# In the United States Court of Appeals for the Eleventh Circuit

No. 21-13866

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STATE OF FLORIDA, STATE OF ALABAMA, STATE OF GEORGIA, GEORGIA HIGHWAY CONTRACTORS ASSOCIATION, GEORGIA MOTOR TRUCKING ASSOCIATION, ROBINSON PAVING CO., SCOTCH PLYWOOD COMPANY, INC., THE KING'S ACADEMY, AND CAMBRIDGE CHRISTIAN SCHOOL,
*Petitioners*,

v.

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, UNITED STATES DEPARTMENT OF LABOR,
*Respondent*.

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## MOTION TO STAY

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ASHLEY MOODY
*Attorney General of Florida*
HENRY C. WHITAKER
*Solicitor General*
DANIEL W. BELL
*Chief Deputy Solicitor General*
EVAN EZRAY
JASON H. HILBORN
*Deputy Solicitors General*
The Capitol, Pl-01
Tallahassee, Florida 32399-1050
(850) 414-3300
Henry.Whitaker@myfloridalegal.com

*Counsel for Petitioner the State of Florida*

JAMES H. PERCIVAL
*Deputy Attorney General of Legal Policy*
NATALIE P. CHRISTMAS
*Assistant Attorney General of Legal Policy*

*Additional Counsel Listed on Signature Page*

## CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT

Counsel for Petitioners certifies that the following is a complete list of interested persons as required by Federal Rule of Appellate Procedure 26.1 and Eleventh Circuit Rules 26.1-1 to 26.1-3:

1. Alliance Defending Freedom (Counsel for Petitioners Cambridge Christian School and The King's Academy)
2. Belinfante, Josh (Counsel for Petitioners Georgia Highway Contractors Association, Georgia Motor Trucking Association, and Robinson Paving Co.)
3. Bell, Daniel (Counsel for Petitioner State of Florida)
4. Bergethon, Ross (Counsel for Petitioner State of Georgia)
5. Bursh, John (Counsel for Petitioners Cambridge Christian School and The King's Academy)
6. Cambridge Christian School (Petitioner)
7. Carr, Christopher (Attorney General of Petitioner State of Georgia)
8. Chang, Frank (Counsel for Petitioners Cambridge Christian School and The King's Academy)
9. Christmas, Natalie (Counsel for Petitioner State of Florida)

10. Cortman, David (Counsel for Petitioners Cambridge Christian School and The King's Academy)
11. Ezray, Evan (Counsel for Petitioner State of Florida)
12. Georgia Highway Contractors Association (Petitioner)
13. Georgia Motor Trucking Association (Petitioner)
14. Hilborn, Jason (Counsel for Petitioner State of Florida)
15. LaCour, Jr., Edmund (Counsel for Petitioner State of Alabama)
16. Marshall, Steve (Attorney General of Petitioner State of Alabama)
17. Moody, Ashley (Attorney General of Petitioner State of Florida)
18. Occupational Safety & Health Administration, Department of Labor (Respondent)
19. Percival, James (Counsel for Petitioner State of Florida)
20. Pico-Prats, Javier (Counsel for Petitioners Georgia Highway Contractors Association, Georgia Motor Trucking Association, and Robinson Paving Co.)
21. Robinson Paving Co. (Petitioner)
22. Scotch Plywood Company, Inc. (Petitioner)
23. State of Alabama (Petitioner)
24. State of Florida (Petitioner)
25. State of Georgia (Petitioner)

26. The King's Academy (Petitioner)

27. Tucker, Ryan (Counsel for Petitioners Cambridge Christian School and The King's Academy)

28. Turner, E. Tatum (Counsel for Petitioner Scotch Plywood Company, Inc.)

29. Turner, Halron W. (Counsel for Petitioner Scotch Plywood Company, Inc.)

30. Waldbeser, Drew (Counsel for Petitioner State of Georgia)

31. Whitaker, Henry (Counsel for Petitioner State of Florida)

32. Wilson, Thomas (Counsel for Petitioner State of Alabama)

No publicly traded company or corporation has an interest in the outcome of this case or appeal.

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## INTRODUCTION

At the President's direction and borne of his "anger at those who haven't gotten vaccinated,"[1] the Occupational Safety and Health Administration seeks to compel roughly one-third of the adult population of the United States to vaccinate. The rule doubles down on the government's recent authoritarian streak, which is marred by failed attempts to impose broadly applicable mandates through *actual* public-health agencies. But even the CDC does not have limitless power to regulate in the name of public health. *See Ala. Ass'n of Realtors v. HHS*, 141 S. Ct. 2485 (2021). It is even less plausible that OSHA, in executing its charge of adopting "occupational safety and health standards," 29 U.S.C. § 652(8), has anything of the kind, either.

The "Emergency Temporary Standard" OSHA issued is neither a workplace standard nor is it a response to an emergency. It is, rather, a backdoor attempt to dictate the personal health decisions of millions of ordinary Americans, many of whom have deeply personal reasons to decline to be vaccinated. OSHA's unprecedented intrusion exceeds its statutory authority—and would exceed the federal government's enumerated powers if it came from Congress. It also fails to satisfy the high bar needed to issue an emergency rule; violates the First Amendment and the Religious Freedom Restoration Act; and threatens Petitioners with irreparable harm unless it is immediately

[1] Remarks by President Biden (Sept. 9, 2021) https://www.whitehouse.gov/briefing-room/speeches-remarks/2021/09/09/remarks-by-president-biden-on-fighting-the-covid-19-pandemic-3/.

stayed. No one doubts that COVID-19 presents a serious public health issue, but if we are to remain "a government of laws and not men," *Harper v. Va. State Bd. of Elections*, 383 U.S. 663, 667 (1966), then the government must follow the law—"even a public health emergency does not absolve [it] of that responsibility." *Calvary Chapel Dayton Valley v. Sisolak*, 140 S. Ct. 2603, 2604 (2020) (Alito, J., dissenting).

Given those "grave statutory and constitutional issues," the Fifth Circuit has already temporarily stayed the ETS. *See BST Holdings LLC v. OSHA*, No. 21-60845 (Nov. 6, 2021). But it is unclear how long the Fifth Circuit's stay will be in place or when it will rule, so Petitioners ask the Court to stay the ETS as well and toll all compliance deadlines it establishes until this case is resolved. Petitioners also ask the Court to order an expedited response to this motion and enter an administrative stay while this motion is pending.

## ARGUMENT

To receive a stay an applicant "must establish (1) a substantial likelihood of success on the merits; (2) danger of irreparable harm if the court denies interim relief; (3) that other parties will not be harmed substantially if the court grants interim relief; and (4) that interim relief will not harm the public interest." *Asbestos Info. Ass'n/N. Am. v. OSHA*, 727 F.2d 415, 418 n.4 (5th Cir. 1984).[2]

[2] It would be impracticable to seek a stay from OSHA because OSHA views its rule as so "necessary" that it dispensed with notice and comment. Fed. R. App. P. 18.

A. Petitioners are likely to succeed on the merits.

OSHA has never used its authority to do anything like what it seeks to do here: dictate the healthcare decisions of roughly one-third of the adult population.[3] OSHA lacks the statutory authority to order that kind of major action, and regardless, did not properly invoke its more limited statutory powers. Before getting to those arguments, however, three overarching principles of statutory interpretation counsel against sanctioning OSHA's power grab.

*First*, "Congress normally preserves the constitutional balance between the National Government and the States," and must speak clearly if it wishes to upset that balance. *Bond v. United States*, 572 U.S. 844, 862 (2014). That balance would be undone were OSHA correct that it may dictate the healthcare decisions of millions.

*Second*, "Congress [must] speak clearly when authorizing an agency to exercise powers of vast economic and political significance." *Ala. Ass'n of Realtors*, 141 S. Ct. at 2489. It did not do so here.

[3] OSHA spins its regulation as "strongly encouraging vaccination." *COVID-19 Vaccination and Testing*, 86 Fed. Reg. 61,402, 61,402 (Nov. 5, 2021). The "encouragement" OSHA provided is "strong" indeed. Workers could of course be fired as an alternative to getting vaccinated. Beyond that, the only other option is to endure weekly mandatory COVID testing, at their own expense, and wear face coverings at work. That costly, intrusive, and inconvenient "exception" only underscores that the rule is, in fact, coercing vaccination.

*Third*, statutes should be read to avoid constitutional concerns. *See United States v. Jin Fuey Moy*, 241 U.S. 394, 401 (1916). Reading the statute to permit this ETS would create grave doubts about its constitutionality.

For one, commerce regulation may not "completely obliterate the Constitution's distinction between national and local authority." *United States v. Morrison*, 529 U.S. 598, 615 (2000). If OSHA may require that all employees either receive a vaccine or submit to testing, OSHA's power is virtually limitless. "People, for reasons of their own, often fail to do things," like getting a vaccine "that would be good for them." *NFIB v. Sebelius*, 567 U.S. 519, 554 (2012). OSHA's reading would allow it to demand that workers attend an annual physical or eat their vegetables. That type of all-encompassing power is not what the founders envisioned. *Id.*

For another, Congress lacks authority to delegate OSHA legislative power. *Indus. Union Dep't., AFL-CIO v. Am. Petroleum Inst.*, 448 U.S. 607, 687 (1980) (Rehnquist, J., concurring). Affording OSHA discretion to regulate any matter related to the general health and safety of the American people would arrogate to an agency the sort of broad policymaking authority that properly rests with Congress.

1. The vaccine mandate is not a workplace regulation.

Nothing in OSHA's authorities comes close to clear authorization for this mandate. Congress granted OSHA limited authority to regulate *workplace* hazards by mandating *workplace* safety measures. "The OSH Act is not a general charter for courts to protect worker safety." *Fla. Retail Fed'n, Inc. v. Attorney Gen.*, 576 F. Supp. 2d 1281,

1298 (N.D. Fla. 2008). Still less is it a public-health charter. *Cf.* 29 USC § 653(b)(1) (OSHA lacks authority where other agencies have it). But OSHA's vaccine mandate is a general health regulation, not a regulation of the workplace. *BST Holdings*, No. 21-60845 (Nov. 6, 2021) (finding "grave statutory" issues with the ETS).

This conclusion flows readily from the statutory scheme. OSHA, as its name suggests, ensures *occupational* safety, not general safety. For that reason, Congress's stated purpose in enacting the OSH Act was to encourage "employers and employees in their efforts to reduce the number of occupational safety and health hazards at their places of employment." 29 U.S.C. § 651(b)(1).

Consistent with that purpose, the Act defines an "occupational safety and health standard" to target the place of employment; defining the term to mean "conditions" that "provide safe or healthful employment and places of employment." 29 U.S.C. § 652(8). Throughout, the Act uses the terms "substances," "agents," and "hazards" to refer to dangers presented by a job, not to dangers that exist in the world generally. One provision, for example, requires the government to prepare a report "listing . . . all toxic substances in industrial usage." 29 U.S.C. § 675. Another requires studies regarding "the contamination of workers' homes with hazardous . . . substances, including infectious agents, transported from the [workers'] workplaces." 29 U.S.C. § 671a(c)(1)(A). And one more allows employers to avoid inspections, unless "major changes in working conditions . . . occur which introduce new hazards in the workplace." 29 U.S.C.

§ 670(d)(4)(B). All these provisions are focused on dangers arising at work because of one's work.

This Court has agreed. "In order for coverage under the Act to be properly extended to a particular area," this Court has explained, "the conditions to be regulated must fairly be considered working conditions, the safety and health hazards to be remedied occupational, and the injuries to be avoided work-related." *Frank Diehl Farms v. Sec'y of Labor*, 696 F.2d 1325, 1332 (11th Cir. 1983).

OSHA also previously regulated with this understanding. When OSHA instituted standards to combat Hepatitis B, it limited its standard to workplaces "with reasonably anticipated occupational exposure to blood or other potentially infectious materials," 56 Fed. Reg. 64,004, 64,089 (Dec. 6, 1991), and it limited its response to a workplace response, requiring, for example, employers to adopt exposure control plans and workplace precautions around the handling of blood, *id.* at 64,175–76.

The OSH Act allows OSHA to regulate workplace dangers by adopting workplace regulations. The ETS does not do that. COVID-19 is not a workplace illness. Nor is the ETS tailored to workplace transmission—it applies to any large employer regardless of the real-world transmission risk. The solution OSHA crafted, moreover, is not workplace-based. It does not, for example, regulate distancing or air flow in the workplace—it regulates employees' private health decisions *outside* work by requiring vaccination or imposing an onerous testing regime. OSHA can no more require

vaccination than it could require workers to receive mental-health treatment to improve workplace conditions indirectly. The ETS, thus, falls outside OSHA's authority.[4]

2. The ETS was issued by an official with no power to issue it.

The ETS was issued by James Frederick, purporting to act as the "Acting Assistant Secretary of Labor." 86 Fed. Reg. 61,551. But when the ETS was issued, there was no "Acting Assistant Secretary of Labor," because two days before the rule's issuance the Assistant Secretary of Labor was sworn in.[5] There is no indication that the Secretary had "die[d], resign[ed]" or was "otherwise unable to perform the functions and duties of the office." 5 U.S.C. § 3345(a). Thus, Frederick had no authority to issue this rule. *SW Gen., Inc. v. N.L.R.B.*, 796 F.3d 67, 81–83 (D.C. Cir. 2015).

[4] If the Court rejects Petitioners' primary statutory argument, then to avoid arrogating to OSHA massive power, it should read OSHA's authority to issue standards narrowly. OSHA ultimately claims its ETS would become a standard under 29 U.S.C. § 655(6)(b)(5). *E.g.*, 86 Fed. Reg. 61,406. That provision, which allows OSHA to regulate "toxic materials and harmful physical agents" does not obviously permit OSHA to regulate viruses. Instead, it can reasonably be read to allow OSHA to regulate poisons and physical agents, such as noise, that cause harm via physical movements. This reading is supported by the rest of the Act, which refers to "concentrations" or "levels," of exposure to toxic materials and harmful physical agents. 29 U.S.C. § 657(c)(3). Normal English speakers would refer to a concentration of a poison or a dangerous level of noise, not a concentration of virus.

[5] OSHA, *Special Edition Meet OSHA's New Leader* (Nov. 3, 2021) https://www.osha.gov/quicktakes/11032021.

### 3. The ETS exceeds OSHA's emergency rulemaking powers.

#### *a) The ETS is not necessary to prevent a grave danger.*

To issue an ETS, the Secretary must determine "(A) that employees are exposed to grave danger from exposure to substances or agents determined to be toxic or physically harmful or from new hazards, and (B) that such emergency standard is necessary to protect employees from such danger." 29 U.S.C. § 655(c)(1). As OSHA explained, "an ETS is necessary only where . . . [the] reduction in danger could not be obtained by enforcement of existing standards, requirements administered by other health authorities, or by widespread voluntary compliance." *See* Dep't of Labor's Response, *In re: AFL-CIO*, No. 20-1158, at 19–20 (D.C. Cir. May 29, 2020) ("Labor Brief"). And in meeting that standard, OSHA must present substantial evidence, *Fla. Peach Growers Ass'n, Inc. v. U.S. Dep't. of Labor*, 489 F.2d 120, 127 (5th Cir. 1974), which requires a "'harder look' at OSHA's action than" the "arbitrary and capricious standard," *Asbestos Info.*, 727 F.2d at 421.

OSHA cannot make that showing because its substantial non-emergency powers are already protecting workers from COVID-19. OSHA's respiratory-protection standard, for instance, requires employers to assess their workplaces for potential exposure to atmospheric contamination and establish a plan to protect workers. *See* 29 C.F.R. § 1910.134(a)–(d). OSHA similarly demands that employers provide appropriate personal protective equipment and sanitize to protect from infectious disease. 29 C.F.R. §§ 1910.132(a)–(h), 1910.141(a)–(h). Finally, the general-duty clause requires employers

to "furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm." 29 U.S.C. § 654(a)(1). When an employer recognizes that a workplace condition might cause workers harm and is feasibly able to remediate it, the general-duty clause demands remediation. *BHC Nw. Psychiatric Hosp., LLC v. Sec'y of Labor*, 951 F.3d 558, 563 (D.C. Cir. 2020). OSHA is already using these powers, having issued over $4 million in COVID-19-related citations.[6] If there are any gaps in those considerable powers, they could be filled by other agencies, State and local officials, and employers. *See* May 29 Letter from Loren Sweatt to Richard Trumka at 3.

OSHA's non-emergency powers are more than sufficient because COVID-19 does not pose a grave danger to many workers. The rule is designed "to protect unvaccinated employees." 86 Fed. Reg. 61,402. But many of the unvaccinated have already been infected, leaving them with "some natural immunity." *United States v. Arencibia*, 2021 WL 2530209, at *4 (D. Minn. June 21, 2021). "[N]atural immunity confers longer lasting and stronger protection against infection, symptomatic disease and hospitalization caused by the Delta variant."[7] *See also* Bhattacharya Decl. And those who lack natural immunity can protect themselves by choosing to be vaccinated or by

[6] OSHA, Inspections with COVID-19 Related Violations (last visited Nov. 7, 2021) https://www.osha.gov/enforcement/covid-19-data/inspections-covid-related-citations.

[7] Sivan Gazit et al., *Comparing SARS-CoV-2 Natural Immunity to Vaccine-induced Immunity: Reinfections Versus Breakthrough Infections* (Aug. 25, 2021), https://www.medrxiv.org/content/10.1101/2021.08.24.21262415v1.full.

"physical distancing, community use of well-fitting masks . . . adequate ventilation, and avoidance of crowded indoor spaces."[8]

Indeed, the Department of Labor's overall response to the pandemic belies any claim of necessity. The Mine Safety and Health Administration, whose emergency powers mirror OSHA's, 30 U.S.C. § 811(b), announced that it would not issue an emergency temporary standard to protect miners from COVID-19.[9] Instead, the MSHA concluded that it could rely on its other powers to ensure that "employees mask[] up and keep . . . away from each other," which would adequately prevent the spread of the virus.[10]

For over a year of the pandemic, even when the number of COVID-19 cases were over *twice* the current level,[11] OSHA declined to issue an ETS.[12] That "failure to act" is "evidence that [the] situation is not a true emergency." *Asbestos Info.*, 727 F.2d at

[8] CDC, Scientific Brief: SARS-CoV-2 Transmission (May 7, 2021), https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/sars-cov-2-transmission.html#anchor_1619805200745.

[9] MSHA, Quarterly Training Call and Stakeholder Meeting (Sept. 29, 2021) at 35:56–37:30, https://www.msha.gov/training-education/quarterly-training-calls.

[10] Suzanne Featherson, *MSHA: Vaccine-Or-Test Rule for Employers Does Not Apply to Mines* (Oct. 15, 2021), https://elkodaily.com/mining/msha-vaccine-or-test-rule-for-employers-does-not-apply-to-mines/article_30f8a7cc-0755-5402-b89b-0e0419305160.html.

[11] New York Times, Coronavirus Map and Cases https://www.nytimes.com/interactive/2021/us/covid-cases.html.

[12] Even if vaccines were not yet available, testing was. OSHA's failure to issue an ETS at that time demonstrates that the testing alternative is only meant to coerce the unvaccinated, not protect employee safety.

423. And when that evidence is coupled with OSHA's other powers, the Department's overall response to COVID-19, and the facts on the ground, the ETS cannot stand.

*b) The ETS overlooks obvious aspects of the problem.*

The ETS standard demands that OSHA "not overlook those obvious distinctions" that make "regulations that are appropriate in one category of cases entirely unnecessary in another." *Dry Color Mfrs. Ass'n, Inc. v. Dep't of Labor*, 486 F.2d 98, 105 (3d Cir. 1973).

That is exactly what OSHA did here. The ETS generally applies to all employers with 100 or more employees. 86 Fed. Reg. 61,403. Although OSHA adopted exceptions for fully outdoor and remote workers, its arbitrary one-hundred-employee line applies even if the nature of an employer's workplace makes the risk of COVID-19 infection exceedingly low. For example, many employees work in conditions that allow them to work largely (but not entirely) alone or outside. They, no matter the size of their employer, face little risk of transmission. For them, OSHA cannot possibly show necessity or danger. By ignoring this obvious aspect of the problem, OSHA exceeded its ETS authority. *See Dry Color Mfrs.*, 486 F.2d at 105.

Indeed, OSHA recognized as much in its previous ETS, which mandated workplace reforms to protect only healthcare workers. In doing so, OSHA cited data that indicated that "healthcare professions in general had the highest predicted risk for COVID–19." 86 Fed. Reg. 32,382, 32,401 (June 21, 2021). OSHA explained that data

by noting that workers who had "frequent contact with sick people[,]" faced an elevated risk from the disease. *Id.* at 32,402.

But none of those findings apply to *all* workspaces. Unlike healthcare workers, many workers do not work "in spaces shared with others," *Id.* at 32,382, much less in places where they face "frequent contact with sick people." *Id.* at 32,402. OSHA tries to avoid that finding by pointing to outbreaks in many sectors. 86 Fed. Reg. 61,412–15. But even accepting that OSHA's anecdotes show that many industries have workplaces that are conducive to COVID-19 transmission, OSHA's data says nothing about the features of individual workplaces that are conducive to COVID-19. That is, OSHA's rule applies to all workplaces maintained by large employers, whether or not the features of the workplace make COVID-19 a grave danger. That is no small thing. OSHA recognizes that "employers in their unique workplace settings may be best situated to understand their workforce and the strategies that will maximize worker protection." 86 Fed. Reg. 61,436. By ignoring the differences between workplaces, OSHA has adopted a standard that elides critical distinctions. *Dry Color Mfrs.*, 486 F.2d at 105.

Another "important aspect[] of the problem," *DHS v. Regents of the Univ. of Cal.*, 140 S. Ct. 1891, 1910 (2020), is the prospect of mass layoffs and resignations. The Kaiser Family Foundation has published data showing that 37 percent of unvaccinated

workers would leave their jobs rather than comply with a mandate like OSHA's.[13] Using OSHA's data, 86 Fed. Reg. 61,435, that would amount to about 11 million workers losing their jobs. OSHA tries to avoid this problem by claiming that the actual numbers leaving will be much lower. 86 Fed. Reg. 61,475. But OSHA cites only one article and five examples to make that point. *Id.* That is an exceedingly thin record on which to bet 12 million jobs. And regardless, OSHA considers the problem only from the perspective of "turnover." *Id.* But that undersells the issue—in normal turnover, departing employees remain in the labor market, filling positions with other employers. Here, however, departing workers will be largely excluded from the labor market. OSHA does not consider that problem at all.

*c) The ETS fails to explain its stark departure from past administrative practice.*

The ETS also fails to explain adequately its departure from OSHA's historical practice—a failure fatal to administrative action. *Regents*, 140 S. Ct. at 1913. OSHA departed from its past practice without adequate explanation in at least three respects.

*First*, OSHA departed from its past practice on vaccination. In 1991, OSHA confronted "significant risks[s]," 56 Fed. Reg. 64,004, 64,007 (Dec. 6, 1991), associated with the Hepatitis B virus. Nonetheless, OSHA rejected calls to mandate the vaccine. *Id.* at 64,154. OSHA reasoned that "mandating worker participation in such a sensitive

[13] Chris Isidore et al., *72% of unvaccinated workers vow to quit if ordered to get vaccinated*, CNN.com (Oct. 28, 2021), https://www.cnn.com/2021/10/28/business/covid-vaccine-workers-quit/index.html.

area would present an array of religious and privacy concerns." *Id.* And OSHA concluded that a voluntary vaccination program was "the best approach to foster greater employee cooperation and trust in the system." *Id* at 64,155. OSHA took a similar approach in June by encouraging, but not requiring, that healthcare workers receive the COVID vaccine. 86 Fed. Reg. 32,599 (Jun. 21, 2021). Again, OSHA explained that "some employees may decline vaccination for a number of reasons, including underlying medical conditions or conscience-based objections." *Id.*

OSHA has now reversed course, adopting a policy that labels mandatory vaccination its "preferred compliance option," 86 Fed. Reg. 61,437, and imposes burdensome requirements, including financial penalties, on employees who choose incorrectly. OSHA attempts to justify its reversal by claiming this emergency is worse. *E.g.*, 86 Fed. Reg. 61,436. But that mischaracterizes OSHA's past action—after all, OSHA concluded that Hepatitis B was "the major infectious bloodborne occupational hazard to healthcare workers," 56 Fed. Reg. 64,009, and in June, OSHA found a grave danger to healthcare workers. OSHA cannot reverse course by claiming that what previously was a grave danger was, really, not that grave after all.

*Second*, OSHA reversed course on the need for an ETS to address COVID-19. In March of last year, OSHA explained that initiating rulemaking "at the same time that the healthcare industry is responding to the COVID-19 public health emergency is counterproductive to both the public health response and robust stakeholder engagement." Mar. 18 Letter from Loren Sweatt to Rep. Robert Scott at 2.

OSHA likewise declined to issue an ETS in May of 2020. *See* May 29 Letter from Loren Sweatt to Richard Trumka. OSHA was clear that "it would be counter-productive" to issue a rule, and that the "best approach" was to "enforce the existing OSH Act requirements" while issuing nimbler "industry-specific" guidance. *Id.* at 2. OSHA concluded that issuing "an ETS . . . would not just be inappropriate, but potentially damaging to the pandemic response effort," *id.* at 3, because "an ETS . . . could very well become . . . counterproductive, as it may be informed by incomplete or ultimately inaccurate information [and] under the statute the ETS would lead to a permanent final rule within six months of its promulgation." *Id.* at 9 n.9. That would be problematic because a flawed rule "would be changeable only through additional, laborious notice-and-comment rulemaking." *Id.* OSHA echoed those points in a D.C. Circuit brief, explaining that issuing an ETS was harmful because it would enshrine "a rigid and necessarily general regulation," which was ill-suited to the rapidly changing scientific understanding of the virus. Labor Brief at 28.

OSHA attempts to explain its shift in strategy by pointing to (stale) on-the-ground developments. 86 Fed. Reg. 61,430–32. But the entire reason OSHA previously declined to issue an ETS was to accommodate new developments. OSHA does not claim that the science is settled. 86 Fed. Reg. 61,421 (science is "evolving"). And indeed,

new "game-changing" treatments for COVID-19 may soon hit the market.[14] Those different circumstances do not explain why OSHA has abandoned its prior approach, which was specifically designed to ensure flexibility in the face of scientific development.

OSHA's explanation is especially problematic because its mandatory policy has acknowledged costs. Because of "a simple human tendency, called 'psychological reactance,'" people "resist curbs on personal freedoms." 86 Fed. Reg. 61,444. Despite that, OSHA has locked in a policy that coerces vaccination. In that sense, OSHA neglected an "important aspect of the problem" by failing to consider the flexibility rationale it had trumpeted since the start of the pandemic. *Regents*, 140 S. Ct. at 1910.

*Third*, OSHA abandoned the sector-by-sector approach it adopted in June. Previously, OSHA had determined that COVID presented a "grave danger to workers in all healthcare settings." 86 Fed. Reg. 32,377. In doing so, OSHA relied on industry-specific data. *Id.* at 32,401. But now, OSHA has eschewed an industry-specific approach. OSHA's new approach did not "consider the alternatives that are within the ambit of" OSHA's existing policy—including regulating additional high-risk sectors or workspaces. *Regents*, 140 S. Ct. at 1913 (cleaned up). Worse, instead of following its former approach, OSHA issued a purposely overbroad rule and promised that it will

[14] Pushkala Aripaka, *Britain approves Merck's COVID-19 pill in world first* (Nov. 5, 2021) https://www.reuters.com/business/healthcare-pharmaceuticals/britain-approves-mercks-oral-covid-19-pill-2021-11-04/.

properly tailor the ETS over time when it gets around to doing the work to learn that "some portion" of the workforce does not face a grave danger. 86 Fed. Reg. 61,403. That gets reasoned decision-making backwards.

