

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

HEALTH FREEDOM DEFENSE FUND, *et al.*,

*Plaintiffs-Appellees,*

v.

JOSEPH R. BIDEN, JR. President of the United States, *et al.*,

*Defendants-Appellants.*

On Appeal from the United States District Court  
for the Middle District of Florida

**BRIEF OF *AMICI CURIAE* PUBLIC HEALTH AND PUBLIC HEALTH LAW EXPERTS  
IN SUPPORT OF DEFENDANTS-APPELLANTS AND REVERSAL**

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**CERTIFICATE OF INTERESTED PERSONS AND CORPORATE  
DISCLOSURE STATEMENT**

Pursuant to Fed. R. App. P. 26.1 and 11th Cir. R. 26.1, *amici curiae* state that, in addition to the persons listed in the Certificates of Interested Persons and Corporate Disclosure Statements that were previously filed, the following persons and entities have an interest in the outcome of this case:

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2. Alexander, Melissa Ballengee
3. American Public Health Association (APHA)
4. Ansorg, Henning
5. Arons, Paul
6. Ashe, Marice
7. Association of American Medical Colleges (AAMC)
8. Autistic Self Advocacy Network (ASAN)
9. Auwaerter, Paul G.
10. Barbot, Oxiris
11. Bard, Jennifer S.
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14. Beckerman, Julia Zoe
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35. Chandler, G. Thomas
36. ChangeLab Solutions
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38. Cohen, Alan B.
39. Convertino, Victoria L.
40. Council of State and Territorial Epidemiologists (CSTE)
41. Crockett, Landis
42. Cronin, Chrysan
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45. Dart, Bruce
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47. DeBruin, Debra
48. Deitchman, Scott
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183. Piatt, Jennifer
184. Pollack, Harold
185. Powderly, William G.
186. Public Health Accreditation Board (PHAB)
187. Public Health Advocacy Institute (PHAI)
188. Public Health Law Center
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191. Raifman, Julia
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193. Recht, Jim

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195. Reiss, Dorit Rubinstein
196. Relman, David A.
197. Relucio, Karen
198. Reverby, Susan M.
199. Richman, Douglas D.
200. Rimer, Barbara K.
201. Robert Wood Johnson Foundation (RWJF)
202. Roper, William L.
203. Rosenbaum, Sara
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*Amici* further state that the APHA, AAMC, ASAN, Center for Public Health Law Research at Temple University James E. Beasley School of Law, ChangeLab Solutions, CSTE, Epilepsy Foundation, GSA, IDSA, JHCHS, NACDD, Network for Public Health Law, O’Neill Institute for National and Global Health Law, Georgetown University Law Center, PHAB, PHAI, Public Health Law Center, Public Health Law Watch, RWJF, Stop TB USA, and Task Force for Global Health are nonprofit organizations with no parent companies and no publicly traded stock.

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## **INTEREST OF *AMICI CURIAE*<sup>1</sup>**

The appendix to this brief includes the full list of individual *amici*. They appear in their personal capacities.

The individual *amici* include **Seven Former Federal Agency Leaders** of the Centers for Disease Control (six) or the Food and Drug Administration (one). They have led the nation's response to health emergencies, ranging from XDR TB to SARS, MERS, Zika, Influenza H1N1, and Ebola. With decades of experience, they are in a unique position to understand the health challenges the nation faces, along with the tools the CDC needs to curb the international importation and interstate spread of novel infectious diseases.

The individual *amici* also include **224 Deans, Chairs, Scholars, Public Health Professionals, and COVID-19 Response Leaders** who have expertise in public health, medicine, health policy, and law. *Amici* include 24 Deans and seven Department Chairs from leading schools of public health, medicine, nursing, and law from throughout the United States. The 193 Scholars and Public Health Practitioners include current and retired health agency leadership from federal, state, local, territorial, and tribal government agencies on the frontlines of our nation's

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<sup>1</sup> No party's counsel authored this brief in whole or in part. No party or party's counsel contributed money that was intended to fund preparing or submitting this brief. No person beyond *amici curiae* or their counsel contributed money intended to fund preparing and submitting this brief.

COVID-19 response. They also reflect scholars who have spent decades studying public health law, as well as governmental and non-governmental leaders who helped create the backbone of public health prevention and protection during the COVID-19 pandemic. Moreover, many are medical professionals working directly with individuals and communities who are at high-risk for death or long-term disability from COVID-19.

The **American Public Health Association (APHA)** is a 150-year-old organization of nearly 22,000 public health professionals. APHA champions the health of all people and all communities, strengthens the profession of public health, shares research and information, promotes best practices, and advocates for public health issues and policies grounded in scientific research.

The **Association of American Medical Colleges (AAMC)** is a nonprofit dedicated to improving health through medical education, health care, medical research, and community collaborations. Its members comprise: all 155 accredited U.S. and 16 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems; and more than 70 academic societies.

The **Autistic Self Advocacy Network (ASAN)** is a nonprofit organization run by and for autistic individuals that provides public education and promotes public policies that benefit autistic individuals and individuals with developmental or other disabilities.



The **Center for Public Health Law Research at Temple University James E. Beasley School of Law** supports the effective use of law for public health through research and training.

