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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION

MONTANA MEDICAL ASSOCIATION, et al., Plaintiffs, and MONTANA NURSES ASSOCIATION, Plaintiff-Intervenors, v. AUSTIN KNUDSEN, et al., Defendants.	CV 21-108-M-DWM FOUNDATIONAL DECLARATION OF JUSTIN K. COLE

I, Justin K. Cole, declare, pursuant to 28 U.S.C. § 1746 and under penalty of perjury, that the foregoing is true and correct:

1. I am an attorney with Garlington, Lohn & Robinson PLLP. I am

counsel for Plaintiffs in the above captioned matter. I have personal knowledge of the information set forth herein based upon my position as counsel in this matter, and provide this Foundational Declaration for the limited purpose of supporting Plaintiffs' Motion for Summary Judgment.

2. Exhibit 1 is a true and correct copy of the Declaration of David King, M.D. dated July 15, 2022, and Dr. King's CV (Deposition Exhibits 1 and 2).

3. Exhibit 2 is a true and correct copy of the Declaration of David Taylor, M.D. dated July 15, 2022, and Dr. Taylor's CV (Deposition Exhibit 8).

4. Exhibit 3 is a true and correct copy of the Declaration and Expert Report of Greg Holzman, M.D., MPH dated July 15, 2022, and Dr. Holzman's CV.

5. Exhibit 4 is a true and correct copy of the Declaration and Expert Report of Bonnie Stephens, M.D. dated July 15, 2022, and Dr. Stephens' CV (Deposition Exhibits 21 and 22).

6. Exhibit 5 is a true and correct copy of the Expert Report of Dr. Jayanta Bhattacharya, dated July 15, 2022 (Deposition Exhibit 25).

7. Exhibit 6 is a true and correct copy of the Expert Report of Ram Duriseti MD, PHD, dated July 15, 2022 (Deposition Exhibit 3).

8. Exhibit 7 is a true and correct copy of the Declaration and Expert Report of Lauren Wilson, dated July 15, 2022 (Deposition Exhibit 6).

9. Exhibit 8 is a true and correct copy of excerpts from the Deposition of David N. Taylor, M.D., dated August 4, 2022.

10. Exhibit 9 is a true and correct copy of excerpts from the Rule 30(b)(6) Deposition of the Montana Department of Public Health & Human Services ("DPHHS"), dated August 18, 2022.

11. Exhibit 10 is a true and correct copy of excerpts from the Rule 30(b)(6) Deposition of the Montana Department of Labor and Industry ("DLI"), dated August 18, 2022.

12. Exhibit 11 is a true and correct copy of excerpts from the Rule 30(b)(6) Deposition of Providence Health and Services – Montana ("Providence"), designee Karyn Trainor, dated August 10, 2022.

13. Exhibit 12 is a true and correct copy of excerpts from the Rule 30(b)(6) Deposition of Providence, designee Kirk Bodlovic, dated August 10, 2022.

14. Exhibit 13 is a true and correct copy of excerpts from the Rule 30(b)(6) Deposition of Western Montana Clinic ("Clinic"), dated August 8, 2022.

15. Exhibit 14 is a true and correct copy of excerpts from the Rule 30(b)(6) Deposition of the Montana Human Rights Bureau ("HRB"), dated August 22, 2022.

16. Exhibit 15 is a true and correct copy of excerpts from the Rule 30(b)(6) Deposition of the Attorney General's Office ("AG"), dated August 19, 2022.

17. Exhibit 16 is a true and correct copy of excerpts from the Rule 30(b)(6) deposition of Five Valleys Urology ("Five Valleys"), dated August 9. 2022.

18. Exhibit 17 is a true and correct copy of Deposition Exhibit 38: CMS Revised Guidance for the Interim Final Rule – Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination, QSO-22-09-ALL, dated January 14, 2022, *Revised* 4/05/22.

19. Exhibit 18 is a true and correct copy of Deposition Exhibit 39: Hospital Attachment *Revised* to CMS's QSO-22-09-ALL-Revised.

20. Exhibit 19 is a true and correct copy of Deposition Exhibit 43: April 8, 2022 Letter from CMS to the Montana State Hospital Re: Involuntary Termination of Medicare Provider Agreement Effective April 12, 2022.

21. Exhibit 20 is a true and correct copy of Deposition Exhibit 44: Excerpts from DPHHS PowerPoint Presentation.

22. Exhibit 21 is a true and correct copy of Deposition Exhibit 49: August 18, 2022 QCOR Survey Activity Report with deficiency citation for a Montana hospital pertaining to the CMS COVID-19 vaccination of facility staff.

23. Exhibit 22 is a true and correct copy of Deposition Exhibit 50: August 18, 2022 QCOR Survey Activity Report with deficiency citation for a Montana hospital pertaining to the CMS COVID-19 vaccination of facility staff.

24. Exhibit 23 is a true and correct copy of Deposition Exhibit 54: Excerpt from DLI's House Bill 702: Frequently Asked Questions re: Healthcare Vaccine Mandate, updated September 24, 2021.

25. Exhibit 24 is a true and correct copy of Deposition Exhibit 57: November 12, 2021 Letter from L. Esau to Mountain Pacific Quality Health.

26. Exhibit 25 is a true and correct copy of Deposition Exhibit 58: December 17, 2021 Letter from L. Esau to Big Sky Resort.

27. Exhibit 26 is a true and correct copy of Deposition Exhibit 59: June 20, 2022 Letter from L. Esau to the Ninth Circuit Judicial Conference.

28. Exhibit 27 is a true and correct copy of Deposition Exhibit 62: Email from D. Oestreicher, dated October 13, 2021.

29. Exhibit 28 is a true and correct copy of Deposition Exhibit 63: January 14, 2021 Letter from D. Oestreicher on behalf of Attorney General Knudsen.

30. Exhibit 29 is a true and correct copy of Deposition Exhibit 66: October 27, 2021 Letter from Governor Gianforte.

31. Exhibit 30 is a true and correct copy of Deposition Exhibit 69:

Declaration of Mary Stukaloff, March 2, 2022, with attachments, also filed at (Doc. 51-2).

32. Exhibit 31 is a true and correct copy of Deposition Exhibit 72: Excerpt from DLI's House Bill 702: Frequently Asked Questions, updated July 26, 2021.

33. Exhibit 32 is a true and correct copy of Deposition Exhibit 74: EEOC Guidance: What You Should Know About COVID-19 and the ADA, the Rehabilitation Act, and Other EEO Laws, updated July 12, 2022.

34. Exhibit 33 is a true and correct copy of Deposition Exhibit 75: HRB Final Investigative Report Case No. 0220103, May 10, 2022 (produced redacted by Defendants).

35. Exhibit 34 is a true and correct copy of Deposition Exhibit 76: HRB Final Investigative Report Case No. 0220103, May 10, 2022 (produced redacted by Defendants).

36. Exhibit 35 is a true and correct copy of Deposition Exhibit 77: HRB Final Investigative Reports--Case Nos. 0210598 (Feb. 25, 2022), 0210610 (Feb. 25, 2022), 0210597 (Feb. 11, 2022), 0220118 (Feb. 25, 2022), 0210579 (Feb. 25, 2022), 0210599 (Feb. 25, 2022), 0210580 (Feb. 11, 2022), 0210581 (Feb. 25, 2022), 0210582 (Feb. 11, 2022) (produced redacted by Defendants). Exhibit 35 has been filed under seal pending leave of Court.

37. Exhibit 36 is a true and correct copy of Deposition Exhibit 80: HRB Final Investigative Report, Case No. 0210440, dated November 22, 2021 (produced redacted by Defendants).

38. Exhibit 37 is a true and correct copy of the excerpts from Plaintiffs' Responses to Defendants' First Combined Discovery Requests, July 29, 2022.