*d) The ETS was based on political pressure and is pretextual.*

Agency action must be set aside when "political pressure … shapes . . . the judgment of the ultimate agency decisionmaker." *Aera Energy LLC v. Salazar*, 642 F.3d 212, 220 (D.C. Cir. 2011). Here, the true reason OSHA acted is clear: President Biden directed OSHA to reach the President's preferred political outcome and OSHA has now two months later issued a rule reverse-engineering a justification for that desired outcome. This influence usurped the statutory authority the OSH Act vests in the Department of Labor, not the President, and therefore makes the rule per se unsupported by substantial evidence. *See Myers v. United States*, 272 U.S. 52, 135 (1926) (there may "be duties so . . . committed to . . . a particular officer as to raise a question whether the President may overrule . . . the officer's interpretation").

Just months ago, OSHA confronted a COVID situation much like the one it confronts now. At that time, OSHA decided to regulate only healthcare workers. 86 Fed. Reg. 32,376. Then President Biden intervened. He announced that OSHA would issue its new rule after he "asked" it to do so.[15] OSHA then "decided" to regulate all

[15] Remarks by President Biden (Oct. 7, 2021), https://www.whitehouse.gov/briefing-room/speeches-remarks/2021/10/07/remarks-by-president-biden-on-the-importance-of-covid-19-vaccine-requirements/.

workers. A "sudden[] revers[al of] course creates the plausible inference that political pressure may have caused the agency to take action it was not otherwise planning to take." *Connecticut v. Dep't of Interior*, 363 F. Supp. 3d 45, 64–65 (D.D.C. 2019).

At a minimum, the agency's purported reasoning for the ETS is pretextual. *See Dep't of Commerce v. New York*, 139 S. Ct. 2551, 2576 (2019). In assessing pretext, courts need not accept "contrived reasons" for agency action. *Id.* Here, the real reason OSHA acted is clear—the President demanded it. OSHA's explanation for the ETS is also "incongruent with what the record reveals about the agency's priorities and decisionmaking process." *Commerce*, 139 S. Ct. at 2575. That is demonstrated by the history—as explained, OSHA confronted essentially the same facts just months apart and reached nearly opposite results. The only difference is the President's intervening request. The rule has therefore unlawfully been dictated by the President's edict, rather than the statutory factors that Congress directed OSHA to consider in regulating the workplace.

4. The ETS violates the First Amendment and RFRA.

The ETS contains no exception for religious employers. It thereby violates the religious autonomy doctrine by determining the qualification of religious school employees based on vaccination status. *See* Minks Decl. ¶¶ 32–34; Martin Decl. ¶¶ 36–38. It interferes with hiring individuals "who play certain key roles," including teachers and others who carry out the religious mission. *Our Lady of Guadalupe Sch. v. Morrissey-Berru*, 140 S. Ct. 2049, 2060, 2064 (2020). More broadly, OSHA's rule effectuates

"entanglement with [the schools'] religious mission." *NLRB v. Cath. Bishop of Chi.*, 440 U.S. 490, 496, 502 (1979) (denying NLRB's jurisdiction).[16]

The ETS also violates 42 U.S.C. § 2000bb-1 ("RFRA"). The ETS substantially burdens religious schools by demanding that they comply or face "substantial economic consequences." *Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682, 720 (2014). Although the schools do not categorically oppose the vaccines, they believe that their employees' religious decisions to remain unvaccinated must be respected. Minks Decl. ¶¶ 16–23; Martin Decl. ¶¶ 13–22. The ETS pressures them to "modify [their] behavior" and "violate [their] beliefs." *Thomas v. Rev. Bd. of Ind. Emp't Sec. Div.*, 450 U.S. 707, 717–18 (1981). Further, the ETS will burden these schools' religious exercise by exacting heavy compliance costs. Minks Decl. ¶¶ 24–34; Martin Decl. ¶¶ 23–39.

OSHA cannot show a compelling interest or narrow tailoring. The ETS "contains myriad exceptions and accommodations for comparable activities"—students and employers with fewer than 100 employees. *Tandon v. Newsom*, 141 S. Ct. 1294, 1298 (2021); *accord Dahl v. Bd. of Trs. of W. Mich. Univ.*, 15 F.4th 728, 735 (6th Cir. 2021). OSHA also cannot show a "properly narrowed" "interest in denying an exception" in rulemaking for religious schools. *Fulton v. City of Phila.*, 141 S. Ct. 1868, 1881 (2021).

[16] OSHA asserts that those "performing . . . religious services" are not covered. 29 C.F.R. § 1975.4. But OSHA's view is that teachers at "a private school . . . owned . . . by a religious organization" are covered. *Id.* OSHA cannot impose such secular control over religious ministry. *Cath. Bishop*, 440 U.S. at 504; *Morrissey-Berru*, 140 S. Ct. at 2069.

5. Petitioners have standing and a cause of action.

The Employer Petitioners have standing because they are directly regulated by the ETS. Minks Decl. ¶¶ 24–34; Martin Decl. ¶¶ 23–39; Skipper Decl. ¶ 17; Moellering Decl. ¶¶ 5–12; Robinson Decl. ¶¶ 7–12; Crowell Decl. ¶¶ 10–16. The State Petitioners also have standing because the ETS damages their economies, *see Alabama v. U.S. Army Corps of Eng'rs*, 424 F.3d 1117, 1130 (11th Cir. 2005); Lloyd Decl. ¶ 8; Heckman Decl. ¶ 9; Dorfman Decl. ¶ 21; causes them to expend resources, *see Chiles v. Thornburgh*, 865 F.2d 1197, 1209 (11th Cir. 1989); Lloyd Decl. ¶ 8; Heckman Decl. ¶ 9; Toomey Decl. ¶ 8; Donald Decl. ¶¶ 9–13; and harms their sovereign and quasi-sovereign interests, *Alfred L. Snapp & Son, Inc. v. Puerto Rico, ex rel., Barez*, 458 U.S. 592, 607 (1982); Lloyd Decl. ¶ 8; Heckman Decl. ¶ 9; Stokes Decl. ¶ 6; Lewandowski Decl. ¶¶ 9–10; Kirkland Decl. ¶¶ 36–38; Reimers Decl. ¶ 10; Toomey Decl. ¶ 9; McMurry Decl. ¶¶ 5–6; Donald Decl. ¶¶ 9–13. Petitioners have a cause of action because they "may be adversely affected by a standard." 29 U.S.C. § 655(f).

B. Petitioners face irreparable harm without a stay.

As explained, Petitioners will suffer harm because of the ETS. That harm is both immediate (because employers need to start planning to implement it now) and irreparable because Petitioners have no recourse at law to remedy it. *Odebrecht Const., Inc. v. Sec'y, Fla. Dept. of Transp.*, 715 F.3d 1268, 1289 (11th Cir. 2013).

### C. The remaining stay factors favor Petitioners.

The equities overwhelmingly favor Petitioners, who will suffer irreparable harm each day the ETS remains in place. And "[f]orcing federal agencies to comply with the law is undoubtedly in the public interest." *Cent. United Life., Inc. v. Burwell*, 128 F. Supp. 3d 321, 330 (D.D.C. 2015). For its part, the government issued the ETS nearly two years into the pandemic and even took two months to promulgate the standard after President Biden announced it. Given that history, the government cannot seriously argue that it or the public will be harmed by a brief stay while this case is expeditiously litigated. That is especially so because the public will continue to have access to vaccines while this case is pending, and many COVID-19 mitigation efforts at the federal, state, and local levels will remain in force.

## CONCLUSION

For the foregoing reasons, the Court should stay the ETS while this case is pending, as the Fifth Circuit has done. Petitioners also respectfully ask the Court to order an expedited response to this motion and administratively stay the ETS until it is resolved.

Respectfully submitted,

ASHLEY MOODY
*Attorney General of Florida*

*/s/ Henry C. Whitaker*
HENRY C. WHITAKER
*Solicitor General*

DANIEL W. BELL
*Chief Deputy Solicitor General*

EVAN EZRAY
JASON H. HILBORN
*Deputy Solicitors General*

JAMES H. PERCIVAL
*Deputy Attorney General of Legal Policy*

NATALIE P. CHRISTMAS
*Assistant Attorney General of Legal Policy*

STATE OF FLORIDA
OFFICE OF THE ATTORNEY GENERAL
The Capitol, Pl-01
Tallahassee, Florida 32399-1050
(850) 414-3300
(850) 410-2672 (fax)
Henry.Whitaker@myfloridalegal.com

*Counsel for the State of Florida*

CHRISTOPHER M. CARR
*Attorney General of Georgia*

ROSS W. BERGETHON
DREW F. WALDBESER
*Deputy Solicitors General*

STEVE MARSHALL
*Attorney General of Alabama*

EDMUND G. LACOUR JR.
*Solicitor General*

THOMAS A. WILSON
*Deputy Solicitor General*

STATE OF GEORGIA
OFFICE OF THE ATTORNEY GENERAL
40 Capitol Square, S.W.
Atlanta, Georgia 30334
(404) 458-3378
(404) 656-2199 (fax)
rbergethon@law.ga.gov
dwaldbeser@law.ga.gov

*Counsel for the State of Georgia*

JOSH BELINFANTE
JAVIER PICO-PRATS
ROBBINS ALLOY BELINFANTE LITTLEFIELD LLC
500 Fourteenth Street NW
Atlanta, GA 30318
404.856.3262 (Direct)
678.701.9381(Main)
Josh.Belinfante@robbinsfirm.com
Javier.Picoprats@robbinsfirm.com

*Counsel for Georgia Highway Contractors Association, Georgia Motor Trucking Association, and Robinson Paving*

HALRON W. TURNER
E. TATUM TURNER
TURNER, ONDERDONK, KIMBROUGH, HOWELL, HUGGINS & BRADLEY, PA
13212 West Central Avenue
Post Office Drawer 1389
Chatom, Alabama 36518
(251) 847-2237
hwt@tokh.com
ett@tokh.com

*Counsel for Scotch Plywood Company, Inc.*

STATE OF ALABAMA
OFFICE OF THE ATTORNEY GENERAL
501 Washington Ave.
Montgomery, AL 36130
(334) 242-7300
(334) 353-8400 (fax)
Edmund.LaCour@AlabamaAG.gov

*Counsel for the State of Alabama*

DAVID A. CORTMAN
JOHN J. BURSCH
FRANK H. CHANG
ALLIANCE DEFENDING FREEDOM
440 First Street NW, Suite 600
Washington, DC 20001
(202) 393-8690
dcortman@ADFlegal.org
jbursch@ADFlegal.org
fchang@ADFlegal.org

RYAN J. TUCKER
ALLIANCE DEFENDING FREEDOM
15100 N 90th Street
Scottsdale, AZ 85260
(480) 444-0020
rtucker@ADFlegal.org

*Counsel for Cambridge Christian School and The King's Academy*

## CERTIFICATE OF COMPLIANCE

1. This document complies with the type-volume limits of Fed. R. App. P. 27 because, excluding the parts of the document exempted by Fed. R. App. P. 32(f), this document contains 5,197 words.

2. This document complies with the typeface and type-style requirements of Fed. R. App. P 27, Fed. R. App. P. 32(a)(5), and Fed. R. App. P. 32(a)(6) because this document has been prepared in a proportionally spaced typeface using Microsoft Word in 14-point Garamond font.

*/s/ Henry C. Whitaker*

## CERTIFICATE OF SERVICE

I hereby certify that on November 8, 2021, I electronically filed the foregoing motion with the Clerk of Court by using the Court's 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.

*/s/ Henry C. Whitaker*

# DECLARATION OF DR. JAYANTA BHATTACHARYA

I, Dr. Jayanta Bhattacharya, declare as follows:

1. I am an adult of sound mind and make this statement voluntarily, based upon my knowledge, education, and experience.

## EXPERIENCE & CREDENTIALS

2. I am a former Professor of Medicine and current Professor of Health Policy at Stanford University School of Medicine and a research associate at the National Bureau of Economic Research. I am also Director of Stanford's Center for Demography and Economics of Health and Aging. I hold an M.D. and Ph.D. from Stanford University. I have published 154 scholarly articles in peer-reviewed journals in the fields of medicine, economics, health policy, epidemiology, statistics, law, and public health, among others. My research has been cited in the peer-reviewed scientific literature more than 11,800 times. My curriculum vitae is attached to this declaration as Exhibit A.
3. I have dedicated my professional career to the analysis of health policy, including infectious disease epidemiology and policy, and the safety and efficacy of medical interventions. I have studied extensively and commented publicly on the necessity and safety of vaccine requirements for those who have contracted and recovered from COVID-19 (individuals who have "natural immunity"). I am intimately familiar with the emergent scientific and medical literature on this topic and pertinent government policy responses to the issue both in the United States and abroad.
4. My assessment of vaccine immunity is based on studies related to the efficacy and safety of the one vaccine to receive full approval from the Food and Drug Administration (FDA) and the two vaccines for which the FDA has granted Emergency Use Authorization (EUA) for use in the United States. These include two mRNA-technology vaccines (manufactured

by Pfizer-BioNTech and Moderna) and an adenovirus-vector vaccine technology (manufactured by Johnson & Johnson). Of those, the Pfizer vaccine, also known as Comirnaty, has full FDA approval.

5. I have not and will not receive any financial or other compensation to prepare this Declaration or to testify in this case. Nor have I received compensation for preparing declarations or reports or for testifying in *any* other case related to the COVID-19 pandemic or any personal or research funding from any pharmaceutical company. My participation here has been motivated solely by my commitment to public health, just as my involvement in other cases has been.

6. I have been asked to provide my opinion on several matters:

   - Whether, based on the current medical and scientific knowledge, immunity after COVID recovery (sometimes referred to as natural immunity) is categorically inferior to vaccine immunity to prevent reinfection and transmission of the SARS-CoV-2 virus;
   - Whether, based on the existing medical and scientific understanding of SARS-CoV-2 transmission and recovery, there is any categorical distinction between natural immunity and vaccine immunity.

7. I can summarize my opinions briefly. The scientific evidence strongly indicates that the recovery from COVID disease provides strong and lasting protection against severe disease if reinfected, at least as good and likely better than the protection offered by the COVID vaccines. While the COVID vaccines are effective at protecting vaccinated individuals against severe disease, they provide only short-lasting and limited protection versus infection and disease transmission. Requiring vaccines for COVID recovered patients thus

provides only a limited benefit while exposing them to the risks associated with the vaccination.

## OPINIONS

### I. Natural Immunity Provides Durable Protection Against Reinfection and Against Severe Outcomes If Reinfected; COVID-19 Vaccines Provide Limited Protection Against Infection but Durable Protection Against Severe Outcomes if Infected.

8. Both vaccine-mediated immunity and natural immunity after recovery from COVID infection provide extensive protection against severe disease from subsequent SARS-CoV-2 infection. There is no reason to presume that vaccine immunity provides a higher level of protection than natural immunity. Since vaccines arrived one year after the disease, there is stronger evidence for long-lasting immunity from natural infection than from the vaccines.

9. Both types of immunity are based on the same basic immunological mechanism—stimulating the immune system to generate an antibody response. In clinical trials, the efficacy of those vaccines was initially tested by comparing the antibody levels in the blood of vaccinated individuals to those who had natural immunity. Later Phase III studies of the vaccines established 94%+ clinical efficacy of the mRNA vaccines against severe COVID illness.[1,2] A Phase III trial showed 85% efficacy for the Johnson & Johnson adenovirus-

[1] Baden, L. R., El Sahly, H. M., Essink, B., Kotloff, K., Frey, S., Novak, R., Diemert, D., Spector, S. A., Rouphael, N., Creech, C. B., McGettigan, J., Khetan, S., Segall, N., Solis, J., Brosz, A., Fierro, C., Schwartz, H., Neuzil, K., Corey, L., Zaks, T. for the COVE Study Group (2021). Efficacy and Safety of the mRNA-1273 SARS-CoV-2 Vaccine. *The New England Journal of Medicine*, *384*(5), 403-416. doi: 10.1056/NEJMoa2035389

[2] Polack, F. P., Thomas, S. J., Kitchin, N., Absalon, J., Gurtman, A., Lockhart, S., Perez, J. L., Pérez Marc, G., Moreira, E. D., Zerbini, C., Bailey, R., Swanson, K. A., Roychoudhury, S., Koury, K., Li, P., Kalina, W. V., Cooper, D., Frenck, R. W. Jr., Hammitt, L. L., Gruber, W. C. (2020). Safety and Efficacy of the BNT162b2 mRNA Covid-19 Vaccine. *The New England Journal of Medicine*, *387*(27), 2603-2615. doi: 10.1056/NEJMoa2034577

based vaccine against severe disease.[3]

10. Immunologists have identified many immunological mechanisms of immune protection after recovery from infections. Studies have demonstrated prolonged immunity with respect to memory T and B cells,[4] bone marrow plasma cells,[5] spike-specific neutralizing antibodies,[6] and IgG+ memory B cells[7] following naturally acquired immunity.

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[3] Sadoff, J., Gray, G., Vandebosch, A., Cárdenas, V., Shukarev, G., Grinsztejn, B., Goepfert, P. A., Truyers, C., Fennema, H., Spiessens, B., Offergeld, K., Scheper, G., Taylor, K. L., Robb, M. L., Treanor, J., Barouch, D. H., Stoddard, J., Ryser, M. F., Marovich, M. A., Douoguih, M. for the ENSEMBLE Study Group. (2021). Safety and Efficacy of Single-Dose Ad26.COV2.S Vaccine against Covid-19. *The New England Journal of Medicine*, *384*(23), 2187-2201. doi: 10.1056/NEJMoa2101544

[4] Dan, J. M., Mateus, J., Kato, Y., Hastie, K. M., Yu, E. D., Faliti, C. E., Grifoni, A., Ramirez, S. I., Haupt, S., Frazier, A., Nakao, C., Rayaprolu, V., Rawlings, S. A., Peters, B., Krammer, F., Simon, V., Saphire, E. O., Smith, D. M., Weiskopf, D., Crotty, S. (2021). Immunological memory to SARS-CoV-2 assessed for up to 8 months after infection. *Science*, *371*, 1-13. doi: 10.1126/science.abf4063 (finding that memory T and B cells were present up to eight months after infection, noting that "durable immunity against secondary COVID-19 disease is a possibility in most individuals").

[5] Turner, J. S., Kim, W., Kalaidina, E., Goss, C. W., Rauseo, A. M., Schmitz, A. J., Hansen, L., Haile, A., Klebert, M. K., Pusic, I., O'Halloran, J. A., Presti, R. M. & Ellebedy, A. H. (2021). SARS-CoV-2 infection induces long-lived bone marrow plasma cells in humans. *Nature*, *595*(7867), 421-425. doi: 10.1038/s41586-021-03647-4 (study analyzing bone marrow plasma cells of recovered COVID-19 patients reported durable evidence of antibodies for at least 11 months after infection, describing "robust antigen-specific, long-lived humoral immune response in humans"); Callaway, E. (2021, May 26). Had COVID? You'll probably make antibodies for a lifetime. *Nature*. https://www.nature.com/articles/d41586-021-01442-9#:~:text=Many%20people%20who%20have%20been,recovered%20from%20COVID%2D191 ("The study provides evidence that immunity triggered by SARS-CoV-2 infection will be extraordinarily long-lasting" and "people who recover from mild COVID-19 have bone-marrow cells that can churn out antibodies for decades").

[6] Ripperger, T. J., Uhrlaub, J. E., Watanabe, M., Wong, R., Castaneda, Y., Pizzato, H. A., Thompson, M. R., Bradshaw, C., Weinkauf, C. C., Bime, C., Erickson, H. L., Knox, K., Bixby, B., Parthasarathy, S., Chaudhary, S., Natt, B., Cristan, E., El Aini, T., Rischard, F., Bhattacharya, D. (2020). Orthogonal SARS-CoV-2 serological assays enable surveillance of low-prevalence communities and reveal durable humor immunity. *Immunity*, *53*(5), 925-933. doi: 10.1016/j.immuni.2020.10.004 (study finding that spike and neutralizing antibodies remained detectable 5-7 months after recovering from infection).

[7] Cohen, K. W., Linderman, S. L., Moodie, Z., Czartoski, J., Lai, L., Mantus, G., Norwood, C., Nyhoff, L. E., Edara, V. V., Floyd, K., De Rosa, S. C., Ahmed, H., Whaley, R., Patel, S. N.,

11. Multiple extensive, peer-reviewed studies comparing natural and vaccine immunity have now been published. These studies overwhelmingly conclude that natural immunity provides equivalent or greater protection against severe infection than immunity generated by mRNA vaccines (Pfizer and Moderna).

12. Specifically, studies confirm the efficacy of natural immunity against reinfection of COVID-19[8] and show that the vast majority of reinfections are less severe than first-time

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Prigmore, B., Lemos, M. P., Davis, C. W., Furth, S., O'Keefe, J., McElrath, M. J. (2021). Longitudinal analysis shows durable and broad immune memory after SARS-CoV-2 infection with persisting antibody responses and memory B and T cells. *medRxiv*, Preprint. (study of 254 recovered COVID patients over 8 months "found a predominant broad-based immune memory response" and "sustained IgG+ memory B cell response, which bodes well for rapid antibody response upon virus re-exposure." "Taken together, these results suggest that broad and effective immunity may persist long-term in recovered COVID-19 patients").

[8] Shrestha, N. K., Burke, P. C., Nowacki, A. S., Terpeluk, P. & Gordon, S. M. (2021). Necessity of COVID-19 vaccination in previously infected individuals. *medRxiv*, Preprint. doi: 10.1101/2021.06.01.21258176 ("not one of the 1359 previously infected subjects who remained unvaccinated had a SARS-CoV-2 infection over the duration of the study" and concluded that those with natural immunity are "unlikely to benefit from COVID-19 vaccination"); Perez, G., Banon, T., Gazit, S., Moshe, S. B., Wortsman, J., Grupel, D., Peretz, A., Tov, A. B., Chodick, G., Mizrahi-Reuveni, M., & Patalon, T. (2021). A 1 to 1000 SARS-CoV-2 reinfection proportion in members of a large healthcare provider in Israel: A preliminary report. *medRxiv*, Preprint. doi: 10.1101/2021.03.06.21253051 (Israeli study finding that approximately 1/1000 of participants were reinfected); Bertollini, R., Chemaitelly, H., Yassine, H. M., Al-Thani, M. H., Al-Khal, A., & Abu-Raddad, L. J. (2021). Associations of vaccination and of prior infection with positive PCR test results for SARS-CoV-2 in airline passengers arriving in Qatar. *JAMA*, *326*(2), 185-188. doi: 10.1001/jama.2021.9970 (study of international airline passengers arriving in Qatar found no statistically significant difference in risk of reinfection between those who had been vaccinated and those who had previously been infected); Pilz, S., Chakeri, A., Ioannidis, J. P. A., Richter, L., Theiler-Schwetz, V., Trummer, C., Krause, R., Allerberger, F. (2021). SARS-CoV-2 re-infection risk in Austria. *European Journal of Clinical Investigation*, *51*(4), 1-7. doi: 10.1111/eci.13520 (previous SARS-CoV-2 infection reduced the odds of re-infection by 91% compared to first infection in the remaining general population); Breathnach, A. S., Duncan, C. J. A., El Bouzidi, K., Hanrath, A. T., Payne, B. A. I., Randell, P. A., Habibi, M. S., Riley, P. A., Planche, T. D., Busby, J. S., Sudhanva, M., Pallett, S. J. C. & Kelleher, W. P. (2021). Prior COVID-19 protects against reinfection, even in the absence of detectable antibodies. *The Journal of Infection*, *83*(2), 237-279. doi: 10.1016/j.jinf.2021.05.024 (0.86% of previously infected population in London became reinfected); Tarke, A., Sidney, J., Methot, N., Yu, E. D., Zhang, Y., Dan, J. M., Goodwin, B., Rubiro, P., Sutherland, A., Wang, E., Frazier, A., Ramirez, S. I., Rawlings, S. A., Smith, D. M., da Silva Antunes, R., Peters, B., Scheuermann, R. H., Weiskopf, D., Crotty, S., Grifoni, A. &

infections.[9] For example, an Israeli study of approximately 6.4 million individuals demonstrated that natural immunity provided equivalent if not better protection than vaccine immunity in preventing COVID-19 infection, morbidity, and mortality.[10] Of the 187,549 unvaccinated persons with natural immunity in the study, only 894 (0.48%) were reinfected; 38 (0.02%) were hospitalized, 16 (0.008%) were hospitalized with severe disease, and only one died, an individual over 80 years of age. Another study, analyzing

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Sette, A. (2021). Impact of SARS-CoV-2 variants on the total $CD4^+$ and $CD8^+$ T cell reactivity in infected or vaccinated individuals, *Cell Reports Medicine 2*(7), 100355 (an examination of the comparative efficacy of T cell responses to existing variants from patients with natural immunity compared to those who received an mRNA vaccine found that the T cell responses of both recovered COVID patients and vaccines were effective at neutralizing mutations found in SARS-CoV-2 variants).

[9] Abu-Raddad, L. J., Chemaitelly, H., Coyle, P., Malek, J. A., Ahmed, A. A., Mohamoud, Y. A., Younuskunju, S., Ayoub, H. H., Kanaani, Z. A., Kuwari, E. A., Butt, A. A., Jeremijenko, A., Kaleeckal, A. H., Latif, A. N., Shaik, R. M., Rahim, H. F. A., Nasrallah, G. K., Yassine, H. M., Al Kuwari, M. G., Al Romaihi, H. E., Al-Thani, M. H., Al Khal, A., Bertollini, R. (2021). SARS-CoV-2 antibody-positivity protects against reinfection for at least seven months with 95% efficacy. *EClinicalMedicine*, *35*, 1-12. doi: 10.1016/j.eclinm.2021.100861 (finding that of 129 reinfections from a cohort of 43,044, only one reinfection was severe, two were moderate, and none were critical or fatal); Hall, V. J., Foulkes, S., Charlett, A., Atti, A., Monk, E. J. M., Simmons, R., Wellington, E., Cole, M. J., Saei, A., Oguti, B., Munro, K., Wallace, S., Kirwan, P. D., Shroti, M., Vusirikala, A., Rokadiya, S., Kall, M., Zambon, M., Ramsay, M., Hopkins, S. (2021). SARS-CoV-2 infection rates of antibody-positive compared with antibody-negative health-care workers in England: a large, multicentre, prospective cohort study. *The Lancet*, *397*(10283), 1459-1469. doi: 10.1016/S0140-6736(21)00675-9 (finding "a 93% lower risk of COVID-19 symptomatic infection… [which] show[s] equal or higher protection from natural infection, both for symptomatic and asymptomatic infection"); Hanrath, A. T., Payne, B., A., I., & Duncan, C. J. A. (2021). Prior SARS-CoV-2 infection is associated with protection against symptomatic reinfection. *The Journal of Infection*, *82*(4), e29-e30. doi: 10.1016/j.jinf.2020.12.023 (examined reinfection rates in a cohort of healthcare workers and found "no symptomatic reinfections" among those examined and that protection lasted for at least 6 months).

