In the Supreme Court of the United States

JOHN DOE, ET AL.,

Applicants,

v.

JANET T. MILLS, IN HER OFFICIAL CAPACITY AS GOVERNOR OF THE STATE OF MAINE, ET AL.

Respondents.

ON EMERGENCY APPLICATION FOR WRIT OF INJUNCTION TO THE HONORABLE STEPHEN G. BREYER, ASSOCIATE JUSTICE OF THE UNITED STATES SUPREME COURT AND CIRCUIT JUSTICE FOR THE FIRST CIRCUIT

MOTION TO FILE BRIEF *AMICUS CURIAE* BY PUBLIC HEALTH ASSOCIATIONS AND SCHOLARS OF PUBLIC HEALTH IN SUPPORT OF RESPONDENTS

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MOTION FOR LEAVE (1) TO FILE AMICUS CURIAE BRIEF OF PUBLIC HEALTH ASSOCIATIONS AND SCHOLARS OF PUBLIC HEALTH IN SUPPORT OF RESPONDENTS AND IN OPPOSITION TO EMERGENCY APPLICATION FOR WRIT OF INJUNCTION, AND TO DO SO (2) IN AN UNBOUND FORMAT ON 8½-BY-11-INCH PAPER, AND (3) WITHOUT TEN DAYS' ADVANCE NOTICE TO THE PARTIES

Movants, public health associations and scholars of public health, respectfully request leave of the Court to (1) file the attached amicus curiae brief in support of respondents and in opposition to applicants' emergency application for a writ of injunction, (2) file the brief in an unbound format on 8½-by-11-inch paper, and (3) file the brief without ten days' advance notice to the parties.

The applicants and state-official respondents do not oppose this motion. The private-party respondents take no position on this motion.

All the proposed *amici* are individuals and nonprofit organizations that have no parent corporations and that are not owned, in whole or in part, by any publicly held corporation. The proposed amici are:

- The American Public Health Association
- Vaccinate Your Family
- National Consumers League
- Immunization Action Coalition
- Arizona Partnership for Immunization
- Dorit R. Reiss, Professor of Law and the James Edgar Hervey Chair in Litigation at the University of California, Hastings College of the Law
- Wendy E. Parmet, George J. and Kathleen Waters Matthews Distinguished Professor of Law and Professor of Public Policy and Urban Affairs at Northeastern University,
- Lance Gable, JD, MPH, Professor of Law, Wayne State University Law School
- Lindsay F. Wiley, Professor of Law & Director, Health Law & policy Program, American Univ. Washington College of Law

- Renée M. Landers, Professor of Law and Faculty Director, Health and Biomedical Law Concentration and Master of Science in Law, Life Sciences Program, Suffolk University Law School
- Stacie Kershner, JD, Associate Director, Center for Law, Health & Society, Georgia State University College of Law
- Scott Burris, Professor and Director, Center for Public Health Law Research, Temple University Beasley School of Law
- Robert I. Field, Drexel University Thomas R. Kline, School of Law and Dornsife School of Public Health
- Jonathan D. Kahn, Northeastern University School of Law
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- Michael R. Ulrich, Assistant Professor of Health Law, Ethics & Human Rights, Boston University School of Public Health and School of Law

Applicants' emergency application was docketed on October 20, 2021. In light of the October 25, 2021 deadline that was set for responding to the application, there was insufficient time for the proposed amici to prepare their brief for printing and filing in booklet form, as ordinarily required by Supreme Court Rule 33.1. Nor, for the same reason, were the proposed *amici* able to provide the parties with ten days' notice of their intent to file the attached brief, as ordinarily required by Rule 37.2(a).

For the foregoing reasons, the proposed amici respectfully request that the Court grant this motion to file the attached proposed amicus brief and accept it in the format and at the time submitted.

Respectfully submitted.

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INTERESTS OF *AMICI CURIAE*[1]

Amici curiae are a diverse group of scholars and professional organizations of public health professionals who are concerned that states and other public authorities be permitted to employ all the tools they need to combat the COVID-19 pandemic. As scholars and practitioners, *amici* have studied and worked with various institutions in organizing against this and other pandemics. In so doing, *amici* have acquired a body of knowledge and experience in the field of immunization and public health that they now seek to share with the Court.

