No. 21-3725

United States Court of Appeals
For the Eighth Circuit

STATE OF MISSOURI, *et al.*,

Plaintiffs-Appellees,

v.

JOSEPH R. BIDEN, JR., in his official capacity as the President of the United States of America, *et al.*,

Defendants-Appellants.

Appeal from the United States District Court
for the Eastern District of Missouri, Eastern Division
The Honorable Matthew T. Schelp, United States District Judge

RESPONSE TO EMERGENCY MOTION FOR STAY PENDING APPEAL

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Introduction

The Secretary of Health and Human Services' sweeping and unprecedented vaccine mandate for healthcare workers threatens to create a crisis in rural healthcare facilities. It would force tens of thousands of workers to choose between losing their jobs or complying with an unlawful federal mandate. But for the district court's preliminary injunction, last year's healthcare heroes would have become this year's unemployed. Preserving the status quo, as the district court did here, was critical to avoid irreparable injury to the States and a catastrophe in rural health care.

Defendants seek an extraordinary stay to undo that necessary remedy and immediately re-impose the mandate, creating confusion, causing a logistical nightmare, and unleashing the "prevalent, tangible, and irremediable" harm that the injunction forestalls. R. Doc. 28, at 30. All this despite the district court's meticulous, 32-page opinion issued after full briefing, where Defendants were entitled to introduce whatever evidence they chose. The district court carefully surveyed thirty declarations submitted by the States describing the devastating impact the mandate will have on healthcare access in rural parts of the States—reliance interests

the Secretary simply failed to consider. The court also reached sound legal conclusions showing the mandate exceeded the Secretary's statutory authority, bypassed notice-and-comment requirements, and was arbitrary and capricious, in violation of the Administrative Procedure Act.

At bottom, the district court got it right, and Defendants are not entitled to a stay of the preliminary injunction pending appeal. *See* R. Doc. 35, at 2 (denying stay pending appeal after finding four factors did "not … weigh in favor" of one).

Statement of Facts

I. The Ongoing Healthcare Worker Crisis

CMS admits that "currently there are endemic staff shortages for almost all categories of employees at almost all kinds of health care providers and supplier[s]." 86 Fed. Reg. 61,555, 61,607 (Nov. 5, 2021). "1 in 5 hospitals," CMS notes, "report that they are currently experiencing a critical staffing shortage." *Id.* at 61,559. In addition, "approximately 23 percent of LTC [long-term-care] facilities report[] a shortage in nursing aides," and "21 percent report[] a shortage of nurses." *Id.*

Plaintiff States' experience confirms this. R. Doc. 28, at 25 (citing declarations). The situation is so dire that over the last few months, many of those States have issued emergency orders to try to alleviate the endemic staffing shortages. R. Doc. 9, at 3, 12 (discussing emergency measures in Missouri, Nebraska, and Wyoming).

II. The President's Shifting Position on Vaccine Mandates

President Biden's Administration originally and correctly affirmed that mandating vaccines is "not the role of the federal government." Press Briefing (July 23, 2021), The White House, https://bit.ly/3Dh3hl8.

Yet on September 9, 2021, amid flagging poll numbers, the Administration exhibited a dramatic about-face. That day, President Biden announced a six-point plan on COVID-19, and to further his first goal of "requir[ing] more Americans to be vaccinated," the President called for several vaccine mandates, including the mandate challenged here. Joseph Biden, Remarks (Sept. 9, 2021), https://bit.ly/31jHiww.

III. The CMS Vaccine Mandate

Nearly two months later, on November 5, 2021, CMS published its vaccine mandate. 86 Fed. Reg. at 61,555. CMS recognizes that this mandate is unprecedented because it had "not previously required any vaccinations." *Id.* at 61,567. Even so, CMS did not comply with its statutory obligations to provide notice and comment or to consult with the States. *See* 5 U.S.C. § 553(b)-(c); 42 U.S.C. § 1395z.