[10] Goldberg, Y., Mandel, M., Woodbridge, Y., Fluss, R., Novikov, I., Yaari, R., Ziv, A., Freedman, L., & Huppert, A. (2021). Protection of previous SARS-CoV-2 infection is similar to that of BNT162b2.vaccine protection: A three-month nationwide experience from Israel. *medRxiv*, Preprint. doi: 10.1101/2021.04.20.21255670

data from Italy found that only 0.31% of COVID-recovered patients experienced a reinfection within a year after the initial infection.[11]

13. Variants do not escape the immunity provided by prior infection with the pre-variant virus or vaccination.[12, 13, 14] This is true of the delta variant as well. In a study of a large population of patients in Israel, *vaccinated* people who had not been previously infected had 13 times higher odds of experiencing a breakthrough infection with the Delta variant than patients who had recovered from COVID but were never vaccinated.[15] They had 27 times higher odds of experiencing subsequent symptomatic COVID disease and 7 times higher odds of hospitalization. The design of this Israeli study was particulary strong – it tracked large cohorts of people over time from the time of vaccination or initial infection, and thus carefully distinguished the effect of time since initial exposure or vaccination in

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[11] Vitale, J., Mumoli, N., Clerici, P., de Paschale, M., Evangelista, I., Cei, M. & Mazzone, A. (2021). Assessment of SARS-CoV-2 reinfection 1 year after primary infection in a population in Lombardy, Italy. *JAMA Internal Medicine*, *181*(10), 1407-1409. doi: 10.1001/jamainternmed.2021.2959

[12] Tarke, A., Sidney, J., Methot, N., Yu, E. D., Zhang, Y., Dan, J. M., Goodwin, B., Rubiro, P., Sutherland, A., Wang, E., Frazier, A., Ramirez, S. I., Rawlings, S. A., Smith, D. M., da Silva Antunes, R., Peters, B., Scheuermann, R. H., Weiskopf, D., Crotty, S., Grifoni, A. & Sette, A. (2021). Impact of SARS-CoV-2 variants on the total $CD4^+$ and $CD8^+$ T cell reactivity in infected or vaccinated individuals, *Cell Reports Medicine 2,* 100355.

[13] Wu, K., Werner, A. P., Moliva, J. I., Koch, M., Choi, A., Stewart-Jones, G. B. E., Bennett, H., Boyoglu-Barnum, S., Shi, W., Graham, B. S., Carfi, A., Corbett, K. S., Seder, R. A. & Edwards, D. K. (2021). mRNA-1273 vaccine induces neutralizing antibodies against spike mutants from global SARS-CoV-2 variants. *bioRxiv*, Preprint. doi: 10.1101/2021.01.25.427948

[14] Redd, A. D., Nardin, A., Kared, H., Bloch, E. M., Pekosz, A., Laeyendecker, O., Abel, B., Fehlings, M., Quinn, T. C. & Tobian, A. A. (2021). $CD8^+$ T-cell responses in COVID-19 convalescent individuals target conserved epitopes from multiple prominent SARS-CoV-2 circulating variants. *Open Forum Infectious Diseases 8*(7), ofab143.

[15] Gazit, S., Shlezinger, R., Perez, G., Lotan, R., Peretz, A., Ben-Tov, A., Cohen, D., Muhsen, K., Chodick, G. & Patalon, T. (2021). Comparing SARS-CoV-2 natural immunity to vaccine-induced immunity: Reinfections versus breakthrough infections. *medRxiv*, Preprint. doi: 10.1101/2021.08.24.21262415

estimating its effect. This is important because both vaccine-mediated and infection-mediated protection against subsequent infection diminish with time.

14. In summary, the overwhelming conclusion of the pertinent scientific literature is that natural immunity is at least as effective against subsequent reinfection as even the most effective vaccines.

15. Furthermore, based on such evidence, many scientists have concluded that natural protection against severe disease after COVID recovery is likely to be long-lasting. A survey article published on June 30, 2021, in the *British Medical Journal* concluded, "[t]here is reason to think that immunity could last for several months or a couple of years, at least, given what we know about other viruses and what we have seen so far in terms of antibodies in patients with COVID-19 and in people who have been vaccinated."[16]

16. These findings of highly durable natural immunity should not be surprising, as they hold for SARS-CoV-1 (the virus that causes SARS) and other respiratory viruses. According to a paper published in *Nature* in August 2020, 23 patients who had recovered from SARS-CoV-1 still possess CD4 and CD8 T cells 17 years after infection during the 2003 epidemic.[17] A *Nature* paper from 2008 found that 32 people born in 1915 or earlier still retained some level of immunity against the 1918 flu strain—some 90 years later.[18]

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[16] Baraniuk, C. (2021). How long does covid-19 immunity last? *The British Medical Journal*, *373*, 1-3. doi: 10.1136/bmj.n1605.

[17] Le Bert, N., Tan, A. T., Kunasegaran, K., Tham, C. Y. L., Hafezi, M., Chia, A., Chng, M. H. Y., Lin, M., Tan, N., Linster, M., Chia, W. N., Chen, M. I. C., Wang, L. F., Ooi, E. E., Kalimuddin, S., Tambyah, P. A., Low, J. G. H., Tan, Y. J. & Bertoletti, A. (2020). SARS-CoV-2-specific T cell immunity in cases of COVID-19 and SARS, and uninfected control. *Nature*, *584*, 457-462. doi: 10.1038/s41586-020-2550-z

[18] Yu, X., Tsibane, T., McGraw, P. A., House, F. S., Keefer, C. J., Hicar, M. D., Tumpey, T. M., Pappas, C., Perrone, L. A., Martinez, O., Stevens, J., Wilson, I. A., Aguilar, P. V., Altschuler,

17. In contrast to the concrete findings regarding the robust durability of natural immunity, it is yet unclear in the scientific literature how long-lasting vaccine-induced immunity will be. Notably, the researchers argue that they can best surmise the predicted durability of vaccine immunity by looking at the expected durability of natural immunity.[19]

18. A recent study from Qatar by Chemaitelly and colleagues, which tracked 927,321 individuals for six months after vaccination concluded that the Pfizer vaccine's "induced protection against infection appears to wane rapidly after its peak right after the second dose, but it persists at a robust level against hospitalization and death for at least six months following the second dose."[20]

19. The key figures from the Qatari study are reproduced immediately below. Panel A shows that vaccine mediated protection against infection peaks at 72.1% zero to four weeks after the second dose, and then declines to 0%, 20 weeks after the second dose. According to this result, vaccines only protect against infection (and therefore disease spread) for a short period of time after the second dose of the mRNA vaccines.

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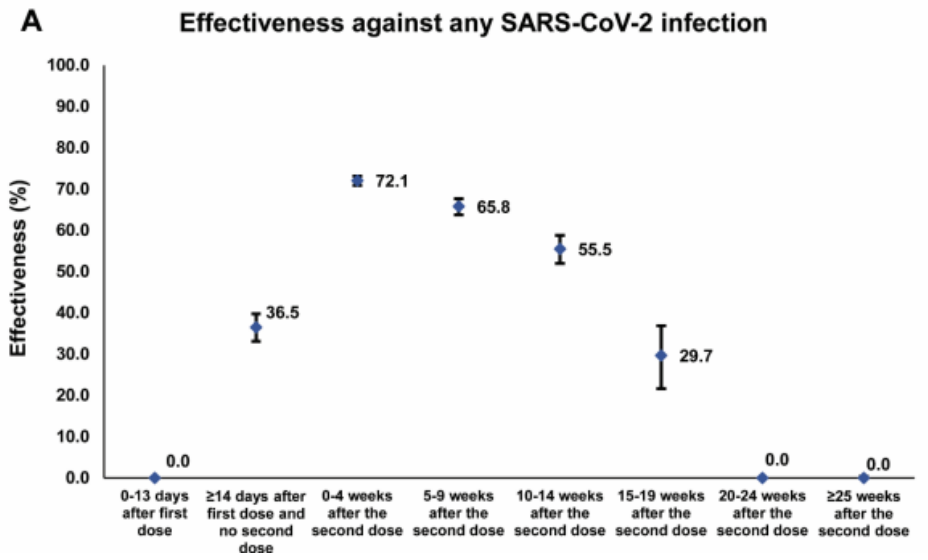
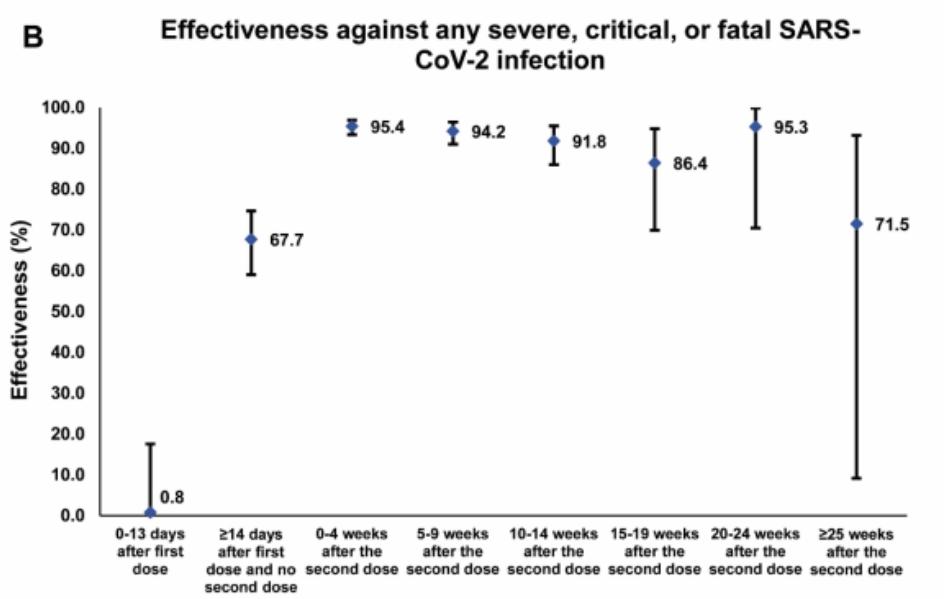
E. L., Basler, C. F., & Crowe Jr., J. E. (2008). Neutralizing antibodies derived from the B cells of 1918 influenza pandemic survivors. *Nature*, *455*, 532-536. doi: 10.1038/nature07231

[19] Ledford, H. (2021). Six months of COVID vaccines: What 1.7 billion doses have taught scientists. *Nature*, *594*(7862), 164-167. doi: 10.1038/d41586-021-01505-x (study notes that "Six months is not much time to collect data on how durable vaccine responses will be. . . . In the meantime some researchers are looking to natural immunity as a guide.").

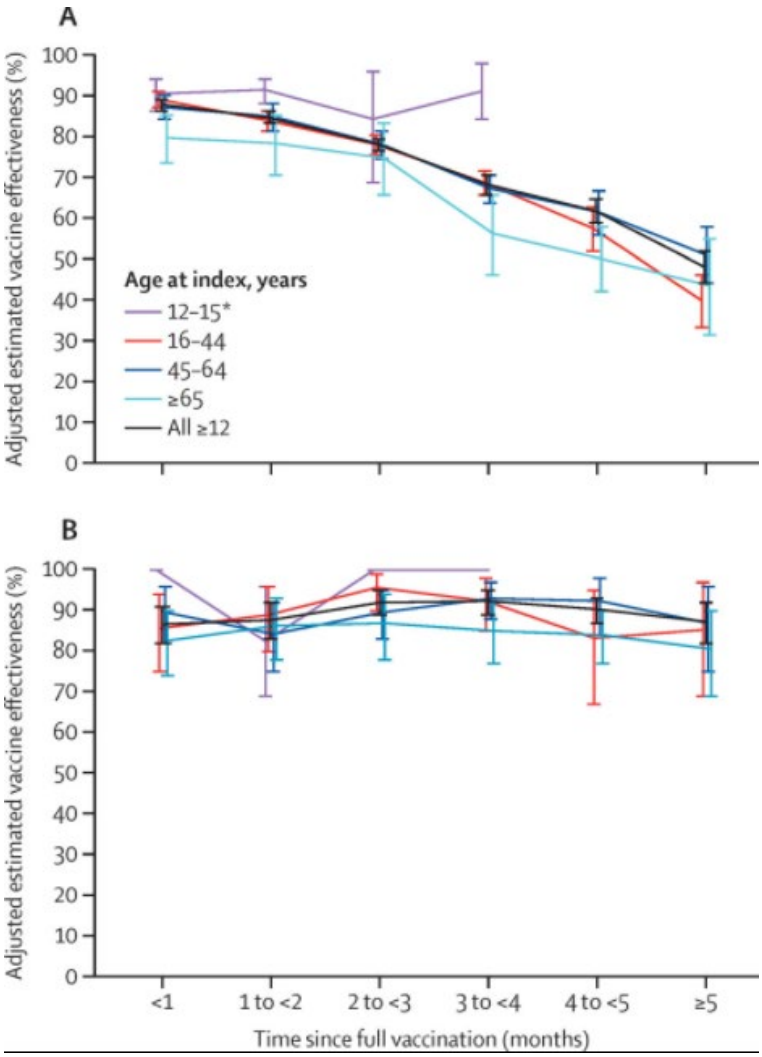
[20] Chemaitelly, H., Tang, P., Hasan, M. R., Al Mukdad, S., Yassine, H. M., Benslimane, F. M., Khatib, H. A. A., Coyle, P., Ayoub, H. H., Kanaani, Z. A., Kuwari, E. A., Jeremijenko, A., Kaleeckal, A. H., Latif, A. N., Shaik, R. M., Rahim, H. F. A., Nasrallah, G. K., Kuwari, M. G. A., Romaihi, H. E. A., Abu-Raddad, L. J. (2021). Waning of BNT162b2 vaccine protection against SARS-CoV-2 infection in Qatar. *medRxiv*, Preprint. doi: 10.1101/2021.08.25.21262584




20. On the other hand, Panel B shows that protection versus severe disease is long lasting after vaccination—even though the person will no longer be fully protected against infection and, presumably, disease spread. At 20-24 weeks after the second dose, the vaccine remains 95.3% efficacious versus severe disease. While it appears to dip after 25 weeks to 71.5% efficacy, the confidence interval is so wide that it is consistent with no decrease whatsoever even after 25 weeks.



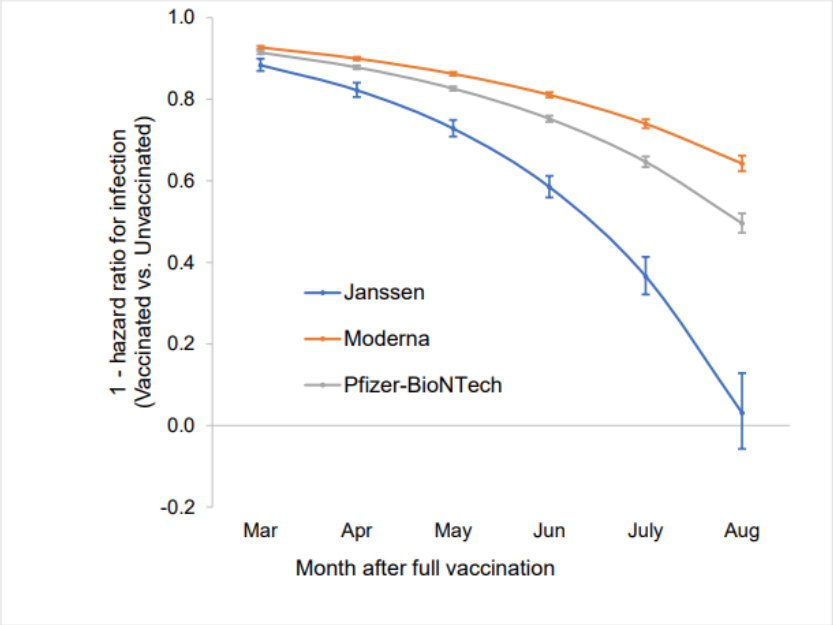
21. The Qatari study is no outlier. A large study in California tracked the infection rates for nearly 5 million patients vaccinated with two doses of the Pfizer mRNA vaccine. The study tracked both SARS-CoV-2 infections as well as COVID-19 related hospitalizations. The figure immediately below plots the trend in vaccine efficacy over time for different age groups in the population cohort. **Panel A** on the right plots effectiveness versus SARS-CoV-2 *infections*.[21] Though the drop in effectiveness is not as steep as in the Qatari study, there is nevertheless a sharp drop. While in the first month, vaccine effectiveness is near 90% for all age-groups, by month 5, it drops to nearly 50% for all the groups. By contrast, **Panel B** plots vaccine efficacy versus




[21] Tartof SY, Slezak JM, Fischer H, Hong V, Ackerson BK, Ranasinghe ON, Frankland TB, Ogun OA, Zamparo JM, Gray S, Valluri SR, Pan K, Angulo FJ, Jodar L, McLaughlin JM. Effectiveness of mRNA BNT162b2 COVID-19 vaccine up to 6 months in a large integrated health system in the USA: a retrospective cohort study. *Lancet*. 2021 Oct 16;398(10309):1407-1416. doi: 10.1016/S0140-6736(21)02183-8. Epub 2021 Oct 4. PMID: 34619098; PMCID: PMC8489881.

*hospitalizations*. It remains high with no decline over time –near 90% throughout the period. The vaccine provides durable private protection versus severe disease, but declining protection versus infection (and hence transmission).

22. Another recent study tracked 620,000 vaccinated US veterans to measure breakthrough infections for the three vaccines in common use in the US.[22] Like the other studies, the authors of the study found a sharp decline in vaccine effectiveness versus infection. Five months after vaccination, the effectiveness of the J&J vaccine dropped from ~90% to less than 10%; the Pfizer vaccine dropped from ~90% to ~50%; and the Moderna dropped from ~90% to ~65%. The figure on this page tracks the decline in effectiveness of the vaccines against infection over time documented in this study. This study corroborates yet another study that documented declining vaccine efficacy in the first three months after vaccination




[22] Cohn BA, Cirillo PM, Murphy CC, et al. Breakthrough SARS-CoV-2 Infections in 620,000 U.S. Veterans, February 1, 2021 to August 13, 2021. medRxiv. October 14, 2021. https://doi.org/10.1101/2021.10.13.21264966;

against disease transmission in the era of the Delta variant.[23]

23. Yet another study conducted in Wisconsin confirmed that vaccinated individuals can shed infectious SARS-CoV-2 viral particles.[24] The authors analyzed nasopharyngeal samples to check whether patients showed evidence of infectious viral particles. They found that vaccinated individuals were at least as likely as unvaccinated individuals to be shedding live virus. They concluded:

> Combined with other studies these data indicate that vaccinated and unvaccinated individuals infected with the Delta variant might transmit infection. Importantly, we show that infectious SARS-CoV-2 is frequently found even in vaccinated persons.

24. Indeed, the CDC recognizes the importance of natural immunity in its updated science brief analyzing the difference in immunity from infection-induced and vaccine-induced immunity.[25] The CDC noted that "confirmed SARS-CoV-2 infection decreased risk of subsequent infection by 80–93% for at least 6–9 months," with some studies showing "slightly higher protective effects (89-93%)." It also noted that "researchers have predicted that the immune response following infection would continue to provide at least 50% protection against reinfection for 1–2 years following initial infection with SARS-CoV-2 or vaccination. This would be similar to what is observed with seasonal coronaviruses."

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[23] Eyre, D. W., Taylor, D., Purver, M., Chapman, D., Fowler, T., Pouwels, K. B., Walker, A. S. & Peto, T. E. A. (2021). The impact of SARS-CoV-2 vaccination on Alpha & Delta variant transmission. *medRxiv*, Preprint. doi: 10.1101/2021.09.28.21264260

[24] Riemersma, K. K., Grogan, B. E., Kita-Yarbro, A., Halfmann, P. J., Segaloff, H. E., Kocharian, A., Florek, K. R., Westergaard, R., Bateman, A., Jeppson, G. E., Kawaoka, Y., O'Connor, D. H., Friedrich, T. C., & Grande, K. M. (2021). Shedding of infectious SARS-CoV-2 despite vaccination. *medRxiv*, Preprint. doi: 10.1101/2021.07.31.21261387

[25] CDC, Science Brief: SARS-CoV-2 Infection-Induced and Vaccine-Induced Immunity (updated Oct. 29, 2021), https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/vaccine-induced-immunity.html#anchor_1635539757101

25. The CDC science brief does claim that vaccine-induced immunity is stronger than immunity from natural infection.[26] The study the CDC relies on to support this claim is not determinative for several reasons.[27] First, its result is contrary to the weight of other evidence, as set forth above. Second, the study compared hospitalization of those infected—and had natural immunity—90-225 days after their infection while against those who had completed their RNA vaccine regime 45-213 days before reinfection. Because immunity—regardless of how gained—wanes over time, the failure to adequately compare like periods means that the study's conclusions are biased in favor of vaccine-induced immunity. Indeed, the study admits this weakness. Third, the study design itself does not permit it to address the critical question of interest – whether COVID-recovery without vaccination or vaccination without COVID-recovery provides stronger protection against COVID-related hospitalization. The study analyzes only patients who are already in the hospital. To obtain an accurate answer to the question of interest, it would need to include and analyze patients before entering the hospital. As it is, the study implicitly and incorrectly assumes that the set of hospitalized patients with COVID-like symptoms is representative of the population at large, which is untrue.

26. In summary, the evidence to date strongly suggests that while vaccines—like natural immunity—protect against severe disease, they, unlike natural immunity, provide only short-lasting protection against subsequent infection and disease spread. In short, there is

[26] *Id.*

[27] Bozio CH, Grannis SJ, Naleway AL, et al. Laboratory-Confirmed COVID-19 Among Adults Hospitalized with COVID-19–Like Illness with Infection-Induced or mRNA Vaccine-Induced SARS-CoV-2 Immunity — Nine States, January–September 2021. MMWR Morb Mortal Wkly Rep. ePub: 29 October 2021.

no medical or scientific reason to believe that vaccine immunity will prove longer-lasting immunity than natural immunity, much less more durable immunity.

## II. The CDC's Recommendation for Vaccination of Recovered COVID Patients Applies with Equal Force to Those Who Have Been Previously Vaccinated, Whose Protection Against Infection Wanes Within a Few Months After Vaccination.

27. The CDC, in the Frequently Asked Questions (FAQ) section of its website encouraging vaccination, provides the following advice to previously recovered patients:[28]

> Yes, you should be vaccinated regardless of whether you already had COVID-19. That's because experts do not yet know how long you are protected from getting sick again after recovering from COVID-19. Even if you have already recovered from COVID-19, it is possible—although rare—that you could be infected with the virus that causes COVID-19 again. Studies have shown that vaccination provides a strong boost in protection in people who have recovered from COVID-19. Learn more about why getting vaccinated is a safer way to build protection than getting infected.

28. The text of this advice by the CDC does not address any of the scientific evidence included here about the lack of necessity for recovered COVID patients to be vaccinated. While it is true that I do not know how long natural immunity after recovery lasts, the immunological evidence to date suggests that protection against disease will last for years.[29] Uncertainty over the longevity of immunity after recovery is a specious reason for not exempting COVID-recovered patients from vaccination mandates, since the same can be said about vaccine mediated immunity. I do not know how long it will last either, and there is no reason to believe it provides longer lasting or more complete immunity than recovery from COVID.

29. Similarly, just as reinfections are possible though rare after COVID recovery, breakthrough infections are possible after vaccination, as the CDC's team investigating vaccine

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[28] Centers for Disease Control and Prevention. (2021, September 28). Frequently asked questions about COVID-19 vaccination. Retrieved October 1, 2019 from https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html

[29] Patel, N. V. (2021, January 6). *Covid-19 immunity likely lasts for years*. MIT Technology Review. https://www.technologyreview.com/2021/01/06/1015822/covid-19-immunity-likely-lasts-for-years/

breakthrough infections itself recognizes.[30] On the same CDC FAQ webpage I cite above,[31] the CDC writes about vaccine-mediated immunity, "We don't know how long protection lasts for those who are vaccinated."

30. The CDC's main concern in this FAQ seems to be to help people understand that it is safer to attain immunity against SARS-CoV-2 infection via vaccination rather than via infection. This is a point not in dispute. Rather, the question is whether someone who *already* has been infected and recovered will benefit on net from the additional protection provided by vaccination. On this point, the CDC's statement in the FAQ is irrelevant. Here again, the possibility of reinfection does not alter the conclusion that, especially for those who have already recovered from COVID, accommodations can be allowed without threatening public safety.

[30] CDC COVID-19 Vaccine Breakthrough Case Investigations Team. (2021). COVID-19 Vaccine Breakthrough Infections Reported to CDC — United States, January 1–April 30, 2021. *Morbidity and Mortality Weekly Report (MMWR)*, *70*(21), 792-793. doi: http://dx.doi.org/10.15585/mmwr.mm7021e3

[31] Centers for Disease Control and Prevention. (2021, September 28). Frequently asked questions about COVID-19 vaccination. Retrieved October 1, 2021 from https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html

## III. Conclusion

31. Based on the scientific evidence to date, those who have recovered from a SARS-CoV-2 infection possess immunity as robust and durable (or more) as that acquired through vaccination. The existing clinical literature overwhelmingly indicates that the protection afforded to the individual and community from natural immunity is as effective and durable as the efficacy levels of the most effective vaccines to date.

32. Based on my analysis of the existing medical and scientific literature, any policy regarding vaccination that does not recognize natural immunity is irrational, arbitrary, and counterproductive to community health.[32]

33. Indeed, now that every American adult, teenager, and child five and above has free access to the vaccines, the case for a vaccine mandate is weaker than it once was. Since the successful vaccination campaign already protects the vulnerable population, the unvaccinated—especially recovered COVID patients—pose a vanishingly small threat to the vaccinated. They are protected by an effective vaccine that dramatically reduces the likelihood of hospitalization or death after infections to near zero. At the same time, natural immunity provides benefits that are at least as strong and may well be stronger than those from vaccines.

34. In conclusion, the emerging evidence from the medical literature finds that COVID-recovered patients have robust and long lasting immunity against SARS-CoV-2 reinfection and that this immunity against infection is better than vaccinated patients who have never had COVID.

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[32] Bhattacharya, J., Gupta, S. & Kulldorff, M. (2021, June 4). *The beauty of vaccines and natural immunity.* Smerconish Newsletter. https://www.smerconish.com/exclusive-content/the-beauty-of-vaccines-and-natural-immunity

35. I declare under penalty of perjury under the laws of the United States of America that, to the best of my knowledge, the foregoing is true and correct.

