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MCP No. 165

**In the United States Court of Appeals
for the Sixth Circuit**

IN RE OSHA RULE ON COVID-19
VACCINATION AND TESTING, 86 FED. REG. 61,402

On Petitions for Review

**BRIEF OF AMERICAN PUBLIC HEALTH ASSOCIATION,
ASSOCIATION OF SCHOOLS AND PROGRAMS OF PUBLIC HEALTH,
ACADEMY OF MANAGED CARE PHARMACY, ALLIANCE OF COMMUNITY HEALTH
PLANS, AMERICAN COLLEGE OF OSTEOPATHIC EMERGENCY PHYSICIANS,
AMERICAN COLLEGE OF PREVENTATIVE MEDICINE, ASSOCIATION OF
AMERICAN MEDICAL COLLEGES, COLLEGE OF AMERICAN PATHOLOGISTS,
COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS, NATIONAL
HISPANIC MEDICAL ASSOCIATION, NATIONAL MEDICAL ASSOCIATION,
NATIONAL SAFETY COUNCIL, ASSOCIATION OF PERIOPERATIVE REGISTERED
NURSES, NATIONAL LEAGUE FOR NURSING,
30 DEANS OF LEADING ACADEMIC PROGRAMS, AND
104 LEADING PUBLIC HEALTH AND HEALTH POLICY SCHOLARS,
AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS'
EMERGENCY MOTION TO DISSOLVE STAY**

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CORPORATE DISCLOSURE STATEMENT

As required by Federal Rule of Appellate Procedure 26.1, *amici curiae* American Public Health Association, Association of Schools and Programs of Public Health, Academy of Managed Care Pharmacy, Alliance of Community Health Plans, American College of Osteopathic Emergency Physicians, American College of Preventative Medicine, Association of American Medical Colleges, College of American Pathologists, Council of State and Territorial Epidemiologists, National Hispanic Medical Association, National Medical Association, National Safety Council, Association of periOperative Registered Nurses, and National League for Nursing state that they are all non-profit entities and have no parent corporations. No publicly owned or traded corporation owns, in whole or in part, any of the *amici*.

INTEREST OF AMICI CURIAE¹

Amici curiae are a diverse group of scholars and professional organizations of public health and health care practitioners who share a deep commitment to the health of American workers and workplace protection. They file this brief to demonstrate to this Court that the overwhelming public-health and scientific consensus contradicts a central premise of the petitioners’ challenge to OSHA’s emergency vaccinate-or-test standard—that COVID-19 poses no particularized risk to workers and workplaces. Through this brief, *amici* also seek to explain that well-established evidence, buttressed by more recent empirical study during the pandemic, shows that vaccination can effectively reduce SARS-CoV-2 exposure and transmission in the workplace.²

The individual *amici*—whose names and affiliations are set forth in the appendix to this brief—are more than one hundred of the country’s leading educators, scholars, and public health and health care professionals, as well as 30 deans and associate deans of leading academic programs across the United States.

¹ *Amici* have moved for leave to file this brief. No party’s counsel authored this brief, in whole or in part, and no party or party’s counsel, nor anyone other than *amici* or their counsel, contributed money intended to fund its preparation or submission.

² “SARS-CoV-2” refers to the virus and “COVID-19” refers to the disease it causes. For the reader’s convenience, however, this brief (like much of the scientific literature) will often refer to “COVID-19” to mean both the virus and the disease.

Collectively, their expertise reflects a wide range of disciplines relevant to worker health and safety, including occupational health and safety, public health, economics and health policy, law and health policy, medicine and the health professions, and other areas of endeavor. Many are members of the National Academies of Sciences, Engineering, and Medicine and some have held prominent positions in both Democratic and Republican administrations.

The individual *amici* are joined by fourteen leading professional organizations that advocate for public-health and health-care issues and policies grounded in scientific research. These organizations represent the interests of public-health professionals, epidemiologists, nurses, advanced practice clinicians, and other health-care workers. The identity and interest of each *amicus curiae* is set forth in the appendix to this brief.

INTRODUCTION

Even before the recent emergence of the Delta and Omicron variants, COVID-19 had profoundly transformed American working life. The virus has shut down workplaces, triggered significant workplace restrictions, infected millions of employees, and sent hundreds of thousands of others to the hospital or the morgue. And particular workplaces, such as meatpacking plants, have repeatedly emerged as our nation's worst hotspots, causing illness and death to those who toil in them.