**ChangeLab Solutions** is a nonpartisan nonprofit that uses the tools of law and policy to advance health equity. It partners with communities across the nation to improve health and opportunity by changing harmful laws, policies, and systems.

The **Council of State and Territorial Epidemiologists (CSTE)** is a nonprofit membership organization of states and territories. CSTE uses the power of epidemiology to fight the spread of diseases and conditions of public health significance. CSTE works to advance public health policy and increase epidemiologic capacity.

The **Epilepsy Foundation** is an advocacy organization leading the fight to overcome the challenges of living with epilepsy and accelerating therapies to stop seizures, find cures, and save lives. In collaboration with community and network partners, the Foundation facilitates connections and promotes education, policy, research, and systemic change.

The **Gerontological Society of America (GSA)** is the oldest and largest interdisciplinary organization devoted to research, education, and practice in the field of aging. The mission of GSA is to advance innovation in aging by fostering

scientific collaboration between researchers, clinicians, educators, and policymakers.

The **Infectious Diseases Society of America (IDSA)** is a nonprofit membership organization with over 12,000 physicians, scientists, and public health experts who specialize in infectious diseases with a purpose to improve the health of individuals, communities, and society by promoting excellence in patient care, education, research, public health, and prevention related to infectious diseases.

The **Johns Hopkins Center for Health Security (JHCHS)** has a mission to protect people's health from epidemics and disasters and to ensure that communities are resilient to major challenges. JHCHS focuses on global health security, emerging infectious diseases and epidemics, medical and public health preparedness and response, deliberate biological threats, and opportunities and risks in the life sciences.

The **National Association of Chronic Disease Directors (NACDD)** improves the health of the public by strengthening state- and territorial-based leadership and expertise for chronic disease prevention and management. NACDD's members protect the health of the public through primary and secondary prevention efforts and work "upstream" on root causes of chronic conditions.

The **Network for Public Health Law** provides nonpartisan legal technical assistance and resources, collaborating with a broad set of partners across sectors to

expand and enhance the use of practical legal and policy solutions to make our communities safer, healthier, stronger, and more equitable. The views expressed in this brief are solely those of Network staff and may not represent those of any affiliated individuals or institutions, including funders and constituents.

The **O’Neill Institute for National and Global Health Law, Georgetown University Law Center** contributes to solving critical health challenges in the United States and across the globe by engaging with policymakers, academics, and journalists on research and advocacy to end pandemics, ensure human rights, and build the right to health around the world.

The **Public Health Accreditation Board (PHAB)** is a nonprofit organization dedicated to advancing the continuous quality improvement of Tribal, state, local, and territorial public health departments.

The **Public Health Advocacy Institute (PHAI) at Northeastern University School of Law** is a nonprofit legal research and advocacy center focused on public health issues. PHAI is committed to research in public health law and policy development, legal technical assistance, and collaborative work at the intersection of law and public health.

The **Public Health Law Center**, a nonprofit public interest legal center at the Mitchell Hamline School of Law, helps community leaders nationwide reduce

chronic disease and advance healthy equity by strengthening the law in dozens of policy areas.

**Public Health Law Watch** is a project of the George Consortium, a nationwide network of over 80 public health law scholars, academics, experts, and practitioners who are dedicated to advancing public health through law.

The **Robert Wood Johnson Foundation (RWJF)** is the nation's largest philanthropy dedicated solely to health. It supports efforts to build a national Culture of Health rooted in equity that provides every individual with a fair and just opportunity for health and well-being.

**Stop TB USA** is an independent nonprofit organization that is dedicated to sharing resources, news, reports, and peer-reviewed publications on TB and other respiratory diseases like COVID-19.

The **Task Force for Global Health** is an international, nonprofit organization that partners to eliminate diseases that have plagued humanity for centuries and to protect the health of populations by helping countries build strong health systems so that all people can realize their right to living a healthy life.

## **STATEMENT OF THE ISSUE**

Whether the District Court incorrectly vacated the Centers for Disease Control and Prevention's (CDC) masking requirement for public transportation ("Mask Mandate"), which was intended to minimize the spread of COVID-19.

## INTRODUCTION AND SUMMARY OF ARGUMENT

The CDC’s masking requirement for transportation was an exercise of its core regulatory powers to stop the spread of communicable diseases through international and interstate transportation. Among Congress’s primary motivations in delegating authority to federal public health agencies (which came to include the CDC) was to enable them to act where states alone could not—including to limit infectious disease spread due to travel between jurisdictions. To accomplish this purpose, Congress granted the CDC flexibility to design measures to combat new contagious diseases. The CDC’s Mask Mandate is not only a proper exercise of that authority; it is precisely the type of federal action for which the CDC was established.

As such, the Mask Mandate fits comfortably within the plain text of Section 361 of the Public Health Services Act (PHSA), codified at 42 U.S.C. § 264. First, the Mask Mandate is a “sanitation” measure, as that term was historically understood—both popularly and especially in the public health context. Second, the masking requirement falls squarely within the statute’s catchall clause, which sweeps in “other measures” that the CDC deems necessary to prevent the spread of disease.