Respectfully submitted,

Dr. Jay Bhattacharya, MD, Ph.D.
Professor of Health Policy
Stanford University

# EXHIBIT

# A

**Address**
Department of Health Policy
Stanford University School of Medicine
615 Crothers Way
Stanford, CA 94305-6006

**Phone:** (650) 736-0404

**Email**: jay@stanford.edu
http://web.stanford.edu/~jay

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**RESEARCH INTERESTS**

Health economics, health policy, and outcomes research

**A. ACADEMIC HISTORY:**

| | | |
|---|---|---|
| Stanford University | A.M., A.B. | 1990 |
| Stanford University School of Medicine | M.D. | 1997 |
| Stanford University Department of Economics | Ph.D. | 2000 |

**B. EMPLOYMENT HISTORY:**

| | |
|---|---|
| 2001 – present | Professor (Assistant to Full), Stanford University School of Medicine, Department of Economics (by courtesy) |
| 2013 – present | Senior Fellow, Stanford Institute for Economic Policy Research |
| 2007 – present | Research Associate, Sphere Institute / Acumen LLC |
| 2002 – present | FRF to Research Associate, National Bureau of Economic Research |
| 2014 – 2021 | Senior Fellow Stanford Freeman Spogli Institute |
| 2001 – 2020 | Professor (Assistant to Full) Department of Health Research and Policy (by courtesy) |
| 2006 – 2008 | Research Fellow, Hoover Institution |
| 1998 – 2001 | Economist (Associate to Full), RAND Corporation |
| 1998 – 2001 | Visiting Assistant Professor, UCLA Department of Economics |

**C. SCHOLARLY PUBLICATIONS:**

PEER-REVIEWED ARTICLES (154 total)

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8. **Bhattacharya J** and Richmond P "On Work and Health Among the American Poor" in Pathways to Self-Sufficiency: Getting Ahead in an Era Beyond Welfare Reform John Karl Scholz and Carolyn Heinrich (eds), New York, NY, Russell Sage Foundation (2009).
9. **Bhattacharya J**, Garber A, MaCurdy T "The Narrowing Dispersion of Medicare Expenditures 1997-2005" in Research Findings in the Economics of Aging, D. Wise (ed.), Chicago, IL, University of Chicago Press (2010)
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11. **Bhattacharya J**, Garber A, Miller M, and Perlroth D "The Value of Progress against Cancer in the Elderly" Investigations in the Economics of Aging, David Wise (ed), Chicago, IL, University of Chicago Press (2012)
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2. Nguyen C, Hernandez-Boussard T., Davies S, **Bhattacharya J**, Khosla R, Curtin C. *Cleft Palate Surgery: Variables of Quality and Patient Safety*. Presented at the 69th Annual American Cleft-Palate Craniofacial Association (2012). [abstract]
3. Patel MI, Ramirez D, Agajanian R, Bhattacharya J, Milstein A, Bundorf MK. "The effect of a lay health worker-led symptom assessment intervention for patients on patient-reported outcomes, healthcare use, and total costs." Journal of Clinical Oncology 36(15 Suppl):6502 [abstract]

## D. PUBLIC AND PROFESSIONAL SERVICE:

JOURNAL EDITING

*Journal of Human Capital,* Associate Editor (2015-present)
*American Journal of Managed Care,* Guest Editor (2016)
*Journal of Human Resources,* Associate Editor (2011-13)
*Forum for Health Economics & Policy*, Editorial Board Member (2001-2012)
*Economics Bulletin*, Associate Editor (2004-2009)

SERVICE ON SCIENTIFIC REVIEW AND ADVISORY COMMITTEES (Selected)

- Standing member of the Health Services Organization and Delivery (HSOD) NIH review panel, 2012-2016
- NIH reviewer (various panels, too numerous to list) 2003-present
- NIH Review Panel Chair: 2018 (P01 review), 2020 (DP1 review).
- Invited Reviewer for the European Research Council, ERC Advanced Grant 2015 RFP
- NIH Stage 2 Challenge Grant Review Panel, July 2009
- Appointed a member of an Institute of Medicine (IOM) panel on the regulation of work hours by resident physicians, 2007-8.
- Standing member of the NIH Social Science and Population Studies Review Panel, Fall 2004-Fall 2008

- Invited Reviewer for National Academy of Sciences report on Food Insecurity and Hunger, November 2005.
- Invited Reviewer for the National Academy of Sciences report on the Nutrition Data Infrastructure, December 2004
- Invited Reviewer for the National Institute on Health (NIH) Health Services Organization and Delivery Review Panel, June 2004, Alexandria, VA.
- Invited Reviewer for the Food Assistance and Nutrition Research Program US Department of Agriculture Economic Research Service Research Proposal Review Panel, June 2004, Stanford, CA.
- Invited Reviewer for the National Institute on Health (NIH) Social Science and Population Studies Review Panel, February 2004, Alexandria, VA.
- Invited Reviewer for the National Institute on Health (NIH) Social Sciences and Population Studies Review Panel, November 2003, Bethesda, MD.
- Invited Reviewer for the National Institute on Health (NIH) Social Science, Nursing, Epidemiology, and Methods (3) Review Panel, June 2003, Bethesda, MD.
- Invited Reviewer for the Food Assistance and Nutrition Research Program US Department of Agriculture Economic Research Service Research Proposal Review Panel, August 2002.
- Research Advisory Panel on Canadian Disability Measurement, Canadian Human Resources Development Applied Research Branch, June 2001 in Ottowa, Canada.
- Invited Reviewer for the National Institute of Occupational Safety and Health R18 Demonstration Project Grants Review panel in July 2000, Washington D.C.
- Research Advisory Panel on Japanese Health Policy Research. May 1997 at the Center for Global Partnership, New York, NY.

TESTIMONY TO GOVERNMENTAL PANELS AND AGENCIES (9)

- US Senate Dec. 2020 hearing of the Subcommittee on Homeland Security and Governmental Affairs. Testimony provided on COVID-19 mortality risk, collateral harms from lockdown policies, and the incentives of private corporations and the government to invest in research on low-cost treatments for COVID-19 disease
- “Roundtable on Safe Reopening of Florida” led by Florida Gov. Ron DeSantis. September 2020.
- “Evaluation of the Safety and Efficacy of COVID-19 Vaccine Candidates” July 2020 hearing of the House Oversight Briefing to the Economic and Consumer Policy Subcommittee.
- US Senate May 2020 virtual roundtable. Safely Restarting Youth Baseball and Softball Leagues, invited testimony
- “Population Aging and Financing Long Term Care in Japan” March 2013 seminar at the Japanese Ministry of Health.
- “Implementing the ACA in California” March 2011 testimony to California Legislature Select Committee on Health Care Costs.
- “Designing an Optimal Data Infrastructure for Nutrition Research” June 2004 testimony to the National Academy of Sciences commission on “Enhancing the Data Infrastructure

in Support of Food and Nutrition Programs, Research, and Decision Making," Washington D.C.

- "Measuring the Effect of Overtime Reform" October 1998 testimony to the California Assembly Select Committee on the Middle Class, Los Angeles, CA.
- "Switching to Weekly Overtime in California." April 1997 testimony to the California Industrial Welfare Commission, Los Angeles, CA.

REFEREE FOR RESEARCH JOURNALS

American Economic Review; American Journal of Health Promotion; American Journal of Managed Care; Education Next; Health Economics Letters; Health Services Research; Health Services and Outcomes Research Methodology; Industrial and Labor Relations Review; Journal of Agricultural Economics; Journal of the American Medical Association; Journal of Health Economics; Journal of Health Policy, Politics, and Law; Journal of Human Resources; Journal of Political Economy; Labour Economics; Medical Care; Medical Decision Making; Review of Economics and Statistics; Scandinavian Journal of Economics; Social Science and Medicine; Forum for Health Economics and Policy; Pediatrics; British Medical Journal

| **Trainee** | **Current Position** |
|---|---|
| Peter Groeneveld, MD, MS | Associate Professor of Medicine, University of Pennsylvania |
| Jessica Haberer, MD, MS | Assistant Professor of Medicine, Harvard Medical School |
| Melinda Henne, MD, MS | Director of Health Services Research, Bethesda Naval Hospital |
| Byung-Kwang Yoo, MD, PhD | Associate Professor, Public Health, UC Davis |
| Hau Liu, MD, MS, MBA | Chief Medical Officer at Shanghai United Family Hospital |
| Eran Bendavid, MD, MS | Assistant Professor, General Medicine Disciplines, Stanford University |
| Kaleb Michaud, MS, PhD | Associate Professor of Medicine, Rheumatology and Immunology, University of Nebraska Medical Center |
| Kanaka Shetty, MD | Natural Scientist, RAND Corporation |
| Christine Pal Chee, PhD | Associate Director of the Health Economics Resource Center, Palo Alto VA |
| Matthew Miller, MD | VP Clinical Strategy and Head of Innovation, Landmark Health |
| Vincent Liu, MD | Research Scientist, Kaiser Permanente Northern California Division of Research |
| Daniella Perlroth, MD | Chief Data Scientist, Lyra Health |
| Crystal Smith-Spangler, MD | Internist, Palo Alto Medical Foundation |
| Barrett Levesque, MD MS | Assistant Professor of Clinical Medicine, UC San Diego Health System |
| Torrey Simons, MD | Clinical Instructor, Department of Medicine, Stanford University |
| Nayer Khazeni, MD | Assistant Professor of Medicine (Pulmonary and Critical Care Medicine), Stanford University |
| Monica Bhargava, MD MS | Assistant Clinical Professor, UCSF School of Medicineilan |
| Dhruv Kazi, MD | Assistant Professor, UCSF School of Medicine |
| Zach Kastenberg, MD | Resident, Department of Surgery, Stanford University |
| Kit Delgado, MD | Assistant Professor, Department of Emergency Medicine and Faculty Fellow, University of Pennsylvania |
| Suzann Pershing, MD | Chief of Ophtalmology for the VA Palo Alto Health Care System |
| KT Park, MD | Assistant Professor, Department of Medicine, Stanford University |
| Jeremy Goldhaber-Fiebert, PhD | Associate Professor, Department of Medicine, Stanford University |
| Sanjay Basu, MD | Assistant Professor, Department of Medicine, Stanford University |
| Marcella Alsan, MD, PhD | Assistant Professor, Department of Medicine (CHP/PCOR), Stanford Univ. |
| David Chan, MD, PhD | Assistant Professor, Department of Medicine (CHP/PCOR), Stanford Univ. |
| Karen Eggleston, PhD | Senior Fellow, Freeman Spogli Institute, Stanford University |
| Kevin Erickson, MD | Assistant Professor, Department of Nephrology, Baylor College of Medicine |
| Ilana Richman, MD | VA Fellow at CHP/PCOR, Stanford University |

| | |
|---|---|
| Alexander Sandhu, MD | VA Fellow at CHP/PCOR, Stanford University |
| Michael Hurley | Medical Student, Stanford University |
| Manali Patel, MD | Instructor, Department of Medicine (Oncology), Stanford University |
| Dan Austin, MD | Resident Physician, Department of Anesthesia, UCSF School of Medicine |
| Anna Luan, MD | Resident Physician, Department of Medicine, Stanford University |
| Louse Wang | Medical Student, Stanford University |
| Christine Nguyen, MD | Resident Physician, Department of Medicine, Harvard Medical School |
| Josh Mooney, MD | Instructor, Department of Medicine (Pulmonary and Critical Care Medicine), Stanford University |
| Eugene Lin, MD | Fellow, Department of Medicine (Nephrology), Stanford University |
| Eric Sun, MD | Assistant Professor, Department of Anesthesia, Stanford University |
| Sejal Hathi | Medical Student, Stanford University |
| Ibrahim Hakim | Medical Student, Stanford University |
| Archana Nair | Medical Student, Stanford University |
| Trishna Narula | Medical Student, Stanford University |
| Daniel Vail | Medical Student, Stanford University |
| Tej Azad | Medical Student, Stanford University |
| Jessica Yu, MD | Fellow, Department of Medicine (Gastroenterology), Stanford University |
| Daniel Vail | Medical Student, Stanford University |
| Alex Sandhu, MD | Fellow, Department of Medicine (Cardiology), Stanford University |
| Matthew Muffly, MD | Clinical Assistant Professor, Dept. of Anesthesia, Stanford University |

**Dissertation Committee Memberships**

| | | | |
|---|---|---|---|
| Ron Borzekowski | Ph.D. in Economics | Stanford University | 2002 |
| Jason Brown | Ph.D. in Economics | Stanford University | 2002 |
| Dana Rapaport | Ph.D. in Economics | Stanford University | 2003 |
| Ed Johnson | Ph.D. in Economics | Stanford University | 2003 |
| Joanna Campbell | Ph.D. in Economics | Stanford University | 2003 |
| Neeraj Sood* | Ph.D. in Public Policy | RAND Graduate School | 2003 |
| James Pearce | Ph.D. in Economics | Stanford University | 2004 |
| Mikko Packalen | Ph.D. in Economics | Stanford University | 2005 |
| Kaleb Michaud* | Ph.D. in Physics | Stanford University | 2006 |
| Kyna Fong | Ph.D. in Economics | Stanford University | 2007 |
| Natalie Chun | Ph.D. in Economics | Stanford University | 2008 |
| Sriniketh Nagavarapu | Ph.D in Economics | Stanford University | 2008 |
| Sean Young | Ph.D. in Psychology | Stanford University | 2008 |
| Andrew Jaciw | Ph.D. in Education | Stanford University | 2010 |
| Chirag Patel | Ph.D. in Bioinformatics | Stanford University | 2010 |
| Raphael Godefroy | Ph.D. in Economics | Stanford University | 2010 |
| Neal Mahoney | Ph.D. in Economics | Stanford University | 2011 |
| Alex Wong | Ph.D. in Economics | Stanford University | 2012 |
| Kelvin Tan | Ph.D. in Management Science | Stanford University | 2012 |
| Animesh Mukherjee | Masters in Liberal Arts Program | Stanford University | 2012 |
| Jeanne Hurley | Masters in Liberal Arts Program | Stanford University | 2012 |
| Patricia Foo | Ph.D. in Economics | Stanford University | 2013 |
| Michael Dworsky | Ph.D. in Economics | Stanford University | 2013 |
| Allison Holliday King | Masters in Liberal Arts Program | Stanford University | 2013 |
| Vilsa Curto | Ph.D. in Economics | Stanford University | 2015 |
| Rita Hamad | Ph.D. in Epidemiology | Stanford University | 2016 |
| Atul Gupta | Ph.D. in Economics | Stanford University | 2017 |
| Yiwei Chen | Ph.D. in Economics | Stanford University | 2019 |
| Yiqun Chen | Ph.D. in Health Policy | Stanford University | 2020 |
| Min Kim | Ph.D. in Economics | Iowa State Univ. | 2021 |
| Bryan Tysinger | Ph.D. in Public Policy | RAND Graduate School | 2021 |

## E. GRANTS AND PATENTS

PATENT (2)

1. "Environmental Biomarkers for the Diagnosis and Prognosis for Type 2 Diabetes Mellitus" with Atul Butte and Chirag Patel (2011), US Patent (pending).
2. "Health Cost and Flexible Spending Account Calculator" with Schoenbaum M, Spranca M, and Sood N (2008), U.S. Patent No. 7,426,474.

GRANTS AND SUBCONTRACTS (42)

CURRENT (6)

| | |
|---|---|
| 2019-2020 | Funder: Acumen, LLC.<br>Title: Quality Reporting Program Support for the Long-Term Care Hospital, Inpatient Rehabilitation Facility, Skilled Nursing Facility QRPs and Nursing Home Compare<br>Role: PI |
| 2018-2020 | Funder: Acumen, LLC.<br>Title: Surveillance Activities of Biologics<br>Role: PI |
| 2018-2020 | Funder: France-Stanford Center for Interdisciplinary Studies<br>Title: A Nutritional Account of Global Trade: Determinants and Health Implications<br>Role: PI |
| 2017-2023 | Funder: National Institutes of Health<br>Title: The Epidemiology and Economics of Chronic Back Pain<br>Role: Investigator (PI: Sun) |
| 2017-2021 | Funder: National Institutes of Health<br>Title: Big Data Analysis of HIV Risk and Epidemiology in Sub-Saharan Africa<br>Role: Investigator (PI: Bendavid) |
| 2016-2020 | Funder: Acumen, LLC.<br>Title: MACRA Episode Groups and Resource Use Measures II<br>Role: PI |

PREVIOUS (36)

| | |
|---|---|
| 2016-2018 | Funder: University of Kentucky<br>Title: Food acquisition and health outcomes among new SNAP recipients since the Great Recession<br>Role: PI |
| 2015-2019 | Funder: Alfred P. Sloan Foundation |

Title: Public versus Private Provision of Health Insurance
Role: PI

2015-2019 Funder: Natural Science Foundation
Title: Health Insurance Competition and Healthcare Costs
Role: Investigator (PI: Levin)

2014-2015 Funder: The Centers for Medicare and Medicaid Services
Title: Effect of Social Isolation and Loneliness on Healthcare Utilization
Role: PI

2014-2015 Funder: AARP
Title: The Effect of Social Isolation and Loneliness on Healthcare Utilization and Spending among Medicare Beneficiaries
Role: PI

2013-2019 Funder: National Bureau of Economic Research
Title: Innovations in an Aging Society
Role: PI

2013-2014 Funder: Robert Wood Johnson Foundation
Title: Improving Health eating among Children through Changes in Supplemental Nutrition Assistance Program (SNAP)
Role: Investigator (PI: Basu)

2011-2016 Funder: National Institutes of Health (R37)
Title: Estimating the Potential Medicare Savings from Comparative Effectiveness Research
Role: PI Subaward (PI: Garber)

2011-2016 Funder: National Institute of Aging (P01)
Title: Improving Health and Health Care for Minority and Aging Populations
Role: PI Subcontract (PI: Wise)

| | |
|---|---|
| 2010-2018 | Funder: National Institutes of Health<br>Title: Clinic, Family & Community Collaboration to Treat Overweight and Obese Children<br>Role: Investigator (PI: Robinson) |
| 2010-2014 | Funder: Agency for Health, Research and Quality (R01)<br>Title: The Effects of Private Health Insurance in Publicly Funded Programs<br>Role: Investigator (PI: Bundorf) |
| 2010-2013 | Funder: Agency for Healthcare Research and Quality<br>Title: G-code" Reimbursement and Outcomes in Hemodialysis<br>Role: Investigator (PI: Erickson) |
| 2010-2013 | Funder: University of Southern California<br>Title: The California Medicare Research and Policy Center<br>Role: PI |
| 2010-2012 | Funder: University of Georgia<br>Title: Natural Experiments and RCT Generalizability: The Woman's Health Initiative<br>Role: PI |
| 2010-2011 | Funder: National Bureau of Economic Research<br>Title: Racial Disparities in Health Care and Health Among the Elderly<br>Role: PI |
| 2009-2020 | Funder: National Institute of Aging (P30)<br>Title: Center on the Demography and Economics of Health and Aging<br>Role: PI (2011-2020) |
| 2009-2011 | Funder: Rand Corporation<br>Title: Natural Experiments and RCT Generalizability: The Woman's Health Initiative<br>Role: PI |
| 2008-2013 | Funder: American Heart Association<br>Title: AHA-PRT Outcomes Research Center<br>Role: Investigator (PI: Hlatky) |
| 2007-2009 | Funder: National Institute of Aging (R01)<br>Title: The Economics of Obesity<br>Role: PI |
| 2007-2009 | Funder: Veterans Administration, Health Services Research and Development Service<br>Title: Quality of Practices for Lung Cancer Diagnosis and Staging<br>Role: Investigator |
| 2007-2008 | Funder: Stanford Center for Demography and Economics of Health and Aging<br>Title: The HIV Epidemic in Africa and the Orphaned Elderly |

Role: PI

2007 Funder: University of Southern California
Title: The Changes in Health Care Financing and Organization Initiative
Role: PI

2006-2010 Funder: National Institute of Aging (K02)
Title: Health Insurance Provision for Vulnerable Populations
Role: PI

2006-2010 Funder: Columbia University/Yale University
Title: Dummy Endogenous Variables in Threshold Crossing Models, with Applications to Health Economics
Role: PI

2006-2007 Funder: Stanford Center for Demography and Economics of Health and Aging
Title: Obesity, Wages, and Health Insurance
Role: PI

2005-2009 Funder: National Institute of Aging (P01 Subproject)
Title: Medical Care for the Disabled Elderly
Role: Investigator (PI: Garber)

2005-2008 Funder: National Institute of Aging (R01)
Title: Whom Does Medicare Benefit?
Role: PI Subcontract (PI: Lakdawalla)

2002 Funder: Stanford Center for Demography and Economics of Health and Aging
Title: Explaining Changes in Disability Prevalence Among Younger and Older American Populations
Role: PI

2001-2003 Funder: Agency for Healthcare Research and Quality (R01)
Title: State and Federal Policy and Outcomes for HIV+ Adults
Role: PI Subcontract (PI: Goldman)

2001-2002 Funder: National Institute of Aging (R03)
Title: The Economics of Viatical Settlements
Role: PI

2001-2002 Funder: Robert Woods Johnson Foundation
Title: The Effects of Medicare Eligibility on Participation in Social Security Disability Insurance
Role: PI Subcontract (PI: Schoenbaum)

2001-2002 Funder: USDA
Title: Evaluating the Impact of School Breakfast and Lunch
Role: Investigator

2001-2002 Funder: Northwestern/Univ. of Chicago Joint Center on Poverty
Title: The Allocation of Nutrition with Poor American Families
Role: PI Subcontract (PI: Haider)

2000-2002 Funder: National Institute on Alcohol Abuse & Alcoholism (R03)
Title: The Demand for Alcohol Treatment Services
Role: PI

2000-2001 Funder: USDA
Title: How Should We Measure Hunger?

Role: PI Subcontract (PI: Haider)

## F. SCHOLARSHIPS AND HONORS

- Phi Beta Kappa Honor Society, 1988
- Distinction and Departmental Honors in Economics, Stanford University, 1990
- Michael Forman Fellowship in Economics, Stanford University, 1991-1992
- Agency for Health Care Policy and Research Fellowship 1993-1995
- Outstanding Teaching Assistant Award, Stanford University, Economics, 1994
- Center for Economic Policy Research, Olin Dissertation Fellowship, 1997-1998
- Distinguished Award for Exceptional Contributions to Education in Medicine, Stanford University, 2005, 2007, and 2013.
- Dennis Aigner Award for the best applied paper published in the *Journal of Econometrics*, 2013

**UNITED STATES COURT OF APPEALS**
**FOR THE ELEVENTH CIRCUIT**

STATE OF FLORIDA, *et al.*,

*Petitioners,*

v. Case No. _____

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, *et al.*,

*Respondents.*

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**DECLARATION OF**
**CATHERINE MOLCHAN DONALD**

I, CATHERINE MOLCHAN DONALD hereby declare:

**Background and Experience**

1. I make this declaration based on my personal and professional knowledge and experience, information available to me in my position in public service, and publicly available information.

2. I am the Chief Financial Officer for the State of Alabama Department of Public Health ("ADPH", or the "Department").

3. As the Chief Financial Officer of ADPH, I am responsible for overseeing the budgets and financial operations of ADPH. As an ADPH executive, I have been involved with the Department's response efforts to the COVID-19 pandemic. Among other things, one of my primary duties is to assess the ways the Department's actions will impact its financial health.

4. ADPH is an agency of the State of Alabama and receives funding from the State.

**ADPH's Approach to Fighting the COVID-19 Pandemic**

5. To combat the COVID-19 pandemic, ADPH offers free COVID-19 tests to Alabamians in 64 of 67 counties across the State. Jefferson and Mobile County Health Departments are separate operational entities which I believe also offer free COVID-19 tests, but I cannot say for certain.

6. The Department offers these tests free of charge and has now exhausted its supply of free tests.

7. ADPH's commitment to offer free testing has led the Department to devote increased staffing resources to testing services statewide. Because ADPH has a limited number of staff, increasing staff allocation to testing has resulted in a decline in the Department's ability to offer non-test-related clinical services.

8. ADPH's non-test-related clinical services are important to public health. These services include, among other things, family planning, non-COVID immunizations, and sexually transmitted disease treatment.

**The Impact of OSHA's New Standard on ADPH**

9. I have reviewed the new Occupational Safety and Health Administration Emergency Temporary Standard (ETS) mandating that non-governmental employers with 100 or more employees require their employees to receive a COVID-19 vaccine or submit to weekly testing. Based on my personal knowledge and experience, the ETS would likely impose increased costs of ADPH.

10. Our records indicate that approximately 48.7% of Alabamians ages 18 and up are fully vaccinated. That means that roughly 1,966,801 Alabamians ages 18 and up are not vaccinated. Many of these people are likely to avail themselves of the ETS's option of weekly testing, which will increase demand for testing.

11. In keeping with the strategy ADPH has implemented to fight the pandemic, ADPH currently plans to continue to offer free testing to all Alabamians going forward.

12. When more Alabamians seek more COVID-19 tests as a result of the ETS, the Department will seek to meet the increased demand. To do so, ADPH will need to allocate more staff to test-related services. In turn, ADPH will have less staff time available for non-test-related services.

13. The ETS will diminish ADPH's non-test-related-service capacities— which, as noted above, provide important health benefits to the people of Alabama— and will cost ADPH financial resources.

14. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct, to the best of my knowledge.

Nov 8, 2021
Date

Catherine Molchan Donald
Chief Financial Officer
Alabama Department of Public Health

**UNITED STATES COURT OF APPEALS**

**FOR THE ELEVENTH CIRCUIT**

STATE OF GEORGIA, *et al.*,

*Petitioners,*

v. Case No. 21-13866-F

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, *et al.*,

*Respondents.*

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## DECLARATION OF ED CROWELL

I, Ed Crowell, hereby attest:

1. I make this declaration based on my personal and professional knowledge and experience, information available to me in my position in public service, and publicly available information.

2. My name is Ed Crowell. I am the President & CEO of the Georgia Motor Trucking Association, Inc. ("GMTA" or the "Company"). I am over the age of 19, and the facts I have set out below are based on my personal knowledge and/or on the records of the Company that are maintained in the ordinary course of business.

3. As President of GMTA, I am responsible for the overall management of the Company, a member of the Board of Directors, and a member of the Executive Committee. My role places me in close communication with both the Company's members, executive management, and the rest of its workforce.

4. Since the 1933, GMTA has sought to procure reasonable governmental policy toward the trucking industry and best practices and citizenship among it's trucking industry members. This involves consistent and regular interaction with policy makers and ongoing training in safety and regulatory compliance among GMTA members.

5. GMTA represents trucking companies which operate in a commodity market that requires them to maintain tight cost controls, productivity, and a safe work environment. Many trucking company employees are highly trained professionals, and all are essential. No commercial truck can operate without an employee's involvement.

6. The damage done by the loss of employees – especially but not only drivers – is uniquely acute in the trucking industry. It takes, at minimum, one driver for each delivery completed. The industry overall is already suffering a shortage of drivers. This has been well documented by American Trucking Associations, Inc. and independent research groups. Regulations that arbitrarily disqualify currently active drivers are highly detrimental to the industry and to individual companies.

7. Trucking company employees are not easily replaceable. In addition to drivers, other positions in trucking operations may be considered safety-sensitive and require higher levels of scrutiny, drug, and background testing. Drivers, properly, face additional employment requirements including clean Motor Vehicle Reports and often previous experience as well as training and the possession of a valid Commercial Driver's License.

8. Many drivers work solo, spending most of their workday in a well-ventilated truck cab or outside. Others work in large, open-air warehouses; some work in offices. GMTA member companies have uniformly and successfully followed CDC & OSHA guidelines to adhere to COVID 19 protocols and as a result have been able to successfully serve customers and maintain operations without above-average Covid positivity.

9. Most GMTA members report strong encouragement of vaccinations, but none has reported making vaccinations mandatory. Indeed, members report their employees uniformly reject calls for mandatory vaccinations whether imposed by the company, state or federal governments.

