AMERICAN CONSTITUTIONALISM

VOLUME I: STRUCTURES OF GOVERNMENT

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Supplementary Material

Chapter 12: The Contemporary Era – Separation of Powers/Nondelegation of Legislative Powers

**Biden v. Missouri, \_\_\_ U.S. \_\_\_** (2022)

*President Joseph Biden on September 9, 2021 announced that the Centers for Medicare and Medicaid Services (CMS) would require all workers to be vaccinated. The CMS issued the rule on November 5, 2021, but implementation was delayed until December 6, 2021. Missouri and other states immediately challenged the rule, claiming that the CMS had no statutory authority to issue the rule and that the CMS had failed to provide for notice and comment before issuing the rule. The local district court agreed and issued preliminary injunction which was sustained by the Court of Appeals for the Eight Circuit. Biden appealed to the Supreme Court of the United States.*

*The Supreme Court by a 5-4 vote reversed the Eighth Circuit. The per curiam opinion held that Congress had authorized this vaccine mandate and that the CMS had good cause under federal law to forego notice and comment. Compare* Biden v. Missouri *(2022) with* National Federation of Independent Business v. Department of Labor, Occupational Safety and Health Administration *(2022). Why did the Court declare that Congress had delegated the power to the CMS to issue a vaccine mandate to health care facilities but that Congress had not delegated the power to OSHA to issue a vaccine mandate to private employers? Note that only two justices (Chief Justice John Roberts and Justice Brett Kavanaugh) thought there was a distinction. Is there a distinction? What is that distinction? Are the dissenters in both cases right that no distinction between the cases exist? If so, does this suggest the orders are legal or illegal?*

Per Curiam.

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First, we agree with the Government that the Secretary's rule falls within the authorities that Congress has conferred upon him.

Congress has authorized the Secretary to impose conditions on the receipt of Medicaid and Medicare funds that “the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services.”  COVID–19 is a highly contagious, dangerous, and—especially for Medicare and Medicaid patients—deadly disease. The Secretary of Health and Human Services determined that a COVID–19 vaccine mandate will substantially reduce the likelihood that healthcare workers will contract the virus and transmit it to their patients.  He accordingly concluded that a vaccine mandate is “necessary to promote and protect patient health and safety” in the face of the ongoing pandemic.

The rule thus fits neatly within the language of the statute. After all, ensuring that providers take steps to avoid transmitting a dangerous virus to their patients is consistent with the fundamental principle of the medical profession: first, do no harm. It would be the “very opposite of efficient and effective administration for a facility that is supposed to make people well to make them sick with COVID–19.”

. . . . [H]ealthcare facilities that wish to participate in Medicare and Medicaid have always been obligated to satisfy a host of conditions that address the safe and effective provision of healthcare, not simply sound accounting. Such requirements govern in detail, for instance, the amount of time after admission or surgery within which a hospital patient must be examined and by whom,  the procurement, transportation, and transplantation of human kidneys, livers, hearts, lungs, and [pancreases](https://1.next.westlaw.com/Link/Document/FullText?entityType=bdrug&entityId=I3707743e475111db9765f9243f53508a&originationContext=document&transitionType=DocumentItem&contextData=(sc.Default)&ppcid=cca2b11c7ba14049b2547f0f7c55b3b5), the tasks that may be delegated by a physician to a physician assistant or nurse practitioner, and, most pertinent here, the programs that hospitals must implement to govern the “surveillance, prevention, and control of ... infectious diseases.” Moreover, the Secretary routinely imposes conditions of participation that relate to the qualifications and duties of healthcare workers themselves. And the Secretary has always justified these sorts of requirements by citing his authorities to protect patient health and safety. . . .

Indeed, respondents do not contest the validity of this longstanding litany of health-related participation conditions. When asked at oral argument whether the Secretary could, using the very same statutory authorities at issue here, require hospital employees to wear gloves, sterilize instruments, wash their hands in a certain way and at certain intervals, and the like, Missouri answered yes: “[T]he Secretary certainly has authority to implement all kinds of infection control measures at these facilities.” Of course the vaccine mandate goes further than what the Secretary has done in the past to implement infection control. But he has never had to address an infection problem of this scale and scope before. In any event, there can be no doubt that addressing infection problems in Medicare and Medicaid facilities is what he does.