The mandate broadly commandeers 15 categories of Medicare- and Medicaid-certified providers and suppliers that are "diverse in nature," 86 Fed. Reg. at 61,602, ranging from LTC facilities serving elderly patients, to Psychiatric Residential Treatment Facilities (PRTFs) for individuals under age 21, *id.* at 61,556. And the agency demands vaccines

for practically every full-time employee, part-time worker, trainee, student, volunteer, and third-party contractor entering those facilities, including all facility staff "regardless of … patient contact," *id.* at 61,570, and third parties working on a "project" who "use shared facilities" such as restrooms, *id.* at 61,571. CMS estimates that 10.3 million individuals will fall under the mandate. *Id.* at 61,603.[1]

CMS rejected the option of allowing workers to undergo "daily or weekly [COVID-19] testing" instead of mandatory vaccination for only one unexplained reason: because the agency believes that "vaccination is a more effective infection control measure" than testing. 86 Fed. Reg. at 61,614. CMS also rejected the alternative of affording different options to healthcare workers who have developed infection-induced (or natural) immunity because it perceives "uncertainties … as to the strength and length of [natural] immunity." *Id.*

[1] Defendants misleadingly assert (at 6) that the mandate "amended the infection-control regulations" for covered facilities. Before the mandate, most of the amended regulations did not purport to address infection control. *E.g.*, 42 C.F.R. §441.151 (entitled "General requirements" and not mentioning infection control).

CMS was "aware of concerns about health care workers choosing to leave their jobs rather than be vaccinated" and knew that "there might be a certain number of health care workers who choose to do so." *Id.* at 61,569. But without seeking public comment or consulting with States, CMS dismissed these concerns because it said "there is insufficient evidence to quantify" that risk and balance it against others. *Id.*

CMS intends for the mandate to "preempt[] inconsistent State and local laws." *Id.* at 61,568. It also demands that "State-run facilities that receive Medicare and Medicaid funding" administer the vaccine mandate by "imposing [it] on their employees," *id.* at 61,613, and by complying with overbearing record-keeping obligations (including tracking booster vaccination status even though the mandate does not (yet) require boosters), *id.* at 61,571. And CMS forces "State surveyors … to assess compliance with" the mandate. *Id.* at 61,574.

IV. The Mandate's Disastrous Consequences

The mandate will have disastrous consequences on healthcare, particularly in rural communities. Plaintiff States submitted thirty declarations detailing the coming catastrophe. R. Doc. 28, at 24-28 (summarizing those declarations). The declarations, many of which indicate how

many healthcare workers are likely to "leave employment" under the mandate, explain that the workforce reduction "will decrease the quality of care provided at facilities, compromise the safety of patients, and place even more stress on the remaining staff." *Id.* at 25. In addition, the loss of staffing "will diminish entire areas of care" within certain facilities and "in many instances will result in *no care at all*, as some facilities will be forced to close altogether." *Id.* at 26-27. These threats face not only private healthcare facilities but also state-run institutions. *E.g.*, R. Doc. 9-2, at ¶¶ 9-10.

None of this should have been a surprise to CMS. The agency admits that vaccination rates "are disproportionately low among nurses and health care aides" in rural locations, 86 Fed. Reg. at 61,566, and that "rural hospitals are having greater problems with employee vaccination … than urban hospitals," *id.* at 61,613. A recent survey predating the mandate also shows that a substantial portion of "unvaccinated workers"—a whopping 72%—"say they will quit" rather than submit to a vaccine mandate. *72% of unvaccinated workers vow to quit*, CNN.com (Oct. 28, 2021), https://cnn.it/3G7JarE. Here, the district court found—and

Defendants did not dispute—that some workers have already followed through and resigned. R. Doc. 28, at 25.