The Mask Mandate is a proper exercise of the CDC’s delegated authority. Accordingly, *amici* ask the Court to reverse the District Court’s decision below.

## ARGUMENT

### I. The CDC's Mask Mandate Is an Exercise of the Agency's Core Regulatory Function

The CDC's core powers include undertaking measures "to prevent the spread of infectious diseases into and throughout the United States." *Laws and Regulations*, Ctrs. for Disease Control & Prevention (Oct. 13, 2021), <https://www.cdc.gov/ncezid/dgmaq/laws-and-regulations.html>; *see also CDC Regulations*, Ctrs. for Disease Control & Prevention (June 30, 2016), <https://www.cdc.gov/regulations/index.html>.

Infectious diseases do not recognize jurisdictional boundaries. For this reason, the CDC and its predecessors<sup>2</sup> have long exercised regulatory authority at national and state borders. This history, along with the rise of air travel and the growth of interstate transit, informed Congress's approach in passing the PHSA. *See, e.g., Hearing on H.R. 3379: A Bill to Codify the Laws Relating to the Public Health*

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<sup>2</sup> The CDC is a part of the Department of Health and Human Services (HHS) that with other agencies, like the Food and Drug Administration (FDA), form the nation's present-day federal public health apparatus. *See HHS Organizational Chart*, U.S. Dep't of Health & Hum. Servs. (Apr. 14, 2022), <https://www.hhs.gov/about/agencies/orgchart/index.html>. This brief references the CDC's currently delegated authority, which other agencies have held previously. *See* Wen W. Shen, Cong. Rsch. Serv., R46758, *Scope of CDC Authority Under Section 361 of the Public Health Service Act (PHSA)* 11–12 (2021) (discussing the delegation of § 264 authority to, *inter alia*, the Public Health Service, the FDA, and the CDC).

*Service, and for Other Purposes Before a Subcomm. of the H. Comm. on Interstate & Foreign Commerce*, 78th Cong. 45 (1944) (in which the Surgeon General testified, in advocating for certain regulatory powers, that “the revolution in travel brought about by the airplane has necessitated the revolution of our methods of control and our defense against disease”); *see also* H.R. Rep. No. 1364, at 24–25 (1944) (in enacting § 264 of the PHSA, identifying “the speed of air travel” and “the present-day mobility of our population” as causes for contagion spread, which can occur “before the disease has become detectable”).<sup>3</sup>

Since no state acting alone can prevent the spread of communicable diseases across state lines, the CDC has filled gaps in the nation’s disease control network, including with respect to interstate and mass transportation. *See, e.g., Legal Authorities for Isolation and Quarantine*, Ctrs. for Disease Control & Prevention (Sept. 17, 2021), <https://www.cdc.gov/quarantine/aboutlawsregulationsquarantineisolation.html> (highlighting the CDC’s authority “to take measures to prevent the spread of communicable diseases between states”); H.R. Rep. No. 1364, at 24 (noting in the

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<sup>3</sup> *See also* Alexandra Sifferlin, *Doctors Inside Emory’s Ebola Unit Speak Out*, Time (Aug. 10, 2014), <https://time.com/3096724/doctors-inside-emorys-ebola-unit-speak-out> (reciting a former CDC Director’s comment that “[w]e live in a world where we are all connected by the air we breathe, the water we drink, the food we eat, and by airplanes that can bring disease from anywhere to anywhere in a day”).

PHSA’s legislative history that, “for half a century[,] the Public Health Service has been charged with the responsibility of preventing the interstate spread of disease”).<sup>4</sup>

While states and municipalities can use their police powers to mitigate the spread of diseases within their borders, they lack the authority to act across jurisdictional lines—for example, by limiting or setting conditions on interstate travel. *See, e.g., Granholm v. Heald*, 544 U.S. 460 (2005); *Or. Waste Sys., Inc v. Dep’t of Env’t Quality of Or.*, 511 U.S. 93 (1994); *see also* Lawrence O. Gostin & Lindsay F. Wiley, *Public Health Law: Power, Duty, Restraint* 96–97 (3d ed. 2016). Further, actions that states can take within their own borders may be inadequate in stopping the spread of disease across state lines. *See, e.g.,* H.R. Rep. No. 1364, at 24 (in which Congress noted, in enacting the PHSA, that “[i]n some situations[,] State and local quarantine measures afford inadequate protection to other States”). Sometimes, only federal action can limit a disease’s spread across the country. Thus, the CDC acts at the height of its authority when it implements, where states alone

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<sup>4</sup> *See also* President Franklin D. Roosevelt, Address at the Dedication of the National Institute of Health, Bethesda, Maryland (Oct. 31, 1940), <https://www.presidency.ucsb.edu/documents/address-the-dedication-the-national-institute-health-bethesda-maryland> (“Disease disregards State as well as national lines and among the States there is, as we know, an inequality of opportunity for health. In such cases the Public Health Service is helping and must continue even more greatly to help.”).



cannot, evidence-based public health measures to prevent the spread of infectious diseases into the country or across state lines.