Ignoring this reality, the petitioners who challenge OSHA’s vaccinate-or-test standard nevertheless assert that “the COVID-19-related risk presented by work is the same risk that arises from human interaction more broadly.” *Arizona et al.*, Initial En Banc Pet. 9 (Doc. 14). In its stay order, the Fifth Circuit panel similarly reasoned that, because COVID-19 is caused by an “airborne virus that is . . . widely present in society,” the risk it poses is “not particular to any workplace.” *BST Holdings, L.L.C. v. OSHA*, 2021 WL 5279381, at *5 (5th Cir. 2021). On this logic, because “the danger presented by COVID-19 is endemic,” it follows that “it is not a danger presented by ‘work or work-related activities.’” Doc. 14 at 6.

Nothing could be further from the truth. The science and the public-health evidence is clear: The nature of both the virus and in-person work makes the workplace particularly at risk for COVID-19 transmission and infection. Because it is an airborne pathogen primarily transmitted through the inhalation of small respiratory particles, SARS-CoV-2 spreads especially well between people who must spend hours together in close quarters indoors. That accurately describes the wide range of America’s workplaces—from food-processing plants and car factories to retail stores and offices.

The science is also clear about the best way to combat COVID-19’s spread—vaccines. All the evidence shows that vaccination significantly reduces the likelihood that workers will transmit COVID-19 and infect other workers, especially when

combined with regular testing and other mitigation measures. And vaccination *drastically* reduces the chance of hospitalization and death. For these reasons, numerous employers have already imposed vaccine requirements, which have engendered widespread vaccination uptake and have consistently proven effective.

Based on this scientific consensus, OSHA issued its emergency temporary standard requiring covered employers to ensure that employees are either vaccinated against COVID-19, or wear masks and undergo regular testing. As the federal respondents persuasively explain, the agency acted well within its statutory authority in issuing the rule. *See* Resp. Emergency Mtn. to Dissolve Stay 9–39 (Doc. 69). But, as this brief seeks to show, OSHA’s vaccinate-or-test standard also reflects the most recent public-health evidence and research on the dangers that the virus poses to the workplace and the efficacy of vaccines against COVID-19’s spread.

As we are all too aware, the costs of delay in this pandemic are enormous. In just the last week, news of a new “variant of concern” named “Omicron” has threatened to wreak havoc on the global economy. Experts contend that the slow pace of vaccination globally is in large part the cause for Omicron’s rise—and it provides an opportunity for more transmissible and dangerous variants to appear in the future. Congress assigned OSHA the responsibility to protect America’s workers and workplaces from grave dangers precisely like COVID-19. This Court should permit OSHA to discharge that responsibility by dissolving the stay.

ARGUMENT

I. COVID-19 is a particularly severe danger in the workplace, and it poses special risks for workers.

Workers, and the workplaces in which they work, are particularly at risk of COVID-19 infection. The mechanics of how the virus is transmitted should make this proposition self-evident. SARS-CoV-2 is an airborne virus that spreads through an infected person’s respiratory particles. *See COVID-19 Vaccination and Testing; Emergency Temporary Standard*, 86 Fed. Reg. 61402, 61409 (Nov. 5, 2021).³ As OSHA explains in its rule, airborne transmission may occur “when people are in close contact with one another in indoor spaces,” particularly “in indoor spaces without adequate ventilation where small respiratory particles are able to remain suspended in the air and accumulate.” *Id.* High risk exposure and infection can occur with relatively brief exposure (less than 15 minutes), and “employees can be exposed to the virus in almost any work setting.” *Id.* at 61409, 61411–12.⁴ Whether working in cubicles clustered in an office building or shoulder-to-shoulder in a food-processing plant, employees “share common areas like hallways, restrooms, lunch rooms[,] and meeting rooms.” *Id.* It is little surprise, then, that indoor workplace environments—

³ All subsequent citations to the OSHA rule’s preamble are labeled “Pmbl.”

⁴ *See also, e.g.*, Center for Disease Control and Prevention, *Scientific Brief: SARS-CoV-2 Transmission* (May 7, 2021), <https://perma.cc/R7Y2-9YAJ>; Kevin P. Fennelly, *Particle sizes of infectious aerosols: Implications for infection control*, 8 *Lancet Respiratory Med.* 914, 914–24 (2020), [https://doi.org/10.1016/S2213-2600\(20\)30323-4](https://doi.org/10.1016/S2213-2600(20)30323-4).

where individuals work in close contact with other employees for many hours each day—are particularly susceptible to the risk of a COVID-19 outbreak as compared to other settings.