39. Exhibit 38 is a true and correct copy of Plaintiffs' Fourth Supplemental Responses to Defendants' First Combined Discovery Requests, August 19, 2022.

40. Exhibit 39 is a true and correct copy of excerpts from Defendants' Responses to Plaintiff's [sic] First Combined Discovery Requests, May 11, 2022.

41. Exhibit 40 is a true and correct audio recording of a One American News Network Dan Ball radio interview of Austin Knudsen, recorded on February 7, 2022, conventionally filed on a flash drive, also available at https://www.spreaker.com/user/oneamericanewsnetwork/2-7-oanra366e-audio (last accessed Aug. 26, 2022). The audio recording was obtained from the referenced website using an add-on extension for the Firefox web browser called Audio Downloader Prime on August 22, 2022.

42. Exhibit 41 is a true and correct copy of the April 28, 2021 Letter from Governor Greg Gianforte to Speaker Galt and President Blasdel with Amendatory Veto.

43. Exhibit 42 is a true and correct copy of the Montana 67th Legislature House Bill No. 702: An Act Prohibiting Discrimination Based on a Person's Vaccination Status or Possession of an Immunity Passport; Providing and Exception and Exemption; Providing an Appropriation; and Providing Effective Dates.

44. Exhibit 43 is a true and correct audio recording of a XM Sirius David Webb radio interview of Austin Knudsen, recorded on November 11, 2021, conventionally filed on a flash drive, also available at https://www.podcastaddict.com/episode/133340150 (last accessed Aug. 26, 2022). The audio recording was obtained by downloading the electronic file from the referenced website using a Firefox web browser on August 22, 2022.

45. Exhibit 44 is a true and correct copy of the Declaration of Jay Bhattacharya in Support of Governor Bill Lee's Opposition to Plaintiffs' Motion for Preliminary Injunction, September 28, 2021, filed in *R.K., et al., v. Governor Bill Lee*, Cause No. 3:21-cv-00725, Doc. 42 (Sept. 28, 2021).

46. Exhibit 45 is a true and correct copy of excerpts from the Deposition of David King, M.D., dated August 2, 2022.

DATED this 26th day of August, 2022.

/s/ Justin K. Cole
Attorneys for Plaintiffs

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
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MONTANA MEDICAL ASSOCIATION, et al.,

Plaintiffs,

and

MONTANA NURSES ASSOCIATION,

Plaintiff-Intervenors,

v.

AUSTIN KNUDSEN, et al.,

Defendants.

Case No. CV 21-00108-DWM

DECLARATION OF DAVID KING, M.D.

4873-8082-6374

I, David King, M.D., declare, pursuant to 28 U.S.C. § 1746 and under penalty of perjury, that the foregoing is true and correct:

1. The facts and opinions set forth in this Declaration are known to me based on my personal knowledge and belief, and based upon my knowledge, research, education, and experience.

2. I have been retained by the Plaintiffs in the above-captioned matter to render certain opinions as contained in this document. I am charging $400 per hour for my work on this matter. I reserve the right to modify, expand upon, or otherwise change these opinions as new or additional information is provided to me.

EXPERIENCE AND CREDENTIALS

3. I obtained my medical doctorate from the University of Washington in 1981, with honors. I performed a family medicine internship and residency at the University of New Mexico from 1981-1984. I am board certified in family medicine, and have been in practice since 1984.

4. I served as the Medical Director of the Clinical Research program at Bozeman Health from 2016 until November 2021. As Medical Director, I facilitated and conducted a number of clinical trials for the Pfizer COVID-19 vaccine at Bozeman Health. I have conducted numerous clinical trials and studies of a number of different vaccines and medication therapies. As a practicing

physician and Medical Director of a Skilled Nursing Facility and of Bozeman Health's Geriatrics Team, I have also had direct experience in the prevention and treatment of COVID infections. Attached as Exhibit A is my curriculum vitae, which further summarizes my professional and clinical education and experience, credentials, and clinical research experience.

OPINIONS

5. Vaccine-preventable communicable diseases are recognized hazards that can cause death or serious harm to those who contract those diseases.

6. There is copious evidence showing that vaccination of individuals helps them stay well or avoid serious illness, hospitalization, or death. Vaccination also markedly reduces reinfection risk. The evidence is overwhelmingly positive. The scientist whose research directly led to the development and use of eight of the fourteen vaccines currently in use by Montana children and adults was a Montana native and Montana State University graduate. Maurice Hilleman's brilliance brought us the vaccines we now use, around the world, to prevent measles, mumps, chickenpox, Hepatitis A, Hepatitis B, Neisseria meningitis, pneumococcal pneumonia, and Hemophilus influenzae.

7. Pertinent studies on this topic are numerous. For purposes of my opinions, I have reviewed numerous such studies over the course of my career and will address several herein.

8. In 1975, a study called "A School Immunization Law is Successful in Texas", authored by Lon Gee and R.F. Sowell, was published in Public Health Reports (vol 90, Jan-Feb 1975 pp. 21-24). The authors noted that compulsory immunization laws have been in effect since the 1800's, and upheld by the U.S. Supreme Court as early as 1905. In 1970, Texas was, as was usual, a nursery of vaccine-preventable diseases. From 1967 to 1971, at 5 ½% of the US population, Texas accounted for, depending on the year, 31%-53% of the ***national*** cases of diphtheria, 10%-17% of US cases of tetanus, 25%-79% of US polio cases, 1%-15% of our rubella cases, and 18%-23% of measles cases in the nation. A new law mandating school vaccine compliance, fostered by a currently unimaginable coalition of citizens, health care advocates and providers, and politicians, was passed in 1971. Comparing 1970 to 1973, Texas saw a drop from 234 to 18 cases of diphtheria, from 14 to 10 cases of tetanus, from 437 to 115 cases of pertussis, from 8,494 to 533 cases of measles, from 8,409 to 1,129 cases of rubella, and from 22 to 0 cases of polio.

9. A study published in the New England Journal of Medicine (NEJM 2020:383(27):2603 Epub 12/10/2020) addressed the COVID vaccine. In 43,548 patients, half of whom were vaccinated with two doses of Pfizer COVID vaccine and half given placebo, there were 8 symptomatic cases in the vaccinated group versus 162 cases in the placebo group. In this study, the vaccines were 95%

effective in preventing symptomatic disease. Similar studies in Israel, UK, Qatar, Scotland, USA, Canada, the US V.A. system, other US health care settings, and US Skilled Nursing Facilities (SNFs) had similar findings.

10. A report in the Morbidity and Mortality Weekly Report (MMWR 2021;70(17):632 Epub 04/30/2021 compared COVID-19 cases in vaccinated vs. unvaccinated residents in 78 Chicago SNFs. "Vaccinated" meant receipt of two doses of mRNA vaccines. Of 627 COVID-19 infections found, only 22 occurred in residents who were 14 days or more past their second injection, showing 28 times the number of infections in the unvaccinated group compared to those who were vaccinated, or 96% efficacy. And, of the 22 who had infections proved after vaccination, two-thirds were asymptomatic, two were hospitalized, and only one died.

11. A MMWR report in August 2021 involving Los Angeles County after the delta variant became dominant showed the delta variant to be more dangerous than previous variants, but still showed extraordinary vaccine efficacy. During the study period, 43,127 residents were found to have COVID. Among those, 25% of fully vaccinated people were positive, compared to 71% of the unvaccinated people. But only 3.2% of the vaccinated subjects were hospitalized, compared to 7.6% of the unvaccinated. In all 29 times as many unvaccinated people were hospitalized than fully vaccinated people, again showing over 96% efficacy in the

vaccine's ability to prevent serious disease. Hospitalization, ICU care, and mechanical ventilation were similarly predominant in the unvaccinated cohort.