Argument

The federal government is not entitled to a stay because it cannot satisfy the "four factors [courts consider] in determining whether to issue a stay pending appeal: (1) whether the stay applicant has made a strong showing that he is likely to succeed on the merits; (2) whether the applicant will be irreparably injured absent a stay; (3) whether issuance of the stay will substantially injure the other parties interested in the proceeding; and (4) where the public interest lies." *Brakebill v. Jaeger*, 905 F.3d 553, 557 (8th Cir. 2018) (cleaned up). A stay "is not a matter of right, even if irreparable injury might otherwise result to the appellant." *Id.* (cleaned up).

I. Defendants Are Unlikely to Succeed on the Merits.

Defendants are not entitled to a stay because they cannot make "a strong showing that [they are] likely to succeed on the merits." *Brakebill*, 905 F.3d at 557. Indeed, this is the "most important factor" of the four. *Id.* This "strong showing" requires the government to demonstrate that the district court abused its discretion by entering an injunction. *Cf. Comprehensive Health of Planned Parenthood Great Plains v. Hawley*, 903 F.3d 750, 754 (8th Cir. 2018); *accord Texas v. United States*, 787

F.3d 733, 747 (5th Cir. 2015) ("To succeed on the merits, the government must show that the district court abused its discretion by entering a preliminary injunction."). Legal conclusions are "reviewed de novo," but factual findings are "reviewed for clear error." *Comprehensive Health*, 903 F.3d at 754; *see also Texas*, 787 F.3d at 747 (same). Defendants (at 12) ignore this deferential standard of review.

A. The District Court Had Jurisdiction.

Defendants first argue (at 13-14) that the district court lacked jurisdiction to issue its preliminary injunction, largely recycling arguments the district court carefully addressed and soundly rejected. R. Doc. 28, at 2-3. Defendants do not (and cannot) retract their prior concession that States cannot use 42 U.S.C. § 1395cc(h)(1)'s procedural mechanism because they are neither "institution[s]" nor "agenc[ies]" "dissatisfied" with the Secretary's determination regarding eligibility or receipt of benefits under that statute. R. Doc. 28, at 2. Thus, consistent with *Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 16 (2000), the district court concluded that 42 U.S.C. § 405(h), as incorporated by 42 U.S.C. § 1395ii, has no application here. R. Doc. 28, at 2.

Defendants, without citing any authority, claim (at 14) that "[i]t makes no difference that the plaintiffs here are States," but that's inconsistent with their own concession and the plain text of § 1395cc(h)(1). States are also "not normal litigants for the purposes of invoking federal jurisdiction," *Massachusetts v. E.P.A.*, 549 U.S. 497, 518 (2007), so any comparison to the nursing home association in *Shalala* is unavailing. *See* R. Doc. 27, at 1-2.

Additionally, the district court found an independent basis for jurisdiction: the States' claims that arise under the Medicaid Act—as opposed to the Medicare Act—"are not subject to the § 405(h)'s jurisdictional bar." R. Doc. 28, at 3 (citing *Avon Nursing & Rehab. v. Becerra*, 995 F.3d 305, 311 (2d Cir. 2021)). Defendants do not challenge that.

B. The States Have Standing.

Defendants next argue (at 14) that the States cannot represent the interests of privately-run facilities within their borders because the States do not have *parens patriae* standing to bring an action against the federal government. *See Alfred L. Snapp & Son, Inc. v. Puerto Rico ex rel. Barez*, 458 U.S. 592, 610 n.16 (1982) (citing *Massachusetts v. Mellon*, 262 U.S. 447, 485–86 (1923)).

However, in *Massachusetts v. E.P.A.*, the Supreme Court noted an important distinction: "There is a critical difference between allowing a State 'to protect her citizens from the operation of federal statutes' (which is what *Mellon* prohibits) and allowing a State to assert its rights under federal law (which it has standing to do)." 549 U.S. at 520 n.17 (citing *Georgia v. Pennsylvania R. Co.*, 324 U.S. 439, 447 (1945)).