The need for federal action to limit interstate disease movement substantially motivated the creation of the U.S. public health apparatus. *See, e.g.,* Shen, *supra* note 2, at 8–9 (describing the expansion of federal authority to prevent infectious disease spread through interstate and international travel); Laura K. Donohue, *Biodefense and Constitutional Constraints*, 4 U. Miami Nat'l Sec. & Armed Conflict L. Rev. 82, 131–32, 135, 137–39 (2014) (noting that preventing disease through trade and travel drove federal public health interventions). For instance, the Communicable Disease Center, a CDC forerunner, opened in 1946 with a central mission to “prevent malaria from spreading across the nation.” *Our History – Our Story*, Ctrs. for Disease Control & Prevention (Dec. 4, 2018), <https://www.cdc.gov/about/history/index.html>. Other predecessor agencies received “interstate and quarantine powers”—which were further expanded during national emergencies—“to prevent the introduction and spread of cholera, yellow fever, smallpox, and plague.” Polly J. Price, *Federalization of the Mosquito: Structural Innovation in the New Deal Administrative State*, 60 Emory L.J. 325, 343 (2010). In promulgating the Mask Mandate, the CDC acted well within the scope of its traditional authority to limit the interstate transmission of a highly contagious, deadly pathogen. *See, e.g.,* Rebecca L. Haffajee et al., *Thinking Globally, Acting*

*Locally—The U.S. Response to COVID-19*, 382 *New Eng. J. Med.* e75(1), e75(1) (2020) (“SARS-CoV-2 is exactly the type of infectious disease for which federal public health powers and emergencies were conceived: it is highly transmissible, crosses borders efficiently, and threatens our national infrastructure and economy. . . . The federal government’s ordinary public health legal authority . . . focuses on measures necessary to prevent the interstate or international spread of disease.”).

The circumstances surrounding the directive further demonstrate that the Mask Mandate was a proper exercise of the CDC’s core regulatory powers. The CDC introduced the Mask Mandate while a massive and sustained public health emergency—one that was recognized by the federal government and every state—raged. *See, e.g.*, Continuation of the National Emergency Concerning the Coronavirus Disease 2019 (COVID-19) Pandemic, 86 *Fed. Reg.* 11,599 (Feb. 24, 2021) (continuing the national emergency declaration); *see also* Joel Achenbach et al., *Winter Coronavirus Wave Ebbs and Deaths Drop, but Experts Fear a Spring Surge*, *Wash. Post* (Feb. 12, 2021), [https://www.washingtonpost.com/health/coronavirus-cases-deaths-dropping/2021/02/12/8e3cc38c-6c8b-11eb-9ead-673168d5b874\\_story.html](https://www.washingtonpost.com/health/coronavirus-cases-deaths-dropping/2021/02/12/8e3cc38c-6c8b-11eb-9ead-673168d5b874_story.html) (reporting on fear of imminent surges in light of new variants and then-current high infection and hospitalization rates).

It is of no moment that the CDC had not previously issued the precise masking directive at issue here.<sup>5</sup> Before the COVID-19 pandemic, the CDC had never faced a communicable respiratory disease outbreak of equivalent magnitude and duration. *See, e.g.,* Berkeley Lovelace Jr., *Covid Is Officially America’s Deadliest Pandemic as U.S. Fatalities Surpass 1918 Flu Estimates*, CNBC (Sept. 20, 2021), <https://www.cnbc.com/2021/09/20/covid-is-americas-deadliest-pandemic-as-us-fatalities-near-1918-flu-estimates.html> (reporting on unprecedented mortality rates caused by COVID); Lauren M. Rossen et al., *Update on Excess Deaths Associated with the COVID-19 Pandemic—United States, January 26, 2020–February 27, 2021*, 70 *Morbidity & Mortality Wkly. Rep.* 570 (2021).

Nor, in prior pandemics, was the CDC required to contend with levels of domestic and global air travel comparable to those that exist today. *See, e.g.,* Rachel E. Baker et al., *Infectious Disease in an Era of Global Change*, 20 *Nature Revs. Microbiology* 193, 198 (2021) (because the “number of airline passengers doubled” to four billion between 2000–2019, hypothesizing that “rapid global air travel is expected to have played a key role in the global spread of SARS-CoV-2”); *The XDR*

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<sup>5</sup> The CDC has, however, imposed limits on travel for the purpose of preventing contagious disease spread. *See, e.g.,* *Travel Restrictions to Prevent the Spread of Disease*, Ctrs. for Disease Control & Prevention (Jan. 28, 2022), <https://www.cdc.gov/quarantine/travel-restrictions.html>; James J. Misrahi, *The CDC’s Communicable Disease Regulations: Striking the Balance Between Public Health & Individual Rights*, 67 *Emory L.J.* 463, 470, 474 (2018).

*Tuberculosis Incident: A Poorly Coordinated Federal Response to an Incident with Homeland Security Implications: Hearing Before the H. Comm. on Homeland Sec.*, 110th Cong. 56 (June 6, 2007) (in which the then-CDC Director emphasized, in the context of an investigation of a traveler with drug resistant tuberculosis, “that infectious diseases are not a thing of the past, and that we need to continually adapt our prevention and response capabilities in an era of increasing threat and globalization”).

