SUPREME COURT OF THE UNITED STATES

Nos. 21A240 and 21A241

JOSEPH R. BIDEN, JR., PRESIDENT OF THE UNITED STATES, ET AL., APPLICANTS
21A240 *v.*
MISSOURI, ET AL.

XAVIER BECERRA, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., APPLICANTS
21A241 *v.*
LOUISIANA, ET AL.

ON APPLICATIONS FOR STAYS

[January 13, 2022]

JUSTICE THOMAS, with whom JUSTICE ALITO, JUSTICE GORSUCH, and JUSTICE BARRETT join, dissenting.

Two months ago, the Department of Health and Human Services (HHS), acting through the Centers for Medicare and Medicaid Services (CMS), issued an omnibus rule mandating that medical facilities nationwide order their employees, volunteers, contractors, and other workers to receive a COVID–19 vaccine. Covered employers must fire noncompliant workers or risk fines and termination of their Medicare and Medicaid provider agreements. As a result, the Government has effectively mandated vaccination for 10 million healthcare workers.

Two District Courts preliminarily enjoined enforcement of the omnibus rule, and the Government now requests an emergency stay of those injunctions pending appeal. Because the Government has not made a strong showing that it has statutory authority to issue the rule, I too would deny a stay.

To obtain a stay, the Government must show that there is (1) a reasonable probability that we would grant certiorari; (2) a fair prospect that we would reverse the judgments below; and (3) a likelihood that irreparable harm will result from denying a stay. *Hollingsworth* v. *Perry*, 558 U. S. 183, 190 (2010) (*per curiam*). Because there is no real dispute that this case merits our review, our decision turns primarily on whether the Government can make a "strong showing" that it is likely to succeed on the merits. *Nken* v. *Holder*, 556 U. S. 418, 426 (2009). In my view, the Government has not made such a showing here.

The Government begins by invoking two statutory provisions that generally grant CMS authority to promulgate rules to implement Medicare and Medicaid. The first authorizes CMS to "publish such rules and regulations . . . as may be necessary to the efficient administration of the [agency's] functions." 42 U. S. C. §1302(a). The second authorizes CMS to "prescribe such regulations as may be necessary to carry out the administration of the insurance programs" under the Medicare Act. §1395hh(a)(1).

The Government has not established that either provision empowers it to impose a vaccine mandate. Rules carrying out the "administration" of Medicare and Medicaid are those that serve "the practical management and direction" of those programs. Black's Law Dictionary 58 (3d ed. 1933). Such rules are "necessary" to "administration" if they bear "an actual and discernible nexus" to the programs' practical management. *Merck & Co., Inc.* v. *United States Dept. of Health and Human Servs.*, 962 F. 3d 531, 537–538 (CADC 2020) (internal quotation marks omitted). Here, the omnibus rule compels millions of healthcare workers to undergo an unwanted medical procedure that "cannot be removed at the end of the shift," *In re MCP No. 165*, 20 F. 4th 264, 268 (CA6 2021) (Sutton, C. J., dissenting from denial of initial hearing en banc). To the extent the rule has any connection to the management of Medicare

and Medicaid, it is at most a "tangential" one. *Merck & Co.*, *Inc.*, 962 F. 3d, at 538.

At oral argument, the Government largely conceded that §1302(a) and §1395hh(a)(1) alone do not authorize the omnibus rule. See Tr. of Oral Arg. 7, 10. Instead, it fell back on a constellation of statutory provisions that each concern one of the 15 types of medical facilities that the rule covers. See 86 Fed. Reg. 61567 (2021). Several of those provisions contain language indicating that CMS may regulate those facilities in the interest of "health and safety." In the Government's view, that language authorizes CMS to adopt any "requirements that [CMS] deems necessary to ensure patient health and safety," including a vaccine mandate applicable to all facility types. Application in No. 21A240, p. 19. The majority, too, treats these scattered provisions as a singular (and unqualified) delegation to the Secretary to adopt health and safety regulations.

The Government has not made a strong showing that this agglomeration of statutes authorizes any such rule. To start, 5 of the 15 facility-specific statutes do not authorize CMS to impose "health and safety" regulations at all. See 42 U. S. C. §§1396d(d)(1), (h)(1)(B)(i), 1395rr(b)(1)(A), 1395x(iii)(3)(D)(i)(IV), 1395i–4(e). These provisions cannot support an argument based on statutory text they lack. Perhaps that is why the Government only weakly defends them as a basis for its authority. See Tr. of Oral Arg. 25–28.