Here, the States are asserting their rights under federal law. Indeed, the States' standing arises out of their procedural rights under the APA, 5 U.S.C. § 702, and their "stake in protecting [their] quasi-sovereign interests[.]" *Massachusetts*, 549 U.S. at 520; *see also Missouri v. Illinois*, 180 U.S. 208, 240–41 (1901) (finding federal jurisdiction appropriate not only "in cases involving boundaries and jurisdiction over lands and their inhabitants, and in cases directly affecting the property rights and interests of a State," but also when the "substantial impairment of the health and prosperity of the towns and cities of the state" are at stake) (cited in *Massachusetts*, 549 U.S. at 520 n.17); *California v. Azar*, 911 F.3d 558, 571 (9th Cir. 2018) (holding in a multi-state challenge seeking to enjoin enforcement of HHS's interim final rules "that the states have standing to sue on their procedural APA claim"); *Texas v. United States*, 809 F.3d

134, 152 (5th Cir. 2015) ("In enacting the APA, Congress intended for those 'suffering legal wrong because of agency action' to have judicial recourse, and the states fall well within that definition.") (citing 5 U.S.C. § 702) (footnote omitted).

Massachusetts v. EPA establishes that when States assert procedural rights, as Plaintiffs do here, they may "litigate as *parens patriae* to protect quasi-sovereign interests—*i.e.*, public or governmental interests that concern the state as a whole." 549 U.S. at 520 n.17 (cleaned up). The district court thus did not err in considering the interests of private healthcare providers because Plaintiffs have standing as *parens patriae* to protect those interests.

In any event, Defendants do not challenge Plaintiffs' standing to sue in the "number of [other] capacities" such as their "sovereign" and "proprietary" capacities. R. Doc. 28, at 2 n.3, 23. The district court found that "[t]hrough their various interests," Plaintiffs "have shown irreparable injury is more than likely in the absence of an injunction." *Id.* at 23-28; *see also* R. Doc. 35, at 2 (denying stay pending appeal because, among other reasons, Plaintiffs' "evidence shows that facilities—rural facilities in particular—likely would face crisis standards of care or will have no

choice but to close to new patients or close altogether, which would cause significant harm to Plaintiffs' citizens") (cleaned up).

For these same reasons, this Court should reject Defendants' argument (at 24-25) to limit the district court's injunction to state-run facilities. In addition to the *parens patriae* interests, Plaintiffs' irreparable sovereign injuries, which include the preemption of their laws that predate the mandate, are more than sufficient to justify applying the injunction throughout their borders.

C. The Mandate Exceeds CMS's Statutory Authority.

The Supreme Court "expect[s] Congress to speak clearly" in at least three circumstances: (1) "when authorizing an agency to exercise powers of vast economic and political significance," *Alabama Ass'n of Realtors v. Dep't of Health & Hum. Servs.*, 141 S. Ct. 2485, 2489 (2021) (per curiam); (2) when "federal law overrides the usual constitutional balance of federal and state powers," *Bond v. United States*, 572 U.S. 844, 858 (2014) (cleaned up); and (3) when "an administrative interpretation of a statute invokes the outer limits of Congress' power," *Solid Waste Agency of N. Cook Cnty. v. U.S. Army Corps of Engineers*, 531 U.S. 159, 172 (2001). All those situations are present here. The mandate imposes politically

controversial public-health policy that threatens to inflict economic ruin on significant segments of the healthcare industry. It seeks to usurp the police power of the States to "protect the public health" by addressing mandatory vaccination—a topic that "do[es] not ordinarily concern the national government." *Jacobson v. Massachusetts*, 197 U.S. 11, 24–25, 38 (1905). And in attempting to mandate vaccines without clear congressional notice to the States, the mandate reaches beyond the outer limits of Congress's power.

The district court correctly found that all of these "fundamental principles" were applicable here, that "clear congressional authorization" was needed, and that no such clear authorization was given. R. Doc. 28, at 4. In response, Defendants (at 16) deny that these clear-statement rules apply, attempting to characterize this sweeping mandate as a routine exercise of the Secretary's regulatory authority under Congress's spending power. Yet this unprecedented mandate is anything but routine. And the "Spending Clause power" cannot be "wielded without concern for the federal balance," lest the federal government be allowed "to set policy in the most sensitive areas of traditional state concern." *NFIB v. Sebelius*, 567 U.S. 519, 675–76 (2012) (plurality op.). A first-of-its-kind vaccine

mandate affecting "billions of dollars" and "millions of people," *King v. Burwell*, 576 U.S. 473, 485 (2015), requires a clear statement of congressional authorization that is absent here.