In enacting the PHS Act in 1944, Congress recognized that new types of threats might arise, and expressly contemplated the need for a decisive national response in such situations. Because Congress could not anticipate with perfect precision all the tools that the CDC would need to stem every future pandemic, Congress delegated to the CDC the authority to take all measures that, in its “judgment[,] may be necessary” to prevent the international or interstate transmission of novel infectious diseases. 42 U.S.C. § 264(a). Through the PHS Act’s capacious language, Congress sought to equip the CDC with the flexibility necessary to manage previously unforeseen threats that might arise. *See, e.g.*, H.R. Rep. No. 1364, at 25 (acknowledging that § 264 was “written broadly enough to apply to any disease,” considering the potential impact of contagion exposure through interstate commerce, and “the impossibility of foreseeing what preventive measure may become necessary”).

As an evidence-based mechanism tailored to reduce disease transmission across state lines, the Mask Mandate is a quintessential use of the CDC's regulatory authority. Masking involves only a minimal intrusion on civil liberties and no significant logistical or financial burdens. At the same time, the epidemiologic support for masking's efficacy in minimizing COVID-19 infections in crowded spaces is extensive. *See, e.g.,* Yanni Li et al., *Face Masks to Prevent Transmission of COVID-19: A Systematic Review and Meta-Analysis*, 49 *Am. J. Infection Control* 900 (2021); John T. Brooks et al., *Effectiveness of Mask Wearing to Control Community Spread of SARS-CoV-2*, 325 *JAMA* 998 (2021). For this reason, nearly every major public health agency, from the CDC to the World Health Organization, has touted the benefits of masking. *See, e.g.,* *Coronavirus Disease (COVID-19) Advice for the Public: When and How to Use Masks*, World Health Org. (Dec. 2021), <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public/when-and-how-to-use-masks>; *Face Masks and COVID-19: Protecting Yourself and Others*, Nat'l Insts. of Health (Nov. 2021), <https://newsinhealth.nih.gov/2021/11/face-masks-covid-19>. Further, during the COVID-19 pandemic, many U.S. jurisdictions imposed their own internal mask mandates, which helped to limit community transmission of SARS-CoV-2. *See, e.g.,* Jing Huang et al., *The Effectiveness of Government Masking Mandates on COVID-*

*19 County-Level Case Incidence Across the United States, 2020*, 41 Health Affairs 445 (2022).

Masking was similarly invoked as an important public health measure during the 1918 Spanish Influenza pandemic—the prior century’s most severe public health crisis. See *1918 Pandemic (H1N1 Virus)*, Ctrs. for Disease Control & Prevention (Mar. 20, 2019), <https://www.cdc.gov/flu/pandemic-resources/1918-pandemic-h1n1.html>. To combat that virus’s spread, several jurisdictions implemented masking ordinances. See, e.g., Bradford Luckingham, *To Mask or Not to Mask: A Note on the 1918 Spanish Influenza Epidemic in Tucson*, 25 J. Ariz. Hist. 191, 194, 196 (1984); Richard H. Peterson, *The Spanish Influenza Epidemic in San Diego, 1918–1919*, 71 S. Cal. Q. 89, 94, 96, 98 (1989); Univ. of Mich. Ctr. for the History of Med. & Mich. Publ’g, *The American Influenza Epidemic of 1918–1919: A Digital Encyclopedia, San Francisco, California* (last visited June 3, 2022), <https://www.influenzaarchive.org/cities/city-sanfrancisco.html>. U.S. health guidance during that outbreak, including from the Department of Health and Sanitation, Emergency Fleet Corporation, recommended mask-wearing when attending to the sick. See, e.g., L.L. Lumsden, *Influenza: Avoid It and Prevent Its Spread: Instructions Issued by the Department of Health and Sanitation, Emergency Fleet Corporation*, 33 Pub. Health Repts. 1731, 1731 (1918) (“If necessarily attending the sick, wear a gauze mask over the nose and mouth.”).

Congress enacted the PHSA to ensure that federal public health agencies would have the flexibility needed to limit communicable diseases' entry into the country and across state lines. That flexibility is vital to the nation's capability to respond to future public health threats—which may involve additional COVID-19 variants and other even more transmissible and deadly diseases. By undercutting CDC's core powers, the decision below, if allowed to stand, would hamstring the CDC's ability to fulfill its central purpose and hinder the federal government's capacity to respond to threats that the states alone cannot meet. This would leave the United States highly vulnerable to the inevitable deadly contagions to come.

## **II. The CDC's Mask Mandate Is Authorized Under the Public Health Service Act**

The Mask Mandate is authorized by the PHSA's plain text, as informed by the historical record and the contemporary meaning of its language. The first sentence of § 264(a) of the PHSA provides in broad terms:

The Surgeon General, with approval of the Secretary, is authorized to make and enforce such regulations as in his judgment are necessary to prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the States or possessions, or from one State or possession into any other State or possession.