12. Multiple studies have been done showing that natural infection is immunogenic. Earlier studies done before the delta variant appeared showed more durable and robust immune responses than more recent studies have done. The problem remains that immune response is variable after natural infection, with no response at all in some patients to robust if temporary immunity in others, whereas the doses of the vaccines are standard, measurable, and trackable. The publicized and incorrect contention that immunity derived from natural infection is both highly effective and highly durable has contributed to vaccine avoidance and abetted the destructiveness of the current pandemic.

13. In 2020 in Denmark a study was done (The Lancet, vol.379, issue 10280, p.1204-1212, Pub Mar 27, 2021 Hansen, Michlmayr, Gubbels, Molbak, Ethelberg) to assess the protection against reinfection with Sars-CoV-2 provided by initial infection alone. It found that "those [unvaccinated] aged 65 and older had less than 50% protection against repeat SARS-CoV-2 infection after the first infection."

14. A study (MMWR Aug 13, 2021/70(32); 1081-1083) by Cavanaugh, Spicer, Thoroughman, Glick, and Winter in Kentucky, with data again preceding the Delta variant surge, compared unvaccinated people with initial infection in

2020 and reinfection in late May and June of 2021. They found that "Kentucky residents who were not vaccinated had 2.34 times the odds of reinfection compared with those who were fully vaccinated…" Their conclusions were that "…among previously infected persons, full vaccination is associated with reduced likelihood of reinfection, and, conversely, being unvaccinated is associated with higher likelihood of being reinfected."

15. Another study (The Lancet, Microbe vol2, issue 12, E666-E675 Pub 12/01/2021 "The Durability of Immunity Against Reinfection by SARS-CoV-2: a Comparative Evolutionary Study, Townsend, Hassler, Wang, Miura, Singh, Kumar, et.al.) led to this comment from the authors: "Reinfection by SARS-CoV-2 under endemic conditions would likely occur between 3 and 63 months after peak antibody response, with a median of 16 months." In other words, based on their work, which, unlike the above, takes into account the behavior of the Delta variant but not that of the far more contagious Omicron variants, unvaccinated people would catch COVID again every year or two. Further, the authors state that

> "Our estimate argues strongly against the claim that a long-standing resolution of the epidemic could arise due to herd immunity from natural infection or that mitigation of the long-term risks of morbidity and mortality can be achieved without vaccination.

16. Another Delta-era study published in MMWR on 11/05/2021 (CDC MMWR Report 11/05/2021/ 70(44); 1539-1544, Laboratory-Confirmed COVID-19 Among Adults Hospitalized with COVID-19-like illness with Infection-Induced or mRNA Vaccine-Induced SARS-CoV-2 Immunity, Bozio et. al.) compared unvaccinated persons newly diagnosed with COVID-19 and with a prior history of COVID-19 infection which occurred between 90 and 179 days previously with newly diagnosed persons with COVID-19 who were fully vaccinated 90-179 days prior to infection with an mRNA vaccine (2 doses). Those unvaccinated persons with only "natural immunity" were found to have 5.49 times greater risk of recurrent infection than those whose immunity was from vaccination. As infection, whether symptomatic or not, is a prerequisite for spread and for viral mutation, it is inescapable to infer that previous infection with SARS-CoV-2 provides inadequate protection if the public health goal is to prevent spread and associated morbidity and mortality, not to mention the societal costs engendered by further spread.

17. Studies done more recently have shown the expected rise in anti-COVID antibodies and improved efficacy with the boosters which are currently being deployed. Pfizer's data shows that neutralizing antibodies are 5 times higher one month after the third dose than one month after the second dose in young and middle-aged subjects, and 11-fold higher in subjects over the age of 65.

18. Much of the information above relates to early waves of the COVID pandemic, through Delta's late 2021 phase. Since then, the COVID threat has been carried by Omicron and its seemingly endless generations of mutant offspring. It has been well established and widely reported that Omicron's successes are because of its remarkable ability to mutate, which has led to an equally remarkable infectiousness. It is far better at spreading than previous COVID strains. Thankfully Omicron has proved, so far, to cause less severe disease than previous COVID strains.

19. Omicron causes illness far more readily than previous strains, but fewer severe illnesses, hospitalizations, and deaths. It more readily infects vaccinated people and those with previous COVID illness, especially those with medical risk factors. These notably include as powerful risk predictors advancing age and obesity, as well as the medical illnesses listed above. Hospitalizations and deaths are largely concentrated in those with medical risk factors, and especially those with multiple risks.

20. As Omicron causes far more infections and earlier infections in vaccinated people (breakthrough infections) and in those who have had previous COVID infection (reinfection) than previous strains, how are we to judge the value of immunization against COVID now? Are vaccination immunity and herd immunity both obsolete concepts with COVID? The answer is apparently yes with

herd immunity, as the inherent mutability of COVID and the unpredictable and rapidly waning duration and effectiveness of the immunity provided by infection coupled with its high infectiousness hold little promise of the benefit of this approach. The answer, however, with vaccination remains no. It does appear that herd immunity with vaccines will be difficult to attain. Given the lack of vaccine availability in large parts of the world, vaccine hesitancy where vaccine availability exists, and outright opposition to vaccination (exemplified by Montana House Bill 702), and given COVID's ability to mutate, prevention of the spread of this disease no longer appears possible. But with our current vaccines we have robust proof that, while being less durable and effective at preventing disease transmission caused by Omicron, they remain highly effective in fully vaccinated people at preventing severe illness requiring hospitalization and at preventing death. As noted in a March 29, 2022 summary from the CDC, "COVID-19 vaccines remain the best public health measure to protect people from COVID-19 and reduce the likelihood of new variants emerging. This includes primary series, booster shots, and additional doses for those who need them."

21. Current vaccines protect against severe illness, hospitalizations, and deaths due to infection with the Omicron variant. However, breakthrough infections in people who are vaccinated can occur. People who are up to date with

their COVID vaccines and get COVID-19 are less likely to develop serious illness than those who are unvaccinated and get COVID-19, as noted above.

As we see in the table below, which includes data from early iterations of Omicron, vaccines (especially mRNA vaccines), while not as effective at preventing infection with Omicron, remain very effective in preventing severe disease.

	Effectiveness at preventing											
	Ancestral		Alpha		Beta		Gamma		Delta		Omicron	
Vaccine	Severe disease	Infection	Severe disease	Infection	Severe disease	Infection	Severe disease	Infection	Severe disease	Infection	Severe disease	Infection
[illegible]												
[illegible]												
[illegible]												
[illegible]												
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Figure 1: https://www.healthdata.org/covid/covid-19-vaccine-efficacy-summary

Vaccination has been and remains our most effective tool to prevent both the spread and the severity of disease.

22. As we have seen, certain diseases, such as COVID-19 and influenza, can mutate into variant strains of the original virus, and some diseases have the ability to mutate more frequently than others. A disease is more likely to mutate the more often it is allowed to replicate, which is determined by the number of times it is transmitted from person to person. These mutations and variants cause a reduction in the durability of an individual's immunity to the disease. The duration of an individual's immunity levels naturally decreases in certain diseases, some more rapidly than others. Immunity to infectious diseases like COVID-19 and influenza fades more quickly than with other diseases. The waning of immunity has led to the implementation of vaccine boosters for a number of vaccines. Vaccine boosters are also utilized after natural infection, to address waning immunity.

23. As it pertains to other vaccine-preventable diseases, such as polio, measles, mumps, rubella, hepatitis, pertussis, chickenpox and others, vaccination remains a critically important form of infectious disease prevention, particularly in healthcare settings.

24. As the studies discussed above and hundreds of others have shown, vaccination is highly effective and critically important in reducing the destruction vaccine-preventable illnesses cause to our way of life, and to our lives themselves. Vaccination is a critical infectious disease prevention tool. Vaccination has been

and remains our most effective tool to prevent both the spread and the severity of disease.