That is precisely what the public-health evidence has shown. OSHA’s vaccinate-or-test standard relies on numerous empirical studies that have found that workers in various occupational sectors have had COVID-19 at substantially higher rates than their surrounding communities. *See, e.g.,* Pmbl.61412–14 (citing studies). State-level data confirm that the workplace environment often facilitates and accelerates the spread of COVID-19—in North Carolina, for example, nearly 80% of COVID-19 “clusters” in the state, and nearly 40% of deaths, have been workplace-related. *See* N.C. Dep’t of Health and Human Servs., *COVID-19 Clusters in North Carolina* (last updated Nov. 22, 2021), <https://perma.cc/SGW8-USTM>; *see* Pmbl.61412. Workers in a wide range of workplaces—like grocery stores, fitness facilities, schools, corrections and detention facilities, and others—experienced up to five times greater rates of infection than the general public. *Id.* at 61414 (citing studies). Moreover, “larger employers are more likely to have many employees gathered in the same location” and therefore more likely to have “larger,” “longer” outbreaks. *Id.* at 61512; *see, e.g.,* Zuelma Contreras et al., *Industry Sectors Highly Affected by Worksite Outbreaks of Coronavirus Disease, Los Angeles County, California, USA, March 19–September 30, 2020*, 27

Emerging Infectious Diseases 1769 (2021), <https://doi.org/10.3201/eid2707.210425> (“[F]acilities employing more on-site staff had larger and longer outbreaks.”).⁵

The increased risk of viral transmission in workplaces has had a devastating effect on workers. That workers who are required to work in person experience disproportionate COVID-19 mortality rates is empirically well-established. *See, e.g.,* Kristin J. Cummings et al., *Disparities in COVID-19 Fatalities among Working Californians*, medRxiv (*preprint*, posted Nov. 11, 2021), <http://doi.org/10.1101/2021.11.10.21266195>. Indeed, substantial evidence confirms links between in-person occupational sectors and “high excess mortality during the pandemic.” Yea-Hung Chen et al., *Excess mortality associated with the COVID-19 pandemic among Californians 18-65 years of age, by occupational sector and occupation: March through November 2020*, 16 PLOS ONE at 2 (2021), <http://doi.org/10.1371/journal.pone.0252454>. Evidence from California, for instance, shows that “excess mortality rose sharply in several essential sectors” where “[i]n-person essential workers” were “not protected by shelter-in-place policies,” suggesting that the rise in mortality is associated with in-person work. *Id.* at 8. Data

⁵ For this reason, OSHA’s decision to focus on employers with more than 100 employees is not just reasonable—it is empirically supported. *See* Resp. Mot. 26–28.

from other states similarly finds a statistically significant higher excess mortality rate for workers who predominately work in person.⁶

These empirical findings are consistent with a “growing body of literature demonstrating occupational risks for SARS-CoV-2 infection.” Chen, *supra*, at 7. And they dovetail with OSHA’s determination that workers who have no choice but to work in person—and who have “little ability to limit contact with . . . coworkers, clients, members of the public, patients, and others”—face increased risk of illness, hospitalization, and death as a result of COVID-19. Pmbl.614,08. In fact, public-health scholars have concluded that “there would have been 57% fewer COVID-19 deaths” if, among other factors, “all individuals had the COVID-19 mortality associated with the safest . . . occupational position”—“non-essential, telework.” Ellicott C. Matthay et al., *Contributions of occupation characteristics and educational attainment to racial/ethnic inequities in COVID-19 mortality*, medRxiv at 3 (*preprint*, posted Oct. 30, 2021), <http://doi.org/10.1101/2021.10.29.21265628>. The evidence thus supports OSHA’s decision to focus its vaccinate-or-test standard on in-person workers, and to exempt employees who work alone, remotely, or exclusively outdoors. *See* Pmbl.61419.

⁶ *See* Oregon Health Auth., *COVID-19 Weekly Report* at 79–85 (Nov. 17, 2021), <https://perma.cc/4VFR-V2BR>; Devan Hawkins, Letitia Davis & David Kriebel, *COVID-19 deaths by occupation, Massachusetts, March 1–July 31, 2020*, 64 Am. J. of Indust. Med. 238 (2021), <http://doi.org/10.1002/ajim.23227>; Washington State Dep’t of Health, *Statewide COVID-19 Outbreak Report* (2021), <https://perma.cc/S5KQ-CU7N>.

The meatpacking industry’s experience with COVID-19 is a particularly instructive—and well-studied—example of how the virus can sweep through workplaces. Disease spread in meatpacking plants has been so severe that, following “multiple reports of widescale coronavirus outbreaks within and around meatpacking facilities, the [Congressional] Select Subcommittee initiated an investigation into coronavirus infections and deaths in meatpacking plants.” Staff of H. Select Subcomm. on the Coronavirus Crisis, 117th Cong., *Memorandum re: Coronavirus Infections and Deaths Among Meatpacking Workers at Top Five Companies Were Nearly Three Times Higher Than Previous Estimates* at 1 (Comm. Print 2021), <https://perma.cc/ZAC7-264F>. Data from “five of the largest meatpacking conglomerates, which represent over 80 percent of the market for beef and over 60 percent of the market for pork in the United States,” indicated that certain plants had nearly *half* of their workforce contract COVID-19 in the first year of the pandemic, *id.* at 1–2—multiples higher than the percentage of the U.S. population that had contracted the disease at that time.