The sentence that follows “informs” this broad grant of authority<sup>6</sup> “by illustrating the kinds of measures that could be necessary: inspection, fumigation, disinfection, sanitation, pest extermination, and destruction of contaminated animals and articles.” *See Ala. Ass’n of Realtors v. U.S. Dep’t of Health & Hum. Servs.*, 141 S. Ct. 2485, 2488 (2021). As the Supreme Court has explained, the measures reflected in § 264(a)’s second sentence “directly relate to preventing the interstate spread of disease by identifying, isolating, and destroying the disease itself.” *Id.*

“Reading both sentences together”—as the Supreme Court requires, *id.*—it is clear that the Mask Mandate falls within the CDC’s authority to take action directly “necessary to prevent the introduction, transmission, or spread” of COVID-19, including through the adoption of “sanitation” or “other measures.”

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<sup>6</sup> By their plain language, § 264(b)–(d) do not provide for additional authority beyond § 264(a) (as the District Court incorrectly suggested). *Health Freedom Defense Fund, Inc. v. Biden*, \_ F. Supp. 3d \_, 2022 WL 1134138, at \*8 (M.D. Fla. Apr. 18, 2022). Instead, they limit the broad authority already delegated under § 264(a) in the case of regulations involving, for instance, the isolation and quarantine of individuals. *See, e.g.*, 42 U.S.C. § 264(b) (“Regulations prescribed *under this section shall not* provide for the apprehension, detention, or conditional release of individuals except for the purpose of preventing the introduction, transmission, or spread of such communicable diseases as may be specified from time to time in Executive orders of the President upon the recommendation of the Secretary, in consultation with the Surgeon General[.]” (emphases added)); *see also Ala. Ass’n of Realtors v. U.S. Dep’t of Health & Hum. Servs.*, 141 S. Ct. 2485, 2487 (2021) (observing that regulations under Subsection (a) have previously involved “quarantining infected individuals”).



### **A. The Mask Mandate Is a Sanitation Measure Under the PHSA**

In the opinion below, the District Court considered two possible meanings of “sanitation” as used in the PHSA: (1) active cleaning, or (2) preservation of cleanliness. *Health Freedom Def. Fund, Inc. v. Biden*, \_\_ F. Supp. 3d \_\_, 2022 WL 1134138, at \*5–\*7 (M.D. Fla. Apr. 18, 2022). The latter definition, the District Court found, would cover the Mask Mandate, while the former definition would not. *Id.* The District Court then concluded that the PHSA used only the former, narrower definition, because it was the more common usage in the period leading up to 1944, according to the Court’s research. *Id.*

The District Court’s narrow reading of “sanitation” to include only active cleaning measures runs contrary to the historical record and divorces the statute’s language from its context in a law Congress enacted in order to address public health threats. Scientific literature around the date of the PHSA’s enactment describe “sanitation” to include preventative measures. *See, e.g.*, J. Howard Beard, *The Contribution of Cholera to Public Health*, 43 *Sci. Monthly* 515, 521 (1936) (noting that cholera “gave terrible emphasis to the urgent need of sanitation—the necessity of,” *inter alia*, “better housing, cleanliness and an efficient organization to prevent and to control contagion”); *see also Home Sanitation*, 55 *Pub. Health Repts.* 2282, 2282–2284 (1940) (describing that “[h]ealth departments are also realizing that home sanitation is important in the control of many diseases,” where sanitation

includes, *inter alia*, fresh air, ventilation (windows), and avoidance of overcrowding). At the time, hospitals and businesses employed “air sanitation” measures, to prevent risks of infection. *See, e.g.*, B.O. Kendall, *Cleaning and Sanitation*, 6 *Sanitarian* 497, 500 (1944). “[B]asic principles of hospital sanitation” included “good ventilation with clean, pure air.” Frank Gohr, *Hospital Sanitation*, 23 *Sanitarian* 75, 76 (1960). Such measures were not limited to active cleaning.

Reading “sanitation” to encompass numerous measures that preserve health is also consistent with the historical use of the term<sup>7</sup> in international regulations for public health. In 1851, countries convened the first International Sanitary Conference to develop standardized procedures to stop the spread of cholera across Europe. Norman Howard-Jones, *The Scientific Background of the International Sanitary Conferences 1851–1938*, at 12–16 (1975). These early discussions were focused on the evidentiary basis of quarantine to stop the spread of cholera, yellow fever, and plague and the developing understanding of the germ theory. *See, e.g.*, Valeska Huber, *The Unification of the Globe by Disease? The International Sanitary Conferences on Cholera, 1851–1894*, 49 *Hist. J.* 453 (2006). The use of “sanitary” to describe these efforts demonstrates that the term was used to refer to a range of public health measures aimed at stopping the spread of disease. Following these

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<sup>7</sup> The etymology of sanitation comes from the Latin “sanitas,” meaning “health.” Sanitas, *Oxford English Dictionary* (last visited May 31, 2022), [www.oed.com/view/Entry/170706](http://www.oed.com/view/Entry/170706).

conferences, countries adopted several International Sanitary Conventions over the later 19th and early 20th centuries. *Id.*

In 1919, the Public Health Service described the importance of “enforcement of rigid rules of sanitation and the avoidance of personal contact” in combatting influenza’s spread. *Influenza*, 34 Pub. Health Repts. 2105, 2106 (1919). As influenza can spread through the air, the sanitation guidance noted that “[t]o guard against this mode of spread[,] the use of face masks has been advocated.” *Id.* at 2108. A 1920 textbook titled *Primer of Sanitation* similarly described mask-wearing as having proved helpful in some hospitals in protecting against influenza. John W. Ritchie, *Primer of Sanitation: Being a Simple Textbook on Disease Germs and How to Fight Them* 48 (1920).