25. Although they are (surprisingly) not accepted by some individuals, the safety and efficacy of vaccines, including the current COVID-19 vaccines, in preventing or lessening severity of illness have been robustly and redundantly proved.

26. Research on how vaccination affects transmissibility of COVID has been later in starting and is still less developed than research regarding safety and efficacy. We will focus on the two mRNA vaccines, as the "single-dose" vaccine available in the US is not as robustly efficacious or as well studied as the mRNA vaccines.

27. Without plunging deeply into basic science, two concepts are worth discussing first.

28. "Viral load" is simply a measurement of the number of virions (individual viruses) which can be counted in a volume of body fluid. The fluid can be blood, urine, nasopharyngeal secretions, etc. High viral loads mean high numbers of viruses.

29. Since "inoculum size" (the number of infectious organisms entering our body in an exposure event) is an important determinant in most infectious diseases, indicating whether we get sick from an exposure, how sick we get, and

how fast we get sick, it is not surprising that it would have impact in COVID cases as well. The more COVID virions we inhale, the faster we get sick and the sicker we get. The more we exhale, the more risk we spread to those around us. The inoculum size in COVID-19 infection relates predominantly to the viral load in the nasopharynx, as the disease is spread largely by exposure to respiratory droplets.

30. On September 15, 2021, the CDC released its "Science Brief: COVID-19 Vaccines and Vaccination" from which, unless otherwise specified, following quotations and conclusions are taken. The CDC noted that multiple studies done in multiple countries showed that fully vaccinated people who nonetheless contracted COVID generally had a lower viral load than unvaccinated people. As "viral load has been identified as a key driver of transmission…", it is reasonable to assume that after vaccinating people they will have lower viral loads, and will be less able to spread COVID. Multiple other studies from multiple countries found significantly reduced likelihood of transmission to household contacts from people infected with SARS-CoV-2 (COVID-19 infection) who were previously vaccinated for COVID-19. The delta variant, characterized by much higher viral loads, particularly in the nasopharynx, has caused more infections in fully vaccinated individuals, but research has shown that while they may be able to transmit the virus, they clear the virus much more rapidly than those who are unvaccinated, reducing the time that they are potentially infectious, and thereby the

risk of transmission. Another study found that "Delta infection in fully vaccinated persons was associated with significantly less transmission to contacts than persons who were unvaccinated or incompletely vaccinated…" (published as a preprint on medRxiv, a forum supported by, among others, Yale and The British Medical Journal, on August 15, 2021). It was a large trial in Guangdong province in China, and included both wild-type (original type of COVID-19 virus) and Delta variant cases. Viral loads were higher in the Delta cases, and duration of infectivity longer. And in fully-vaccinated individuals, they found a three-fold decrease in viral load in the pharynx of those who tested positive for COVID, compared to unvaccinated individuals.

31. While the volume of evidence proving the efficacy of vaccination for COVID is huge, that proving the reduction of transmissibility is not as large. Yet data is accumulating that viral load is generally lower and faster to resolve in fully vaccinated individuals who nonetheless contract COVID infection (including asymptomatic cases), as is data proving that fully vaccinated individuals spread infection less.

32. Unvaccinated individuals are more likely than vaccinated individuals to contract vaccine-preventable diseases and are also more likely to transmit those diseases to others.

33. In short, vaccination does reduce illness and death from COVID-19 infection, as it does for a host of other vaccine-preventable diseases, and does reduce transmission as well.

34. Hippocrates, in his work *Of The Epidemics,* circa 400 BC, wrote "The physician ***must***…have two special objects in view with regard to disease, namely, to do good or ***to do no harm.***" (emphasis mine). This last phrase has evolved over the intervening millennia into "First, do no harm." While not historically accurate, it captures the intent of Hippocrates well. It means, simply, that providers of health care, at all levels, must put the health and safety of their patients as their foremost priority.

35. Historically, this has meant healthcare providers remain current on their own vaccinations to protect their patients from unnecessary risk of contracting vaccine-preventable diseases. Vaccination requirements have been a common staple of healthcare in America. This includes the ability of a healthcare provider or healthcare facility to know a caregiver's vaccination status, and take meaningful steps to address situations where unvaccinated workers seek to treat patients, especially immunocompromised and particularly vulnerable ones. Medical standard of care principles require knowing and addressing the immunization status of healthcare workers in healthcare settings, particularly settings where physicians and other providers provide treatment to particularly

vulnerable patient populations, such as intensive care settings (i.e. ICU), neonatal or pediatric intensive care settings, and cancer care settings, among others. It becomes particularly important for healthcare providers to be vaccinated when they treat patients with vulnerable immune systems, who are unable to develop individual protection through vaccination due to health conditions or age.

36. Healthcare facilities and workers have an obligation to comply with national standards of care in the care and treatment of patients.

37. Montana House Bill 702 prevents Montana healthcare providers from complying with the nationally recognized standard of mandating vaccinations for healthcare workers, ensuring certain patient populations are not exposed to unvaccinated individuals, and tracking vaccination status/records for healthcare workers.

38. Healthcare providers have an obligation to treat their patients in a safe and individualized manner.

39. Hospitals, Critical Access Hospitals, and Offices of Private Physicians treat patients that have physical impairments that substantially impact major life activities. Those impairments can make them more susceptible to vaccine-preventable illnesses and increase their risk of serious harm or death from such illnesses. Faced with such a situation, a facility would perform an individualized assessment of whether a reasonable accommodation under the ADA is available to

the patient absent an undue hardship or direct threat to the hospital's operations, including the safety of its patients. In order to do that analysis, facilities need to know the vaccination status of the healthcare workers, so they can ensure that nonvaccinated individuals will not be providing care to such patients.

40. The standard of care requires an individual assessment of a patient care encounter and determination of whether the particular patient requires treatment only by vaccinated staff members. If so, then the facility needs to be able to ensure that the patient is only treated by vaccinated staff members. This would require the facility to treat vaccinated staff members differently than unvaccinated staff members.

41. Healthcare providers occasionally have to transfer patients to different facilities during the course of their care. Transferring patients to a facility that does not protect patients against unvaccinated individuals can jeopardize patient care.

42. Immunocompromised people, more specifically those with conditions such as cancer, HIV infection, impaired immunity as the direct result of autoimmune diseases and the medications needed to treat them, advanced age, diabetes, organ transplants, those with heart, lung, kidney, and liver diseases, and those who reside in long-term care facilities, are well-known to be more easily sickened by COVID-19 or other infectious diseases, to catch these transmittable

diseases more easily, and to require hospitalization or die more often from these diseases than those who are not immunocompromised. There are numerous physical impairments that substantially limit major life activities that also impact a person's ability to fight off infection and risk of serious illness. These individuals should limit contact with non-vaccinated individuals for their safety.

43. This fact applies to a number of diseases, but recent statistics from the current and ongoing COVID pandemic highlight this reality. The immune impairment is significant enough that a CDC report on August 13, 2021 noted that over 40% of U.S. breakthrough infections (those occurring in fully vaccinated individuals) were in immunocompromised patients, despite the fact that such patients make up only 2.7% of the population. This led to the CDC recommendation that "Close contacts of immunocompromised people should be strongly encouraged to be vaccinated against COVID-19". This was in reference to non-medical close contacts, as it should have not required stating that providers of medical care to those individuals, in deference to the "Hippocratic Oath" and their own consciences, would already have been fully vaccinated. Alas, vaccination in health care workers is far from complete. We also know of patients who have avoided needed medical care because they are afraid to be cared for by unvaccinated providers.

44. Certain immunocompromised individuals should not be exposed to unvaccinated individuals.

45. On July 21st, 2021 a joint statement of over 50 medical associations, including the American Medical Association, the American College of Physicians, the American Public Health Association and the like, published a *Joint Statement in Support of COVID-19 Vaccination Mandates for All Workers in Health and Long-Term Care.* (This is attached in its entirety). It says, in summary, "This is the logical fulfillment of the ethical commitment to put patients…first and take all steps necessary to ensure their health and well-being."