10. Comments from member trucking companies include reports of at least 25% of employees refusing to get the vaccinated. These employees indicate they would leave to work for a smaller carrier that was not included in the mandate. Extrapolating that total staffing of a firm means many could potentially lose drivers and office staff, which

would have a significant impact on the operations of member companies and the operations of their shippers. In addition, while warehousing operations are not technically part of the GMTA, the association expects a similar number of employees leaving those operations.

11. Many member companies have been offering monetary incentives since April to employees to get fully vaccinated. In such instances, some companies have reported that less than 50% of their employees are vaccinated, and many have said they will quit before they are compelled to do so.

12. Reports from other member companies have more concerning numbers. Some companies have estimates of 30% of their drivers leaving if a vaccination requirement is enforced.

13. If these employees quit, GMTA member trucking companies will suffer significant harm. Moreover, companies in other industries and consumers that depend on the smooth performance of trucking companies will likewise be harmed. Additionally, the impact will not be uniform, essentially creating "winners and losers" through regulation as some companies will lose more capacity than others.

14. On November 5, 2021, the Occupational Safety and Health Administration issued an Emergency Temporary Standard that requires companies with over 100 employees to force their employees to either receive a COVID-19 vaccine or receive weekly COVID-19 testing. Companies that fail to comply face stiff penalties for each violation.

15. To attempt to replace these employees, GMTA members will have to engage in an urgent recruitment process, costing the company significant time and money. It takes as long as two-years and seven weeks to replace a Commercial Drivers License truck driver. Training takes a minimum of seven weeks and most trucking companies are not allowed by their insurers to employ a driver with less than two years of experience. A significant exodus of drivers and other industry employees will have huge economic and human costs.

16. Resignations also have the capacity to diminish morale across the entire workforce. The trucking industry has an older-than-average workforce. Mandate-inspired resignations will remove decades of skill and experience and have a demoralizing effect on those who remain. Younger drivers and workers will lose mentors as well.

17. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Nov. 8, 2021

Date:

Ed Crowell, President, GMTA

**UNITED STATES COURT OF APPEALS**

**FOR THE ELEVENTH CIRCUIT**

STATE OF FLORIDA, *et al.*,

*Petitioners,*

v. Case No. 21-13866-F

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, *et al.*,

*Respondents.*

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**DECLARATION OF JEFFREY H. DORFMAN**

I, Jeffrey H. Dorfman, hereby attest:

1. I make this declaration based on my own personal and professional knowledge and experience, information available to me in my position in public service, and publicly available information.

2. I currently serve as the state fiscal economist of Georgia, appointed by the Governor to that role in August 2019. I further have thirty-two years of experience as a professor of economics at The University of Georgia, where I still hold that position. My expertise is in statistical analysis of economic data, macroeconomics, and quantitative analysis of economic policies. I have published economic textbooks, roughly one hundred peer-reviewed academic journal articles, and hundreds of op-ed

articles on economic policy published in outlets such as Forbes, realclearmarkets.com, and The Atlanta Journal-Constitution. My primary job duty is forecasting state revenue collection and the effect on those collections of various proposed policies.

3. I have reviewed the Occupational Safety and Health Administration's Emergency Temporary Standard (ETS) mandating that all non-government employers with 100 or more employees require their workforce be fully vaccinated against COVID-19 or submit to weekly testing.

4. According to the Census Bureau's Statistics on U.S. Businesses, of Georgia's 3,975,657 employees in 2018, 2,770,603 worked for employers with 100 or more employees and, thus, would be subject to such a mandate. That represents 69.7% of all employees in Georgia.[1]

5. Georgia's vaccination rate is 50% as of October 26, 2021, and likely somewhat lower for working age citizens, so I estimate that approximately 1.4 million workers are unvaccinated in Georgia and subject to the ETS.[2]

6. Polling shows that a portion of unvaccinated workers will quit rather than get vaccinated or be tested on a weekly basis. For example, in Kaiser Family Foundation published results of a poll conducted in mid-October 2021. In that poll, 37% of unvaccinated workers self-report they will quit their jobs rather than submit to mandatory vaccination or weekly testing.[3] This suggests overall compliance could be as low as 81.5% (50% vaccinated + (63% of the 50% unvaccinated) = 50% + 31.5% = 81.5% of all workers).

7. The same Kaiser Family Foundation poll reports that only 5% of unvaccinated workers report having actually quit their jobs.

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[1] Data downloadable at https://www2.census.gov/programs-surveys/susb/tables/2018/us_state_naics_detailedsizes_2018.xlsx

[2] Georgia's Department of Public Health reported 56% of Georgians had received one dose and 50% were fully vaccinated as of October 26, 2021. Data available at: https://experience.arcgis.com/experience/3d8eea39f5c1443db1743a4cb8948a9c

[3] Hamel, Liz, et al. "KFF COVID-19 Vaccine Monitor: October 2021." October 28, 2021. Available at https://www.kff.org/coronavirus-covid-19/poll-finding/kff-covid-19-vaccine-monitor-october-2021/

8. Reports from other states and businesses that have imposed vaccine mandates suggest that around 90% of unvaccinated workers would get vaccinated rather than lose their jobs or submit to weekly testing.[4] For example, Tyson Foods (a large Georgia employer) has reported 91% compliance with its vaccine mandate.[5]

9. We can use these poll results and actual observations of existing mandates to estimate the likely impact of this new, federal mandate. On the high end, we could experience as many as 37% of unvaccinated workers quitting (or 18.5% of the total workforce); in the middle, it might only be 10% of workers; and on the low end it could be as few as 5% of workers.

10. If 37% of Georgia's 1.4 million unvaccinated workers refuse to comply with the ETS mandate, that means 518,000 Georgia employees could lose their jobs.

11. If 10% of Georgia's 1.4 million unvaccinated workers refuse to comply with the ETS mandate, that means 140,000 Georgia employees could lose their jobs.

12. If 5% of Georgia's 1.4 million unvaccinated workers refuse to comply with the ETS mandate, that means 70,000 Georgia employees could lose their jobs.

13. Employers have been having great difficulty hiring workers (as evidenced by ubiquitous help wanted signs). The latest State Job Openings and Labor Turnover Notes from the U.S. Bureau of Labor Statistics shows that Georgia had a job opening rate of 8%, a hiring rate of 5.5% and a separation rate (workers quitting or being fired) of 5.5% in August.[6] Because workers are leaving and being hired at the same rate, employers made no progress filling job openings.

14. If employers are unable to find timely replacements for even that 5 percent of the workforce conservatively estimated to be prone to quit in the face of the vaccine mandate, that would represent a loss of 70,000 employees. The middle and high

[4] Hsu, Andrea. "Faced with losing their jobs, even the most hesitant are getting vaccinated," NPR. October 7, 2021. Available online at https://www.npr.org/2021/10/07/1043332198/employer-vaccine-mandates-success-workers-get-shots-to-keep-jobs

[5] Hirsch, Lauren. "After Mandate, 91% of Tyson Workers Are Vaccinated," New York Times, September 30, 2021. Available at https://www.nytimes.com/2021/09/30/business/tyson-foods-vaccination-mandate-rate.html

[6] State Job Openings and Labor Turner Over News Release. U.S. Bureau of Labor Statistics. October 21, 2021. Available at https://www.bls.gov/news.release/jltst.htm

estimates, based on experience in other states and the Kaiser Family Foundation poll, would see Georgia losing between 140,000 and 518,000 workers from its pool of covered workers that pay into the state's Unemployment Trust Fund.

15. The state of Georgia collects payroll taxes on covered employees to fund the State's Unemployment Trust Fund. Those taxes are levied at a flat rate on the first $9,550 of wages per calendar year. The payroll tax rates vary by employer based on their past claims history, but the average rate is about 2%.

16. That means each unreplaced worker will cost the Unemployment Trust Fund approximately $190 in revenue. If covered employment drops by 70,000, the Trust Fund would fail to collect $13.3 million. At 140,000 lost workers, the loss grows to $26.6 million and at the high estimate of 518,000 lost workers, the state would lose $98.4 million.

17. Because the balance in the Unemployment Trust Fund has been reduced by an unprecedentedly high number of payouts during the pandemic, lost revenue to the trust fund at this time increases the possibility that Georgia could experience an Unemployment Trust Fund shortfall. If the Unemployment Trust Fund does experience a shortfall, the state must make that up from other funds, raising payroll taxes, or borrowing from the federal government and thereby potentially incurring interest costs.

18. The proposed vaccine mandate would also discourage some people for looking for jobs and make other unemployed people ineligible for most jobs with employers over 100 employees, thereby artificially elevating the state's unemployment rate. This higher unemployment rate will cause funds to be disbursed from the Unemployment Trust Fund more quickly, further damaging the fund's economic stability.

19. To the extent that a reduced workforce also reduces the earned income of Georgia citizens and the sales and profits of Georgia companies, the State of Georgia will also lose additional tax revenues from the general fund. If income, sales, and profits are reduced by 1% in a similar manner to covered employment, the state general fund revenues would be reduced by approximately $200 million per year.[7]

[7] Annual revenues from personal income tax, sales tax, and corporate income tax are currently expected to exceed $22 billion in fiscal year 2022. Fiscal year 2021 numbers can be found at https://sao.georgia.gov/document/document/21grrrsecured/download

20. This calculation only assumes that household incomes, retail sales, and corporate profits would fall at the same rate as employment. This is actually an overly conservative assumption as workers at large employers get paid more on average and large corporations pay the vast majority of state corporate income taxes.[8] In reality, the losses would likely be higher.

21. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

11/5/2021
Date

Jeffrey H. Dorfman

[8] See, for example, "Do Big Companies Pay More Than Small?" available at https://www.ivyexec.com/career-advice/2015/do-big-companies-pay-more-than-small/ which reports on data from the Statistics on U.S. Businesses data set used earlier to compute the share of workers are employers that will be impacted by the mandate.

**UNITED STATES COURT OF APPEALS**
**FOR THE ELEVENTH CIRCUIT**

STATE OF FLORIDA, *et al.*,

*Petitioners,*

v. Case No. 21-13866-F

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, *et al.*,

*Respondents.*

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## DECLARATION OF JAMES HECKMAN

I, James Heckman, hereby declare:

1. I make this declaration based on my own personal and professional knowledge and experience, information available to me in my position in public service, and publicly available information.

2. I am currently employed with the Florida Department of Economic Opportunity (DEO) as the Interim Bureau Chief of Workforce Statistics and Economic Research and Chief Economist. I have six years of experience analyzing Florida's labor market as a Research Associate, Economist, Program Manager, Administrator, and now Bureau Chief with the Bureau of Workforce Statistics and Economic Research. This includes production and publication of monthly labor statistics for the State of Florida, analyzing economic policy initiatives, presenting analysis of local labor market conditions to external stakeholders, and managing a team of research associates and economists.

3. I have reviewed the Occupational Safety and Health Administration's Emergency Temporary Standard (ETS) mandating that all non-government employers with 100 or more employees require their workforce be fully vaccinated against COVID-19 or submit to weekly testing.

4. According to the Quarterly Census of Employment and Wages,[1] 8,683 employers across the State of Florida employed 100 or more workers in March of 2021, which equates to 4,598,482 jobs in Florida (60.7 percent of total employment statewide). Table 1 provides further detail.

**Table 1: Florida Private Employers with 100 Employees or More**

| Industry | Number of Private Employers | March 2021 Employment |
|---|---|---|
| Administrative and Waste Services | 1,097 | 908,887 |
| Retail Trade | 730 | 803,055 |
| Health Care and Social Assistance | 1,517 | 704,629 |
| Accommodation and Food Services | 813 | 382,133 |
| Finance and Insurance | 459 | 296,210 |
| Professional and Technical Services | 668 | 223,095 |
| Transportation and Warehousing | 329 | 215,519 |
| Manufacturing | 645 | 202,277 |
| Wholesale Trade | 501 | 168,702 |
| Construction | 610 | 145,882 |
| Arts, Entertainment, and Recreation | 257 | 124,019 |
| Educational Services | 237 | 98,679 |
| Real Estate and Rental and Leasing | 208 | 79,888 |
| Information | 169 | 78,082 |
| Other Services, Except Public Administration | 191 | 58,311 |
| Management of Companies and Enterprises | 111 | 47,175 |
| Agriculture, Forestry, Fishing and Hunting | 111 | 36,754 |
| Utilities | 24 | 21,887 |
| Mining, Quarrying, and Oil and Gas Extraction | 6 | 3,298 |
| **Grand Total** | **8,683** | **4,598,482** |

Source: Florida Department of Economic Opportunity, Bureau of Workforce Statistics and Economic Research, Quarterly Census of Employment and Wages Program.

5. According to data collected by the U.S. Census Bureau between August 18 and August 30 of 2021, 1.8 million employed individuals in Florida (23.1 percent of Florida workers) have not received any doses of a COVID-19 vaccine. Over 1.2 million of those unvaccinated persons work for a private company or non-profit organization. Table 2 provides further detail.

[1] The Quarterly Census of Employment and Wages program produces employment and wages data by industry and geography based on all employers covered by state unemployment insurance laws.

**Table 2: COVID-19 Vaccination Status by Employment Sector**
**Population 18 Years and Older; Florida**

| Sector of Employment | Received COVID-19 Vaccine? Yes | No |
|---|---|---|
| Government | 745,024 | 125,964 |
| Private company | 3,708,737 | 1,137,346 |
| Nonprofit organization | 596,668 | 105,050 |
| Self-employed | 743,533 | 399,517 |
| Family business | 161,530 | 24,967 |
| Did not report | 65,113 | 16,547 |
| **Total Employment** | **6,020,606** | **1,809,392** |
| Not Employed - Working Age (Ages 25-54) | 1,638,503 | 1,374,068 |
| **Total Not Employed** | **6,770,887** | **1,883,868** |
| Did not report employment status | 484,577 | 183,586 |
| **Total** | **13,276,069** | **3,876,845** |

Source: U.S. Census Bureau, Household Pulse Survey

Calculations by Florida Department of Economic Opportunity, Bureau of Workforce Statistics and Economic Research

6. According to national polling from the Kaiser Family Foundation, 30 percent of unvaccinated workers say they will leave their job if their employers require vaccination or weekly testing, 56 percent say they would submit to weekly testing, and 12 percent say they would be willing to get vaccinated.

7. While DEO is not aware of specific vaccination-related data regarding employees subject to the ETS, for purposes of rough calculations, one can apply the general data on vaccination rates and vaccination preferences discussed in ¶¶ 5–6 to the number of jobs subject to the ETS discussed in ¶ 4. Such a rough calculation demonstrates that over 1,062,000 jobs in Florida that are subject to the rule could belong to unvaccinated individuals, over 594,000 of which may immediately be subject to weekly testing and over 318,000 of which may quit their jobs.

8. Further, the ETS will impact over 1.3 million unvaccinated working age Floridians (ages 25–54) who are not currently employed. This constitutes 46 percent of the entire working age population in Florida that do not have a job.

9. Many of said individuals are currently collecting unemployment from the State of Florida. Between March 15, 2020, to October 12, 2021, the State of Florida paid out $7,300,432,050 in state Reemployment Assistance benefits. Because a substantial portion of those collecting unemployment from the State will be unwilling to get vaccinated or submit to weekly testing, *see* ¶ 6, the ETS is likely to deter at least some of these individuals from reentering the work force—or at a minimum cause them to limit their employment search to companies not subject to the ETS—causing the State

of Florida to continue to incur unemployment payment expenses that are higher than what Florida would incur absent the ETS.

10. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

11/4/2021
Date

James Heckman
Interim Bureau Chief of Workforce Statistics and Economic Research and Chief Economist
Florida Department of Economic Opportunity

**UNITED STATES COURT OF APPEALS**
**FOR THE ELEVENTH CIRCUIT**

STATE OF FLORIDA, *et al.*,

*Petitioners,*

v. Case No. 21-13866-F

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, *et al.*,

*Respondents.*

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**DECLARATION OF**
**CARL WESLEY KIRKLAND, JR.**

I, CARL WESLEY KIRKLAND JR., hereby declare:

1. I make this declaration based on my personal and professional knowledge and experience, information available to me in my position in public service, and publicly available information.

2. I am the Deputy Director of Institutional Operations for the Florida Department of Corrections (FDC). In that position I am responsible for overseeing the Bureau of Security Operations, Officer Radio Communications, Population Management, Prison Rape Elimination Act (PREA), and American Correctional Association (ACA).

3. FDC is the state's largest agency. Currently, FDC houses approximately 79,000 inmates at forty-nine major institutions operated by FDC, and seven major institutions operated by private contractors. FDC is responsible for each inmate's care, custody, and control. These institutions must be operational 24 hours a day, 7 days a week, 365 days a year.

4. As part of these responsibilities, FDC contracts with approximately 1,000 companies, non-profit organizations, and other entities to provide it with essential goods and essential services required to meet its everyday operational needs. FDC relies

on these contractors for things like food, clothing, security, health-related matters, infrastructure, IT, sanitation, and transportation, just to name a few. The importance of these goods and services cannot be overstated; their timely and competent delivery is required. Disruptions in the delivery of these goods or services can result in severe ramifications to operations and to the safety, health, wellbeing of the inmates, and our ability to meet constitutional, statutory, and regulatory requirements.

5. As detailed below, the Occupational Safety and Health Administration Emergency Temporary Standard, which requires non-government employers with 100 or more employees to require a COVID-19 vaccine or weekly testing and the wearing of a face covering at work in lieu of vaccination for each of its employees, will have a significant detrimental effect on FDC's operations.

**Administration Program Area**

6. Under the Administration program area, contracted goods and services fall into five main contractor categories: 1) substance use disorder treatment, 2) community release centers, 3) inmate services, 4) safety service, and 5) fleet related. Each of these categories and the major contractors within those categories are discussed below. Each of the identified contractors are subject to OSHA regulations and have more than 100 employees.

7. Substance Use Disorder Treatment Contractors. FDC uses private contractors Gateway Foundation Inc. and Geo Reentry Services, LLC, to provide substance use disorder treatment for inmates in prison. And FDC uses the following private contractors to provide substance use disorder treatment for offenders in the community: WestCare GulfCoast-Florida, Inc.; DACCO Behavioral Health, Inc.; Psychosocial Rehabilitation Center, Inc.; Drug Abuse Foundation, Inc.; Phoenix Programs of Florida, Inc.; Meridian Behavioral Healthcare, Inc.; First Steps of Florida; The Salvation Army; Livestream Behavioral Center, Inc.; Henderson Behavioral Health, Inc.; and Chemical Addition Recovery Effort, Inc.

8. If the workforce for these contractors is reduced, even temporarily, it could result in required treatment being delayed or even denied. This in turn will have negative consequences on an inmate's ability to reintegrate into the community upon release or to recover from their addictions, thus increasing the likelihood of a return to prison. This will place an additional burden on an already overcrowded and understaffed prison system.

9. Community Release Center Contractors. FDC uses private contractors Bridges of America Inc.; The Transition House, Inc.; Goodwill Industries-Suncoast

Inc.; and SMA Healthcare to provide community release center services for inmates nearing release. If their workforce is reduced, even temporarily, it could result in inmates not being able to utilize the re-entry services. In turn, those inmates will be forced to remain at the state institution until their release into the community, stressing the already overcrowded prison system. This could result in the loss of 545 beds from capacity. The inmates would be housed in emergency beds at an FDC institution. FDC would have to initiate Control Release protocol in March 2022 as required by § 947.146, Florida Statutes. Not only that, inmates will be less prepared for their release and reintegration into the community should reentry services be eliminated or reduced thus increasing a likelihood of a return to prison. Again, this will result in an increase in the population of an already overcrowded prison system.

Inmate Services Contractors.

10. FDC uses private contractors Global Tel*Link Corporation to provide telephone services to the inmate population. If their workforce is reduced, even temporarily, this could negatively impact the adequacy of the service to inmates, and their families for vital telephone communications.

11. FDC uses private contractor Securus Technologies to provide inmate communication and educational devices. If their workforce is reduced, even temporarily, it could be unable to provide adequate technological support for the inmate devices used to communicate with family as well as to provide educational opportunities for assisting with re-entry into the community.

12. FDC uses private contractor Trinity Services Group Inc. to provide commissary and food preparation for inmates. If their workforce is reduced, even temporarily, it could be unable to provide adequate services.

13. FDC uses private contractor Cheney Brothers to provide food to all FDC institutional kitchens for meal preparation. If their workforce is reduced, even temporarily, it could result in food delivery delays impacting FDC's ability to provide meals to the inmates in violation of minimum statutory standards.

Safety Services Contractors.

14. FDC uses private contractor Johnson Controls Inc. to provide Life Safety Equipment inspection, maintenance, testing and repair services for these items in accordance with the National Fire Protection Association (NFPA) Standards 1, 10, 13, 17A, 24, 25, 70, 72, and 96 in all facilities used to house inmates in Florida's correctional system. If their workforce is reduced, even temporarily, it will likely impact their ability

to provide the timely and necessary repairs to the fire prevention, detection, and suppression systems in the prisons. This in turn would expose the state to liability and more importantly pose a direct life safety hazard to inmates and employees.

15. FDC uses private contractor Gregory Pest Control to provide routine pest control services for Florida's prison facilities. If their workforce is reduced, even temporarily, it will likely impact their ability to provide the timely and necessary pest control services for FDC. This can and likely would result in infestations posing a hazard to inmates and is a particular health and safety concern for the food preparation areas of the compound. FDC follows the Federal Food Safety Standards which are incorporated by reference in F.A.C. 64E-11.003 Food Hygiene Standards. Without ongoing pest control services, FDC could potentially become non-compliant with these standards. And failure to comply could result in the Department of Health requiring FDC to close its kitchens.

Fleet Related Contractors.

16. FDC uses private vehicle dealer Duval Ford, Garber Automotive Group to provide vehicles for inmate transportation, probation officer duties, and other correctional functions. FDC uses private contractor American Aluminum Accessories, Inc. to provide vehicle modifications for inmate transport vehicles. And FDC uses private contractor Wright Express Inc. to provide fuel/maintenance purchasing card capabilities. These contractors collectively allow FDC to acquire vehicles, make necessary modifications, and keep their fleet of vehicles operational on the road. If their workforce is reduced, even temporarily, it would negatively impact FDC's ability to meet its transportation responsibilities, i.e., to safely transport inmates and monitor offenders in community.

**Community Corrections Program Area**

17. Under the Community Corrections program area, contracted goods and services fall into two main categories: 1) GPS Electronic Monitoring and 2) Victim Services. Each of these categories and the contractors within those categories are discussed below. Each of the identified contractors are subject to OSHA regulations and have more than 100 employees.

18. GPS Electronic Monitoring Contractor. FDC uses private contractor Attenti Inc. to provide active GPS electronic equipment and services for offenders under community supervision and for inmates incarcerated in community release centers. If their workforce is reduced, even temporarily, it could result in a diminished ability to adequately monitor offenders in the community as required by statute. This, in turn,

would subject the community to unnecessary danger.

19. Victim Services Contractor. FDC uses a private contractor Appriss Inc. to provide survivors, victims of crime, and other concerned citizens access to timely and reliable information about offenders under supervision and inmates in prisons. If their workforce is reduced, even temporarily, it could potentially impact the ability of survivors, victims of crime, and others to receive critical offender and inmate status updates and release notifications for inmates and offenders. This, in turn, would subject the community to unnecessary danger.

**Facility Maintenance Program Area**

20. Under the Facility Maintenance program area, contracted goods and services fall into three main categories: 1) Engineering & Utilities Infrastructure Service, 2) Facility Maintenance and Construction Services, and 3) Facility Design Services Contractors. Each of these categories and the major contractors within those categories are discussed below. Each of the identified contractors are subject to OSHA regulations and have more than 100 employees.

Engineering and Utilities Infrastructure Services Contractors.

21. FDC uses private contractor U.S. Water Services, Corporation to provide water and wastewater facility operator services for all facilities that have a water/wastewater facility in Florida's correctional system. If their workforce is reduced, even temporarily, it could be unable to provide the necessary oversight, water, and wastewater operations in state owned prison facilities, which will bring the facilities in non-compliance with state and federal regulations and could cause a shutdown of these institutions.

22. FDC uses private contractor Brenntag Mid-South, Inc. to provide water and wastewater laboratory testing services for all facilities that have a water/wastewater facility in Florida's correctional system. If their workforce is reduced, even temporarily, it could be unable to provide the necessary laboratory testing of water and wastewater facilities in state owned prison facilities, which will bring the facilities in non-compliance with state and federal regulations and could cause a shutdown of these institutions.

23. FDC uses private contractor Graybar Electric Company, Inc. to provide Pelco camera systems for all facilities in Florida's correctional system. If their workforce is reduced, even temporarily, it could be unable to provide safety products that are needed in state owned prison facilities, which will cause the inmate and field staff to be in an unsafe and insecure setting.

24. FDC uses private contractor Zabatt Power Systems, Inc. to provide emergency generator repair and preventative maintenance for all generator systems in all facilities in Florida's correctional system. If their workforce is reduced, even temporarily, it could be unable to ensure that the power in all institutions is constant and available. Due to the severe weather Florida faces, our commercial electricity supply is impacted several times throughout the year. Having electricity is critical to meet our duty to protect the public, staff, and inmates. The loss of electricity will impact life safety equipment and systems, electronic perimeter intrusion detection systems, lighting, locking systems and controls, and food service operations, among other things.

25. FDC uses private contractor Cornerstone Detention Products, Inc. to provide repair and maintenance to the Perimeter Security Systems in numerous facilities in Florida's correctional system. If their workforce is reduced, even temporarily, it could be unable to ensure that the security systems at the Florida correctional institutions are constant and available, which will jeopardize the safety of the public.

Facility Maintenance and Construction Services Contractors.

26. FDC uses private contractor Ajax Building Company LLC to provide building construction services for the new Mental Health Treatment Facility at Lake Correctional Institution in Clermont, FL. If their workforce is reduced, even temporarily, it could be unable to provide the necessary building construction services for the Lake C.I. Mental Health Treatment project and delay the project schedule preventing inmates from receiving vital mental health treatment services and preventing FDC from meeting its commitments under Florida law.

27. FDC uses private contractor Charles Perry Partners, Inc.; Turner Construction Company; and Core Construction Services of Florida, LLC to provide continuing building construction and repair services for FDC throughout the State. If their workforce is reduced, even temporarily, it could be unable to provide the necessary continuing building construction services and delay ongoing project schedules preventing the department from meeting fiscal deadlines and from meeting its commitments under Florida law.

Facility Design Services Contractors.

28. FDC uses private contractor Hellmuth Obata & Kassabaum, Inc. to provide architectural design services for the new Mental Health Treatment Facility at Lake Correctional Institution in Clermont, FL. If their workforce is reduced, even temporarily, it could be unable to provide the necessary design services for the Lake

C.I. Mental Health Treatment project and delay the project schedule preventing inmates from receiving vital mental health treatment services and preventing FDC from meeting its commitments under Florida statute.

29. FDC uses private contractor Dewberry Architects, Inc. to provide continuing architectural design services for both Regions Two and Three of the State. If their workforce is reduced, even temporarily, it may be unable to provide the necessary design services for the department and delay projects currently scheduled. This could prevent FDC from meeting its fiscal deadlines and possibly other commitments under Florida law.

**Institutional Operators Program Area**

30. The major contractors under the Institutional Operations program area are discussed below. Each of the identified contractors are subject to OSHA regulations and have more than 100 employees.