The terms “sanitary” and “sanitation” continued to be used to refer to a range of public health measures into the middle of the 20th century. For example, in 1951, countries adopted the International Sanitary Regulations under the WHO Constitution, consolidating all prior international sanitary conventions. *See* Howard-Jones, *supra*, at 15. In 1969, the International Sanitary Regulations were renamed as the International Health Regulations partly because the term “sanitary” was no longer “in line with health definitions now in use.” World Health Assembly, *Fourteenth Report of the Committee on International Quarantine and Special Review of the International Sanitary Regulations* 14 (1968). This change

demonstrates the increased use of the broad term “health” to capture measures that were historically (including through the 1940s) termed “sanitary” measures.

Despite this history, the District Court found that the narrower use of “sanitation” as active cleaning was more common around the time of the PHSA’s enactment and therefore was the meaning used in the statute. That conclusion ignores that in enacting the PHSA—a statute designed to protect public health—Congress most likely used the term “sanitation” in its public health sense.

Further, the District Court relied on historical dictionaries to justify its conclusion that “sanitation” had a more common but narrow meaning related to active cleaning. *Health Freedom Defense Fund*, 2022 WL 1134138, at \*5, \*10. However, historical dictionaries undermine, rather than support, that determination. A 1929 edition of Funk & Wagnalls defined “sanitation” as “the devising and applying of measures for preserving and promoting public health.” Sanitation, *New Standard Dictionary of the English Language* 2172 (1929). Although the dictionary secondarily defined the term as “the removal or neutralization of elements injurious to health,” *id.*, that was sanitation’s less common meaning, *see id.* at xii (“If a word has two or more meanings, the most common meaning has been given first.”).

A later edition of Funk & Wagnalls explained that “if the term has two or more different meanings, each definition is set off unmistakably by a bold-faced figure, as **1** ... **2** ... **3**.” Funk & Wagnalls, *New Practical Standard Dictionary of the*

*English Language* vii (1946). In that dictionary, the word “sanitation” is again defined without such numbered formatting, indicating only one sense: “The practical application of sanitary science; the removal or neutralization of elements injurious to health.” Sanitation, *id.* at 1160. Thus, rather than providing two distinct definitions, dictionaries from around the time of the PHSA’s enactment indicate a single broad definition of “sanitation” related to sanitary science broadly understood, including but not limited to the neutralization of elements injurious to health. *See generally* Stefan Th. Gries et al., *Unmasking Textualism: Linguistic Misunderstanding in the Transit Mask Order Case and Beyond*, 123 COLUM. L. REV. F. (forthcoming 2022).

This broader, health-related meaning of “sanitation” is also supported by the editions of Black’s Law Dictionaries published around the time of the PHSA’s enactment. Between 1933 and 1968, Black’s defined sanitation as: “Devising and applying of measures for preserving and promoting public health; removal or neutralization of elements injurious to health; practical application of sanitary science.”<sup>8</sup> Sanitation, *Black’s Law Dictionary* 1581 (3d ed. 1933); Sanitation,

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<sup>8</sup> These dictionaries cite *Smith v. State*, 129 S.E. 542 (Ga. 1925), which quotes the definition from an earlier Funk & Wagnalls dictionary and describes “recognized methods of sanitation, such as vaccination to prevent smallpox, serums to prevent typhoid fever, diphtheria, scarlet fever, and the like, the purification of water, the destruction of the mosquito which produces yellow fever and malaria, and other well-known methods of sanitation.” *Id.* at 545.

*Black's Law Dictionary* 1508 (4th ed. 1951); Sanitation, *Black's Law Dictionary* 1508 (4th rev. ed. 1968). Ballentine's Law Dictionaries support the same conclusion. *E.g.*, Sanitary, *Ballentine's Law Dictionary* 455 (1st ed. 1916) (defining "sanitary" as "Pertaining to the public health"); Sanitary Regulations, *Ballentine's Law Dictionary* 1138 (3d ed. 1968) (defining "sanitary regulations" as "Building regulations imposed in the interest of health" or "Regulations intended to prevent the spread of communicable diseases").

The District Court's reasoning is also in tension with many sanitary measures historically undertaken pursuant to § 264(a) by the Food and Drug Administration (which also exercises authority under the PHSA). These measures do not fall within the precise parameters of any of the other enumerated terms in § 264(a) and, like the Mask Mandate, are preventative in nature. *See, e.g.*, Final Regulations for Collection, Processing and Storage, 40 Fed. Reg. 53,532, 53,541, 53,542 (Nov. 18, 1975) (codified at 21 C.F.R. pts. 606 and 640) (describing procedures to "prevent contamination" of blood and noting that blood should be "stored in a safe, sanitary and orderly manner"); Transfer of Regulations, 40 Fed. Reg. 5,620, 5,625 (Feb. 6, 1975) (codified at 21 C.F.R. pts. 1240 and 1250) (regulating the temperature for storage of perishable food and drink). Imposing the District Court's narrow reading of "sanitation," as limited to active cleaning, would not only invalidate the Mask

Mandate; it would jeopardize other longstanding federal measures to protect public health.