46. Health care providers must put the health and safety of their patients first. Now that there are effective and safe vaccines readily available at no cost, there can be no more excusing those who carry COVID-19 and its detrimental impacts into the workplaces where they care for patients, whether immunocompromised or not. No more of these patients should be sickened or die because of the disregard of their safety posed by unvaccinated individuals charged with the responsibility of their care. This applies with equal force to other, long-standing vaccines that have minimized or effectively eliminated the risks of diseases such as smallpox, polio, and measles. To continue to contain these deadly diseases, further contain COVID-19, and be prepared to address the next pandemic, an increased embrace of vaccines in the healthcare setting is needed.

Montana House Bill 702 does the opposite. Montana House Bill 702 stands in the way of health care providers providing a safe environment for their patients and staff.

47. Vaccination cannot be abandoned as a critical infectious disease prevention measure. Other forms of disease prevention, such as masking, while certainly helpful, cannot serve as a substitute for vaccination. Simple masking is not equally as effective as vaccination in preventing the spread and severity of disease. Masking does not protect against bloodborne pathogens, or the spread of pathogens through surface contact. Masking is less effective than vaccination, especially when the mask wearer is noncompliant or semi-noncompliant with wearing the mask (i.e. allowing a mask to slip down, not wearing the mask at all times, or using ill-fitting or ineffective masks).

48. These principles should apply with equal force in all healthcare settings. For instance, hospitals and physician offices are similarly situated in all meaningful ways when it comes to treating patients. Physicians of all types of specialties treat similar types of patients in acute hospital settings as well as outpatient physician clinic or office settings. Physician offices and hospitals are similarly situated to long-term care settings such as assisted living facilities and skilled nursing facilities. Primary care physicians as well as subspecialists treat elderly and immunocompromised patients in clinic settings, hospital settings, rural

swing-bed hospital settings, and nursing homes and long-term care settings. The similarity of these facilities is highlighted by the use of swing-beds in critical access hospitals. Very often, those beds are used in the exact same manner as nursing homes and long-term care facilities. The facilities provide the same (or similar) care to similarly situated patients by similarly situated healthcare workers. The ethical principles of these healthcare providers and duties to their patients and fellow coworkers are unchanged whether the healthcare provider is providing treatment in a hospital, physician office, or long-term care setting. There is no basis for treating these different facilities in a different manner when it comes to the ability to mandate vaccines for vaccine-preventable illnesses.

49. Montana House Bill 702's dangers are not limited to COVID, but all vaccine-preventable illnesses. While technology has changed, with mechanical ventilators having replaced iron lungs, polio has not. It remains eager to cripple and kill our family members if we allow vaccinations to lapse. Polio has been largely eradicated due to the use of vaccines. Smallpox has been eradicated, outside of the lab setting, due to the use of vaccines. Measles and mumps severely injure or kill far fewer individuals due to the use of vaccines.

50. Patients seek out healthcare facilities for help and to receive medical care in order to get better. Exposing patients to non-vaccinated workers exposes those patients to injury or even death.

51. Additionally, the presence of unvaccinated medical workers undermines the credibility of health care providers when they urge vaccine-hesitant patients to become vaccinated, even when the vaccines may be in the best interest of the patients and of the public at large.

52. Requiring vaccination or preventing unvaccinated individuals from direct contact with certain patient populations is a reasonable step to protect and accommodate those with compromised immune systems or other serious illnesses that impact their ability to fight off disease or increase their risk for serious injury or death.

53. In short, Montana House Bill 702 endangers patients and, indeed, all Montanans and Montana visitors. It does so by opposing the hard-won knowledge and proven strategies in infectious disease prevention of the last 2 ½ centuries, putting us again at risk of the social disruption and unnecessary sickness, maiming, and death caused by vaccine-preventable diseases.

David King, M.D.

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EDUCATION:

1977-1981	University of Washington, Seattle WA Doctor of Medicine with honors
1975-1977	Montana State University, Bozeman MT Post Graduate
1969-1973	Columbia University, New York City NY Bachelor of Arts Cum Laude

POSTDOCTORAL TRAINING:

1981-1984	Family Medicine Internship and Residency, University of New Mexico, Albuquerque NM

BOARD CERTIFICATION: Diplomate, American Board of Family Medicine – 1984 - Present

HONORS: Alpha Omega Alpha medical honor society - 1981

EXPERIENCE:

2011-Present	Bozeman Deaconess Health Group-Belgrade Clinic, Belgrade MT Medical Doctor
2020-Present	Bozeman Health Geriatrics Team Medical Director
2016-Present	Bozeman Health Deaconess Hospital d/b/a Bozeman Health Clinical Research, Bozeman MT Medical Director Principal Investigator/ Sub-Investigator
2007-Present	Bridger Rehab and Care (SNF), Bozeman MT Medical Director
1986-Present	Aviation Medical Examiner
1990-Present	USCIS Civil Surgeon Immigration Medical Examiner
2001-2015	Bozeman Health Family Doctors Urgent Care Medical Doctor
1990-2019	Mountain View Care Center (SNF), Bozeman MT Medical Director
2009-2016	Rocky Mountain Hospice Medical Director
1984-2011	Belgrade Clinic, PLLP, Belgrade MT Medical Doctor

CLINICAL RESEARCH EXPERIENCE:

2021-	Inpatient treatment trial with AMPION IV or inhaled for severe or critical COVID-19 pneumonia. **AMPIO**
2020-	Adaptive platform treatment trial for outpatients with COVID-19 (Adapt Out COVID). **National Institute of Allergy and Infectious Diseases (NIAID)**
2020-	Study to describe the safety, tolerability, immunogenicity, and efficacy of RNA vaccine candidates against COVID-19 in healthy individuals **Pfizer**
2020-	Efficacy, safety, and pharmacokinetics of APT-1011 in subjects with Eosinophilic Esophagitis (EoE) **Elodi Pharmaceuticals**
2019-	A phase 3, Randomized, Double-blind, Parallel Placebo-controlled Induction study of Mirikizumab in conventional-failed biologic-failed patients with moderately to severely active Ulcerative Colitis. **Lilly**
2019-	A phase 2, Randomized, Double-blind, Dose-range-finding Study of MD-7246 Administered Orally for 12 Weeks to Treat Abdominal Pain in Patients with Diarrhea-predominant Irritable Bowel Syndrome. **Ironwood Pharmaceuticals, Inc**
2018-	A Phase 3, Placebo-Controlled, Randomized, Observer-Blinded Study to Evaluate the Efficacy, Safety, and Tolerability of a Clostridium Difficile Vaccine in Adults 50 years of Age and Older **Pfizer**
2018-	A Phase 3b, Randomized, Double-bind ,Placebo-controlled, Parallel-group Trial of Linaclotide 290 µg Administered Orally for 12 Weeks Followed by a 4-week Randomized Withdrawal Period in Patients with Irritable Bowel Syndrome with Constipation **Ironwood**
2018-	SERES-013:ESOSPOR IV: An open-label extension study SERES-012 evaluating SER-109 in adult subjects with recurrent clostridium difficile infection (RCDI) **Seres**
2018-	SERES-012: ECOSPOR III : A Phase 3 Multicenter, Randomized, Double Blind, Placebo-Controlled, Parallel-Group Study to Evaluate the Safety, Tolerability and Efficacy of SER-109 vs. Placebo to Reduce Recurrence of Clostridium difficile Infection (COi) in Adults Who Have Received Antibacterial Drug Treatment for Recurrent COi (RCDI) **Seres**
2017-2021	A phase III randomized, double-blind trial to evaluate efficacy and safety of once daily empagliflozin 10 mg compared to placebo, in patients with chronic Heart Failure with preserved Ejection Fraction (HFpEF) **Boehringer Ingelheim**
2017-2017	A 52 week, open label evaluation of the effects of sacubitril/valsartan (LCZ696) therapy on biomarkers, myocardial remodeling and patient-reported outcomes in heart failure with reduced left ventricular ejection fraction **Novartis**
2017-2018	A Phase 3, Multicenter randomized, Double-blind Study of a Single Dose of S-033188 Compared with Placebo or Oseltamivir 75 mg Twice Daily for 5 Days in Patients with Influenza at High Risk of Influenza Complications **Shionogi**
2016-2017	A Phase 3, Multicenter, Randomized, Double-blind Study of a Single Dose of S-033188 Compared with Placebo of Oseltamivir 75 mg Twice Daily for 5 Days in Otherwise Healthy Patients with Influenza **Shionogi**
2017-	A Phase 3, Placebo-Controlled, Randomized Observer-Blinded Study to Evaluate the Efficacy, Safety, and Tolerability a Clostridium Difficile Vaccine in Adults 50 years of Age and Older **Pfizer**
2017-	A Randomized, Blinded, Parallel Group, Placebo-Controlled, Multiple Dose, Multicenter, Multinational Study to Compare the Therapeutic Equivalence of a Budesonide 80 mcg/Formoterol Fumarate Dihydrate 4.5 mcg Inhalation Aerosol to Symbicort in Adolescent and Adult Patients with Asthma **Watson**
2016-	A Phase 3, Multicenter, Double-blind Extension Study to Evaluate Maintenance of Efficacy of Oral Budesonide Suspension (OBS) and Long-term Treatment Effect of OBS in Adolescent and Adult Subjects (11 to 55 Years of Age, Inclusive) with Eosinophilic Esophagitis (EoE) **Shire**
2015-	Oral Budesonide Suspension (OBS) in Adolescent and Adult Subjects (11 to 55 Years of Age,Inclusive) with Eosinophilic Esophagitis: A Phase 3 Randomized, Double-blind, Placebo-controlled Study **Shire**