31. FDC uses private contractors Waste Pro of Florida, Inc.; Waste Management Inc of FL; and Allied Waste Services of North America, LLC to provide non-regulated trash collection. If their workforces are reduced, even temporarily, these contractors could be unable to provide essential waste collection services. The result would be an increase of rodents and insects that transmit disease and pose a significant health risk to staff and inmates. Additionally, if waste is accumulated, FDC would violate health regulations, and the impacted institutions could be subjected to a financial penalty.

32. FDC uses private contractors Lawman's & Shooters Supply Inc; Lou's Police Distributors, Inc.; and GL Distributors, Inc. to provide lethal and less-lethal munitions, crowd control supplies, and personal safety devices and weapons. If their workforces are reduced, even temporarily, they could be unable to provide timely delivery of the above equipment. The result would be a reduction in training in these high liability areas, thus placing staff, inmates, and the public at significant risk.

33. FDC uses private contractor Williams Communications, Inc. to provide radio communications repair services. If their workforces are reduced, even temporarily, they could be unable to provide a timely response to repair our communications equipment, including base stations, mobile radios, and portable radios. These communication devices are critical to the safe operation of a correctional institution, and inoperable radios create a communication breakdown, impacting institutional operations and leadership's ability to respond to emergencies efficiently. This places staff, inmates, and the public at significant risk.

34. FDC uses private contractor Craftmaster Hardware, LLC to provide locks, locking systems, and security hardware and accessories. If their workforces are reduced, even temporarily, they could be unable to provide timely delivery of the security equipment. The result would be inoperable locking systems that control inmate movement within an institution. These control points are critical to the safe operation of a correctional institution, and broken locking systems place staff, inmates, and the public at significant risk.

**Private Prison Contractors**

35. The State of Florida contracts with GEO Group, MTC, and CoreCivic to house approximately 10,000 of FDC inmates. These contracts are managed by the Florida Department of Management Services. If their workforce is reduced, even temporarily, it could result in the loss of approximately 2,500 beds from capacity. The inmates would be housed in emergency beds at an FDC institution. FDC would have to initiate Control Release protocol in March 2022 as required by § 947.146, Florida Statutes.

* * *

36. As outlined above, FDC is wholly reliant on private contractors for much of its daily operations. A reduction in workforce for even one of these contractors, let alone many or all, will have a detrimental and costly ripple effect—some effects will be immediate, others will impact FDC for years to come (i.e., recidivism and the resulting overcrowding due to inadequate reentry or substance abuse services). It is difficult to accurately predict the full impact of the Emergency Temporary Standard on FDC operations, but it will surely be significant. Even assuming an identified impact is small standing alone, in the aggregate and over time these are anything but small.

37. Price impacts were not discussed above, however, it is very possible that the costs associated with workforce rebuilding or other direct impacts for a vaccine mandate on the contractors could ultimately be passed on to FDC in the form of higher prices for goods and services or perhaps create an environment where supply of goods and services is more limited, resulting in an increased demand, stiffer competition, and a resulting increase in procurement costs. Additionally, fines levied against FDC for non-compliance with state and federal regulations could have a substantial fiscal impact on FDC, and potential closures of institutions would have a severe impact on overcrowding, thus jeopardizing the safety of the public, staff, and inmates.

38. It should also be noted that there are many more FDC contractors that are subject to OSHA regulations that have more than 100 employees; the above is a

sampling of the major contractors in the identified FDC program areas.

39. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct, to the best of my knowledge.

11/4/2021
Date

CARL WESLEY KIRKLAND JR
Deputy Director of Institutional Operations
Florida Department of Corrections

**UNITED STATES COURT OF APPEALS**
**FOR THE ELEVENTH CIRCUIT**

STATE OF FLORIDA, *et al.*,

*Petitioners,*

v. Case No. 21-13866-F

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, *et al.*,

*Respondents.*

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**DECLARATION OF PATTY LEWANDOWSKI**

I, Patty Lewandowski, hereby declare:

1. I make this declaration based on my own personal and professional knowledge and experience, information available to me in my position in public service, and publicly available information.

2. I am currently employed by the Florida Department of Health (DOH) as the Bureau Chief of Bureau of Public Health Laboratories. I have been in this role since April 2018.

3. DOH is a state agency charged with protecting and promoting the health of all residents and visitors in the state through organized state and community efforts including cooperative agreements with the State's sixty-seven counties.

4. I have reviewed the new Occupational Safety and Health Administration Emergency Temporary Standard (ETS) mandating that non-government employers with 100 or more employees require their employees to receive a COVID-19 vaccine or submit to weekly testing. Based on my personal knowledge and experience, the ETS would likely have several adverse effects on Florida generally and on DOH specifically.

5. I understand from the Department of Economic Opportunity's separate declaration that hundreds of thousands of unvaccinated employees in Florida are likely

to begin immediately seeking weekly testing as a result of the ETS. Such an increase in testing has the potential to overwhelm current testing capacity.

6. DOH currently contracts for one state-run COVID-19 testing site in Palm Beach County. This testing site provides COVID-19 testing to any person who seeks a test, without charge, regardless of the person's reason for taking a test. In the DOH's experience, testing mandates by private businesses result in at least some of those employees seeking tests at the state-run site. For example, when the Centers for Medicare and Medicaid Services implemented testing requirements, a significant number of employees of health care facilities that did not operate their own testing systems began using the state-run testing site.

7. Although local communities have established private and public testing sites, DOH anticipates that these sites will not be able to support the increased demand generated by the ETS. Consequently, employers may reasonably anticipate that county health departments will provide additional testing or operate additional testing sites. Testing capacity at county health departments, however, is limited. Testing resources at county health departments are designed for outbreak investigations, congregate case investigation, and limited community expansion. To support the exponential increase in demand, DOH will likely be forced to contract for testing services to operate additional sites across the state.

8. In addition to state-run testing sites, an increase in testing would affect laboratories operated by DOH. DOH currently runs three such laboratories. Initially, DOH transported samples from suspected cases to the state laboratories. This is because a sample collected by any provider who reported a suspect case, wherever located (for example, county health departments, private health care practices, hospitals), is subject to high priority testing by a state laboratory. Currently, DOH transports COVID-19 test samples by commercial carrier. Private laboratories that are contracted to DOH may also have their own courier transport samples. The current capacity at the three laboratories is 9,000 tests per day, which was quickly exceeded during the recent testing surge in Broward County. This surge resulted from a decision of the Broward County Board of County Commissioners to fund additional testing by the Broward County Health Department, primarily for testing residents at all assisted living facilities in the County. The Broward County Board of County Commissioners provided all of the funding for this additional testing.

9. Although DOH uses federal grant funds to cover these costs, these tasks occupy the time of state personnel and state resources, and federal grants funds are finite.

10. Finally, the ETS creates the risk of a testing shortage. The largest testing day ever in Florida was approximately 196,000 people on January 29, 2021. For September 2021, the average number of individuals tested per day in Florida was approximately 106,000. The increased demand for testing created by the ETS will require the commercial laboratories that supply collection kits to increase production and their corresponding testing capacity. Because employers will not be required to pay for employee testing, DOH's state laboratories, state personnel and state resources will be further burdened by employees obtaining testing at DOH sites or county health departments. Moreover, if there is another testing surge unrelated to the requirements of the ETS, the increased demand for testing created by the ETS will cause an increase in the turn-around time for result reporting. An increase in testing demand will result in longer times between sample collection and results. This is because the time required to perform the test on each sample cannot be accelerated due to increased demand.

11. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct, to the best of my knowledge.

11-4-2021

Date

Patty Lewandowski
Bureau Chief, Bureau of Public Health Laboratories
Florida Department of Health

**UNITED STATES COURT OF APPEALS**
**FOR THE ELEVENTH CIRCUIT**

STATE OF FLORIDA, *et al.*,

*Petitioners,*

v. Case No. 21-13866-F

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, *et al.*,

*Respondents.*

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**DECLARATION OF STATE OF FLORIDA, DEPARTMENT OF CHILDREN AND FAMILIES**

I, Tony Lloyd, hereby declare:

**Background and Experience**

1. I make this declaration based on my personal and professional knowledge and experience, information available to me in my position in public service, and publicly available information.

2. I am the Assistant Secretary for Administration for the State of Florida, Department of Children and Families (DCF).

3. I have over 32 years of experience working in the public sector. This includes a decade as a city manager or assistant city manager in several Georgia cities. In Florida state Government, I have served as Budget Director at the Department of Revenue, CFO at the Department of Economic Opportunity, 7 years as Budget Chief in the Florida House of Representatives, and the last 2 years as Assistant Secretary at the Department of Children and Families.

4. DCF is the statewide agency that works in partnership with local communities to protect the vulnerable, promote strong and economically self-sufficient families, and advance personal and family recovery and resiliency. DCF provides a multitude of services to the public that include programs for child welfare, domestic violence

survivors and their families, human trafficking, substance abuse and mental health, and public benefits.

5. DCF's fiscal year begins on July 1 of each year and ends on June 30 of the following year. DCF is financed by Federal, State, and local funds.

**Economic Self Sufficiency**

6. DCF's Economic Self-Sufficiency Program helps to promote strong and economically self-sufficient communities by determining eligibility for food, cash, and medical assistance for individuals and families on the road to economic recovery. Assistance programs include food assistance, temporary cash assistance, and the Medicaid Program.

7. In the State fiscal year 2020–2021, the breakdown of the State and Federal contribution to the Medicaid, Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), and Homelessness programs were as follows:

| | **Admin** | **%** | **Benefits** | **%** |
|---|---|---|---|---|
| **Medicaid** | **$ 136,868,215** | | | |
| *State* | *$ 45,002,546* | *33%* | | |
| *Federal* | *$ 91,865,669* | *67%* | | |
| | | | | |
| **TANF** | **$ 195,955,426** | | **$ 97,354,893** | |
| *State* | *$ 5,572,064* | *3%* | *$ 79,371,900* | *82%* |
| *Federal* | *$ 190,383,362* | *97%* | *$ 17,982,993* | *18%* |
| | | | | |
| **SNAP** | **$ 178,846,995** | | | |
| *State* | *$ 86,779,136* | *49%* | | |
| *Federal* | *$ 92,067,859* | *51%* | | |
| | | | | |
| **Homelessness** | **$ 4,872,540** | | **$ 12,863,307** | |
| *State* | | | *$ 12,863,307* | *100%* |
| *Federal* | *$ 4,872,540* | *100%* | | |

8. The Occupational Safety and Health Administration Emergency Temporary Standard (ETS) that mandates either COVID-19 vaccination or weekly testing gravely affects businesses and employees in Florida. Assuming the ETS causes some employees to quit or lose their jobs, the ETS will directly impact the amount of State

money spent to both administer and provide benefits under DCF programs. Because these programs use gross household income to determine eligibility, even one household member becoming unemployed could cause an entire household to become eligible for benefits. Each additional eligible household imposes additional costs on the State, both in terms of the resources required to administer the program to more recipients and in terms of more payment of benefits.

9. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct, to the best of my knowledge.

11/4/2021
Date

T. B Lloyd
Tony Lloyd
Assistant Secretary for Administration
State of Florida, Department of Children and Families

**U.S. Department of Labor**

Occupational Safety and Health Administration
Washington, D.C. 20210

MAR 18 2020

The Honorable Robert C. "Bobby" Scott
Chairman
Committee on Education and Labor
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Scott:

The Department of Labor received your letter regarding the Occupational Safety and Health Administration's (OSHA) response to the recent outbreak of Coronavirus Disease 2019 (COVID-19), as well as OSHA's infectious disease rulemaking activity. The President and his administration are taking aggressive action to protect public health. As you know, the President signed a bipartisan spending bill making $8.3 billion in funding available to help fight COVID-19. He also has supported legislation passed by the House to, among other things, make medical testing more widely available and affordable and to support employee paid leave and unemployment insurance payments. And, on March 13, he issued the "Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease Outbreak." These actions are part of a far broader effort by a number of federal departments and agencies as the government works to monitor, contain, and mitigate the spread of the virus. OSHA takes the virus's potential risk to workers very seriously and is actively participating in the overall federal response to this emerging threat.

Presently, the U.S. Centers for Disease Control and Prevention (CDC) is recommending that healthcare workers follow standard and transmission-based infection control precautions for suspected cases of COVID-19. The CDC's interim guidelines are frequently updated and already include recommendations for worker protection that incorporate the lessons learned from prior outbreaks of pandemic influenza, severe acute respiratory syndrome, Middle East respiratory syndrome, and Ebola. For example, the interim recommendations already refer to OSHA's personal protective equipment (PPE) standards (29 CFR 1910 Subpart I), the Respiratory Protection standard (29 CFR 1910.134), and the General Duty clause (Section 5(a)(1) of the Occupational Safety and Health Act of 1970), as well as links to the OSHA respiratory protection training videos.

Moreover, OSHA has a number of existing enforcement tools it is using to help address worker protections for COVID-19. As noted, OSHA's PPE standards already address exposure issues of workers to require the use of gloves, eye, and face protection, as well as respiratory protection. The Bloodborne Pathogens standard applies to occupational exposure to human blood, certain body fluids, and other potentially infectious materials; and the provisions of the standard offer a framework that will control some transmission of the virus. And, the General Duty clause authorizes enforcement action in cases involving "recognized hazards that are causing or are likely to cause death or serious physical harm"—which could include improper exposure to

COVID-19. OSHA can and will use enforcement, as necessary, to ensure the protection of workers exposed to COVID-19.

OSHA is also working proactively to assist employers seeking information to protect workers from illness. The agency recently issued a guidance document, "Guidance on Preparing Workplaces for COVID-19," which details steps employers can take to reduce workers' risk of exposure. OSHA also recently created a Coronavirus Safety and Health Topics page on its website at http://www.osha.gov/SLTC/ to help assure the safety and health of America's workers. OSHA will continue to update this website as new information becomes available.

And, following President Donald J. Trump's March 11, 2020 memorandum on the availability of respirators during the COVID-19 outbreak, OSHA issued new temporary guidance aimed at ensuring healthcare workers have full access to needed N95 respiratory protection in light of anticipated shortages.

In your letter, you inquired about OSHA's regulatory activity with respect to an infectious disease standard. OSHA believes that the healthcare industry fully understands the gravity of the situation and is taking the appropriate steps to protect its workers while responding to the public health emergency. The CDC guidelines, for instance, are universally distributed, and public awareness of COVID-19 is high. We believe that working on a formal rulemaking at the same time that the healthcare industry is responding to the COVID-19 public health emergency is counterproductive to both the public health response and robust stakeholder engagement. For example, the efforts employers would take to document compliance with such a standard would distract them from other vital response activities. OSHA can best meet the needs of America's workers by being able to rapidly respond in a flexible environment.

We note that OSHA is able to issue an Emergency Temporary Standard (ETS) when there is a minimum level of workplace safety practice that is necessary to protect workers, but is not being followed by employers. For the reasons identified above, however, we currently see no additional benefit from an ETS in the current circumstances relating to COVID-19. OSHA is continuing to monitor this quickly evolving situation and will take the appropriate steps to protect workers from COVID-19 in coordination with the overall U.S. government response effort.

Thank you for your shared commitment to occupational safety and health. For further assistance, please contact the Office of Congressional and Intergovernmental Affairs at (202) 693-4600.

Sincerely,

Loren Sweatt
Principal Deputy Assistant Secretary

**UNITED STATES COURT OF APPEALS**
**FOR THE ELEVENTH CIRCUIT**

STATE OF FLORIDA, *et al.*,

*Petitioners,*

v. Case No. 21-13866-F

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, *et al.*,

*Respondents.*

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**DECLARATION OF RANDAL L. MARTIN**

I, Randal L. Martin, swear or affirm as follows:

1. I am over the age of 21 years of age and competent to testify to the matters attested herein.

2. I am the President of The King's Academy and have held this position since June 2016.

**The Mission of The King's Academy**

3. The King's Academy is a private, non-profit, college-preparatory, Christian school. We offer education for students at Pre-K–12 level, and we are located in West Palm Beach, Florida.

4. The King's Academy was established in 1970 by a group of businesspeople who saw the need for a centrally located interdenominational Christian school to serve Palm Beach County. The first student body at The King's Academy consisted of 196 students. Today, more than 3,700 alumni have earned their diplomas from The King's Academy.

5. The King's Academy is dedicated to Jesus Christ, the King of kings and Lord of lords. Christian faith—as stated in our Statement of Faith—informs everything we do.

6. Our mission is to assist the home and church in their endeavor to "train up a child in the way he should go" (Proverbs 22:6), to share salvation through Jesus Christ, and to graduate Christian leaders who seek to impact their world for the King of kings through academic excellence and spiritual vitality.

7. The King's Academy seeks to faithfully provide its students with a distinctively Christian, world-class education. We employ highly qualified Christian teachers and administrators who will faithfully set a godly example as they build Christian character,

scholarship, patriotism, and a strong work ethic in our students. We believe that these attributes are all instrumental to serving Christ.

8. At The King's Academy, we believe that teachers are "living curriculum" for our students. In addition to teaching their subjects excellently, they are all fervent Christians, prayerful servant leaders, and encouragers. Our ultimate desire is to develop lifelong disciples of Christ.

9. For these reasons, we cannot carry out our religious and educational mission without our committed teachers who are strong Christians. They play a key, irreplaceable role.

10. To be sure, our school invests heavily in our teachers to make them more excellent—including investing in their advanced degrees and professional experiences, promoting diversity, and cultivating meaningful relationships among colleagues. However, our primary focus remains for faculty to emphasize leading students to Christ.

11. Our school also cannot function and fulfill its religious mission without the Christian staff who also play key roles. Critically, we believe that the example set by all of our employees—faculty and staff—should be one that is commensurate with representing Christ and His redeeming work in our lives as ministers of the Gospel.

12. The King's Academy currently hires 265 employees. This includes 127 teachers, 12 administrative staff, and 126 support staff.

**The King's Academy's Stance on Vaccination**

13. The COVID-19 outbreak has changed The King's Academy significantly. We have added thorough health and safety protocols, which included personnel training, temperature checks, availability of online learning, requirements for when to wear face masks, and social distancing. Keeping everyone safe and healthy is our priority.

14. The King's Academy does not oppose the currently available brands of COVID-19 vaccination.

15. As faithful Christians, we believe that science, medicine, and all other blessings come from God. This includes the development of the COVID-19 vaccines.

16. But we also believe that Christian individuals may reach different conclusions about whether to receive the vaccines based on their conscience.

17. The Bible teaches us that we should follow our conscience and that we should respect others' conscience (1 Corinthians 10:28–31).

18. And it is our sincerely held religious belief that it is sinful to directly act against our conscience (Romans 14:23).

19. It is our sincerely held religious belief that the conscience of a faithful Christian may lead him or her to refrain from receiving the COVID-19 vaccine.

20. For example, like the Christian Church has done since earliest times, The King's Academy affirms and believes that abortion is a sin that should be avoided. I understand that some Christians may have religious objections to COVID-19 vaccines because their development or testing involved the use of abortion-derived fetal cells. Because of that, some faithful Christians may refrain from the currently available vaccines.

21. On the other hand, other Christians may also—in good conscience—choose to receive the vaccines. Many Christian theologians have explained that the connection between abortions and vaccines is remote and so is the moral culpability for receiving the vaccines.

22. All that is to say, The King's Academy believes that God has given us science and vaccines. But it is also our sincerely held religious belief that Christians can disagree about vaccination according to the dictates of his or her conscience and religious belief.

**The Impact of OSHA's Unlawful Vaccine Mandate**

23. The King's Academy hires more than 100 full-time and in-person employees.

24. It is my understanding that The King's Academy falls within the reach of Occupational Safety and Health Administration ("OSHA")'s recently issued Emergency Temporary Standard ("ETS").

25. It is also my understanding that The King's Academy will be required to enforce the ETS on our own employees under threat of severe penalties.

26. I believe that this mandate will cause irreparable harm for us.

27. Based on current information, The King's Academy has employees who are unvaccinated for a variety of reasons, including religious objections. Based on current information, we estimate that the majority of our employees have not been vaccinated.

28. We believe that our employees should have the freedom to decide, consistent with their conscience and Christian belief, whether they would receive a COVID-19 vaccination.

29. We would not issue a vaccine mandate with or without the ETS because of our religious belief regarding conscience.

30. We would either have to bear the testing costs ourselves or pass them onto our employees. Both options substantially burden our religious mission and our faith. If we bear the testing costs, the costs will be significant—estimated to be more than a thousand dollars per unvaccinated employee per year—and diverted from our resources that would otherwise go toward providing Christian education. If we pass the costs to our employees, this will interfere with our ability to attract great faculty and staff who are needed to carry out our religious education mission. This cost burden will certainly burden some of the employees' religious and conscientious decisions to

remain unvaccinated. That would be contrary to our own Christian belief regarding conscience. And we may need to reimburse those employees for testing costs.

31. Regardless of who bears the cost of testing, the testing requirement will substantially burden us.

32. We also anticipate that our employees will be forced to devote a significant amount of time and effort to comply with the weekly testing and masking requirements.

33. It could take our employees hours to get a simple COVID-19 test.

34. OSHA's regulatory requirements mandate us to keep records to demonstrate compliance with OSHA's regulations and standards, including the ETS. This means that our administrative and school staff will need to devote precious time, personnel, and resources to collect, verify, and record vaccination and/or testing information. Because such information will contain our employees' HIPAA-protected health information, such an endeavor will involve an implementation of careful policies and training. We estimate this record-keeping requirement to cost us additional resources, but we cannot accurately quantify the value of lost employee time.

35. The King's Academy's mission of providing Christian education will be hindered by the loss of employee time and diversion of the school's resources to implement the requirements of the ETS.

36. OSHA's threat of punitive fines may result in removing from premises or firing employees who do not submit to the mandates of the ETS.

37. Again, we hire our teachers and staff to model Christian virtues to our students. They are not fungible products; they are top-quality employees who are also strong Christians whom we carefully select and invest in.

38. OSHA will hamper and harm our ability to recruit and retain teachers of Christian faith. Without good teachers and staff who are faithful to the Bible and our Christian mission, we cannot carry out our mission and live out our faith. The ETS places a significant burden on our ability to hire good Christian teachers just because they have chosen to remain unvaccinated for a variety of reasons. In other words, the ETS will hamper The King's Academy's exercise of religion and religious mission of providing Christian education.

39. We believe that, as a religious institution, we should have autonomy in hiring faculty and staff who are Christian.

Pursuant to 28 U.S.C. § 1746, I declare that the foregoing is true and correct.

Executed on November 5, 2021

Randal L. Martin

**U.S. Department of Labor**

Office of the Assistant Secretary
For Occupational Safety and Health
Washington, D.C. 20210

May 29, 2020

Richard L. Trumka
President, AFL-CIO
815 16th St. NW
Washington, D.C. 20210

Dear President Trumka:

This letter is in response to your correspondence, dated March 6, 2020, in which the American Federation of Labor and Congress of Industrial Organizations (AFL-CIO), on behalf of several labor organizations, petitioned the Occupational Safety and Health Administration (OSHA) to promulgate an emergency temporary standard (ETS) to protect working people from occupational exposure to infectious diseases, including coronavirus disease 2019 (COVID-19).

As an initial matter, I appreciate you sharing your suggestions regarding OSHA's response to the COVID-19 pandemic. Ensuring worker safety and health during this unprecedented crisis remains the agency's top priority, and we value your feedback regarding OSHA's efforts to-date. I share your concern for the health and safety of America's workers during this challenging time, and mourn the workers we have lost to COVID-19.

That said, after thorough review and consideration of your petition, as well as your post-petition correspondence,[1] OSHA has decided to deny your petition for an ETS for infectious diseases. At this juncture, OSHA has determined that it lacks compelling evidence to find that an undefined category of infectious diseases generally pose a grave danger for which an ETS would be an appropriate remedy, and even if it did, it would not be necessary for OSHA to issue an ETS to protect workers from infectious diseases.

Although not specifically requested in your petition, OSHA also has also determined that it is not necessary to issue an ETS to specifically protect workers from COVID-19, which can result from exposure to the novel severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). OSHA has concluded that its provision of guidance and enforcement of employers' existing legal obligations under the Occupational Safety and Health Act (OSH

[1] This includes your post-petition letters to Secretary Scalia, dated April 28, 2020 ("April 28 Letter") and May 7, 2020 ("May 7 Letter").

Act), in combination with COVID-19-related requirements and guidelines by other entities, renders an ETS unnecessary.

Moreover, given that the SARS-CoV-2 virus is a novel infectious pathogen that poses danger inside and outside of the workplace, and is the subject of a constantly-evolving multi-agency response, it would be counter-productive for OSHA to attempt to fashion a SARS-CoV-2 exposure standard at this juncture. OSHA has determined that the best approach for responding to the pandemic is to enforce the existing OSH Act requirements that address infectious disease hazards, while also issuing detailed, industry-specific guidance that can be quickly amended and adjusted as its understanding of the virus grows. This approach is more effective than promulgating a rigid set of requirements for all employers in all industries based on limited information, and best utilizes OSHA resources.

**Background**

Section 6(c) of the OSH Act authorizes OSHA to issue an ETS only if the Secretary of Labor determines (1) that employees are exposed to a grave danger from exposure to substances or agents determined to be toxic or physically harmful, and (2) that issuance of an ETS is necessary to protect employees from that danger. An ETS is promulgated without the benefit of notice and comment, and becomes effective immediately upon publication in the Federal Register. As such, ETSs have been referred to as the "most dramatic weapon in [OSHA's] arsenal." *Asbestos Info. Ass'n/N. Am. v. Occupational Safety & Health Admin.*, 727 F.2d 415, 426 (5th Cir. 1984). Once an ETS is published, section 6(c) requires OSHA to commence a rulemaking proceeding under its regular rulemaking procedures and issue a permanent standard to replace the ETS within six months of the ETS' publication.

To find that a "grave danger" exists, OSHA must have compelling evidence of a serious health impairment involving incurable, permanent, or fatal consequences. *See Fla. Peach Growers Ass'n Inc. v. U.S. Dept. of Labor*, 489 F.2d 120, 132 (11th Cir. 1974). A "grave danger" poses a degree of risk that is higher than the "significant risk" that is required to promulgate a permanent safety and health standard under Section 6(b) of the OSH Act. *Compare Indus. Union Dep't, AFL-CIO v. Am. Petroleum Inst.*, 448 U.S. 607, 640 (1980) (permanent standard) to *Dry Color Mfrs. Ass'n. v. Dept. of Labor*, 486 F.2d 98, 104-105 (ETS). To find that an ETS is "necessary" to address a grave danger specific to the workplace, OSHA must be able to show that the ETS would substantially reduce the grave danger during the time the ETS would be in effect, and that such a reduction could not be obtained by enforcing existing OSH Act requirements or widespread voluntary efforts to address the hazard. *See Asbestos Info.*, 727 F.2d at 422, 426; *Pub. Citizen Health Research Grp. v. Auchter*, 702 F.2d 1150 (D.C. Cir. 1983) (per curiam)

Accordingly, to issue the ETS that you request in your petition, OSHA would need compelling evidence that all infectious diseases collectively pose a grave danger to workers, and that enforcement of existing OSHA requirements and/or widespread voluntary efforts would not substantially reduce that danger. As discussed below, OSHA lacks sufficient evidence to find that infectious diseases generally pose a grave danger to

worker safety, and even if they did, an ETS would not be necessary because enforcement of existing OSH Act requirements can substantially reduce hazards related to infectious diseases.