And his response is not a surprising one. [Vaccination](https://1.next.westlaw.com/Link/Document/FullText?entityType=mproc&entityId=Iaff07d61475411db9765f9243f53508a&originationContext=document&transitionType=DocumentItem&contextData=(sc.Default)&ppcid=cca2b11c7ba14049b2547f0f7c55b3b5) requirements are a common feature of the provision of healthcare in America: Healthcare workers around the country are ordinarily required to be vaccinated for diseases such as [hepatitis B](https://1.next.westlaw.com/Link/Document/FullText?entityType=disease&entityId=Icb540ebf475411db9765f9243f53508a&originationContext=document&transitionType=DocumentItem&contextData=(sc.Default)&ppcid=cca2b11c7ba14049b2547f0f7c55b3b5), [influenza](https://1.next.westlaw.com/Link/Document/FullText?entityType=disease&entityId=Ibe3faab6475411db9765f9243f53508a&originationContext=document&transitionType=DocumentItem&contextData=(sc.Default)&ppcid=cca2b11c7ba14049b2547f0f7c55b3b5), and [measles](https://1.next.westlaw.com/Link/Document/FullText?entityType=disease&entityId=Ib522241f475411db9765f9243f53508a&originationContext=document&transitionType=DocumentItem&contextData=(sc.Default)&ppcid=cca2b11c7ba14049b2547f0f7c55b3b5), mumps, and [rubella](https://1.next.westlaw.com/Link/Document/FullText?entityType=disease&entityId=Ib89b1dfa475411db9765f9243f53508a&originationContext=document&transitionType=DocumentItem&contextData=(sc.Default)&ppcid=cca2b11c7ba14049b2547f0f7c55b3b5). As the Secretary explained, these pre-existing state requirements are a major reason the agency has not previously adopted vaccine mandates as a condition of participation.

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. . . . [T]he interim rule is not arbitrary and capricious. Given the rulemaking record, it cannot be maintained that the Secretary failed to “examine the relevant data and articulate a satisfactory explanation for” his decisions to (1) impose the vaccine mandate instead of a testing mandate; (2) require [vaccination](https://1.next.westlaw.com/Link/Document/FullText?entityType=mproc&entityId=Iaff07d61475411db9765f9243f53508a&originationContext=document&transitionType=DocumentItem&contextData=(sc.Default)&ppcid=cca2b11c7ba14049b2547f0f7c55b3b5) of employees with “natural immunity” from prior COVID–19 illness; and (3) depart from the agency's prior approach of merely encouraging [vaccination](https://1.next.westlaw.com/Link/Document/FullText?entityType=mproc&entityId=Iaff07d61475411db9765f9243f53508a&originationContext=document&transitionType=DocumentItem&contextData=(sc.Default)&ppcid=cca2b11c7ba14049b2547f0f7c55b3b5).  Nor is it the case that the Secretary “entirely failed to consider” that the rule might cause staffing shortages, including in rural areas.  As to the additional flaws the District Courts found in the Secretary's analysis, particularly concerning the nature of the data relied upon, the role of courts in reviewing arbitrary and capricious challenges is to “simply ensur[e] that the agency has acted within a zone of reasonableness.”

. . . Justice ALITO takes issue with the Secretary's finding of good cause to delay notice and comment. But the Secretary's finding that accelerated promulgation of the rule in advance of the winter flu season would significantly reduce COVID–19 infections, hospitalizations, and deaths,  constitutes the “something specific,”  required to forgo notice and comment. And we cannot say that in this instance the two months the agency took to prepare a 73-page rule constitutes “delay” inconsistent with the Secretary's finding of good cause. Second, we agree with the Secretary that he was not required to “consult with appropriate State agencies,”  in advance of issuing the interim rule. Consistent with the existence of the good cause exception, which was properly invoked here, consultation during the deferred notice-and-comment period is permissible. We similarly concur with the Secretary that he need not prepare a regulatory impact analysis discussing a rule's effect on small rural hospitals when he acts through an interim final rule; that requirement applies only where the Secretary proceeds on the basis of a “notice of proposed rulemaking,”  followed by a “final version of [the] rule.”

The challenges posed by a global pandemic do not allow a federal agency to exercise power that Congress has not conferred upon it. At the same time, such unprecedented circumstances provide no grounds for limiting the exercise of authorities the agency has long been recognized to have. Because the latter principle governs in these cases, the applications for a stay presented to Justice ALITO and Justice KAVANAUGH and by them referred to the Court are granted.