Next, the Government identifies eight definitional provisions describing, for example, what makes a hospital a "hospital." These define covered facilities as those that comply with a variety of conditions, including "such other requirements as the Secretary finds necessary in the interest of . . . health and safety." §1395x(e)(9); see also §§1395x(dd)(2)(G), (*o*)(6), (ff)(3)(B)(iv), (cc)(2)(J), (p)(4)(A)(v), (aa)(2)(K), 1395k(a)(2)(F)(i). The Government similarly invokes a saving clause for "health and safety"

regulations applicable to "all-inclusive care" programs for the elderly, see §§1395eee(f)(4), 1396u–4(f)(4), and a requirement that long-term nursing facilities "establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment . . . to help prevent the development and transmission of disease," §1395i–3(d)(3).

The Government has not made a strong showing that this hodgepodge of provisions authorizes a nationwide vaccine mandate. We presume that Congress does not hide "fundamental details of a regulatory scheme in vague or ancillary provisions." *Whitman* v. *American Trucking Assns., Inc.*, 531 U. S. 457, 468 (2001). Yet here, the Government proposes to find virtually unlimited vaccination power, over millions of healthcare workers, in definitional provisions, a saving clause, and a provision regarding long-term care facilities' sanitation procedures. The Government has not explained why Congress would have used these ancillary provisions to house what can only be characterized as a "fundamental detail" of the statutory scheme. Had Congress wanted to grant CMS power to impose a vaccine mandate across all facility types, it would have done what it has done elsewhere—specifically authorize one. See 22 U. S. C. §2504(e) (authorizing mandate for "such immunization . . . as necessary and appropriate" for Peace Corps volunteers).

Nonetheless, even if I were to accept that Congress could have hidden vaccine-mandate power in statutory definitions, the language in these "health and safety" provisions does not suggest that Congress did so. Take, for example, 42 U. S. C. §1395x(e), which defines "hospital" for certain purposes. Three subsections define hospitals as providers of specific patient services, see §§1395x(e)(1), (4), (5), and five describe administrative requirements that a facility must meet to qualify as a covered hospital, see §§1395x(e)(2)–(3), (6)–(8). The final subsection then pro-

vides that a "hospital" must also "mee[t] *such other* requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services." §1395x(e)(9) (emphasis added).

Contrary to the Government's position, this kind of catchall provision does not authorize every regulation related to "health and safety." As with all statutory language, context must inform the scope of the provision. See *AT&T Corp.* v. *Iowa Utilities Bd.*, 525 U. S. 366, 408 (1999) (THOMAS, J., concurring in part and dissenting in part) (citing *Neal* v. *Clark*, 95 U. S. 704, 708 (1878)). "[W]here, as here, a more general term follows more specific terms in a list, the general term is usually understood to embrace only objects similar in nature to those objects enumerated by the preceding specific words." *Epic Systems Corp.* v. *Lewis*, 584 U. S. ___, ___ (2018) (slip op., at 12) (internal quotation marks omitted). That presumption is particularly forceful where the statutory catchall refers to "such other" requirements, signaling that the subjects that come before delimit any residual authority. See *ibid.* Here, in §1395x(e), none of the myriad subsections preceding the "health and safety" subsection suggests that the Government can order hospitals to require virtually all hospital personnel to be vaccinated. Rather, these subsections show that HHS' residual authority embraces only administrative requirements like those that precede it—including "provid[ing] 24-hour nursing service," "maintain[ing] clinical records on all patients," or having "bylaws in effect." §§1395x(e)(2), (3), (5). A requirement that all healthcare workers be vaccinated is plainly different in kind. The same reasoning applies to almost all of the Government's proposed facility-specific statutes. See §§1395x(aa)(2), (dd)(2), (*o*)(6); see also §§1395x(ff)(3)(B), (p)(4)(A), (cc)(2), 1395eee, 1396u–4(f)(4).

Only one facility-specific provision is arguably different. It regulates long-term care facilities and mandates an "infection control program" among its "health and safety"

provisions. §1395i–3(d)(3). But that infection-control provision focuses on sanitizing the facilities' "environment," not its personnel. *Ibid.* In any event, even if this statutory language justified a vaccine mandate in long-term care facilities, it could not sustain the omnibus rule. Neither the "infection control" language nor a reasonable analog appears in any of the other facility-specific provisions. Basic interpretive principles would thus suggest that CMS lacks vaccine-mandating authority with respect to the other types of facilities. See *Russello* v. *United States*, 464 U. S. 16, 23 (1983). And, of course, the omnibus rule cannot rest on the long-term care provision alone. By CMS' own estimate, long-term care facilities employ only 10% of the 10 million healthcare workers that the rule covers. 86 Fed. Reg. 61603. Put simply, the oblique reference to "infection control" in the definitional provision for long-term care facilities cannot authorize an omnibus vaccine mandate covering *every* type of facility that falls within CMS' purview.