Additionally, although such an ETS was not specifically requested in your petition, OSHA has also determined that it is not necessary to issue an ETS addressing the specific danger of COVID-19. Employers are already obligated under the OSH Act to protect workers from exposure to infectious disease agents, including the SARS-CoV-2 virus. Doubtless, all across the country, many employers are making good faith efforts to comply with the OSH Act's requirements, as well as with the myriad guidance on controlling exposure to the SARS-CoV-2 virus that has been issued by OSHA, other federal agencies including the Centers for Disease Control and Prevention (CDC), and industry associations, and with the requirements and guidance from State and local officials. OSHA's enforcement of its applicable mandatory standards, combined with the regulated community's compliance with existing requirements and non-mandatory guidelines for limiting exposure to the SARS-CoV-2 virus, renders an ETS unnecessary.

Furthermore, OSHA has determined that, as a policy matter, attempting to issue an ETS to regulate workplace exposure to COVID-19 would not just be inappropriate, but potentially damaging to the pandemic response effort: Rather than attempting to construct a standard based on today's evolving understanding of the virus and workplace exposure realities, OSHA's time and resources are better spent enforcing the OSH Act and issuing industry-specific guidance to help employers protect workers from COVID-19 based on the best information that is currently available.

**An ETS is Not Necessary to Generally Protect Employees from Infectious Diseases.**

Though much of your petition discusses the specific danger of COVID-19, the remedy that your petition requests is "an Emergency Temporary Standard to protect working people from occupational exposure to infectious diseases, including COVID-19." Petition ("Pet."), p. 1; *see also* Pet., p. 12. Your petition argues that "[w]hile COVID-19 is the most recent global health threat, infectious disease outbreaks and other biological threats will continue to occur," and therefore OSHA should issue an ETS that "comprehensively addresses an employer's responsibility to protect workers from infectious diseases," including "future infectious agents." *Id.* at 6. You state that the scope of the ETS should be "comprehensive," and that the ETS "should apply to all workers who perform essential functions and are at an elevated risk of occupational exposure to coronavirus," as well as to "workers with close contact to potential zoonotic sources of infection." *Id.* at 9.

OSHA lacks evidence to conclude that all infectious diseases to which employees may be exposed at a workplace constitute a "grave danger" for which an ETS is an appropriate remedy. Your petition does not explain how infectious diseases as a group pose a grave and urgent threat to workers, let alone provide compelling evidence that those diseases pose a grave danger to worker health. Section 6(c) does not authorize OSHA to issue broad-sweeping health standards to address entire classes of known and unknown substances and agents; rather, it provides extremely limited authority to immediately issue

a standard if it is necessary to address *specific* substances or agents that are proven to pose a grave danger to workers. *See Fla. Peach Growers*, 489 F.2d at 120, 129-30, 132 (11th Cir. 1974) (an ETS may be issued "only in those emergency situations which require it" to remedy a specific danger with "incurable, permanent, or fatal consequences"); *Dry Color Mfrs.*, 486 F.2d at 104-05 (evidence showing that a particular agent has the potential to cause harm is insufficient to support an ETS). Your petition does not support that such action is necessary.

Moreover, the OSH Act already requires employers to address hazards related to infectious disease exposure at the workplace. As you acknowledge in your petition, *see* Pet., p. 8, several existing OSHA standards play a role in protecting workers from infectious diseases at the workplace, including OSHA's personal protective equipment standard (§ 1910.132), respiratory protection standard (§ 1910.134), sanitation standard (§ 1910.141), and bloodborne pathogens standard (§ 1910.1030). Additional protection is provided by the OSH Act's general duty clause, which requires employers to furnish their employees with a workplace that is "free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees." To clarify how employers can fulfill their obligation to protect their employees from infectious diseases at the workplace, OSHA has published numerous guidance materials,[2] including (as discussed below) extensive specific guidance on how employers can protect employees from COVID-19.

You do not dispute in your petition that OSHA standards and the general duty clause currently protect against infectious disease hazards, but instead contend that those requirements are "not enough," and that only a comprehensive infectious disease standard can effectively control workplace exposure to infectious diseases. *See* Pet. at 8-9. However, the Act does not authorize the issuance of an ETS merely to supplement an existing regulatory scheme. Rather, OSHA must be able to show that existing protections are wholly inadequate, leaving an ETS as the only means of substantially reducing the grave danger. The mandatory OSHA standards outlined above in conjunction with industry-specific guidance can substantially reduce the general threat that infectious diseases pose to worker health. Accordingly, OSHA cannot find that an ETS is necessary, even setting aside the lack of evidence indicating that infectious diseases categorically pose a grave danger to workers.

**An ETS is Not Necessary to Protect Employees from the Specific Danger Posed By COVID-19.**

As discussed above, your March 6, 2020 petition requests an ETS to comprehensively address the danger posed by *all* infectious diseases, both known and unknown. However, your post-petition correspondence suggests that you may also seek an ETS to specifically address the danger posed by COVID-19. *See* April 28 Letter, pp. 5-6; May 7 Letter, p. 2. OSHA has determined that issuing an ETS to specifically protect employees from COVID-19 is not necessary. Putting aside whether COVID-19 qualifies as a "grave danger" under section 6(c), issuing an ETS is not necessary. Enforcement of existing OSH Act

[2] *See, e.g.*, OSHA's Hospital Respiratory Protection Program Tool Kit (May 2015), available at: https://www.osha.gov/Publications/OSHA3767.pdf.

requirements, paired with OSHA's publication of extensive COVID-19 guidance, can substantially reduce the hazard of COVID-19, and provides a superior method for responding to the challenges posed by a novel infectious agent than the issuance of an ETS. Moreover, attempting to permanently address workplace exposure to SARS-CoV-2 based on the evolving information that is currently available to the agency could have counterproductive consequences, and would deprive the agency of the flexibility that it needs to respond to new information during the current pandemic.

Within the workplace, the OSH Act requires employers to take action to protect employees from hazards associated with exposure to infectious disease agents. Several OSHA standards are particularly relevant to preventing exposure to the SARS-CoV-2 virus at the workplace:[3]

- *Respiratory Protection Standard* (§ 1910.134): OSHA's respiratory protection standard requires the use of respirators whenever it is necessary to protect the health of an employee. The standard requires employers to assess whether respiratory protection is necessary whenever there is potential for employees to be overexposed to atmospheric contamination, and if respiratory protection is necessary, the employer must implement a comprehensive respiratory protection program. Respiratory protection is required under this standard whenever airborne biological agents pose a hazard to employees. *See* Respiratory Protection Final Rule, 63 Fed. Reg. 1152, 1180 (Jan 8. 1998).

- *Personal Protective Equipment Standard* (§ 1910.132): OSHA's general PPE standard imposes a number of obligations on employers to ensure that workers have and use necessary protective equipment to keep them safe from workplace hazards, including infectious disease agents. The standard requires employers to: conduct an assessment of the hazards employees are likely to be exposed to; select appropriate PPE based on the assessment; provide the PPE at no cost to employees; train employees; and assure that employees have understood the training. Employers must consider the use of a wide variety of PPE, including "for eyes, face, head, and extremities, protective clothing, respiratory devices, and protective shields and barriers." § 1910.132(a). Application of OSHA's PPE standard, 29 C.F.R. § 1910.132(a)-(h), to COVID-19 is consistent with how the agency has historically treated the standard.[4]

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[3] A more comprehensive listing of pertinent OSHA standards is available at: https://www.osha.gov/SLTC/covid-19/standards.html.

[4] *See, e.g.,* Letter of Interpretation (LOI) to Vivian Erickson (Jan. 19, 2010), available at: https://www.osha.gov/laws-regs/standardinterpretations/2010-01-19 (noting 1910.132 "would apply where [PPE] is deemed necessary to protect workers from infectious diseases" not covered elsewhere); LOI to Allen Cooper (Aug. 7. 2007), https://www.osha.gov/laws-regs/standardinterpretations/2007-08-07 (noting 1910.132 requires employers to "provide adequate measures to protect employees who may be exposed to potentially hazardous agents, including infectious materials"); OSHA

- *Sanitation Standard* (§ 1910.141): OSHA's sanitation standard provides hygiene requirements that, directly and indirectly, address the potential for infectious disease agents to spread at the workplace. Specifically, the sanitation standard requires that employers: keep workplaces clean to the extent possible; provide potable water of sufficient quality for personal washing and drinking; provide sufficient toilet and washing facilities, to include hot and cold or tepid running water, hand soap or a similar cleansing agent, and adequate means of hand-drying; provide showers where applicable, with adequate body soap, hot and cold water, and clean towels; and provide change rooms where necessary for removal of contaminated protective clothing. § 1910.141(a)–(e).

Additionally, OSHA's general duty clause requires employers to furnish their employees with a workplace that is "free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees." There can be no dispute that COVID-19 is a recognized hazard. Indeed, the entire American public is acutely aware of the threat, and our day-to-day lives have been uprooted as the nation works together to reduce the disease's spread.

To assist employers' efforts to fulfill their duty of protecting workers from exposure to the SARS-CoV-2 virus, OSHA has published numerous guidance documents, often in conjunction with the CDC. Over the past few months, OSHA has developed—both independently and in conjunction with several federal partners[5]—a broad arsenal of

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Instruction CPL 02-01-050, Enforcement Guidance for Personal Protective Equipment in General Industry ("PPE Directive") at 30 (Feb. 10, 2011), https://www.osha.gov/OshDoc/Directive_pdf/CPL_02-01-050.pdf (listing as examples of PPE required to be provided by employer "[i]tems used in medical/laboratory settings to protect from exposure to infectious agents (aprons, lab coats, goggles, disposable gloves, shoe covers, etc.)"); *Peter Cooper Corp.*, 10 BNA OSHC 1203, 1204 n.4, 1211 (No. 76–596, 1981) (affirming 1910.132(a) citation for failure to provide necessary protective clothing and respirators to employees exposed to infectious disease anthrax); Am. Dental Ctrs., 14 BNA OSHC 1710, 1990 WL 118162, at *1–3 (Nos. 89–1369 & –1857, 1990) (ALJ) (affirming application of 1910.132(a) to employer's failure to provide safety goggles with masks or face shields against potential exposure to saliva containing infectious diseases).

[5] At the federal level, OSHA has worked closely with a plethora of federal agencies, specifically: the Department of Health and Human Services (including CDC; NIOSH; the Centers for Medicare and Medicaid Services; and the Food and Drug Administration); the Department of Transportation (including the Federal Transit Administration; Federal Aviation Administration; and Pipeline and Hazardous Materials Safety Administration); the Department of Agriculture (including the Food Safety and Inspection Service); the Department of Homeland Security (including the Federal Emergency Management Agency); the Environmental Protection Agency; and the Departments of Justice,

guidance documents, alerts, enforcement memoranda, news releases, posters, and videos addressing COVID-19–related health and safety issues.[6] For example:

- On March 9, 2020, OSHA issued initial and comprehensive "Guidance on Preparing Workplaces for COVID-19," which advised employers in every industry on the importance of taking immediate action to prepare their workplace for the impact of COVID-19, including outlining steps that all employers should take to reduce workers' exposure to the coronavirus. OSHA Publication No. 3990-03-2020 (available at: https://www.osha.gov/Publications/OSHA3990.pdf)

- More recently, OSHA issued comprehensive joint interim guidance with the CDC specifically tailored to the Meat and Poultry Processing Workers and Employers, issued on April 26, 2020; and Manufacturing Workers and Employers, issued on May 12, 2020. *See* https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/meat-poultry-processing-workers-employers.html; https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-manufacturing-workers-employers.html

- OSHA has also issued a series of industry-specific alerts that provide targeted guidance on practices and procedures that will help protect workers' health and safety in numerous specific industries, including retail, package delivery, manufacturing, construction, restaurants, dentistry, rideshare and taxi service, retail pharmacies, and nursing home and long term care facilities. *See* https://www.osha.gov/SLTC/covid-19/news_updates.html.

Not only does this abundant, industry-specific guidance regarding COVID-19 guide employers' efforts to comply with the OSH Act, but also—as you noted in your April 28 letter, p. 6—such guidance documents can support enforcement actions taken under the general duty clause.

Of course, SARS-CoV-2 is not uniquely a workplace hazard, and a vast range of federal, state, and local authorities have, simultaneous with OSHA's efforts, been issuing an array of guidelines and directives to protect workers from coronavirus. Each of the fifty states has issued at least some orders and guidance on COVID, many of which speak—often in mandatory ways—on the issues which your petition suggests OSHA should address.[7]

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Commerce, State, and Defense. OSHA has kept in near-constant contact with OSHA state plans in states that have established them.

[6] All of OSHA's guidance materials pertaining to COVID-19 can be found on the agency's COVID-19 webpage, https://www.osha.gov/SLTC/covid-19/index.html.

[7] The State of Georgia, for example, has promulgated detailed requirements specific to a wide variety of businesses, including restaurants; tattoo parlors, estheticians, massage therapists, tanning salons, and hair salons; movie theaters; bowling alleys; ambulatory surgical centers; childcare facilities; and summer camps. Ga. Exec. Order, Reviving a

Cities such as New York, Los Angeles, San Francisco, and Chicago have provided detailed requirements and recommendations for employers as well. Private industry has also taken efforts to protect workers, and have leveraged their expertise to offer industry-specific guidance.[8] OSHA, and the Department as a whole, has closely monitored state and local government orders and guidance related to coronavirus, as well as guidance developed by private industry. When combined with OSHA's diligent enforcement of existing OSH Act requirements related to infectious disease exposure at the workplace, the regulated community's widespread compliance with COVID-19-related safety guidelines and directives further evinces that an ETS is unnecessary.

Furthermore, OSHA, within its discretion, has determined that this two-pronged approach—*i.e.*, enforcing existing OSH Act requirements related to infectious disease hazards, while also continuing to publish detailed and industry-specific guidance to employers on COVID-19—is the best method for ensuring that workers are protected from COVID-19. As you note in your petition, there are many "unknowns" regarding the novel SARS-CoV-2 virus, Pet., p. 10, and given that the world's understanding of the virus is evolving on a daily basis, OSHA's ability to quickly amend and supplement its guidance to employers and workers is paramount. For example, when your petition was first received, known symptoms of COVID-19 were limited to fever, cough, or shortness of breath, and the CDC was advising that general members of the public not wear masks; now, the list of symptoms has grown to encompass chills, muscle pain, sore throat, loss of taste or smell, and more, and the CDC recommends wearing cloth face coverings in all

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Healthy Georgia (May 12, 2020), available at: https://gov.georgia.gov/document/2020-executive-order/05122002/download. The State of Texas has issued no fewer than sixty checklists containing a mixture of required and minimum recommended measures to mitigate coronavirus transmission and covering everything from manufacturers and retailers to museums, wedding venues, and rodeos. Governor's Strike Force to Open Texas, Office of the Texas Governor, available at: https://gov.texas.gov/organization/opentexas (last visited May 27, 2020). Other states have enacted similar protections on an emergency basis.

[8] For example, the International Franchise Association has established uniform guidelines for fitness centers, restaurants, and hotels, among other industries. Int'l Franchise Ass'n, Franchise Reopening Blueprint, May 2020, available at: https://community.franchise.org/sites/default/files/2020-05/franchise-reopening-blueprint_05082020_0.pdf. Additionally, Target has published its approach to retail operations during the pandemic for others to consider using or adapting, suggesting policies and mitigation measures, checklists, and sample posters in English and Spanish. Target Corp., SAFE Retail, May 1, 2020, https://corporate.target.com/_media/TargetCorp/about/pdf/Target_SAFE_Retail_Considerations-for-Retail-Operations-Post-COVID-19.pdf. Similarly, Kroger has offered a "blueprint for businesses." Kroger Co., Sharing What We've Learned: A Blueprint for Businesses, May 13, 2020, available at: https://www.thekrogerco.com/wp-content/uploads/2020/04/Krogers-Blueprint-for-Businesses.pdf.

public settings. *See* CDC Coronavirus Disease 2019 (COVID-19) Topic Page, Symptoms of Coronavirus, available at: https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html; Use of Cloth Face Coverings to Help Slow the Spread of COVID-19, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/diy-cloth-face-coverings.html. *See also* Jacey Fortin, *Surfaces Are 'Not the Main Way' Coronavirus Spreads, C.D.C. Says*, New York Times (May 22, 2020), available at: https://www.nytimes.com/2020/05/22/health/cdc-coronavirus-touching-surfaces.html (reporting that "[e]xperts at the C.D.C. and elsewhere are still learning about the new coronavirus"). Unlike an ETS—which would necessarily be based on today's limited understanding of the SARS-CoV-2 virus, and would be onerous to modify once promulgated[9]—OSHA's two-pronged approach allows the agency to tailor guidance to specific industries and work settings, and gives the agency the flexibility to quickly adjust its guidance as necessary. Given that we learn more about COVID-19 every day, setting rules in stone through an ETS (and later a permanent rule) may undermine worker protection by permanently mandating precautions that later prove to be inefficacious.

Moreover, as a practical matter, an ETS is a poorly-suited approach for protecting workers against SARS-CoV-2 because no standard that covers all of the Nation's workers would protect all of those workers equally. Hastily manufacturing an exposure standard that would cover all workers (as you request) would be ineffectual, as the appropriate protections for protecting workers from infectious diseases vary widely from industry-to-industry. *See* OSHA, Infectious Diseases SER Background Document ("SER Backgrounder") 29-30, osha.gov/dsg/id/OSHA-2010-0003-0239.pdf (discussing how even within healthcare industry, while "best practices" may be similar, numerous factors affect assessment of most appropriate protections in a given workplace). Further complicating such an endeavor, adequate safeguards for workers could differ substantially based on their geographic location, as the pandemic has had dramatically different impacts on different parts of the country. Unlike an ETS, OSHA's strategy for responding to the pandemic allows the agency to offer tailored guidance that takes into account the realities of specific industry settings and locations.

In your petition, you claim that OSHA's guidelines regarding COVID-19 (including those jointly published with the CDC) are "largely voluntary," and that absent a comprehensive ETS, employers have "the discretion to implement, ignore, or selectively follow the guidelines issued by the agencies." Pet., p. 6; *see also* April 28 Letter, p. 3 (arguing that OSHA and the CDC's joint meat and poultry processing guidelines are insufficient because they are "only voluntary guidelines, and according to the agencies, impose no obligations on employers to comply"). Your argument overlooks the existing legal authorities, discussed above, that require employers to take action to protect employees from infectious diseases, including COVID-19. Furthermore, you recognize that such guidelines can

[9] An ETS once issued could very well become ineffective or counterproductive, as it may be informed by incomplete or ultimately inaccurate information. Even worse, under the statute the ETS would lead to a permanent final rule within six months of its promulgation, see 29 U.S.C. § 655(c)(3), an extraordinarily rapid pace for OSHA rulemaking. Faulty requirements ensconced in the final rule would be changeable only through additional, laborious notice-and-comment rulemaking, further sapping agency resources.

support an action under the OSH Act's general duty clause. *See* April 28 Letter, p. 6; May 7 Letter, p. 2. Enforcement of existing OSH Act requirements, paired with OSHA's publication of extensive COVID-19 guidance, can substantially reduce the hazard of COVID-19, and provides a superior method for responding to the challenges posed by a novel infectious agent than the issuance of an ETS.

Your post-petition correspondence also contests whether OSHA is, in fact enforcing the existing OSH Act requirements related to infectious disease exposure. April 28 Letter, p. 5; May 7 Letter, p. 2. Let me assure you that OSHA is taking appropriate enforcement action. The pandemic continues to receive OSHA's unflinching attention. Throughout the pandemic, OSHA has used its existing arsenal of enforcement tools to compel employers to protect their workers from COVID-19. To date, OSHA has initiated thousands of investigations of complaints related to COVID-19, opened hundreds of inspections, and repeatedly emphasized the rights of workers to report, without retaliation, unsafe and unhealthful working conditions. Many investigations have closed after OSHA received adequate assurances from employers that workers were being appropriately protected. In other cases, investigations and inspections are still open and could result in citations either under the general duty clause or under one of the mandatory standards discussed above. OSHA's investigatory process is resource-intensive and time consuming, sometimes taking six months to complete. Accordingly, OSHA's issuance of only one citation thus far for COVID-19 related violations resulting from OSHA's enforcement efforts to date is not surprising. It would be no different under an ETS.

Finally, your April 28 letter criticizes various OSHA policy actions taken in response to the pandemic, including OSHA's April 3, 2020 enforcement memorandum regarding "Enforcement Guidance for Respiratory Protection and the N95 Shortage Due to the Coronavirus Disease 2019 (COVID-19) Pandemic," April 10, 2020 memorandum on Enforcement Guidance for Recording Cases of Coronavirus Disease 2019 (COVID-19), and April 13, 2020 Interim Enforcement Response Plan for Coronavirus Disease 2019 (COVID-19).[10] *See* April 28 Letter, pp. 3-5. Your April 28 letter also provides various suggestions on policy actions that OSHA should take to better respond to the pandemic, including issuing "an interim final rule that requires all employers to maintain a COVID-19 log of all worker infections and deaths from COVID-19," *Id. at* p. 3, conducting "off-site investigations to fully enforce the law, including the issuance of citations for violations, as a supplement to onsite inspections," *Id.* p. 7, and "launch[ing] a major training and education initiative to protect workers from COVID-19." *Id.* at p. 10. While we appreciate your feedback and constructive suggestions, these matters of policy are within OSHA's discretion and do not affect the agency's determination that its existing legal authorities, buttressed by the extensive and specific guidance that OSHA has published regarding COVID-19, render it unnecessary to issue an ETS for COVID-19.

[10] OSHA updated this guidance on May 19, 2020 by issuing an Updated Interim Enforcement Response Plan (Updated Enforcement Plan), which became effective on May 26, 2020. *See* https://www.osha.gov/memos/2020-05-19/updated-interim-enforcement-response-plan-coronavirus-disease-2019-covid-19.

OSHA appreciates your interest in occupational safety and health, and the passion with which you seek to protect workers from the SARS-CoV-2 virus.

Sincerely,

Loren Sweatt
Principal Deputy Assistant Secretary

**UNITED STATES COURT OF APPEALS**
**FOR THE ELEVENTH CIRCUIT**

STATE OF FLORIDA, *et al.*,

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*Respondents.*

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## DECLARATION OF RUSSELL R. McMURRY

I, Russell R McMurry, hereby attest:

1. I make this declaration based on my own personal and professional knowledge and experience, information available to me in my position in public service, and publicly available information.

2. I currently serve as Commissioner of the Georgia Department of Transportation (GDOT). In that role, I am the Commissioner for GDOT and I am a professional engineer registered in accordance with Chapter 15 of Title 43 and I am experienced in highway engineering.

3. I am aware of the Occupational Safety and Health Administration's Emergency Temporary Standard (ETS) mandating that all non-government employers with 100 or more employees require their workforce be fully vaccinated against COVID-19 or submit to weekly testing.

4. The Georgia Department of Transportation plans, designs, constructs, maintains, and improves the State's roads, bridges, and interstate highways. The agency also provides planning and financial support for other modes of transportation including rail, transit, general aviation, and bicycle and pedestrian programs.

5. In order to carry out this responsibility, the department relies on and contracts with private contractors to assist with this responsibility. Many of GDOT's contractors have over 100 employees and would thus be subject to the OSHA Mandate.

6. If these contractors experienced significant staffing shortages or other business interruptions due to the mandate, it could cause delays to the completion of existing GDOT projects or could result in increased prices for new projects.

7. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing opinion is true and correct.

11/08/2021
Date

Russell R. McMurry
Russell R. McMurry, P.E.
Commissioner

**UNITED STATES COURT OF APPEALS**
**FOR THE ELEVENTH CIRCUIT**

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# DECLARATION OF SHAWN MINKS

I, Shawn Minks, swear or affirm as follows:

1. I am over the age of 21 years of age and competent to testify to the matters attested herein.

2. I am the Head of School of Cambridge Christian School and have held this position since March of 2016.

## Cambridge Christian School and Its Religious Mission

3. Cambridge Christian is an independent, co-educational, private Christian school that provides K-12 education. Cambridge Christian is located in Tampa, Florida.

4. In 1964, Seminole Presbyterian Church founded Seminole Presbyterian School, which later became an independent Christian school called Cambridge Christian.

5. Since its founding, Cambridge Christian sought to reach the greater Tampa area and beyond for Christ through the avenue of education. Cambridge Christian seeks to train and raise up future leaders who academically, socially, and spiritually can serve the local and global community for Christ.

6. Christian faith permeates everything that Cambridge Christian does. Our Statement of Faith affirms orthodox Christian beliefs, such as the inerrancy of the Bible; the Trinity; the virgin birth, sinless life, death, resurrection, ascension, and promised return of Jesus Christ; the necessity of faith in Jesus for salvation; the necessity of the ministry of the Holy Spirit for Christians to live a godly life; and the spiritual unity of the Christian Church.

7. Our mission is to glorify God in all that we do—to minister to students and families by sharing the message of Jesus Christ and the Bible; to demonstrate excellence at every level of

academic, athletic, and artistic involvement; to develop strength of character; and to serve the local and global community.

8. We also have the vision of developing our students into fearless defenders of the faith in partnership with their parents and the Bible-believe church community so that others will know and serve God and recognize the truth and authority of the Bible.

9. These essential Christian beliefs inform our Core Values.

a. "Church Connected"—We expect all board members, administration, faculty, and staff to be active members in a Bible-believing church, and we also seek to strengthen and partner with the local church communities.

b. "Christ-like Character"—It is critically important for us to hire teachers and staff whose actions and attitudes model Christ and Christian faith. We will encourage our students to live this out.

c. "Parent Partnership"—We believe that parents have the primary, God-ordained responsibility to educate the children. For that reason, our education tools will be designed to be shared with the family. It is critical that our teachers and staff understand this goal.

d. "Educational Excellence"—We believe that educational excellence cannot be separated from God's wisdom and Christian virtues. We hire and train teachers to cultivate these Christian virtues in our students. And teaching every subject from a Biblical worldview is important to us.

e. "Service Before Self"—Our desire is to train our students to identify their spiritual gifts and use them to glorify God through service in their local school, church, and community.

f. "Biblical Worldview"—We govern ourselves according to Biblical principles and integrate the Bible into every aspect of the school's life.

10. At Cambridge Christian, there isn't necessarily a clear distinction between a "secular" class or a "religious" class. Our comprehensive curriculum is taught from a Biblical worldview. We affirm that education must be based on God's word as absolute truth (Matthew 24:35; Psalm 119).

11. We cannot carry out religious and educational mission without our dedicated Christian teachers and staff who are believers in the evangelical philosophy of Cambridge Christian.

12. Our teachers play a key role as described above. Our teachers are expected to promote Cambridge Christian's mission and core values.

13. Our teachers live out their Christian faith on campus by leading corporate prayer in class, praying with individual and small groups of students, integrating Biblical truth within subject area content, answering questions about the Christian faith, attending chapel with students, and maintaining a discipling relationship with individual students.

14. Our school also cannot function and fulfill its religious mission without the dedicated and talented staff who also play key roles. We depend on our staff to carry out our Christian mission and to model Christ by living out our Core Values.