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION

MONTANA MEDICAL ASSOCIATION, et al.,

Plaintiffs,

and

MONTANA NURSES ASSOCIATION,

Plaintiff-Intervenors,

v.

AUSTIN KNUDSEN, et al.,

Defendants.

Case No. CV 21-00108-DWM

DECLARATION AND EXPERT REPORT OF DAVID TAYLOR, M.D.

I, David Taylor, M.D., declare, pursuant to 28 U.S.C. § 1746 and under penalty of perjury, that the foregoing is true and correct:

1. The facts and opinions set forth in this Declaration are known to me based on my personal knowledge and belief, and based upon my knowledge, research, education, and experience.

2. I have been retained by the Plaintiffs in the above-captioned matter to render certain opinions as contained in this document. I am charging $400 per hour for my work on this matter. I reserve the right to modify, expand upon, or otherwise change these opinions as new or additional information is provided to me.

EXPERIENCE AND CREDENTIALS

3. I obtained my medical doctorate from Harvard Medical School in 1974, and an advanced masters degree in Medical Parasitology from the London School of Hygiene and Tropical Medicine in 1978. I performed an internship and residency at the State University of New York, and a fellowship as in Geographic Medicine at Johns Hopkins University International Center for Medical Research in Panama.

4. I am board certified in internal medicine with a subspeciality in infectious disease. I am a Fellow in the American College of Physicians and the Infectious Diseases Society of America, and a Member of the American Society of

Microbiology and American Epidemiological Society. I served in the US Army from 1980 to 2002, retiring as a Colonel in the US Army Medical Corps. Over the course of my career, I served in many positions with Walter Reed Army Institute of Research, including: Investigator, Department of Bacterial disease; Investigator, Department of Enteric Infections; Chief, Department of Clinical Trials; Clinical Director, Department of Enteric Infections; and Acting Director, Division of Communicable Diseases and Immunology. Further, from 2002 through 2004, I was a Research Professor at the Department of International Health with Johns Hopkins Bloomberg School of Public Health. From 2015 through 2018, I worked for PATH, an international, nonprofit global health organization--serving as Senior Medical Officer for its Vaccine Development Global Program and Senior Medical Officer of its Drug Development Global Program. Attached as Exhibit A is my curriculum vitae, which further summarizes my professional and clinical education and experience, credentials, editorial activities and professional publications.

OPINIONS

5. Vaccination is the single best strategy to protect the health of the US population against communicable diseases. FDA approved vaccines, including those under an Emergency Use Authorization, are safe and effective.

6. Vaccine is defined as a substance used to stimulate the production of

antibodies and provides immunity against one or several diseases, prepared from the causative agent of a disease, its products, or a synthetic substitute, treated to act as an antigen without inducing the disease. Vaccines are used to prevent disease.

7. The public health strategy related to vaccination is two-fold; one is to protect the vaccinated individual and the other is to protect the general population by providing what is called "herd immunity". Herd immunity occurs when enough people become immune to a disease to make its spread unlikely. As a result, the entire community is protected, even those who are not themselves immune. Herd immunity is usually achieved through vaccination, but it can also occur through natural infection. Because of this, vaccination and immunity status are critical in protecting against communicable disease, both at a micro and macro level.

8. Edward Jenner discovered the smallpox vaccine in 1796 and began the era of scientific inquiry into vaccines to prevent infectious diseases. By 2020, the list of childhood recommended vaccines included: Diphtheria, Tetanus, Pertussis--given in combination as DTaP; Measles, Mumps and Rubella--given in combination as MMR, inactivated Polio (IPV), Haemophilus influenzae type B (Hib), Hepatitis B, Varicella, Hepatitis A, Pneumococcal, Influenza and Rotavirus. These vaccines were introduced after decades of research and clinical studies.

9. DTaP was developed in the 1940s and was the first childhood immunization that went into widespread distribution. These vaccines are

composed of inactivated toxins known as toxoids. The pertussis vaccine has undergone improvements and is now referred to as the acellular pertussis vaccine which contains other components in addition to the toxoid.

10. In the 1950s, the polio vaccine was developed. The Salk vaccine was made from an inactivated polio virus (IPV) and the Sabin vaccine was made from an attenuated (weakened) polio virus (OPV).

11. In the 1960s vaccines for measles, mumps and rubella were developed and combined into the MMR vaccine. All three components of the MMR vaccine are live, attenuated viruses.

12. In the 1980s the vaccine for Haemophilus influenza type B was developed. This vaccine was composed a subunit of the bacteria called the capsule that was stabilized by conjugating it to a carrier protein.

13. The hepatitis B vaccine was also developed in the 1980s. This vaccine is also a subunit vaccine and was the first recombinant vaccine. The surface protein of hepatitis B is produced in a yeast culture.

14. The 1990s saw the introduction of the varicella (chickenpox) vaccine, rotavirus, hepatitis A and pneumococcal vaccines.

15. All of these vaccines are recommended for all infants usually before the age of 2 years. Because immunization programs have been so successful, it is hard to imagine how terrible these diseases were and how fortunate we are to have

vaccines to so successfully protect against these diseases. These vaccines have been extraordinarily successful in preventing childhood infectious diseases. Table 1 summarizes the decline in vaccine preventable diseases in the United States in the years since these vaccines were introduced.