Defendants (at 15) invoke their general rulemaking authority under statutes like 42 U.S.C. § 1302(a). But they "overread" the precedent they cite and misconstrue those statutes, which permit regulations "necessary" to Medicare and Medicaid's "administration," because this mandate is far removed from "the practical management and direction of" these programs. *Merck & Co. v. HHS*, 962 F.3d 531, 536–38 (D.C. Cir. 2020). Simply put, those statutes do not give "Defendants the 'superpowers' they claim." *Louisiana v. Becerra*, No. 3:21-CV-03970, 2021 WL 5609846, at *10 (W.D. La. Nov. 30, 2021), *appeal docketed*, No. 21-30734 (5th Cir. 2021).[2]

Accordingly, "even if Congress's statutory language was susceptible to CMS's exceedingly broad reading—which it is most likely not—Con-

[2] In their briefing below, Plaintiffs addressed the details of the statutes that CMS relies on and explained why their plain language does not justify the agency's broad and unprecedented mandate. *See* R. Doc. 9, at 23-27; R. Doc. 27, at 3-5.

gress did not clearly authorize CMS to enact the this politically and economically vast, federalism-altering, and boundary-pushing mandate, which Supreme Court precedent requires." R. Doc. 28, at 8.

D. The Mandate Violates Multiple Procedural Requirements.

The district court determined that CMS did not establish good cause to excuse compliance with notice-and-comment procedural requirements. R. Doc. 28, at 8-13. The good-cause standard is particularly stringent here, the court concluded, given "the unprecedented, controversial, and health-related nature of the mandate," and "CMS's own delay undermines its 'emergency' justification." *Id.*

In arguing that the district court erred, Defendants primarily recite (at 22) CMS's general reasons for the mandate, but this will not suffice. The agency must "point to something specific that illustrates a particular harm that will be caused by the delay required for notice and comment." *United States v. Brewer*, 766 F.3d 884, 890 (8th Cir. 2014). To satisfy that particularized showing, Defendants also invoke (at 22) speculation about a coming "spike" of COVID-19 and the "flu season." But as the district court explained, CMS admits that the "intensity" of the flu season "cannot be predicted." R. Doc. 28, at 11 n.15 (quoting 86 Fed. Reg. at

61,584). This kind of "mere possibility" about "future harm" cannot establish good cause. *Brewer*, 766 F.3d at 890. Holding otherwise is inconsistent with this Court's admonition that the good-cause exception be "reluctantly countenanced." *Nw. Airlines, Inc. v. Goldschmidt*, 645 F.2d 1309, 1321 (8th Cir. 1981).

CMS also failed to comply with its procedural obligation under 42 U.S.C. § 1395z to "consult with appropriate State agencies" before creating a rule like this. While the district court did not rely on CMS's violation of 42 U.S.C. § 1395z, that is another reason why Defendants are unlikely to prevail on appeal. *See Louisiana*, 2021 WL 5609846, at *12 (holding States "are likely to succeed on the merits that the CMS Mandate is contrary to" 42 U.S.C. § 1395z); *cf. Campbell v. Comm'r*, 943 F.2d 815, 818 (8th Cir. 1991) (appellate court "may affirm a trial court's decision on any ground supported by the record, whether or not that ground was addressed by the lower court").