For its part, the Court does not rely on the Government's proffered statutory provisions. Instead, it asserts that CMS possesses broad vaccine-mandating authority by pointing to a handful of CMS regulations. To begin, the Court does not explain why the bare existence of these regulations is evidence of what Congress empowered the agency to do. Relying on them appears to put the cart before the horse.

Regardless, these regulations provide scant support for the sweeping power the Government now claims. For example, CMS regulations that mandate the number of hours a dietician must practice under supervision, *ante*, at 6 (citing 42 CFR §483.60 (2020)), or that prescribe "the tasks that may be delegated . . . to a physician assistant or nurse practitioner," *ante,* at 6 (citing §483.30(e)), cannot support a vaccine mandate for healthcare personnel.

The Court also invokes a regulation requiring hospitals to implement programs that "govern the 'surveillance, prevention, and control of . . . infectious diseases,'" *ante,* at 6

(quoting §482.42), as well as a few regulations that require "infection and prevention control programs" at some (but apparently not all) facility types. See *ante*, at 3 (citing, *inter alia*, §482.42). But many of these infection-control regulations, like the infection-control program set out at 42 U. S. C. §1395i–3(d)(3), are far afield from immunization. See, *e.g.*, 42 CFR §§485.725(b)–(e) (specifying requirements for "aseptic techniques," "housekeeping services," "[l]inens," and "[p]est control"). And insofar as they do touch on immunization, they require only that facilities *offer* their *residents* the opportunity to obtain a vaccine, along with "the opportunity to refuse" it. §483.80(d)(1). These regulations are not precedents for CMS' newfound authority *mandating* that all *employees* be vaccinated.

Finally, our precedents confirm that the Government has failed to make a strong showing on the merits. "We expect Congress to speak clearly when authorizing an agency to exercise powers of vast economic and political significance." *Alabama Assn. of Realtors* v. *Department of Health and Human Servs.*, 594 U. S. ___, ___ (2021) (*per curiam*) (slip op., at 6) (internal quotation marks omitted). And we expect Congress to use "exceedingly clear language if it wishes to significantly alter the balance between state and federal power." *Ibid.* (internal quotation marks omitted). The omnibus rule is undoubtedly significant—it requires millions of healthcare workers to choose between losing their livelihoods and acquiescing to a vaccine they have rejected for months. Vaccine mandates also fall squarely within a State's police power, see *Zucht* v. *King*, 260 U. S. 174, 176 (1922), and, until now, only rarely have been a tool of the Federal Government. If Congress had wanted to grant CMS authority to impose a nationwide vaccine mandate, and consequently alter the state-federal balance, it would have said so clearly. It did not.

* * *

These cases are not about the efficacy or importance of COVID–19 vaccines. They are only about whether CMS has the statutory authority to force healthcare workers, by coercing their employers, to undergo a medical procedure they do not want and cannot undo. Because the Government has not made a strong showing that Congress gave CMS that broad authority, I would deny the stays pending appeal. I respectfully dissent.

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[January 13, 2022]

JUSTICE ALITO, with whom JUSTICE THOMAS, JUSTICE GORSUCH, and JUSTICE BARRETT join, dissenting.

I join JUSTICE THOMAS's dissent because I do not think that the Federal Government is likely to be able to show that Congress has authorized the unprecedented step of compelling over 10,000,000 healthcare workers to be vaccinated on pain of being fired. The support for the argument that the Federal Government possesses such authority is so obscure that the main argument now pressed by the Government—that the authority is conferred by a hodgepodge of scattered provisions—was not prominently set out by the Government until its reply brief in this Court. Before concluding that the Federal Government possesses this authority, we should demand stronger statutory proof than has been mustered to date.

But even if the Federal Government has the authority to require the vaccination of healthcare workers, it did not have the authority to impose that requirement in the way

it did. Under our Constitution, the authority to make laws that impose obligations on the American people is conferred on Congress, whose Members are elected by the people. Elected representatives solicit the views of their constituents, listen to their complaints and requests, and make a great effort to accommodate their concerns. Today, however, most federal law is not made by Congress. It comes in the form of rules issued by unelected administrators. In order to give individuals and entities who may be seriously impacted by agency rules at least some opportunity to make their views heard and to have them given serious consideration, Congress has clearly required that agencies comply with basic procedural safeguards. Except in rare cases, an agency must provide public notice of proposed rules, 5 U. S. C. §553(b); the public must be given the opportunity to comment on those proposals, §553(c); and if the agency issues the rule, it must address concerns raised during the notice-and-comment process. *United States* v. *Nova Scotia Food Products Corp.*, 568 F. 2d 240, 252 (CA2 1977); see also *Motor Vehicle Mfrs. Assn. of United States, Inc.* v. *State Farm Mut. Automobile Ins. Co.*, 463 U. S. 29, 43 (1983). The rule may then be challenged in court, and the court may declare the rule unlawful if these procedures have not been followed.