That food processing workers are particularly at risk of transmission might not come as a surprise. They endure “long shifts in enclosed facilities” shared “with hundreds, if not thousands, of other workers,” with “collective[]” breaks in the “same” “common areas,” in “close quarters” on the “facility floor,” “unable to socially distance by virtue of the production line layout[].” *Id.* at 4. But while the

“high-density, fast-paced environments of food production facilities pose a barrier to proper adherence to COVID-19 prevention measures, such as social distancing . . . and cleaning of shared spaces,” “these challenges are not unique to food production facilities.” Contreras, *supra*, at 1769.

Like those in food production and meatpacking, workers in “other sectors” encounter “distinctive” factors related to in-person work, such as “increased contact with the public” or “shared equipment[] and common spaces,” that “similarly increase the risk of COVID-19 worksite exposure.” *Id.* at 1769, 1772. High COVID-19 case incidence rates have occurred in the workforces of many important economic sectors—in manufacturing, transportation and warehousing, and wholesale trade. *Id.* at 1770. “High-density environments,” “close contact in production lines, long shifts, shared equipment[] and common spaces,” “shared transportation,” “poor ventilation and sanitation,” and “increased contact with the public” all contribute to “particular[] risk for COVID-19 exposure.” *Id.* at 1772–73.

The COVID-19 pandemic has also pulled back the curtain on the way that workplace conditions and risks can exacerbate the existing health disparities between white workers and workers of color. The early months of the pandemic sickened and killed people of color in the United States at higher rates than non-Hispanic white people. This is not only a result of underlying economic and health disparities but is also because people of color occupy a disproportionately high number of jobs that

qualify as “essential work” or otherwise require them to work in person. *See* Tiana N. Rogers et al., *Racial Disparities in COVID-19 Mortality Among Essential Workers in the United States*, 12 *World Med. & Health Pol’y* (Special Issue: Symposium on Coronavirus 2019: Social Determinants, Disparities, and Impacts) 1 (2020), <http://doi.org/10.1002/wmh3.358>; Chen, *supra*, at 7 (“Excess mortality in high-risk occupational sectors was evident across all race and ethnic groups in stratified analyses, with notably high relative and per-capita excess in Latino and Black Californians.”).⁷

Regardless of race or socioeconomic status, the evidence is clear: In-person workers “are at greater risk of SARS-CoV-2 infection” because their “working conditions bring[] them into closer contact with those already infected,” and are “at greater risk of more severe infections when exposed to SARS-CoV-2.” Pouran D. Faghri et al., *COVID-19 Pandemic: What has work got to do with it?*, 63 *J. of Occupational & Env’tl. Med.* e245, e247 (2021), <http://doi.org/10.1097/JOM.0000000000002154>. The workplace, in other words, presents particularized and special dangers of COVID-19 transmission and infection. OSHA was therefore right to determine that

⁷ *See also, e.g.,* Contreras, *supra*, at 1773; 117th Cong., *Memorandum re: Coronavirus*, *supra*, at 8; Hans R. House et al., *Agricultural workers in meatpacking plants presenting to an emergency department with suspected COVID-19 infection are disproportionately Black and Hispanic*, 28 *Acad. Emergency Med.* [Special Issue: (In)Equity in EM] 1012 (2021), <http://doi.org/10.1111/acem.14314>.

the virus poses an especially grave danger to America's in-person workers and to act quickly and decisively to address that grave danger.

II. Vaccines are the most effective tools for reducing COVID-19 transmission and infection in workplaces.

There is no better way to prevent the transmission, morbidity, and mortality of COVID-19 than vaccination. The scientific evidence supporting this conclusion, too, is clear. As OSHA explained, numerous large-scale studies have confirmed the “power of vaccines to safely protect individuals” from transmission and infection of COVID-19, including from the Delta variant. Pmbl.614117–19, 61431.⁸ Unvaccinated adults of prime working age (18 to 49 years) are 15.2 times more likely to be hospitalized and 17.2 times more likely to die of COVID-19 than fully vaccinated