Professor Wendy E. Parmet is the George J. and Kathleen Waters Matthews Distinguished Professor of Law and Professor of Public Policy and Urban Affairs at Northeastern University, where she is the faculty director of the Center on Health Policy and Law. Professor Parmet is the author of over 100 law review and peer reviewed articles on public health law. Her books include *The Health of Newcomers: Immigration, Health Policy and the Case for Global Solidarity,* co-authored with Patricia Illingworth (2017, NYU Press) and *Populations, Public Health, and the Law* (2009, Georgetown University Press). Professor Parmet is also Associate Editor for Law and Ethics for the American Journal of Public Health.

Professor Dorit R. Reiss is s a Professor of Law and the James Edgar Hervey Chair in Litigation at the University of California, Hastings College of the Law. She specializes in

[1] No counsel for a party authored this brief in whole or part, and no counsel or party made a monetary contribution to fund the preparation or submission of this brief. No one other than the *amici curiae* and their counsel made any monetary contribution to its preparation and submission. The parties were given notice and did not oppose this filing.

vaccines law and policy and has written widely about vaccines exemptions. She has, for example, authored "Litigating Alternative Facts: School Vaccine Mandates in the Courts." 21 J. of Con. L. 207 (2018).

The **American Public Health Association**, founded in 1872, is the nation's leading public health organization. It 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 23,000 individual members, including public health professionals, 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.

A complete list of *amici* is appended.

INTRODUCTION AND SUMMARY OF ARGUMENT

Vaccine mandates work. From the eradication of smallpox—beginning with the imposition of America's first vaccine mandate in the early 19th century—to the near elimination of polio, measles, mumps, and rubella—achieved through vaccine mandates on school children—the effectiveness of such mandates is beyond dispute. Any serious effort to end the COVID-19 pandemic must have vaccine mandates at its heart; no other public health intervention can substitute.

But, to work, vaccine mandates must be applied properly. In two recent cases—measles outbreaks in California and New York—coordinated efforts to spread misinformation about vaccines led to an increase in people claiming the religious exemption to the states' mandates. And, predictably, this led to outbreaks of what should have been preventable diseases. As a response to those outbreaks, California and New York revoked the religious exemption, and neither state has seen a measles outbreak since.

In light of these two powerful case studies, it should not be surprising that some states, when enacting COVID-19 vaccine mandates, have forgone religious exemptions. Experience has shown that the number of people who claim religious exemptions far exceeds—sometimes by orders of magnitude—those who claim and are eligible for medical exemptions. The number of people seeking religious exemptions has also fluctuated dramatically across jurisdictions and over time. Religious exemptions undermine a state's interest in public health, by putting at risk people who cannot get vaccinated, like small children, or people for whom the vaccine is less effective, like the immunocompromised. Medical exemptions—aimed as they are at protecting the health of the exempt individual—advance this interest.

A holding that states must allow religious exemptions to their COVID-19 vaccine mandates would set a dangerous precedent. It would quickly spread to other vaccine mandates and beyond, leading to a resurgence in preventable disease and undermining a public health system that has taken decades to build and that has saved countless lives.

ARGUMENT

I. Vaccine Mandates Are Essential To Reduce Community Transmission of COVID-19

Vaccine mandates are an irreplaceable tool in the fight against COVID-19. Such mandates have a strong historical track record, demonstrating their unique and vital importance in defeating disease and protecting public health.

The first vaccine mandate in the United States was a 1809 law in Massachusetts requiring universal vaccination for smallpox (with a medical exemption for certain children).[2] Vaccine mandates like that one were essential to the eradication of the disease in the United States, which occurred by 1949, as other states followed Massachusetts in imposing mandates.[3] Similarly, following a push by the Centers for Disease Control and Prevention (CDC), by 1980 every state passed mandatory vaccination laws for school children, which dramatically lowered the incidence of diseases like measles and pertussis.[4] And while it is still early

[2] Daniel A. Salmon, et al, "Compulsory vaccination and conscientious or philosophical exemptions: past, present, future," 367 The Lancet 436-42 (February 4, 2006).