In these cases, the relevant agency did none of those things, and the Court rewards this extraordinary departure from ordinary principles of administrative procedure. Although today's ruling means only that the Federal Government is likely to be able to show that this departure is lawful, not that it actually is so, this ruling has an importance that extends beyond the confines of these cases. It may have a lasting effect on Executive Branch behavior.

Because of the importance of notice-and-comment rulemaking, an agency must show "good cause" if it wishes to skip that process. 5 U. S. C. §553(b)(3)(B). Although this Court has never precisely defined what an agency must do

to demonstrate good cause, federal courts have consistently held that exceptions to notice-and-comment must be "'narrowly construed and only reluctantly countenanced.'" *Mack Trucks, Inc.* v. *EPA*, 682 F. 3d 87, 93 (CADC 2012) (quoting *Utility Solid Waste Activities Group* v. *EPA*, 236 F. 3d 749, 754 (CADC 2001)); see also C. Koch & R. Murphy, Good Cause for Avoiding Procedures, 1 Admin. L. & Prac. §4:13 (3d ed. 2021).

The agency that issued the mandate at issue here, *i.e.*, the Centers for Medicare and Medicaid Services (CMS), admits it did not comply with the commonsense measure of seeking public input before placing binding rules on millions of people, but it claims that "[t]he data showing the vital importance of vaccination" indicate that it "cannot delay taking this action." 86 Fed. Reg. 61555, 61583 (2021). But CMS's generalized justification cannot alone establish good cause to dispense with Congress's clear procedural safeguards. An agency seeking to show good cause 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 (CA8 2014) (internal quotation marks omitted).

Although CMS argues that an emergency justifies swift action, both District Courts below held that CMS fatally undercut that justification with its own repeated delays. The vaccines that CMS now claims are vital had been widely available 10 months before CMS's mandate, and millions of healthcare workers had already been vaccinated before the agency took action. President Biden announced the CMS mandate on September 9, 2021, nearly two months before the agency released the rule on November 5, and the mandate itself delayed the compliance deadline further by another month until December 6. 86 Fed. Reg. 61555; *id.,* at 61573 (making implementation of the vaccine mandate begin "30 days after publication" and completed "60 days after publication"). This is hardly swift.

CMS argues that its delay, "even if true," does not provide a "reason to block a rule" that it claims will protect patient health. Application in No. 21A241, p. 36. It claims that its departure from ordinary procedure after extraordinary delay should be excused because nobody can show they were prejudiced by the lack of a comment period before the rule took effect. But it is CMS's affirmative burden to show it has good cause, not respondents' burden to prove the negative. *Northern Arapahoe Tribe* v. *Hodel*, 808 F. 2d 741, 751 (CA10 1987). Congress placed procedural safeguards on executive rulemaking so agencies would consider "important aspect[s] of the problem[s]" they seek to address before restricting the liberty of the people they regulate. *State Farm*, 463 U. S., at 43. Because CMS chose to circumvent notice-and-comment, States that run Medicaid facilities, as well as other regulated parties, had no opportunity to present evidence refuting or contradicting CMS's justifications before the rule bound them. And because CMS acknowledged its own "uncertainty" and the "rapidly changing nature of the current pandemic," 86 Fed. Reg. 61589, it should have been *more* receptive to feedback, not less. "[A]n utter failure to comply with notice and comment cannot be considered harmless if there is any uncertainty at all as to the effect of that failure." *Sugar Cane Growers Cooperative of Florida* v. *Veneman*, 289 F. 3d 89, 96 (CADC 2002).

Today's decision will ripple through administrative agencies' future decisionmaking. The Executive Branch already touches nearly every aspect of Americans' lives. In concluding that CMS had good cause to avoid notice-and-comment rulemaking, the Court shifts the presumption against compliance with procedural strictures from the unelected agency to the people they regulate. Neither CMS nor the Court articulates a limiting principle for why, after an unexplained and unjustified delay, an agency can regulate first and listen later, and then put more than 10 million

healthcare workers to the choice of their jobs or an irreversible medical treatment.

Therefore, I respectfully dissent.