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Justice [THOMAS](https://1.next.westlaw.com/Link/Document/FullText?findType=h&pubNum=176284&cite=0216654601&originatingDoc=I323fb9a374a711eca163ded3a824bfdf&refType=RQ&originationContext=document&transitionType=DocumentItem&ppcid=cca2b11c7ba14049b2547f0f7c55b3b5&contextData=(sc.Search)&analyticGuid=I323fb9a374a711eca163ded3a824bfdf), with whom Justice [ALITO](https://1.next.westlaw.com/Link/Document/FullText?findType=h&pubNum=176284&cite=0153052401&originatingDoc=I323fb9a374a711eca163ded3a824bfdf&refType=RQ&originationContext=document&transitionType=DocumentItem&ppcid=cca2b11c7ba14049b2547f0f7c55b3b5&contextData=(sc.Search)&analyticGuid=I323fb9a374a711eca163ded3a824bfdf), Justice [GORSUCH](https://1.next.westlaw.com/Link/Document/FullText?findType=h&pubNum=176284&cite=0183411701&originatingDoc=I323fb9a374a711eca163ded3a824bfdf&refType=RQ&originationContext=document&transitionType=DocumentItem&ppcid=cca2b11c7ba14049b2547f0f7c55b3b5&contextData=(sc.Search)&analyticGuid=I323fb9a374a711eca163ded3a824bfdf), and Justice [BARRETT](https://1.next.westlaw.com/Link/Document/FullText?findType=h&pubNum=176284&cite=0505709001&originatingDoc=I323fb9a374a711eca163ded3a824bfdf&refType=RQ&originationContext=document&transitionType=DocumentItem&ppcid=cca2b11c7ba14049b2547f0f7c55b3b5&contextData=(sc.Search)&analyticGuid=I323fb9a374a711eca163ded3a824bfdf) join, dissenting.

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To obtain a stay, the Government must show that there is (1) a reasonable probability that we would grant certiorari; (2) a fair prospect that we would reverse the judgments below; and (3) a likelihood that irreparable harm will result from denying a stay. . . .

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. . . . Rules carrying out the “administration” of Medicare and Medicaid are those that serve “the practical management and direction” of those programs. Such rules are “necessary” to “administration” if they bear “an actual and discernible nexus” to the programs’ practical management.  Here, the omnibus rule compels millions of healthcare workers to undergo an unwanted medical procedure that “cannot be removed at the end  To the extent the rule has any connection to the management of Medicare and Medicaid, it is at most a “tangential” one.

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The Government has not made a strong showing that this agglomeration of statutes authorizes any such rule. To start, 5 of the 15 facility-specific statutes do not authorize CMS to impose “health and safety” regulations at all. . . . The Government has not made a strong showing that this hodgepodge of provisions authorizes a nationwide vaccine mandate. We presume that Congress does not hide “fundamental details of a regulatory scheme in vague or ancillary provisions.”  Yet here, the Government proposes to find virtually unlimited [vaccination](https://1.next.westlaw.com/Link/Document/FullText?entityType=mproc&entityId=Iaff07d61475411db9765f9243f53508a&originationContext=document&transitionType=DocumentItem&contextData=(sc.Default)&ppcid=cca2b11c7ba14049b2547f0f7c55b3b5) power, over millions of healthcare workers, in definitional provisions, a saving clause, and a provision regarding long-term care facilities’ sanitation procedures. The Government has not explained why Congress would have used these ancillary provisions to house what can only be characterized as a “fundamental detail” of the statutory scheme. Had Congress wanted to grant CMS power to impose a vaccine mandate across all facility types, it would have done what it has done elsewhere—specifically authorize one.

Nonetheless, even if I were to accept that Congress could have hidden vaccine-mandate power in statutory definitions, the language in these “health and safety” provisions does not suggest that Congress did so. Take, for example, [42 U. S. C. § 1395x(e)](https://1.next.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000546&cite=42USCAS1395X&originatingDoc=I323fb9a374a711eca163ded3a824bfdf&refType=RB&originationContext=document&transitionType=DocumentItem&ppcid=cca2b11c7ba14049b2547f0f7c55b3b5&contextData=(sc.Search)#co_pp_7fdd00001ca15), which defines “hospital” for certain purposes. Three subsections define hospitals as providers of specific patient services, and five describe administrative requirements that a facility must meet to qualify as a covered hospital. The final subsection then provides that a “hospital” must also “mee[t] *such* *other* requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services.”