E. The Mandate is arbitrary and capricious.

Most notable about Defendants' arbitrary-and-capricious discussion is what it does not say. The district court identified five reasons why the mandate is arbitrary and capricious: (1) CMS's lack of evidence regarding

most of the covered healthcare facilities; (2) CMS's improper rejection of alternatives; (3) the mandate's irrationally broad scope; (4) CMS's pretextual change in course; and (5) CMS's failure to consider or properly weigh reliance interests and the risk that this failure will impose devastating consequences on healthcare services. R. Doc. 28, at 14-23. Defendants address (at 18-21) only the second reason in part and the fifth reason in whole, ignoring the rest. Their total silence on most of the district court's arbitrary-and-capricious analysis shows that Defendants are unlikely to prevail. *See Richland/Wilkin Joint Powers Auth. v. United States Army Corps of Engineers*, 826 F.3d 1030, 1040 (8th Cir. 2016) (plaintiff seeking preliminary injunction need only establish likelihood of success on the merits on "any one of [its] claims") (alteration in original) (citation omitted). And even on the two points that Defendants contest, their arguments are unpersuasive.

Improperly Rejected Alternatives. The district court identified two alternatives that CMS improperly rejected: "daily or weekly testing" for all workers; and different treatment for workers with "natural immunity."

R. Doc. 28, at 16-17. Defendants do not even try to defend the arbitrariness of CMS's decision to reject the testing option. That alone betrays their inability to prevail on appeal.

Moreover, Defendants mischaracterize what the district court said about natural immunity, arguing (at 19) that the court "substitut[ed] its views on epidemiology for the judgment of public health experts." The court did no such thing. It merely noted that CMS "contradicts itself regarding the value of natural immunity" when it acknowledges that individuals who "have recovered from infection … *are no longer sources of future infections*." R. Doc. 28, at 17 (quoting 86 Fed. Reg. at 61,604). Furthermore, while CMS questions the supposed "uncertainties" about "the strength and length" of natural immunity "compared to people who are vaccinated," 86 Fed. Reg. at 61,614, it simultaneously concedes that "the duration of vaccine effectiveness" is "not currently known," *id.* at 61,615. "Such contradictions," the district court aptly observed, "are tell-tale signs of unlawful agency actions." R. Doc. 28, at 17.

Reliance Interests and Devastating Consequences on Healthcare. The district court held that "CMS did not properly consider *all* necessary re-

liance interests of facilities, healthcare workers, and patients" in "concluding that the mandate's benefits outweigh the risks to the healthcare industry." R. Doc. 28, at 21. "CMS looked only at evidence from interested parties in favor of the mandate," and by dispensing with procedural rulemaking requirements, the agency "ignored evidence showing that the mandate threatens devastating consequences" throughout the nation. *Id.* at 21-22.

Despite CMS's recognition that "compliance with [the mandate] may create some short-term disruption of current staffing levels for some providers or suppliers in some places," 86 Fed. Reg. at 61,609, if "[e]ven a small fraction" of unvaccinated healthcare workers leave their jobs, *id.* at 61,612, the agency dismissed those concerns because it thought "there is insufficient evidence to quantify" and balance those against other risks. *Id.* at 61,569. But as the district court held, it was irrational for CMS to foreclose interested "parties' ability to provide information regarding the mandate's effects on the healthcare industry, while simultaneously dismissing those concerns based on 'insufficient evidence.' " R. Doc. 28, at 21.

On appeal, Defendants rely heavily (at 18) on a joint statement of professional associations supporting vaccine mandates for healthcare workers. But this simply proves the district court's point that CMS acted arbitrarily in "look[ing] only at evidence from interested parties in favor of the mandate, while completely ignoring evidence from interested parties in opposition." R. Doc. 28, at 21. The thirty declarations filed in this case show that there is a different perspective widely prevalent in the healthcare industry that CMS unreasonably ignored.

Defendants argue (at 20) that CMS reasonably dismissed the workforce concerns by relying on "empirical data." This data is nothing more than the experiences of a few private healthcare systems that implemented vaccine mandates in mostly urban areas. But those cherry-picked examples cannot bear the weight CMS puts on them. A privately imposed mandate for a specific healthcare system is a poor proxy for a nationwide government-imposed mandate. And the experiences of healthcare providers in mainly urban areas, which have larger labor pools and higher community vaccination rates than rural areas, is not representative of the impact on rural providers. Put differently, "whatever

might make sense in Chicago, St. Louis, or New York City, could be actually counterproductive and harmful in rural communities like Memphis (MO) or McCook (NE)." R. Doc. 28, at 30.