15. Cambridge Christian hires 144 employees. This includes 73 teachers, 14 administrative staff, and 57 support staff.

**Cambridge Christian's Stance on Vaccination**

16. Cambridge Christian is not categorically opposed to the currently available brands of COVID-19 vaccination.

17. As faithful Christians, we believe that God uses science, medicine, and other means of "common grace" to bless us. There is no question that the COVID-19 vaccines will help us protect ourselves and the most vulnerable in this pandemic. And we thank God for this development.

18. However, at the same time, as faithful Christians, we also believe that people—in good conscience—may reach different conclusions about whether to receive the vaccines. The Bible teaches us that we should follow our conscience and that we should respect others' conscience within the bounds of what the Bible permits and forbids (1 Corinthians 10:28–30).

19. It is our sincerely held religious belief that the conscience of a faithful Christian may lead him or her to refrain from receiving the COVID-19 vaccine.

20. For example, because Cambridge Christian's beliefs are formed by the Bible and the Christian faith, we believe that abortion is a grave sin. Jeremiah 1:4-5 and Psalm 139 teach us that God formed us in the womb and that He set us apart even before we were born. For that reason, the Christian Church has opposed abortion and infanticide from earliest times.

21. It is our sincerely held religious belief that abortion is murder in violation of the Ten Commandments (Exodus 20:13). It is my understanding that the currently available brands of COVID-19 vaccines involve the use of abortion-derived fetal cells in their development or testing. Faithful Christians who are concerned about the grave issue of abortion may conclude that she or he should refrain from using this type of vaccine. However, other faithful Christians may conclude that because of the remote connection between the initial abortions and the vaccines, it may be permissible to receive the vaccines.

22. And it is our sincerely held religious belief that it is sinful to directly act against our conscience (Romans 14:23).

23. To reiterate, it is our sincerely held religious belief that the COVID-19 vaccines—although beneficial in combatting the pandemic—is to be received by a Christian in accordance with his or her conscience.

**The Impact of OSHA's Unlawful Vaccine Mandate**

24. Because Cambridge Christian hires more than 100 in-person employees, it is covered by Occupational Safety and Health Administration ("OSHA")'s recently issued Emergency Temporary Standard ("ETS").

25. The ETS—which forces Cambridge Christian to administer it—will cause significant and irreparable injuries.

26. Based on current information, Cambridge Christian has employees who are unvaccinated for a variety of reasons, including religious objections.

27. Consistent with our Christian beliefs, we believe that our employees should have the freedom to decide, consistent with their conscience and Christian belief, whether they would receive COVID-19 vaccination.

We would not dictate our employees' private health choices that implicate their conscience and religious beliefs if we were not mandated to do so by the ETS. Doing so would violate not only our employees' Christian belief, but also our belief concerning abortion and conscience. We would either have to bear the testing costs ourselves or pass them onto our employees. Both options substantially burden our religious mission and our faith. If we bear the testing costs, the costs will be significant—estimated an additional $3,000 per month—and diverted from our resources that would otherwise go toward providing Christian education. If we pass the costs to our employees, this will interfere with our ability to attract great faculty and staff who are needed to carry out our religious education mission. This cost burden will certainly burden some of the

employees' religious and conscientious decisions to remain unvaccinated. That would be contrary to our own Christian belief regarding conscience. And we may need to reimburse those employees for testing costs. Regardless of who bears the cost of testing, the testing requirement will substantially burden us.

28. OSHA's regulatory requirements mandate us to keep records to demonstrate compliance with OSHA's regulations and standards, including the ETS. This means that our administrative and school staff will need to devote precious time, personnel, and resources to collect, verify, and record vaccination and/or testing information. Because such information will contain our employees' sensitive health information, such an endeavor will involve an implementation of careful policies and training. We estimate this record-keeping requirement to cost us an additional $1500/month, but we cannot accurately quantify the value of lost employee time.

29. We also anticipate that our employees will be forced to devote a significant amount of time and effort to comply with the weekly testing and masking requirements.

30. Testing may become difficult to obtain in our area, and it could take our employees hours to get a simple COVID-19 test.

31. Even the slight loss of employee time and the school's expenditure of these additional compliance costs detract from Cambridge Christian's core mission to provide Christian education to the students within the greater Tampa area.

32. Furthermore, OSHA's threat of punitive fines may result in removing or firing employees who do not submit to the mandates of the ETS. Again, Cambridge Christian hires its teachers and staff to support its mission to provide Christian education to our students. And we vet and hire teachers with this mission in mind.

33. The ETS interferes with—and irreparably injures—our ability to select teachers of Christian faith and staff. Without good teachers and staff who are faithful to the Bible and our Christian mission, we cannot carry out its mission to educate the students from a Biblical worldview. Nevertheless, the ETS places a significant burden on our ability to hire good Christian teachers just because they have chosen to remain unvaccinated for a variety of reasons. In other words, the ETS will hamper Cambridge Christian's religious mission.

34. As a religious organization engaged in religious education, Cambridge Christian strongly believes that it—consistent with the teachings of the Bible and Christian faith—should have autonomy in hiring faculty and staff.

Pursuant to 28 U.S.C. § 1746, I declare that the foregoing is true and correct.

Executed on November 5, 2021

Shawn Minks

**UNITED STATES COURT OF APPEALS**

**FOR THE ELEVENTH CIRCUIT**

STATE OF GEORGIA, *et al.*,

*Petitioners,*

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OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, *et al.*,

*Respondents.*

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**DECLARATION OF DAVID MOELLERING**

I, David Moellering, hereby attest:

1. I make this declaration based on my personal and professional knowledge and experience, information available to me in my position in the Georgia Highway Contractors Association, and that are publicly available.

2. My name is David Moellering, I am the President & CEO of the Georgia Highway Contractors Association. ("GHCA"). I am over the age of 19, and the facts I have set out below are based on my personal knowledge and/or on the records of GHCA that are maintained in the ordinary course of business.

3. As President of GHCA, I am responsible for the overall management of the company, a member of the Board of Directors, and a member of the Executive Committee. My role places me in close communication with both members of GHCA, executive management, and the rest of its workforce.

4. GHCA is the leading advocate for the construction and maintenance of the roads and bridges in Georgia. With Georgia growing at the pace it is, this industry is vital to the expansion and continued excellence of our great state. Because of this, GHCA has a strong interest in policy making to ensure that construction and maintenance can continue at the appropriate levels that are required.

5. GHCA represents road construction and repair companies which require a safe work environment to be able to continue productivity at the speed the state is growing. There are more than 123,000 miles of public roads in Georgia and nearly 15,000 bridges, meaning that contractors need road workers now, and GHCA is there to facilitate that employment for these vital jobs.

6. The loss of employees by the member companies of GHCA would be devastating to the productivity and growth of Georgia. Georgia roads are used at a large rate and need constant care and expansion. This workforce needs a constant influx of trained professionals to handle the appropriate tools and materials to accomplish these jobs.

7. GHCA member company employees are not easily replaceable. These companies employ highly specialized individuals with certifications and training required for their professions. The companies employ: civil engineers, foremen, heavy equipment operators, CDL truck drivers, carpenters, as well as various other professions needed to work on the constructions and maintenance of Georgia's roads. Put simply, the loss of employees due to the OSHA ETS would cause financial harm and injury to GHCA's member companies.

8. On November 5, 2021, the Occupational Safety and Health Administration issued an Emergency Temporary Standard that requires companies with over 100 employees to force their employees to either receive a COVID-19 vaccine or receive weekly and costly COVID-19 testing. Companies that fail to comply face stiff penalties for each violation.

9. GHCA members have reported strong backlash from employees due to the OSHA ETS. These comments from employees and member companies could include loss of employment of up to 40% of workers, loss of morale, and loss of contracts.

10. The loss of a large portion of the workforce would cause significant delays in completion of state and federally funded projects and detrimentally impact GHCA's member companies, the economy of Georgia, and the livelihood of its citizens. With

Georgia being a large thoroughfare for the southeast of the United States, this would also impact tourists and citizens of other states crossing Georgia's borders and using its roads.

11. These delays would cause widespread damage among different industries. As an example, delays in construction and maintenance of Georgia roads would further damage the availability of goods and services which have already been hurt by COVID-19 requirements at ports and trucking firms. Further, this will cause supply chain issues as both contractors and suppliers will lose employees, preventing materials from making their way to end users.

12. For the reasons mentioned above, the potential loss of a large number of employees would be devastating to the morale of the industry, causing issues in productivity, and would overall be harmful to the state of Georgia.

13. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

11-8-21

Date:

David Moellering, President, GHCA

**UNITED STATES COURT OF APPEALS**
**FOR THE ELEVENTH CIRCUIT**

STATE OF FLORIDA, *et al.*,

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*Respondents.*

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## DECLARATION OF THOMAS E. REIMERS

I, THOMAS E. REIMERS, hereby declare:

1. I make this declaration based on my personal and professional knowledge and experience, information available to me in my position in public service, and publicly available information.

2. I am the Health Services Director of the Florida Department of Corrections (FDC). In that position, I am responsible for overseeing the delivery of all medical services, including contract management and monitoring, resolving operational issues in the field, supervising all clinical areas and professionals, and developing FDC's comprehensive health care delivery system and promulgating all health care standards relating to the management structure of the health care system and the provision of health care services to inmates, health care policies, health care plans, quality management systems and procedures, health service bulletins, and treatment protocols in accordance with section 945.6034, Florida Statutes.

3. Over the past few years, the State of Florida has experienced a shortage of medical and mental health staff, and the ability to recruit and retain qualified staff to work in state prison institutions has been challenging. Staff shortages have greatly increased since the outbreak of COVID-19. Additionally, mental health providers have increased opportunities to provide services via telehealth in the community, further dwindling the

pool of available professionals to provide services in a correctional institutional environment.

4. Since approximately May 2016, the FDC has contracted with a private vendor, Centurion of Florida, LLC (Centurion) to satisfy its duty of providing medical and mental health care and treatment to most of its inmates. From June 2017 to the present, Centurion has provided, through contract with the FDC, all of the comprehensive medical and mental health services for FDC inmates.

5. Throughout the contractual term with Centurion, the vendor has experienced challenges with its staffing levels, including the recruitment and retention of qualified nursing staff, medical physicians, psychiatrists, psychologists, and mental health professionals.

6. Since the outbreak of COVID-19, these staffing challenges have become more significant and widespread. On or about February 15, 2020, Centurion had a 3.1 percent vacancy rate (97 full-time equivalents, or FTEs). On or about August 29, 2020, the vacancy rate increased to 9.2 percent (290 FTEs). As of September 25, 2021, Centurion's vacancy rate is 18.3 percent (553 FTEs). A high percentage of vacancies are in critical nursing and mental health positions.

7. Centurion has been proactively trying to address staff recruitment and retention challenges by increasing employee compensation. From May 2020 to September 2021, the vendor took the following actions: (A) Provided an across-the-board pay increase for all employees (June 2020); (B) Implemented salary increases at institutions with high vacancy rates (including multiple increases at some sites), with a focus on nursing and mental health positions; (C) Established shift differentials for employees working evening and overnight shifts; (D) Established shift incentives for employees who cover shifts at another institution; and (E) Established and then increased sign-on/retention bonuses (up to $5,000).

8. The vendor's ability to recruit and retain these positions during the pandemic, however, has been further exacerbated by exorbitant sign-on bonuses for registered nurses to work in COVID-19 units. In some hospitals, these bonuses have recently increased. Centurion is unable to compete with these bonuses to recruit staff and these bonuses have also made it more difficult to retain existing staff.

9. Centurion employs more than 100 employees and is subject to the new Occupational Safety and Health Administration Emergency Temporary Standard (ETS), which requires Centurion to mandate that its employees receive a COVID-19 vaccine and provide acceptable proof of vaccination status, or submit to weekly testing

and the wearing of a face covering at work in lieu of vaccination.

10. I am concerned that the ETS will further exacerbate the shortage of medical and mental health staff for FDC's institutions and hinder the Department's Eighth Amendment obligations to provide minimally adequate medical and mental health services, even though the ETS does not apply directly to FDC.

11. As of October 14, 2021, Centurion has 3,279 employees performing services in Florida. Of these, 1,689 are unvaccinated or have not reported a vaccination status.

12. Medical and mental health vacancies have already increased almost six-fold during the COVID-19 pandemic. Further deterioration of staffing levels resulting from a vaccine mandate could lead to a complete inability to provide care and services at some locations and comply with court mandated settlement agreements.

13. The increase in the use of as-needed staff, who may be assigned into service without proper training on FDC protocols, procedures, and care requirements, may lead to service deficiencies and poor continuity of care.

14. The FDC may experience challenges in meeting mandatory statutory requirements and litigation related requirements for inmates with hearing, mobility, and vision disabilities, and those needing inpatient mental health care.

15. The FDC has protocols in place to educate inmates and staff on the importance of voluntary vaccination, social distancing, handwashing, and the importance of promptly reporting symptoms, even if fully vaccinated. FDC provides COVID-19 vaccines to any inmate who chooses to receive one.

16. Presently, the Department requires that all staff and inmates in the medical units continue to wear face coverings and utilize PPEs as appropriate. As COVID-19 cases continue to decrease in Florida and in the institutions, the Department anticipates the suspension of this requirement for staff and inmates. COVID-19 testing is widely available and utilized as clinically indicated.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct, to the best of my knowledge.

11/4/21
Date

THOMAS REIMERS
Health Services Director Florida Department of Corrections

**UNITED STATES COURT OF APPEALS**

**FOR THE ELEVENTH CIRCUIT**

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*Respondents.*

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**DECLARATION OF DARRELL ROBINSON**

I, Darrell Robinson, hereby attest:

1. I make this declaration based on my personal and professional knowledge and experience, information available to me in my position in the Robinson Paving Company, and that are publicly available.

2. My name is Darrell Robinson, I am a Senior Vice President for Robinson Paving Company ("RPC"). I am over the age of 19, and the facts I have set out below are based on my personal knowledge and/or on the records of RPC that are maintained in the ordinary course of business.

3. As Senior Vice President of RPC, I am responsible for overseeing the company as a senior executive, and all of its employees.

4. RPC has been in business for 50 years, proudly serving the Columbus and Fort Benning area. We provide a wide area of services including: paving, grading, drainage, clearing, concrete, and asphalt sales and millings.

5. RPC's work ensures that other vital industries are able to function. Examples of this include the paving of driveways, airport runways, highways, roads, and parking lots so that other professionals in other industries may have a way to travel to and from work. Without proper paving, or other services we provide, these other industries would not be able to operate.

6. On November 5, 2021, the Occupational Safety and Health Administration issued an Emergency Temporary Standard ("ETS") that requires companies with over 100 employees to force their employees to either receive a COVID-19 vaccine or receive weekly COVID-19 testing. Companies that fail to comply face stiff penalties for each violation.

7. RPC employees have expressed significant disapproval of the OSHA ETS. There is an expected loss of 50% of our existing employees who are currently unvaccinated. Many of these employees are tenured employees who have been loyal to our company for 20 years, and would cause a loss of morale and senior leadership for new hires.

8. The loss of a large portion of our employees will cause our company to potentially miss completion dates on existing contracts. These include tax dollar funded, governmental projects. An example of a governmental contract which would be negatively impacted is for the work on improvements to the Lawson airfield at Fort Benning. The failure to complete projects by a contractual deadline will result in penalties and loss of revenue.

9. The ETS requirements for compliance and administration will negatively impact revenue and productivity. This includes cost of testing and down time required to administer tests and documentation.

10. Hiring new employees has already been difficult since the pandemic originated. Our employment is currently down by 20% with no qualified new hires available. The ETS will make our hiring process even more difficult.

11. RPC works with equipment that has a high overhead cost. This equipment is necessary to complete road construction projects and the equipment will be idle due to the losses from the ETS.

12. For the reasons mentioned above, the potential loss of a large number of employees in our company would cause delays in the construction of critical projects, would make hiring more difficult than it already is, and would overall be harmful to the state of Georgia.

13. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

11.8.21

Date:

Darrell Robinson, Senior Vice President,
Robinson Paving Company

**UNITED STATES COURT OF APPEALS**
**FOR THE ELEVENTH CIRCUIT**

STATE OF FLORIDA, *et al.*,

*Petitioners,*

v. Case No. 21-13866-F

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, *et al.*,

*Respondents.*

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## DECLARATION OF GRAY SKIPPER

My name is Gray Skipper. I am the Vice President of Scotch Plywood Company, Inc. ("Scotch Plywood" or the "Company"). I am over the age of 19, and the facts I have set out below are based on my personal knowledge and/or on the records of the Company that are maintained in the ordinary course of its business.

1. As the Vice President of Scotch Plywood, I am responsible for the overall management of the Company, a member of the Board of Directors, and Trustee for the Helen O'Melia Skipper Beneficiary Trust, which is a twenty-five percent shareholder of Scotch Plywood. My role places me in close communication with the Company's shareholders, executive management, and the rest of its workforce.

2. Since the 1965, Scotch Plywood has sought to procure the best timber available for the production and sale of high-quality, construction-grade plywood. This

process involves spending substantial time outdoors sourcing our timber. Once purchased, the timber is hauled to green-end facilities. These facilities and the final lay-up facility in Fulton, Alabama are large manufacturing warehouses. The timber or wood is manufactured in several stages. The first stage is to produce green veneer, dry veneer, and then laying-up dry veneer to press and grade out the final product, Southern Yellow Pine Plywood.

3. Scotch Plywood operates in a commodity market that requires the Company to maintain very tight cost controls, productivity, and a safe work environment. Each employee is critical to the Company's ability to operate safely and have a path to profitability. The Company cannot operate without its employees.
4. In fact, the loss of even one employee can harm the Company. Due to worker shortages in the month of September 2021, we had a 5% increase in overtime hours worked over the same period in 2020. The plywood production was virtually the same for the comparable periods. The overtime increase was created from the current worker shortage at our facility in Fulton, Alabama.
5. The Company's employees are not easily replaceable. In 2019, prior to COVID 19, we would have 50 to 100 applicants for one open position at our Fulton, Alabama operation. In 2021, we recently received 4 applicants and half did not pass the drug screening test. Our current retention rate, which is hired and retained after 1 year, for new hires is currently only 10 percent.
6. Scotch Plywood currently has 428 employees.

7. Most of our employees work in large, open-air warehouses. We have installed or retrofitted some positions per CDC and OSHA guidelines to adhere to the six feet guidance in the COVID 19 protocols. If the employees find themselves in a situation where they are closer than six feet for a specified amount of time, per protocols, they are required to wear a face mask.

8. Ninety-five employees have thus far tested positive test for COVID-19, or 22% of our workforce, and another sixty-two of our employees, or 15% of our workforce, have already been exposed to COVID-19. This represents over one-third of our workforce who have developed natural immunity to the virus. As of October 31, 2021, 186 employees, or 43% of our workforce, have reported that they are fully vaccinated. Therefore, at least 75% of our workforce has had the virus, been exposed to the virus, or received full vaccinations.

9. Scotch Plywood has not required any of its employees to receive a COVID-19 vaccination. We have encouraged employees to explore the pros and cons of the approved vaccines with their respective physicians.

10. On November 5, 2021, the Occupational Safety and Health Administration issued an Emergency Temporary Standard (ETS) that requires companies with over 100 employees to force their employees to either receive a COVID-19 vaccine or receive weekly COVID-19 testing. Companies that fail to comply with the ETS face stiff penalties for each violation.

11. Unless forced to comply with the ETS, Scotch Plywood will not require any of its employees to receive a COVID-19 vaccination or be subject to weekly testing.

12. In a recent survey conducted by the Company's Human Resources Department, 102 of its employees, or 24% of our workforce, have stated that they will NOT take a COVID-19 Vaccine and will NOT submit to weekly testing. If the mandate comes into effect on January 4, 2022, as communicated, these individuals will lose their jobs. Many of them could end up working for one of the Company's smaller local workforce competitors, where they would not be subject to the ETS.

13. If these employees quit, Scotch Plywood will suffer significant harm. We estimate that it would immediately impact at least 20% of our mills' production.

14. To attempt to replace these employees, the Company will have to engage in an urgent recruitment process, costing the Company significant time and money. The Company will then have to train the new employees, further taxing the Company's economic and human resources.

15. Moreover, of the employees who have threatened to resign should they be forced to receive vaccinations or submit to weekly testing mandates, many have worked with the Company for over 10 years, have developed an uncommon level of mastery of their craft, and are therefore not realistically replaceable on an interim basis.

16. Resignations also have the capacity to diminish morale across the entire workforce. For example, a long-time (16 years) millwright just resigned giving no reason for his resignation. The rest of the millwright workforce are asking for increases in pay and other compensation. This has diminished morale negatively and could possibly impact workforce productivity.

17. If the Company is forced to follow the ETS, we know 102 of the Company's employees will resign. The Company will have to seek, hire, and train replacements, many of whom will be unable to adequately replace the resigned workers; and the Company's workforce will suffer diminished morale and corresponding diminished productivity. This will lower our competitiveness in the marketplace. Each of these results will constitute a significant and irreparable harm to the Company.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed on November 5th, 2021.

Gray Skipper
Vice President
Scotch Plywood Company, Inc.

**UNITED STATES COURT OF APPEALS**
**FOR THE ELEVENTH CIRCUIT**

STATE OF FLORIDA, *et al.*,

*Petitioners,*

v. Case No. 21-13866-F

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, *et al.*,

*Respondents.*

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## DECLARATION OF RYAN STOKES

I, Ryan Stokes, hereby declare:

1. I make this declaration based on my personal and professional knowledge and experience, information available to me in my position in public service, and publicly available information.

2. I am currently employed by the Florida Department of Management Services (DMS) as Director of the Division of State Group Insurance. I've been with the Division for ten years, serving as both the Financial Manager and Chief of Financial & Fiscal Management prior to my appointment as Director earlier this year. In those roles I progressively managed the financial aspects of the State Group Insurance Program as well as data analytics for the Division.

3. DMS is a state agency charged with, among other things, the purchase of health insurance coverage for Florida's state employees under the State Group Health Insurance Program. The State Group Health Insurance Program covers active and retired employees, their eligible dependents, and surviving spouses from the executive, legislative, and judicial branches of state government, state universities, and other statutorily defined agencies. All but one of the insurance plans offered under the State Group Health Insurance Program are self-funded, wherein the State of Florida pays the cost of covered claims directly.

4. I have reviewed the new Occupational Safety and Health Administration Emergency Temporary Standard (ETS) mandating that non-government employers

with 100 or more employees require their employees to receive a COVID-19 vaccine or submit to weekly testing.

5. An increase in COVID-19 testing in Florida will increase the State Group Health Insurance Program's costs.

6. The State Group Health Insurance Program provides health insurance for Florida's state employees and offers employees the option to also insure their spouses and children up to age twenty-six (26) (or older in certain circumstances). As of October 2021, the State Group Health Insurance Program had approximately 96,077 dependents, age 18 and older, enrolled who are not currently employed with the State of Florida and could be employed by a private business. The State Group Health Insurance Program covers the cost for COVID-19 testing for all covered employees and dependents, regardless of symptoms, when medically necessary. Initial determinations as to medical necessity are made by the insurer. If determined medically necessary, testing will increase the cost to the State of Florida's self-funded insurance plans. If determined to not be medically necessary, the State of Florida will still incur indirect administrative costs if the denial of a claim is appealed. Members may appeal the denial of a claim, first to the insurer and subsequently to an Independent Review Organization and the Division of State Group Insurance. A denial by the Division of State Group Insurance entitles the member to an administrative hearing. The resulting final order is then subject to judicial review. Associated administrative costs of the appeal vary. If determined to be medically necessary, the costs for COVID-19 testing range from $27.90–$129.50, depending on the testing location.

7. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct, to the best of my knowledge.

DocuSigned by:
Ryan Stokes
FF111DF156DA44B...

11/4/2021 | 4:36 PM EDT

Date

Ryan Stokes, Director
Division of State Group Insurance
Florida Department of Management Services

**UNITED STATES COURT OF APPEALS**

**FOR THE ELEVENTH CIRCUIT**

STATE OF GEORGIA, *et al.*,

*Petitioners,*

v. Case No. 21-13866-F

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, *et al.*,

*Respondents.*

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**DECLARATION OF KATHLEEN E. TOOMEY**

I, Kathleen E. Toomey, hereby attest:

1. I make this declaration based on my personal and professional knowledge and experience, information available to me in my position in public service, and publicly available information.

2. I am currently serving as Commissioner of the Georgia Department of Public Health and as the State Health Officer. In these roles, I oversee programs related to health promotion and disease prevention, maternal and child health, infectious disease and immunization, environmental health, epidemiology, emergency preparedness and response, emergency medical services, volunteer health services, healthy equity, vital records, the State Public Health Laboratory and other services. I was appointed Commissioner in March of 2019 by Governor Brian Kemp. Prior to my appointment,

I served as District Health Director for Fulton County and in many other leadership roles with state and federal health agencies.

3. The Georgia Department of Public Health (DPH) is the state agency responsible for protecting and promoting public health through organized state and community efforts involving 18 health districts and 159 county health departments pursuant to O.C.GA. §§ 31-2A-1 et seq.; these efforts include epidemiological investigations and laboratory facilities and services in the detection and control of disease, as well as the regulation of emergency medical services (EMS).

4. I have reviewed the new Occupational Safety and Health Administration Emergency Temporary Standard (ETS) mandating that non-government employers with 100 or more employees require their employees to receive a COVID-19 vaccine or submit to weekly testing.

5. Given the number of unvaccinated individuals in Georgia and the anticipated difficulty in persuading these individuals to obtain vaccination, the ETS mandate for employees may increase the number of individuals seeking weekly COVID-19 testing and create challenges for the current testing infrastructure in Georgia.

6. Public testing sites are designed to support surveillance and diagnostic testing needs and lack the capacity to support mass testing initiatives, such as weekly COVID-19 testing of employees. The state operated testing sites typically collect fewer than 1,500 specimens per day; the highest single day of specimen collection was 17,323 on 12/21/2020. This level of capacity is not sufficient for high volumes of routine COVID-19 testing.

7. The Department currently contracts with outside vendors for additional testing sites; both public and private testing sites generally provide COVID-19 testing to any person who seeks a test regardless of the person's reason for taking a test. However, even with both public and private testing resources, mass testing at a statewide level could be challenging. Even at our highest levels of testing, public and private sites combined have conducted fewer than 80,000 tests per day. Weekly testing of employees may strain testing capabilities and could lead to shortages in staffing and supply resources; traffic congestion and logistical issues; delays in turnaround times for test results; and potential diversion of symptomatic or exposed residents from testing sites that are overcrowded.

8. To accommodate significant increases in weekly testing, the Department would likely need to contract with an outside vendor to operate additional sites across the state. Weekly testing also may trigger limitations on insurance coverage, which may require the Department to rely on time-limited federal funding more heavily, and/or to redirect federal resources currently budgeted for other mitigation efforts, and may result

in additional cost to the state if increased testing costs are not sufficiently covered by federal funding.

9. The Department also licenses ambulance services, air ambulance services, medical first responders and neonatal transport services. The State is already experiencing a statewide shortage of EMS personnel. Any further attrition in resources caused by the ETS mandate could impact the State's ability to respond to emergency situations and ensure timely access to care and treatment.

10. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

11/5/2021

Date

Kathleen E. Toomey, M.D., M.P.H.
Commissioner and State Health Officer
Georgia Department of Public Health