[3] "Smallpox," Centers for Disease Control and Prevention (July 12, 2017) available at https://www.cdc.gov/smallpox/; Rajaie Batnij, "Historical evidence to inform COVID-19 vaccine mandates," 397 The Lancet 10276 (Feb. 27, 2021).

[4] Salmon, *supra*, at 439.

in the process, data show that widespread COVID vaccination has made a "substantial impact on mitigating COVID-19 outbreaks."[5]

With COVID-19, no public health intervention can take the place of vaccine mandates. Measures designed to encourage people to voluntarily accept vaccination have not been sufficiently effective. For instance, a recent working paper for the National Bureau of Economic Research investigated the effect of financial incentives, advertising, and other interventions on the unvaccinated and found that they "did not meaningfully increase [COVID-19] vaccination rates."[6] This result is no surprise, given the public health sector's experience with longstanding efforts to increase flu immunization, which conclusively establishes that mandates cannot be replaced by voluntary measures. A study of efforts to vaccinate healthcare workers for influenza found that *no* effort short of mandates could achieve a vaccination rate over the 90% required for herd immunity.[7]

Nor can testing and contract tracing—although a critical part of any COVID-19 mitigation strategy—take the place of vaccine mandates. For testing to have a significant effect on reducing community transmission of COVID-19—according to a study of a "multiscale

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[5] Sumehda Gupta, et al., "Vaccinations Against COVID-19 May Have Averted Up to 140,000 Deaths in the United States," 40 Health Aff. 1465 (2021); Lok Wong Samson, et al., "Associations Between County-level Vaccination Rates and COVID-19 Outcomes Among Medicare Beneficiaries," Research Report No. HP-2021-23, Office of the Assistant Secretary for Planning and Evaluation, U.S. Dept. of Health and Human Services (Oct. 2021) (estimating reduction of approximately 265,000 COVID-19 infection and 39,000 deaths among Medicare beneficiaries).

[6] Tom Chang, et al., "Financial Incentives and Other Nudges Do Not Increase COVID-19 Vaccinations among the Vaccine Hesitant," NBER Working Paper 29403 (October 2021).

[7] Tiffany L. Wang, et al., "Mandatory influenza vaccination for all healthcare personnel: a review on justification, implementation and effectiveness," 29 Current Opinion in Pediatrics 00, 4 (2017) ("promot[ion]" of voluntary vaccination at workplaces resulted in vaccination rate under 90%); see also, *e.g.*, Alexandra M. Stewart & Marisa A. Cox, "State law and influenza vaccination of health care personnel," 31 National Library of Medicine 5, 827-32 (Jan. 21, 2013) ("[O]nly an institutional mandate for influenza vaccination proved to achieve the Healthy People 2020 objective of vaccinating 90% of HCP").

model that incorporates SARS-CoV-2 transmission at the population level and daily viral load dynamics at the individual level" published in Lancet Public Health—there must be "mass diagnostic testing"—*i.e.* testing entire populations without regard to symptoms.[8] A literature review aggregating studies of COVID-19 testing strategies published in Nature Reviews revealed that mass diagnostic testing must be accompanied by contact tracing, which is "laborious and time-consuming, and becomes increasingly difficult in the context of an ongoing viral transmission" like COVID-19.[9] And all of this must be carried out by a "community [that] is fully engaged and individuals [who] comply with and participate in confinement measures and adequately use personal protective equipment."[10] Because of these "intimidating" difficulties, "only a few countries" —not including the United States—"have been able to scale such program[s] to the levels required to contain pandemic waves."[11]

II. Medical Exemptions To Vaccine Mandates Are Not Comparable To Religious Exemptions

The Court has made clear that a law that prohibits religious conduct but allows secular conduct that undermines the asserted state interest in a comparable way is not "generally applicable" and is thus subject to struct scrutiny. *Fulton v. City of Philadelphia*, 141 S. Ct. 1868, 1877 (2021). But that is not the case here. Medical exemptions are not comparable to religious exemptions for three critical reasons.