Table 1. Baseline 20th century annual morbidity and 1998 provisional morbidity from diseases with vaccines recommended before 1990 for universal use in children – United States

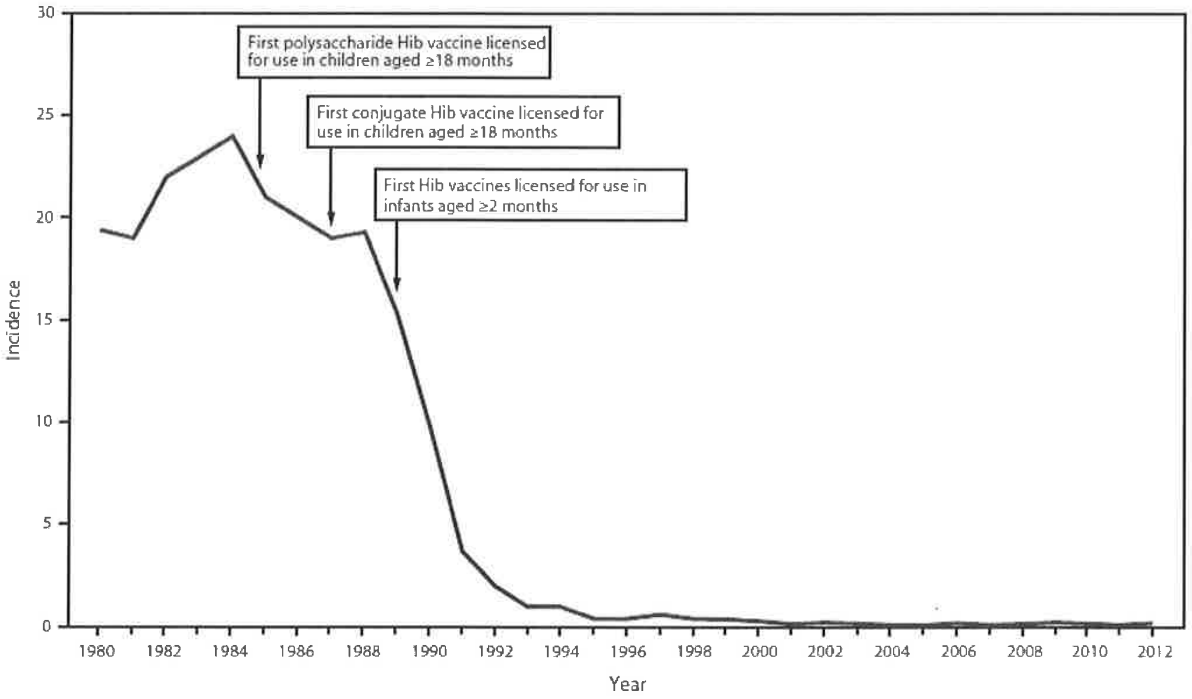
Disease	Pre-vaccine era deaths	Post vaccine era deaths	Percent mortality decrease
Diphtheria	175,885	1	100.0%
Pertussis	147,271	6,279	95.7%
Tetanus	1,314	34	97.4%
Poliomyelitis	16,316	0	100.0%
Measles	503,209	89	100.0%
Mumps	152,209	606	99.6%
Rubella	47,745	345	99.3%
H. influenzae type B	20,000	54	99.7%

Summarized from Roush SW, Murphy TV; Vaccine-Preventable Disease Table Working Group. Historical comparisons of morbidity and mortality for vaccine-preventable diseases in the United States. JAMA. 2007;298:2155-63. doi: 10.1001/jama.298.18.2155. PMID: 18000199.

Also see Ventola CL. Immunization in the United States: Recommendations, Barriers, and Measures to Improve Compliance: Part 1: Childhood Vaccinations. P T. 2016;41(7):426-436.

16. Figure 1 demonstrates the temporal relationship between the introduction of Haemophilus influenzae type b vaccines (Hib) and the steep decline of the disease in the United States. Hib caused sepsis and meningitis in infants and, in addition to the numerous children who died from Hib, many children never fully recovered after Hib infection. Critically, after the Hib conjugate vaccine was introduced and vaccination was encouraged, the disease virtually disappeared.

Figure 1. Impact of Haemophilus influenzae type b (Hib) vaccines on the annual incidence per 100,000 children <5 years old in the United States, 1980-2012



Reference for Figure 1. Briere EC, Rubin L, Moro PL, Cohn A, Clark T, Messonnier N; Division of Bacterial Diseases, National Center for Immunization and Respiratory Diseases, CDC. Prevention and control of Haemophilus influenzae type b disease: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR Recomm Rep 2014; 63(RR-01):1–14.

17. The modern age of school-based vaccination programs began in the 1950s with the Salk or inactivated polio vaccine (IPV). IPV was first tested in 1954 in a vaccine study that enrolled over 600,000 children. The results were reported in April 1955 and mass school-based vaccination programs began thereafter. Much like the Covid vaccine, IPV showed high (~90%) protection against paralytic polio but only 60-70% protection against infection and mild disease. In a short time, nearly all Americans under the age of 40 were vaccinated for polio. In subsequent years poliomyelitis cases fell by half each year from 30,000 cases in 1955, to 15,000 cases in 1956, to 7,000 cases in 1957 etc. The Sabin oral attenuated polio vaccine (OPV) came into use in the 1960s. Because of the near eradication of polio in the US, the OPV trials were conducted overseas in areas of high endemicity. These overseas trials were successful and gave credence to the idea that polio could be controlled, even in the most remote parts of the world. The World Health Organization ("WHO") oversees the distribution of polio vaccine to the poorest nations through the expanded program for immunization. Through these efforts and many others there, has been a 99% reduction in paralytic polio worldwide, since vaccination has become prevalent. The last case of polio in the US occurred in 1979 and the last case in the Western

Hemisphere was reported in 1991 in Peru—essentially indicating that polio has been eradicated in the Western Hemisphere due to widespread use of vaccines.

18. The second disease that encouraged school-based mandatory immunization programs was measles. Measles is a highly infectious viral disease of childhood. Measles can cause high fever, peeling of the skin, and encephalitis. Complications due to Measles can result in brain damage, blindness, or death. In the 1960s, there were many school-based measles outbreaks. Using the same tissue culture techniques that were used for polio vaccine an attenuated vaccine was developed and became widely available, first as a monovalent vaccine and then combined with the mumps and rubella vaccine (MMR). Similar to the measles, mumps can cause meningitis, encephalitis, decreased fertility/sterility, and death. Rubella can cause heart defects, brain disorders, and other damages. Significantly, if a pregnant person contracts rubella, it can result in severe and permanent birth defects or death.

19. In 1977, the US federal government set up the Childhood Immunization Initiative aimed at increasing vaccination rates for seven vaccine preventable diseases-- diphtheria, pertussis, tetanus (DTaP), measles, mumps, rubella (MMR), and polio. Today, all states, the District of Columbia and US territories have vaccination requirement for children to attend school and childcare facilities. State laws establish vaccination requirements, as well as mechanisms for

enforcement and rules for exemption. These programs have increased immunization rates to over 90% nationwide. Although the great increase in vaccination rates have substantially reduced incidences of these diseases, even the 90% immunization rate may not stop all outbreaks. For example, outbreaks of measles and pertussis are still common in areas with low vaccination rates.

20. From babies to teenagers to adults, people need vaccines throughout their lives to provide them with immunity from potentially dangerous infectious diseases. Without vaccines, children are at risk for serious illness, disability, or death, from complications from diseases such as meningitis due to Haemophilus influenzae type b (Hib), measles, and whooping cough (pertussis).

21. Vaccines for human papillomavirus (HPV) and influenza are also frequently included as requirements or, at a minimum, strongly recommended. Meningococcal vaccines have also been required in older children.

22. In addition to the required vaccines, other safe and effective vaccines such as hepatitis A and B, pneumococcal, varicella, and rotavirus are all part of the Centers for Disease Control's ("CDC") list of recommended vaccines.

23. The Covid epidemic has had both direct and indirect impact on childhood immunizations. According to a recent report from the CDC (1), nearly 400,000 fewer children entered kindergarten during the 2020-21 school year because of pandemic-related disruptions. Since childhood immunizations are

the workplace is critical to maintaining a safe care environment and reduce the risk of transmissibility of infectious diseases.