⁸ See, e.g., Seyed M. Moghadas et al., *The impact of vaccination on COVID-19 outbreaks in the United States*, Nat'l Inst. of Health at 2 (*preprint*, revised Jan. 2, 2021), <https://doi.org/10.1101/2020.11.27.20240051> (finding that widespread COVID-19 vaccination has made a “substantial impact on mitigating COVID-19 outbreaks”); Lok Wong Samson, et al., *Associations Between County-level Vaccination Rates and COVID-19 Outcomes Among Medicare Beneficiaries*, Rep. No. HP-2021-23, Office of the Assistant Secretary for Planning and Evaluation, U.S. Dep't of Health and Hum. Servs., at 1 (Oct. 2021), <https://perma.cc/PN3Y-8J32> (estimating reduction of approximately 265,000 COVID-19 infections and 39,000 deaths among Medicare beneficiaries); see also Sumehda Gupta, et al., *Vaccinations Against COVID-19 May Have Averted Up to 140,000 Deaths in the United States*, 40 Health Affs. 1465 (2021), <http://doi.org/10.1377/hlthaff.2021.00619>; Mark W. Tenforde et al., *Association Between mRNA Vaccination and COVID-19 Hospitalization and Disease Severity*, 326 JAMA 2043, 2048 (2021) <https://doi.org/10.1001/jama.2021.19499>.

people in the same age range.⁹ And so-called “natural immunity” is no substitute: Vaccines are five times more effective in preventing serious illness and hospitalization than a previous COVID-19 infection.¹⁰

Although vaccines are generally effective at preventing infection, hospitalization, and death, they are particularly so in the workplace context. Extensive evidence has shown vaccination “reduce[s] the presence and severity of COVID-19 cases in the workplace,” and effectively “ensur[es]” that workers are protected from being infected and infecting others. Pmbl.61434, 61520, 61528–29 (citing studies). This is true for two straightforward reasons. *First*, vaccinated employees are in the aggregate significantly less likely to bring the virus into the workplace. Pmbl.61418–19; *see also, e.g.*, Pmbl.61403, 61418–19, 61435, 61438, 61528–29. *Second*, even those vaccinated workers who get infected are far less likely to spread the virus. *See id.* Although it is true that COVID-19 vaccines, like other vaccines, do

⁹ Heather M. Scobie et al., CDC, *Monitoring Incidence of COVID-19 Cases, Hospitalizations, and Deaths, by Vaccination Status—13 U.S. Jurisdictions, April 4–July 17, 2021*, 70 Morbidity & Mortality Weekly Rpt. 1284 (Sept. 10, 2021), <https://perma.cc/QD6J-P24N>; *see* Pmbl.61418.

¹⁰ Catherine H. Bozio et al., CDC, *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*, 70 Morbidity & Mortality Weekly Rpt. 1539 (Oct. 29, 2021), <https://perma.cc/RS9F-FPXJ>.

not *completely* prevent transmission of COVID-19 to others, growing evidence shows that they significantly decrease it.¹¹

A recent study of COVID-19 transmission and infection among law enforcement officers, firefighters, and other first responders highlights the vital need for vaccination of workers. The study found that the incidence of COVID-19 in unvaccinated firefighters was five times higher than in vaccinated firefighters—and *twenty times* higher for unvaccinated law enforcement officers. Alberto J. Caban-Martinez et al., *High Burden of COVID-19 among Unvaccinated Law Enforcement Officers and Firefighters*, medRxiv at 6 (*preprint*, posted Nov. 26, 2021), <https://doi.org/10.1101/2021.11.24.21266396>. On average, according to the study, first responders were sick with COVID-19 for over two weeks and missed close to 40 hours of work due to their illness. *See id.* These findings, the authors wrote, “suggest that state and local governments with large numbers of unvaccinated first responders may

¹¹ *See, e.g.,* Anika Singanayagam et al., *Community transmission and viral load kinetics of SARS-CoV-2 Delta (B.1.617.2) variant in vaccinated and unvaccinated individuals*, Lancet Infectious Diseases (2021), [https://doi.org/10.1016/S1473-3099\(21\)00648-4](https://doi.org/10.1016/S1473-3099(21)00648-4) (vaccinated individuals spread Delta to the unvaccinated at twice the rate as to the vaccinated); Po Ying Chia et al., *Virological and serological kinetics of SARS-CoV-2 Delta variant vaccine-breakthrough infections: a multi-center cohort study*, medRxiv (*preprint*, posted July 31, 2021), <https://doi.org/10.1101/2021.07.28.21261295> (shorter infectious period for vaccinated individuals); Ross J. Harris et al., *Effect of Vaccination on Household Transmission of SARS-CoV-2 in England*, New Eng. J. of Med. (Aug. 19, 2021), <https://perma.cc/MP8W-DSPM>.

face major disruptions in their workforce due to COVID-19 illness” absent meaningful vaccination-and-testing requirements. *Id.* at 4.