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[8] Zhanwei Du, et al., "Comparative cost-effectiveness of SARS-CoV-2 testing strategies in the USA: a modelling study," 6 Lancet Public Health 185 (Feb. 4, 2021). Note that this study was conducted before the Delta variant, which is even harder to control with non-pharmaceutical interventions, became common.

[9] Tim R. Mercer & Mark Salit, "Testing at scale during the COVID-19 pandemic," 22 Nature Reviews Genetics 415, 420 (July 2021).

[10] Olivier Vandenberg, et al., "Considerations for diagnostic COVID-19 tests," 19 Nature Reviews Microbiology 171, 180 (March 2021)

[11] Du, *supra*, at 190.

First, medical exemptions do not undermine a state's interest in public health. In enacting a vaccine mandate, the state pursues its general interest in public health by reducing the contagion, morbidity, mortality associated with COVID-19. Additionally, vaccine mandates protect people who cannot be vaccinated (small children and the medically exempt) and those for whom the vaccine is less effective (the immunocompromised, among others). The vaccine mandate likewise furthers the state's interest in public health by reducing the strain on hospitals and healthcare workers, which can be brought to the point of collapse by pandemics.[12]

Medical exemptions advance these goals. Medical exemptions allow individuals for whom the vaccine is "medically contraindicated" to forgo receiving it. This could be because an individual has a severe allergic reaction to a component of the vaccine, for example.[13] For these individuals, the risk of significant negative health effects from the vaccine outweighs the risk of ill effects from COVID-19. Thus, when the state grants exceptions for those with medical contraindications, it promotes the health and safety of everyone within its jurisdiction.

On the other hand, a state may reasonably conclude that religious exemptions undermine the state's interest in public health. Leaving aside the risks that those invoking religious exemptions take upon themselves, unvaccinated individuals spread the virus at higher rates

[12] "Hospitals Reported that COVID-19 Pandemic Has Significantly Strained Health Care Delivery," Office of Inspector General, Department of Health and Human Services (March 2021) available at https://oig.hhs.gov/oei/reports/OEI-09-21-00140.pdf

[13] "Contraindications and Precautions," Centers for Disease Control and Prevention (Oct. 8, 2021) available at https://www2.cdc.gov/vaccines/ed/covid19/pfizer/20060.asp

than the vaccinated.[14] It is harder for a state to protect people who cannot be vaccinated or for whom the vaccine is less effective, like children and the immunocompromised, from COVID-19 when the rate of transmission of the disease is elevated by a large number of people with religious exemptions. A state thus may reasonably conclude that religious exemptions directly undermine the state's interest in protecting the welfare of people who cannot be vaccinated or for whom the vaccine is less effective, without any offering any compensating public health benefit—a qualitative difference from medical exemptions.

Second, unlike medical exemptions, religious exemptions to vaccine mandates have been linked to serious outbreaks of preventable diseases in recent years. For instance, in New York during the 2018-19 school year, 654 people, mostly children, contracted measles.[15] The outbreak was heavily concentrated among those 26,000 children with religious exemptions, and, as a result, the state revoked that exemption to its vaccine mandate for school children.[16] Similarly, in 2015, California suffered a measles outbreak linked to children visiting Disneyland who were "unvaccinated because of personal beliefs."[17] As a result, California also revoked its non-medical exemptions to vaccine mandates.[18] The measles outbreak in California came just five years after that state suffered a pertussis outbreak involving 9,000

[14] While Covid-19 vaccines do not completely prevent transmission to others, increasing evidence suggests they decrease it. See, *e.g.*, Ross J. Harris, et al., "Effect of Vaccination on Household Transmission of SARS-CoV-2 in England," New England J. of Med. (June 23, 2021).

[15] Jane R. Zucker, et al., "Consequences of Undervaccination — Measles Outbreak, New York City, 2018–2019," 382 New England J. of Med. 10009-17 (March 12, 2020); Lena H. Sun, "New York City declares end to largest measles outbreak in nearly 30 years," Washington Post (Sept. 3, 2019).

