of different states'

experiences with COVID-19, we highlight several recent articles that examine response characteristics across all 50 states. Adolph et al. examined the timing of five social-distancing interventions across all 50 states, including recommendations and restrictions against public gatherings, school closures, restrictions on restaurants, closures of nonessential businesses, and statewide stay-at-home orders.¹⁸ Focusing on the first few weeks of the pandemic (February 26–April 6), the authors noted the criticality of the timing of the interventions, given that doubling times for COVID-19 in the first few weeks had been estimated by several investigators to be as short as three days. The authors found that the political party of the governor was the most important predictor of early adoption of social-distancing policies—with Republican governors adopting and implementing more slowly. Although intriguing, the article does not examine subsequent reopening policies, nor does it attempt to make any associations between the timing of social-distancing policies and pandemic outcomes (i.e., subsequent caseload, hospitalizations, or deaths).

In a recent policy brief for the Urban Institute, Treskon and Docter examined both state- and local-level COVID-19–related policymaking, finding that states that tended to preempt local laws more often tended to have passed fewer COVID-19 state-level policies.¹⁹ These policies included both restrictive policies (e.g., bans on large gatherings) and supportive policies (e.g., mandatory paid sick leave). In their analyses, Missouri and Alabama were among the states with the highest level of state preemption, whereas New York was among states with the lowest level of preemption, with Washington intermediate. Given their findings, the authors

surmised that “preemption may be less about a belief that states are a more appropriate venue for some sorts of policymaking and more about a general reluctance to legislate and desire to stop local actions to do so.”^{19(p8)}

Finally, in a recent *Foreign Affairs* article, Jha posited that states that “embraced” science have been much more successful in managing the pandemic, with responses and outcomes that more closely resembled European success, compared with those states that have been antiscience, whose responses and outcomes have more closely paralleled Brazil’s.²⁰ Although the author does not clearly define the criteria by which states were categorized as science versus antiscience, the article merits attention if only for its examination of state COVID-19 actions in contrast to the historical leanings toward federalism versus national government. Essentially all the science-driven states are led by Democratic governors, the antiscience states by Republican governors. There is at least irony in the author’s view that more liberal state governments, historically more supportive of national governmental approaches, took matters into their own hands, with earlier and more comprehensive measures to combat COVID-19, whereas conservative state governments, historically more inclined to federalism, followed the president’s lead, which has frequently presented an antiscience perspective. Although constitutionally backed, the states’ go-it-alone approach to COVID-19 meant that efforts were inefficient and led to misinformation, and because there was no coordination between states, states fell into competition with one another for scarce resources.

The findings from these articles on all 50 states lead us to the following insights

on what has mattered in the four states of our focus in the absence of a clear, coordinated federal response: (1) early interventions; (2) local decision-making, especially for large urban areas; and (3) state-level policies and practices driven by science. Causal inferences, though, must be avoided. The potential confounders are myriad: testing and reporting of cases and deaths vary across states and are not immediately comparable, states that experienced COVID-19 earliest were states with Democratic governors, states that are less densely populated and experienced COVID-19 later are predominately led by Republican governors; and the current political categorization of these states is a point in time along a complex historical evolution.

THE IMPACT OF THE NOVEMBER ELECTIONS

For the four states we focused on, the November elections resulted in few changes at the state level, likely indicating that there would not be a significantly different policy approach to the pandemic. The new presidential administration, however, will likely have a more coordinated, science-based federal approach and a return to the usual lead role that CDC has had in previous epidemics. Within days of being declared the president-elect, Joseph Biden announced his Coronavirus Task Force, which includes highly reputable medical and public health experts with relevant experiences and expertise.²¹ Further studies may produce clearer evidence of how and why specific state responses could have directly or indirectly affected the pandemic, which can provide additional policy options for states to consider. [AJPH](#)

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

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