Defendants also rely (at 10) on New York's experience in imposing a statewide vaccine mandate on healthcare workers. But the *New York Times* article that the mandate cites raises cause for serious concern. 86 Fed. Reg. at 61,569 n.159 (citing *Thousands of N.Y. Health Care Workers Get Vaccinated Ahead of Deadline*, N.Y. Times (Sept. 28, 2021)). It reported that when the mandate took effect, only 92% of "the state's more than 650,000 hospital and nursing home workers had received at least one vaccine dose." That means 8% of healthcare workers in the State—a total of 52,000 people—had not even begun the vaccination process. This directly undercuts CMS's assertion, which immediately follows its *Times* citation, that the mandate "will result in *nearly all* health care workers being vaccinated." 86 Fed. Reg. at 61,569 (emphasis added).

Beyond this, the *Times* article noted that New York "hospitals and nursing homes continue[d] to brace for potential staffing shortages," and that "even minor staff losses because of [the mandate] could put some patients at risk." The article also observed that the "governor declared a

state of emergency" just days before the mandate's deadline "allow[ing] her to use the National Guard to fill staffing shortages." And it reported that a hospital-affiliated nursing home in Buffalo placed 20% of its staff "on unpaid leave … for refusing to get vaccinated," causing the facility to "transfer[] staff in from other facilities, reduc[e] beds at the nursing home[,] and suspend[] some elective surgeries at the hospital." Faced with these disturbing facts, it was unreasonable for CMS to fail to even mention them, let alone to rely on this article to *dismiss* the workforce shortage concerns.[3]

Defendants then speculate (at 21) that the mandate's "adverse effect on the labor market" will "be offset by a reduction" in absenteeism. But this conjecture unreasonably ignores that maintaining a larger pool of workers, even if some might have a bout with COVID-19, is better than categorically excluding an entire class of individuals.

[3] Recent developments continue to demonstrate the fallout from New York's mandate. *See Long Island hospital temporarily closing ER*, ABC 7 New York (Nov. 22, 2021), https://bit.ly/3G6rzA2 ("The emergency department at a Nassau County hospital has temporarily closed due to nursing staff shortages as a result of New York's vaccine mandate.").

Defendants also surmise (at 11) that there might be "a return to work of employees who have stayed" away for fear of unvaccinated coworkers. This is baseless guesswork. CMS cites no evidence that such workers exist, and it strains credulity to suggest that they do. A person who harbors such fears would still have to work with unvaccinated *patients*, and it is irrational to assume that they would be willing to work with unvaccinated patients but not unvaccinated coworkers.

Defendants lastly insist (at 21) that any workforce losses will be easily swallowed up within "the ordinary churn in the market for labor in the health care industry." Not so. CMS admits that the mandate covers "virtually all health care staff" and that it disqualifies all unvaccinated workers from those positions. 86 Fed. Reg. at 61,573. Excluding an entire category of workers from most healthcare jobs is not the ordinary "churn" of the labor market. The notion that "business as usual" measures can counteract the impending doom is unreasonable. And the highly credible evidence from Plaintiffs' thirty declarants belies the Government's rose-tinted views on this point.