Contrary to the Government's position, this kind of catchall provision does not authorize every regulation related to “health and safety.” As with all statutory language, context must inform the scope of the provision. . . .  Here, in [§ 1395x(e)](https://1.next.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000546&cite=42USCAS1395X&originatingDoc=I323fb9a374a711eca163ded3a824bfdf&refType=RB&originationContext=document&transitionType=DocumentItem&ppcid=cca2b11c7ba14049b2547f0f7c55b3b5&contextData=(sc.Search)#co_pp_7fdd00001ca15), none of the myriad subsections preceding the “health and safety” subsection suggests that the Government can order hospitals to require virtually all hospital personnel to be vaccinated. Rather, these subsections show that HHS’ residual authority embraces only administrative requirements like those that precede it—including “provid[ing] 24-hour nursing service,” “maintain[ing] clinical records on all patients,” or having “bylaws in effect.”  A requirement that all healthcare workers be vaccinated is plainly different in kind.

Only one facility-specific provision is arguably different. It regulates long-term care facilities and mandates an “infection control program” among its “health and safety” provisions.  But that infection-control provision focuses on sanitizing the facilities’ “environment,” not its personnel.  In any event, even if this statutory language justified a vaccine mandate in long-term care facilities, it could not sustain the omnibus rule. Neither the “infection control” language nor a reasonable analog appears in any of the other facility-specific provisions. Basic interpretive principles would thus suggest that CMS lacks vaccine-mandating authority with respect to the other types of facilities. . . .

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. . . . CMS regulations that mandate the number of hours a dietician must practice under supervision,  or that prescribe “the tasks that may be delegated ... to a physician assistant or nurse practitioner,” cannot support a vaccine mandate for healthcare personnel. The Court also invokes a regulation requiring hospitals to implement programs that “govern the ‘surveillance, prevention, and control of ... infectious diseases,’ ”  as well as a few regulations that require “infection and prevention control programs” at some (but apparently not all) facility typesBut many of these infection-control regulations, are far afield from immunization. And insofar as they do touch on immunization, they require only that facilities *offer* their *residents* the opportunity to obtain a vaccine, along with “the opportunity to refuse” it.  These regulations are not precedents for CMS’ newfound authority *mandating* that all*employees* be vaccinated.

Finally, our precedents confirm that the Government has failed to make a strong showing on the merits. “We expect Congress to speak clearly when authorizing an agency to exercise powers of vast economic and political significance.” And we expect Congress to use “exceedingly clear language if it wishes to significantly alter the balance between state and federal power.” [*Ibid.*](https://1.next.westlaw.com/Link/Document/FullText?findType=Y&serNum=2054383217&pubNum=0000708&originatingDoc=I323fb9a374a711eca163ded3a824bfdf&refType=RP&originationContext=document&transitionType=DocumentItem&ppcid=cca2b11c7ba14049b2547f0f7c55b3b5&contextData=(sc.Search))(internal quotation marks omitted). The omnibus rule is undoubtedly significant—it requires millions of healthcare workers to choose between losing their livelihoods and acquiescing to a vaccine they have rejected for months. Vaccine mandates also fall squarely within a State's police power, and, until now, only rarely have been a tool of the Federal Government. If Congress had wanted to grant CMS authority to impose a nationwide vaccine mandate, and consequently alter the state-federal balance, it would have said so clearly. It did not.

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

Justice [ALITO](https://1.next.westlaw.com/Link/Document/FullText?findType=h&pubNum=176284&cite=0153052401&originatingDoc=I323fb9a374a711eca163ded3a824bfdf&refType=RQ&originationContext=document&transitionType=DocumentItem&ppcid=cca2b11c7ba14049b2547f0f7c55b3b5&contextData=(sc.Search)&analyticGuid=I323fb9a374a711eca163ded3a824bfdf), with whom Justice [THOMAS](https://1.next.westlaw.com/Link/Document/FullText?findType=h&pubNum=176284&cite=0216654601&originatingDoc=I323fb9a374a711eca163ded3a824bfdf&refType=RQ&originationContext=document&transitionType=DocumentItem&ppcid=cca2b11c7ba14049b2547f0f7c55b3b5&contextData=(sc.Search)&analyticGuid=I323fb9a374a711eca163ded3a824bfdf), Justice [GORSUCH](https://1.next.westlaw.com/Link/Document/FullText?findType=h&pubNum=176284&cite=0183411701&originatingDoc=I323fb9a374a711eca163ded3a824bfdf&refType=RQ&originationContext=document&transitionType=DocumentItem&ppcid=cca2b11c7ba14049b2547f0f7c55b3b5&contextData=(sc.Search)&analyticGuid=I323fb9a374a711eca163ded3a824bfdf), and Justice [BARRETT](https://1.next.westlaw.com/Link/Document/FullText?findType=h&pubNum=176284&cite=0505709001&originatingDoc=I323fb9a374a711eca163ded3a824bfdf&refType=RQ&originationContext=document&transitionType=DocumentItem&ppcid=cca2b11c7ba14049b2547f0f7c55b3b5&contextData=(sc.Search)&analyticGuid=I323fb9a374a711eca163ded3a824bfdf) join, dissenting.