Other research during the COVID-19 pandemic has confirmed the efficacy of vaccination against workplace transmission and infection. A study of frontline workers from December 2020 through August 2021 concluded that “full vaccination with COVID-19 vaccines was 80% effective in preventing” COVID-19 infection, “further affirming the highly protective benefit of full vaccination up to and through the most recent summer U.S. COVID-19 pandemic waves.” Ashley Fowlkes et al., CDC, *Effectiveness of COVID-19 Vaccines in Preventing SARS-CoV-2 Infection Among Frontline Workers Before and During B.1.617.2 (Delta) Variant Predominance*, 70 Morbidity & Mortality Weekly Rpt. 1167 (Aug. 27, 2021), <https://perma.cc/Q3EW-4GYM>. And studies of vaccination in health-care workers have shown that vaccinated employees are not just less likely to be infected—on average, they miss fewer days of work and experience milder symptoms if they are infected. See Earl Strum et al., *Healthcare workers benefit from second dose of COVID-19 mRNA vaccine: Effects of partial and full vaccination on sick leave duration and symptoms* (preprint, posted Nov. 21, 2021), <https://doi.org/10.1101/2021.11.17.21266479>.¹²

¹² See also, e.g., Tamara Pilishvili et al., *Effectiveness of mRNA Covid-19 Vaccine among U.S. Health Care Personnel*, N. Eng. J. Med. (Sept. 22, 2021), <http://doi.org/10.1056/NEJMoa2106599>; Annalee Yassi et al., *Infection control, occupational and public health measures including mRNA-based vaccination against SARS-CoV-2*

Given the compelling data, it is not surprising that many employers with experience dealing with widespread COVID-19 outbreaks have recognized the need to require vaccination. To return to the meatpacking industry, as noted above, meatpacking facilities suffered particularly extensive and severe COVID-19 outbreaks in the early days of the pandemic. Several major employers responded with vaccine requirements covering their entire workforce, which have proved highly effective at achieving adherence. Less than three months after Tyson Foods mandated coronavirus vaccines for all its 120,000 U.S. workers, for example, more than 96 percent are vaccinated.¹³ This is true across industries. As OSHA explained in its rule, “[e]vidence shows that mandating vaccination has proven to be an effective method for increasing vaccination rates” and that “[s]ignificant numbers of workers would get vaccinated if their employers required it.” Pmbl.61435 (citing Kaiser Family Found., *Does The Public Want To Get A COVID-19 Vaccine* (Sept. 2021)). Indeed, “many workers who were vaccinated over the last four months were motivated by their employer requiring vaccination.” *Id.*; see, e.g., Shawn Hubler, ‘Mandates Are Working’: Employer Ultimatums Lift Vaccination Rates, So Far, N.Y. Times

infections to protect healthcare workers from variants of concern: a 14-month observational study using surveillance data, 16 PLOS ONE (2021), <https://doi.org/10.1371/journal.pone.0254920>.

¹³ Lauren Hirsch, *Days away from its deadline, Tyson Foods reaches a 96 percent vaccination rate*, N.Y. Times (Oct. 26, 2021), <https://perma.cc/B2EU-RSU6>.

(Sept. 30, 2021), <https://perma.cc/JE86-3T69> (observing that when employers require workers to get vaccinated, vaccination rates increase to over 90 percent).

Finally, it should not be overlooked that vaccination in the workplace reduces the opportunities for the virus to continue to mutate by reducing transmission and length of infection—meaning that vaccination could prevent future, more deadly, variants of COVID-19. *See* Ting-Yu Yeh & Gregory P. Contreras, *Full vaccination against COVID-19 suppresses SARS-CoV-2 delta variant and spike gene mutation frequencies and generates purifying selection pressure*, medRxiv at 2 (*preprint*, posted Aug. 10, 2021), <https://doi.org/10.1101/2021.08.08.21261768> (study of 16 countries finding that “the vaccination coverage rate is inversely correlated to the mutation frequency of the . . . SARS-CoV-2 delta variants”). The escalating global concerns about the recently discovered Omicron variant serve as a timely reminder that vaccination is an indispensable tool that not only protects worker health and safety, but can prevent widescale social and economic disruption.

III. OSHA properly determined that its vaccinate-or-test standard is essential to protect workers.

The Occupational Safety and Health Act of 1970 allows OSHA to issue emergency temporary standards when the agency “determines (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 explained above, the public-health evidence makes abundantly clear that both criteria are satisfied here. Because they work in person, employees covered by the standard are subject to severe and particularized risk of illness, hospitalization, and death as a result of COVID-19. And the empirical data collected since the release of COVID-19 vaccines indicates that vaccination is by far the most effective tool to prevent further transmission and infection.