F. The Eleventh Circuit's Decision Is Thoroughly Flawed.

In a Fed. R. App. 28(j) letter, Defendants cite the Eleventh Circuit's recent 2-to-1 decision on the CMS mandate, but as explained in Plaintiffs' response, the majority's opinion is unpersuasive in every way. *See Florida v. HHS*, No. 21-14098, 2021 WL 5768796 (11th Cir. Dec. 6, 2021). On the statutory authorization question, *Florida* held that the major-questions doctrine did not apply even though it admitted that mandating these vaccines is "an issue of economic and political significance[.]" *Id.* at *12. Concerning the procedural notice-and-comment issue, the court merely rubber-stamped as "sufficient"—without analysis—CMS's basis "to dispense with the notice-and-comment requirement." *Id.* at *14. And as for its arbitrary-and-capricious analysis, the Eleventh Circuit, like Defendants here, failed to address most of the deficiencies that the district court identified in this case. *Id.* at *15. This Court should thus decline to follow the Eleventh Circuit's thoroughly flawed reasoning.

II. The Remaining Factors Weigh Against a Stay.

Under the second stay factor, the Court considers whether the government will be "irreparably injured absent a stay." *Brakebill*, 905 F.3d at 557. And the final two factors consider the harms that a stay will

impose on Plaintiffs and the public. *Id.* All these factors weigh against Defendants' request.

No Irreparable Harm on Defendants. Preventing Defendants from enforcing CMS's unlawful mandate pending appeal will inflict no cognizable injury—let alone irreparable harm—on them. Government officials "do[] not have an interest in the enforcement of" an unlawful statute or regulation. *N.Y. Progress & Prot. PAC v. Walsh*, 733 F.3d 483, 488 (2d Cir. 2013). That is why the district court determined that "any interest CMS may have in enforcing an unlawful rule is likely illegitimate." R. Doc. 28, at 31.

Irreparable Harm on Plaintiffs. The district court held that Plaintiffs have shown a likelihood of "irreparable injury" in their sovereign, quasi-sovereign, and proprietary capacities without an injunction. R. Doc. 28, at 23. The irreparable sovereign harm consists of Plaintiffs' inability "to enforce their duly enacted laws surrounding vaccination mandates." *Id.* at 24. The irreparable quasi-sovereign injury includes harm to Plaintiffs' citizens because the loss of healthcare staff, reduction of services, and closure of facilities will "imped[e] access to care for the elderly and for persons who cannot afford it." *Id.* at 24-27. And Plaintiffs, as operators

of state-run healthcare facilities, will also experience irreparable proprietary harms such as the "business and financial effects of a lost or suspended employee, compliance and monitoring costs associated with the Mandate, [or] the diversion of resources necessitated by the Mandate." *Id.* at 28 (quoting *BST Holdings, LLC v. OSHA*, --- F.4th --- , No. 21-60845, 2021 WL 5279381, at *8 (5th Cir. Nov. 12, 2021)).

Public Interest. The district court held that the public interest favors "enjoining the mandate[] and thus preserving the 'status quo.'" R. Doc. 28, at 30. Indeed, if the mandate were to take effect, it "will have a crippling effect on a significant number of healthcare facilities in Plaintiffs' states, especially in rural areas, create a critical shortage of services (resulting in *no medical care at all* in some instances), and jeopardize the lives of numerous vulnerable citizens." *Id.* at 29-30.

Defendants argue (at 23) that the public interest nonetheless favors a stay because "patients may die" from "COVID-19 infections transmitted to them by staff." But according to CMS, "the effectiveness of the vaccine to prevent disease transmission by those vaccinated [is] not currently known." 86 Fed. Reg. at 61,615; *see also id.* at 61,612 ("predicting the full range of benefits … is all but impossible"); R. Doc. 35, at 2 (making these

same points in denying stay pending appeal). Defendants' public-interest argument is thus admittedly speculative.

In contrast, Plaintiffs' evidence shows that the mandate will drive out healthcare workers, reduce services, and close facilities—all of which will harm people seeking healthcare. The public interest thus weighs decidedly against Defendants. *Compare* R. Doc. 35, at 2 (denying stay pending appeal because, among other reasons, "a stay of the injunction would be against the public's interest" since it would jeopardize "the ability of healthcare facilities to provide proper care, and thus, save lives").

Conclusion

The Court should deny Defendants' motion.

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I hereby certify that on December 8, 2021, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Eighth Circuit by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

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Certificate of Compliance

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