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

But even if the Federal Government has the authority to require the [vaccination](https://1.next.westlaw.com/Link/Document/FullText?entityType=mproc&entityId=Iaff07d61475411db9765f9243f53508a&originationContext=document&transitionType=DocumentItem&contextData=(sc.Default)&ppcid=cca2b11c7ba14049b2547f0f7c55b3b5) of healthcare workers, it did not have the authority to impose that requirement in the way it did. Under our Constitution, the authority to make laws that impose obligations on the American people is conferred on Congress, whose Members are elected by the people. Elected representatives solicit the views of their constituents, listen to their complaints and requests, and make a great effort to accommodate their concerns. Today, however, most federal law is not made by Congress. It comes in the form of rules issued by unelected administrators. In order to give individuals and entities who may be seriously impacted by agency rules at least some opportunity to make their views heard and to have them given serious consideration, Congress has clearly required that agencies comply with basic procedural safeguards. Except in rare cases, an agency must provide public notice of proposed rules,  the public must be given the opportunity to comment on those proposals, [§ 553(c)](https://1.next.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000546&cite=5USCAS553&originatingDoc=I323fb9a374a711eca163ded3a824bfdf&refType=RB&originationContext=document&transitionType=DocumentItem&ppcid=cca2b11c7ba14049b2547f0f7c55b3b5&contextData=(sc.Search)#co_pp_4b24000003ba5); and if the agency issues the rule, it must address concerns raised during the notice-and-comment process.  The rule may then be challenged in court, and the court may declare the rule unlawful if these procedures have not been followed.

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

Because of the importance of notice-and-comment rulemaking, an agency must show “good cause” if it wishes to skip that process. Although this Court has never precisely defined what an agency must do to demonstrate good cause, federal courts have consistently held that exceptions to notice-and-comment must be “ ‘narrowly construed and only reluctantly countenanced.’ ”

The agency that issued the mandate at issue here, *i.e.*, the Centers for Medicare and Medicaid Services (CMS), admits it did not comply with the commonsense measure of seeking public input before placing binding rules on millions of people, but it claims that “[t]he data showing the vital importance of [vaccination](https://1.next.westlaw.com/Link/Document/FullText?entityType=mproc&entityId=Iaff07d61475411db9765f9243f53508a&originationContext=document&transitionType=DocumentItem&contextData=(sc.Default)&ppcid=cca2b11c7ba14049b2547f0f7c55b3b5)” indicate that it “cannot delay taking this action.”  But CMS's generalized justification cannot alone establish good cause to dispense with Congress's clear procedural safeguards. An agency seeking to show good cause must “point to something specific that illustrates a particular harm that will be caused by the delay required for notice and comment.”

Although CMS argues that an emergency justifies swift action, both District Courts below held that CMS fatally undercut that justification with its own repeated delays. The vaccines that CMS now claims are vital had been widely available 10 months before CMS's mandate, and millions of healthcare workers had already been vaccinated before the agency took action.

 President Biden announced the CMS mandate on September 9, 2021, nearly two months before the agency released the rule on November 5, and the mandate itself delayed the compliance deadline further by another month until December 6.  This is hardly swift.

. . . [I]it is CMS's affirmative burden to show it has good cause, not respondents’ burden to prove the negative.  Congress placed procedural safeguards on executive rulemaking so agencies would consider “important aspect[s] of the problem[s]” they seek to address before restricting the liberty of the people they regulate.  Because CMS chose to circumvent notice-and-comment, States that run Medicaid facilities, as well as other regulated parties, had no opportunity to present evidence refuting or contradicting CMS's justifications before the rule bound them. . . .

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

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