Yet even under the District Court’s artificially narrow definition, in which sanitation is limited to “the removal or neutralization of elements injurious to health,” *Health Freedom Def. Fund*, 2022 WL 1134138, at \*5, the CDC has the authority to impose the Mask Mandate. Mask wearing does, in fact, neutralize and remove injurious airborne particles and droplets, preventing inhalation and infection. *See, e.g.*, Brian M. Gurbaxani et al., *Evaluation of Different Types of Face Masks to Limit the Spread of SARS-CoV-2: A Modeling Study*, 12 *Sci. Reps.* 1, 1–3 (2022).

In sum, mask wearing in the service of health has long been understood as a paradigmatic form of sanitation, and comfortably fits within the term “sanitation” as used in the PHSA.

### **B. Catchall Language in § 264(a) Encompasses the Mask Mandate**

In addition to “sanitation” measures, the PHSA authorizes the CDC to adopt “other measures” that the CDC deems “necessary.” 42 U.S.C. § 264(a). The Mask Mandate is authorized under this term.

The District Court read “other measures” to be restricted to only measures virtually identical to those previously enumerated—that is, sanitation and the like. *Cf.* Brett M. Kavanaugh, Book Review, *Fixing Statutory Interpretation*, 129 *Harv. L. Rev.* 2118, 2160 (2016) (describing the *ejusdem generis* canon). However, many

scholars and judges reject such a narrow interpretive approach. *See, e.g., id.* (in which Justice Kavanaugh advises “to be wary of adding implicit limitations to statutes that the statutes’ drafters did not see fit to add”). Given the legislative history of the PHSA, in which Congress sought to empower the CDC to respond to unforeseen health threats, “other measures” should not be understood so restrictively but rather as a signal that the list is non-exhaustive, albeit one limited to measures that directly combat the spread and transmission of disease. *See Ala. Ass’n of Realtors*, 141 S. Ct. at 2488 (noting that the measures reflected in § 264(a)’s second sentence “directly relate to preventing the interstate spread of disease by identifying, isolating, and destroying the disease itself”).

Even if the PHSA’s “other measures” reference is restricted to measures that are similar to the previously enumerated measures, the Mask Mandate would be authorized. Every explicitly named measure aims to prevent the direct transmission of infectious diseases. So does the Mask Mandate. As such, it falls within even the narrowest interpretation of “other measures.”

## CONCLUSION

For the foregoing reasons, *amici* respectfully request that this Court reverse the District Court’s decision.



June 7, 2022

Respectfully submitted,

*/s/ Robert A. Braun*

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**CERTIFICATE OF COMPLIANCE WITH RULE 32(g)**

I hereby certify that the foregoing brief complies with Fed. R. App. P. 32(a)(7)(B) and Fed. R. App. P. 29(a)(5) because it contains 5,187 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f) and 11th Cir. R. 32-4.

I further certify that this brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced font in Microsoft Word using 14-point Times New Roman.

Date: June 7, 2022

Respectfully submitted,

/s/ Robert A. Braun

## APPENDIX OF INDIVIDUAL *AMICI CURIAE*<sup>9</sup>

### Former Federal Agency Leaders

1. Richard E. Besser, MD, CDC Director, 2009 (Acting)
2. William Foege, MD, MPH, CDC Director, 1977–1983
3. Tom Frieden, MD, MPH, CDC Director, 2009–2017
4. Julie Gerberding, MD, MPH, CDC Director, 2002–2009
5. Margaret Hamburg, MD, FDA Commissioner, 2009–2015
6. Jeffrey Koplan, MD, MPH, CDC Director, 1998–2002
7. William L. Roper, MD, MPH, CDC Director, 1990–1993

### Deans

8. Thomas E. Burroughs, PhD, MS, MA, Dean and Professor, SLU College for Public Health and Social Justice, Saint Louis University
9. G. Thomas Chandler, MS, PhD, Dean and Professor of Environmental Health Sciences, Arnold School of Public Health, University of South Carolina
10. Erwin Chemerinsky, Dean and Distinguished Professor of Law, Berkeley Law
11. James Curran, Dean, School of Public Health, Emory University
12. Carlos del Rio, Executive Associate Dean, Emory School of Medicine & Grady Health System, Distinguished Professor, Department of Medicine, Division of Infectious Diseases, Emory University School of Medicine, Professor, Hubert Department of Global Health, Rollins School of Public Health, Co-Director, Emory Center for AIDS Research
13. Karen Drenkard, PhD, RN, NEA-BC, FAAN, Associate Dean of Clinical Practice and Community Engagement, School of Nursing Center for Health Policy and Medical Engagement, The George Washington University
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**CERTIFICATE OF SERVICE**

I hereby certify that on June 7, 2022, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Eleventh Circuit by using the appellate CM/ECF system.

I certify that all counsel in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

Date: June 7, 2022

Respectfully submitted,

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