Given the evidence, OSHA reasonably decided that its vaccinate-or-test standard was necessary to address the grave danger that COVID-19 poses to American workers. This decision is not unprecedented: The agency “has long recognized the importance of vaccinating workers against preventable illnesses to which they may be exposed on the job.” Pmbl.61433–34. In 1991, under President George H.W. Bush, OSHA adopted what is known as the “bloodborne pathogens standard” to prevent the transmission of hepatitis B, hepatitis C, and HIV. *See* 29 C.F.R. § 1910.1030. As part of that standard, the agency required employers to make the hepatitis B vaccine available to employees in any workplace with potential exposure to bloodborne pathogens. *See id.* § 1910.1030(b); *see generally Am. Dental Ass’n v. Martin*, 984 F.2d 823, 824 (7th Cir. 1993). That standard resulted in a significant increase in the number of employees accepting hepatitis B vaccination, and “a dramatic decline in the incidence of HBV infections” among covered workers. *See* Francis J. Mahoney et al., *Progress Toward the Elimination of Hepatitis B Virus Transmission*

Among Health Care Workers in the United States, 157 *Archives of Internal Med.* 2601, 2604 (1997), <http://doi.org/10.1001/archinte.1997.00440430083010>. The bloodborne pathogens standard addressed viruses whose potential transmission “between workers is minimal in comparison to the SARS-CoV-2 virus; Hepatitis B and HIV are transmitted through blood and certain body fluids, whereas the SARS-CoV-2 virus spreads through respiratory droplets that can travel through the air from worker-to-worker.” Pmbl.61436. Therefore, OSHA determined that, in the case of COVID-19, merely offering vaccination to workers would be insufficient. To protect against workplace spread of this rapidly transmitted, airborne virus, it was necessary to require vaccination or regular testing and masking. *See id.*

That determination warrants deference. As Chief Justice Roberts has recognized, the “precise question” of what restrictions should be imposed during “the pandemic is a dynamic and fact-intensive matter subject to reasonable disagreement.” *S. Bay United Pentecostal Church v. Newsom*, 140 S. Ct. 1613, 1613 (2020) (Roberts, C.J., concurring in denial of certiorari). Congress has entrusted OSHA with the responsibility to protect workplace safety and health, particularly when workers are faced with a grave danger—which the COVID-19 pandemic indisputably is. Based on an extensive administrative record replete with public-health and scientific evidence showing that vaccination is the most effective tool to prevent COVID-19 transmission and infection in the workplace, the agency issued

its vaccinate-or-test standard. Given this careful and deliberative process, OSHA’s rule “should not be subject to second-guessing by an ‘unelected federal judiciary,’ which lacks the background, competence, and expertise to assess public health.” *Id.* at 1614. This Court has held that OSHA “is entitled to great deference,” and that its organic statute “should be read broadly to afford workers the broadest possible protection.” *Nat’l Eng’g & Contracting Co. v. OSHA*, 928 F.2d 762, 768 (6th Cir. 1991). Even more so when, as here, the agency adopted its rule to deal with “changing facts on the ground.” *S. Bay United*, 140 S. Ct. at 1614 (Roberts, C.J., concurring).

And the facts on the ground continue to change. In just the last few days, countries around the world have once again closed their borders and instituted lockdowns in response to the threat of a new, more transmissible COVID-19 variant. Whatever may prove true of this latest variant, others are sure to follow. The public-health evidence has uniformly concluded that vaccines are the primary way to prevent the rise and spread of such variants, thereby protecting our nation’s workplaces and workers. Because OSHA’s vaccinate-or-test standard appropriately reflects this overwhelming scientific consensus, this Court should uphold it.

CONCLUSION

Amici curiae respectfully request that this Court grant the respondents’ emergency motion to dissolve the stay of OSHA’s rule.

Respectfully submitted,

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APPENDIX

INSTITUTIONAL *AMICI CURIAE*

American Public Health Association. APHA champions the health of all people and all communities; strengthens the profession of public health; shares the latest research and information; promotes best practices; and advocates for public health issues and policies grounded in scientific research. APHA represents more than 22,000 individual members and is the only organization that combines a nearly 150-year perspective, a broad-based member community, and the ability to influence federal policy to improve the public's health.

Association of Schools and Programs of Public Health. ASPPH is the voice of accredited academic public health, representing more than 135 schools and programs accredited by the Council on Education for Public Health. The Association seeks improved health for everyone, everywhere by strengthening the capacity of its members.

Academy of Managed Care Pharmacy. AMCP is the professional association leading the way to help patients get the medications they need at a cost they can afford. AMCP's diverse membership of pharmacists, physicians, nurses, biopharmaceutical professionals, and other health care specialists leverage their expertise in clinical evidence and economics to optimize medication benefit design and population health management. AMCP helps patients access cost-effective and safe medications, including vaccines using evidence-based medication use strategies while promoting affordable health care solutions.