[16] *Id.*

[17] "Measles Outbreak — California, December 2014–February 2015," Centers for Disease Control and Prevention (Feb. 20, 2015) available at https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6406a5.htm

[18] Lin, Rong-Gong, and Karlamangla, Soumya. "Vaccination rate jumps in California after tougher inoculation law," The Los Angeles Times (April 13, 2017).

reported cases in which ten infants died, a dramatic increase over the norm.[19] Clusters of nonmedically exempt individuals—such as those who obtained religious exemptions—played an important role in causing the outbreak, with one study concluding that outbreaks were more than twice as likely in communities with such a cluster.[20]

Crucially, the number of children with religious exemptions to New York and California's vaccine mandates rose significantly before their respective outbreaks, apparently as a consequence of coordinated efforts by anti-vaccine campaigners.[21] A similar anti-vaccination campaign is underway against the COVID-19 vaccine, complete with misinformation spread over social media networks.[22] Thus, should the Court require states to offer religious exemptions to COVID-19 vaccine mandates, we expect to see an unusually high number of people seeking them.[23]

Third, religious exemptions are not comparable to medical exceptions because many more people qualify for religious exemptions and because those people may be clustered geographically, increasing risk of transmission. Studies by the CDC and scholars have confirmed that, where a religious exemption is offered, the number of people who claim it is, on

[19] Jessica E. Atwell, et al., "Nonmedical Vaccine Exemptions and Pertussis in California, 2010," 132 Pediatrics 4 (Oct 2013).

[20] *Id.*

[21] Azhar Hussain, "The Anti-vaccination Movement: A Regression in Modern Medicine," 10 Cureus e2919 (July 2018). See also Sun *supra* ("Anti-vaccine groups had been particularly active [in New York]."); Steven Salzburg, "Whooping Cough Epidemic: Blame The Anti-Vaccination Movement," Forbes (Oct. 11, 2010).

[22] See, *e.g.*, Sahil Loomba, "Measuring the impact of COVID-19 vaccine misinformation on vaccination intent in the UK and USA," 5 Nature Human Behavior 337-48 (2021); Remarks of Professor Douglas Laycock, Hearing on Protecting Lives and Livelihoods: Vaccine Requirements and Employee Accommodations, House Subcommittee on Workforce Protection, 117 Cong. at 13 (Oct. 26, 2021) ("large and organized anti-vaccine movement").

[23] While data have yet to be systematically collected, there are signs this is already occurring. *E.g.* Michael Brice-Saddler and Jasmine Hilton, "Thousands of D.C. health care workers remain unvaccinated amid flurry of religious exemption requests," Washington Post (Oct. 2, 2021).

average, *orders of magnitude* greater than the number of people seeking a medical exemption. For instance, the CDC estimated that during the 2018-19 school year just 0.3% of kindergarteners were medically exempt from vaccine requirements while 2.2% were exempt for non-medical reasons, including religious belief.[24] In some states the percentage of kindergarteners claiming non-medical exemptions has risen as high as 7.5%, while, over a similar time period, no state had a rate of medical exemptions over 1.5% (with a median medical exemption rate of just 0.2%).[25]

The number of people claiming religious exemptions is also more unpredictable. The rate of people with medical exemptions is relatively constant, "showing little heterogeneity over time."[26] In contrast, the number of religious exemptions is much more variable over time, while remaining greater than the number of medical exemptions,[27] making it difficult for policy makers to predict and contain the transmission of the disease, which in turn increases the rate of disease transmission.

Additionally, those seeking religious exemptions often cluster geographically.[28] These clusters of unvaccinated individuals pose a greater threat to public health than if the same

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[24] Ranee Seither, et al., "Vaccination Coverage with Selected Vaccines and Exemption Rates Among Children in Kindergarten — United States, 2018–19 School Year," Centers for Disease Control and Prevention (Oct. 18, 2019), available at https://www.cdc.gov/mmwr/volumes/68/wr/mm6841e1.htm; see also, *e.g.*, Jenelle L. Mellerson, et al., "Vaccination Coverage for Selected Vaccines and Exemption Rates Among Children in Kindergarten — United States, 2017–18 School Year," Centers for Disease Control and Prevention (Oct. 18, 2018) (0.2% medical; 2.0% non-medical), available at https://www.cdc.gov/mmwr/volumes/67/wr/mm6740a3.htm.

[25] Robert A. Bednarcyk, et al., "Current landscape of nonmedical vaccination exemptions in the United States: impact of policy changes," 18 Expert Rev. Vaccines, 175-190 (Feb. 2019).

[26] *Id.*

[27] *Id.*

[28] See Atwell, *supra*, at 4.

number of unvaccinated individuals were evenly distributed because "having clusters of these susceptible children in densely populated areas further increases the likelihood of large outbreaks."[29] People with medical exemptions do not tend to cluster in the same way, and so the risks they pose are correspondingly less severe and, for that reason, not comparable to those created by religious exemptions. *Id*.

III. Requiring Religious Exemptions Will Broadly Undermine Public Health

A holding by this Court that states must allow religious exemptions to COVID-19 vaccine mandates would have broad and dangerous consequences for public health. Such a holding would undoubtedly expand to other vaccine mandates, increasing the number of unvaccinated individuals across various contexts in which states aim to control infectious diseases through vaccinations. These include healthcare institutions and emergency services, where workers and responders are often exposed to people who are immunocompromised; primary schools, with children who are vulnerable to any number of diseases like measles and pertussis; and institutions of higher learning, where students are routinely vaccinated against diseases like meningitis. These diseases are subject to vaccine mandates because of how communicable they are.

Measles, for example, "is one of the most contagious diseases."[30] According to the CDC, it is "so contagious that if one person has it, up to 90% of the people close to that person who are not immune will also become infected."[31] And "[i]nfected people can spread measles to

[29] Bednarcyk, *supra,* at 180.

[30] "Transmission of Measles," Centers for Disease Control and Prevention (Nov. 5, 2020) available at https://www.cdc.gov/measles/transmission.html

[31] *Id.*

others from four days before through four days after the rash appears."[32] Thus, one person with a religious exemption who contracts measles puts at risk everyone around them who cannot be vaccinated—because they are too young or medically exempt—for four days before the individual with the exemption is even aware they are sick. And the virus "can live for up to two hours in an airspace after an infected person leaves an area."[33] So if someone infected with measles enters a grocery store, everyone who cannot be vaccinated who enters that store over the next hour could be at risk as well.

Nor is it clear how such a holding could be limited to vaccine mandates. Should the Court rule that states must grant religious exemptions to vaccine mandates in this case, it would be only a matter of time before, say, federal prisoners demand the right to a religious exemption from tuberculosis testing. The Bureau of Prisons currently allows medical, but not religious exemptions from such tests.[34] And indeed, if healthcare workers are allowed religious exemptions to vaccine mandates, from what other mandates will they be allowed to exempt themselves? The requirement to conduct newborn screenings? The requirement to wear masks and gloves?

Over decades of hard won lessons, the United States has dramatically reduced and even eradicated many diseases that once plagued earlier generations. Vaccine mandates were and are an indispensable policy in this ongoing effort. Already, in cases like the New York and California measles outbreaks, we have seen what happens when organized efforts

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[32] *Id.*

[33] *Id.*

[34] "Clinical Guidance," Federal Bureau of Prisons 3 (Feb. 2020) available at https://www.bop.gov/resources/pdfs/TB_CPG.pdf

to undermine vaccine mandates succeed. So far, states have been able to limit the damage from those efforts by eliminating religious exemptions. But should the Court hold that such exemptions are constitutionally required, states would lose that tool. The consequences for public health would be predictable and disastrous. For that reason, and for those offered above, we urge this Court to reject claims for religious exemptions from COVID-19 vaccination mandates.

CONCLUSION

The decision below should be affirmed.

Respectfully submitted.

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OCTOBER 2021

APPENDIX

PUBLIC HEALTH ASSOCIATIONS AND SCHOLARS OF PUBLIC HEALTH AS *AMICI*

This Appendix provides amici's titles and institutional affiliations for identification purposes only. The listing of these affiliations does not imply any endorsement of the view expressed herein by *amici*'s institutions.

- The American Public Health Association
- Vaccinate Your Family
- National Consumers League
- Immunization Action Coalition
- Arizona Partnership for Immunization
- Dorit R. Reiss, Professor of Law and the James Edgar Hervey Chair in Litigation at the University of California, Hastings College of the Law
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