Alliance of Community Health Plans. ACHP is a national leadership organization of top-performing health plans and provider organizations. ACHP's members are not-for-profit, community-based and regional health plans that provide high-quality health coverage and care to more than 24 million Americans, in 36 states and the District of Columbia. We are leading the industry in practical, proven reforms around primary care delivery, value-based payment and data-driven systems improvement.

American College of Osteopathic Emergency Physicians. ACOEP provides invaluable personal and professional support to the emergency medicine community, empowering members to provide outstanding care for themselves and their patients while successfully navigating the evolving practice of medicine.

The American College of Preventive Medicine. ACPM is a professional, medical society of more than 2,000 physicians dedicated to improving the health and quality of life of individuals, families, communities and populations. Preventive medicine physicians bridge the divide between public health and clinical practice applying their knowledge and skills in medicine, social, economic, and behavioral sciences to improve health through disease prevention and health promotion. ACPM advocates for policy and practice that bolsters disease prevention efforts and creates healthier communities.

Association of American Medical Colleges. AAMC is a nonprofit association dedicated to transforming health through medical education, health care, medical research, and community collaborations. Its members are all 155 accredited U.S. and 17 accredited Canadian medical schools; more than 400 teaching hospitals and health systems; and more than 70 academic societies.

College of American Pathologists. As the world's largest organization of board-certified pathologists and leading provider of laboratory accreditation and proficiency testing programs, CAP provides services to patients, pathologists, and the public by fostering and advocating excellence in the practice of pathology and laboratory medicine worldwide. Pathologists are physicians whose diagnoses drive care decisions made by patients, primary care and specialist physicians, and surgeons.

Council of State and Territorial Epidemiologists. CSTE works to advance public health policy and epidemiologic capacity. We support effective public health surveillance and epidemiologic practice through training, capacity development, and peer consultation; develop standards for practice; promote effective use of epidemiologic data to guide public health practice and improve health; and advocate for scientifically based policy. CSTE has 2200+ members working in applied epidemiology across all domains including occupational health, acute and chronic diseases and conditions.

National Hispanic Medical Association. Established in 1994, NHMA is a non-profit association representing the interests of 50,000 licensed Hispanic physicians in the United States. The mission of the organization is to empower Hispanic physicians to lead efforts to improve the health of Hispanic and other underserved populations in collaboration with Hispanic state medical societies, residents, medical students, and other public and private sector partners.

National Medical Association. Established in 1895, NMA is the nation's oldest and largest professional and scientific organization representing more than 50,000 African American physicians and their patients, and advocating for parity and justice in medicine, the elimination of health disparities and promotion of health equity.

National Safety Council. NSC has been America's leading safety advocate for over 100 years. As a mission-based nonprofit organization, NSC works to eliminate the leading causes of preventable death and injury, focusing our efforts on the workplace, roadways, and impairment. We create a culture of safety to keep people safer in the workplace and beyond so they can live their fullest lives. Our more than 15,500 member companies represent 7 million employees at nearly 50,000 U.S. worksites.

The Association of periOperative Registered Nurses. AORN was founded in 1949 to establish a national community for operating room nurses who sought to share best practices for patients undergoing surgery. The organization represents 43,000 professionals who share a passion for advancing perioperative nursing and ensuring patient safety and optimal outcomes.

The National League for Nursing. NLN is the oldest nursing organization in the United States, representing more than 1,200 nursing schools, 40,000 members, and 25 regional constituent leagues. The NLN provides teaching resources and faculty development opportunities to assist them to educate and clinically prepare our nation's nurses. The League promotes excellence in nursing education to build a strong, diverse nursing workforce to advance the health of our nation and the global community.

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CERTIFICATE OF COMPLIANCE

This *amicus* brief contains 4,571 words, excluding the parts of the document exempted by Federal Rule of Appellate Procedure 32(f) and 6th Circuit Rule 32(b). Because this exceeds the limits set out in Rule 27(d)(2) and Rule 29(a)(5), *amici* have concurrently filed a motion for leave to file an oversize brief. This brief complies with the typeface requirements of Rule 32(a)(5) and the type-style requirements of Rule 32(a)(6) because it has been prepared in proportionally spaced typeface using Microsoft Word in 14 point Baskerville font.

/s/Deepak Gupta
Deepak Gupta

CERTIFICATE OF SERVICE

I hereby certify that on November 30, 2021 I electronically filed the foregoing brief with the Clerk of the Court for the U.S. Court of Appeals for the Sixth Circuit by using the CM/ECF system. All participants are registered CM/ECF users, and will be served by the appellate CM/ECF system.

/s/Deepak Gupta
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