25. Certain diseases, such as Covid-19 and influenza, can mutate into variant strains of the original virus, and some diseases have the ability to mutate more frequently than others. A disease is more likely to mutate the more often it is allowed to replicate, which occurs based upon its opportunity for growth, including the number of times it is transmitted from person to person. These mutations and variants cause a reduction in the durability of an individual's immunity to the disease. The duration of an individual's immunity levels naturally decrease as to certain diseases, some more slowly than others. Immunity to certain respiratory and gastrointestinal illnesses (again, like Covid-19 and influenza) fades more quickly than other diseases. The waning of immunity has led to the implementation of vaccine boosters for a number of vaccines. Vaccine boosters are also utilized after natural infection, to address waning immunity.

26. All of the vaccines discussed herein are approved by the U.S. Food and Drug Administration (FDA), including the Pfizer-BioNTech Covid-19 vaccine (ages 15 and older). Further, several of the Covid-19 vaccines were approved by the FDA under an Emergency Use Authorization—the Moderna Covid-19 vaccine (ages 18 and up), Pfizer-BioNTech Covid-19 vaccine (ages 5 to 15), and

verified upon entry to kindergarten, it is unknown how many of those kids received childhood vaccinations for common diseases.

1. Seither R, Laury J, Mugerwa-Kasujja A, Knighton CL, Black CL. Vaccination Coverage with Selected Vaccines and Exemption Rates Among Children in Kindergarten - United States, 2020-21 School Year. MMWR Morb Mortal Wkly Rep. 2022 Apr 22;71(16):561-568. doi: 10.15585/mmwr.mm7116a1. PMID: 35446828; PMCID: PMC9042357.

Along with school attendance, there has also been a decrease in well-child visits during the Covid epidemic. When parents do bring their children for well-child visits, concerns about coronavirus vaccines are now reflected in attitudes toward routine immunizations. Covid vaccine hesitation can influence acceptance of the routine childhood immunizations.

24. Immunization rates are critical in preventing outbreaks. Immunization rates of 95% are needed to interrupt disease transmission. Thus, the unknown vaccination status of 10% of kindergarten-aged children is concerning. Vaccination coverage among kindergartners nationwide for the 2020-21 school year dropped to 94% - below the CDC target rate of 95%. *See* (1), *supra*. In Montana, Covid vaccine exemptions in health care facilities were approximately twice as high as the national average which in part is caused by the opposing state and federal mandates. Given these declining vaccination rates, healthcare providers' ability to embrace and act upon vaccination and immunization status in

Janssen/Johnson & Johnson Covid-19 vaccine (ages 18 and older). Subsequently, the Moderna and Pfizer vaccines were fully approved by the FDA (table 2).

Table 2. FDA approval timelines for the mRNA Covid vaccines

			FDA approval dates	
Company	Covid vaccine	Marketing name	EUA	Full
Pfizer	mRNA	Comirnaty	Dec. 2020	Aug. 2021
Moderna	mRNA	Spikevax	Dec. 2020	Jan. 2022

27. The FDA ensures that the vaccines children receive are safe and effective. A vaccine is a medical product. Like any medicine, vaccines can cause side effects, but most are minor and short-lived, such as a low-grade fever, or pain and redness at the injection site. Severe, long-lasting side effects of vaccines are extremely rare. The risk of being harmed by vaccines is much smaller than the risk of serious illness from the diseases they prevent. Ensuring the safety and effectiveness of vaccines is one of the FDA's top priorities.

28. The FDA ensures that vaccines undergo a rigorous and extensive development program. The development programs for vaccines include studies conducted by the manufacturers to meet FDA standards for safety and effectiveness in the target population. Manufacturers conduct clinical trials according to plans that have been evaluated by the FDA and reflect the FDA's

considerable expertise in clinical trial design and methods. The FDA approves a vaccine only if it determines that the vaccine's benefits outweigh its risks.

29. The National Foundation for Infectious Diseases has summarized the importance of vaccination as follows:

(1) Vaccine-preventable diseases have not gone away.

The viruses and bacteria that cause illness and death still exist and can be passed on to those who are not protected by vaccines. While many diseases are not common in the US, global travel makes it easy for diseases to spread.

(2) Vaccines will help keep you healthy.

The Centers for Disease Control and Prevention (CDC) recommends vaccinations throughout your life to protect against many infections. When you skip vaccines, you leave yourself vulnerable to illnesses such as shingles, pneumococcal disease, flu; as well as HPV and hepatitis B, both leading causes of cancer.

(3) Vaccines are as important to your overall health as diet and exercise.

Like eating healthy foods, exercising, and getting regular check-ups, vaccines play a vital role in keeping you healthy. Vaccines are one of the most convenient and safest preventive care measures available.

(4) Vaccination can mean the difference between life and death.

Vaccine-preventable infections can be deadly. Every year in the US, prior to the COVID-19 pandemic, approximately 50,000 adults died from vaccine-preventable diseases.

(5) Vaccines are safe.

The US has a robust approval process to ensure that all licensed vaccines are safe. Potential side effects associated with vaccines are uncommon and much less severe than the diseases they prevent.

(6) Vaccines will not cause the diseases they are designed to prevent.

Vaccines contain either killed or weakened viruses or bacteria, making it impossible to get the disease from the vaccine.

(7) Young and healthy people can get very sick, too.

Infants and older adults are at increased risk for serious infections and complications, but vaccine-preventable diseases can strike anyone. If you are young and healthy, getting vaccinated can help you stay that way.

(8) Vaccine-preventable diseases are expensive.

Diseases not only have a direct impact on individuals and their families, but also carry a high price tag for society as a whole, exceeding $10 billion per year. An average flu illness can last up to 15 days, typically with five or six missed work or school days. Adults who get hepatitis A lose an average of one month of work.

(9) When you get sick, your children, grandchildren, and parents may be at risk, too.

Adults are the most common source of pertussis (whooping cough) infection in infants which can be deadly for babies. When you get vaccinated, you are protecting yourself and your family as well as those in your community who may not be able to be vaccinated.

(10) Your family and co-workers need you.

In the US each year, millions of adults get sick from vaccine-preventable diseases, causing them to miss work and leaving them unable to care for those who depend on them, including their children and/or aging parents.

From the National Foundation For Infectious Diseases
https://www.nfid.org/immunization/10-reasons-to-get-vaccinated/

30. Since the Covid pandemic began in January 2020 until today (May 17, 2022), there have been 84 million cases and over 1 million deaths reported in the US and 553 million cases and 6 million deaths worldwide. The enormity of the pandemic has almost no modern precedent.

31. In 1918-19 flu epidemic, the mortality rate in the US was 6 per 1,000, thus far in the Covid pandemic (2020-21) the mortality rate is 2 per 1,000 and counting.

32. The number of Covid cases and mortality rate in the US and worldwide was, as follows:

Table 3. Covid cases and death as of May 17, 2022

	Cases	Deaths
US	84,357,607	1,026,899
Worldwide	523,559,119	6,291,622

33. The below table summarizes the comparative mortality rates for Covid and the 1918 influenza epidemic in the US:

Table 4 Comparison of Mortality rate of Covid 2020-22 and Influenza (1918-19) Pandemics

	Covid	1918 flu
Deaths	1,026,899	675,000
US Population	330,000,000	105,000,000
Mortality Rate	0.0031	0.0064
Deaths/100	0.31	0.64
Deaths/1,000	3	6

34. Vaccine development for the Covid-19 virus began as soon as the virus was isolated and sequenced to determine the genetic structure of the virus. The US government under President Donald Trump established Operation Warp Speed to provide funding for vaccines, drugs, diagnostics, and other public health measures. Two companies, Pfizer in collaboration with BioNTech and Moderna, began to develop messenger RNA vaccines (based on years of research that had already been conducted on mRNA vaccines) which was a new and potentially more rapid method of vaccine development and manufacture.

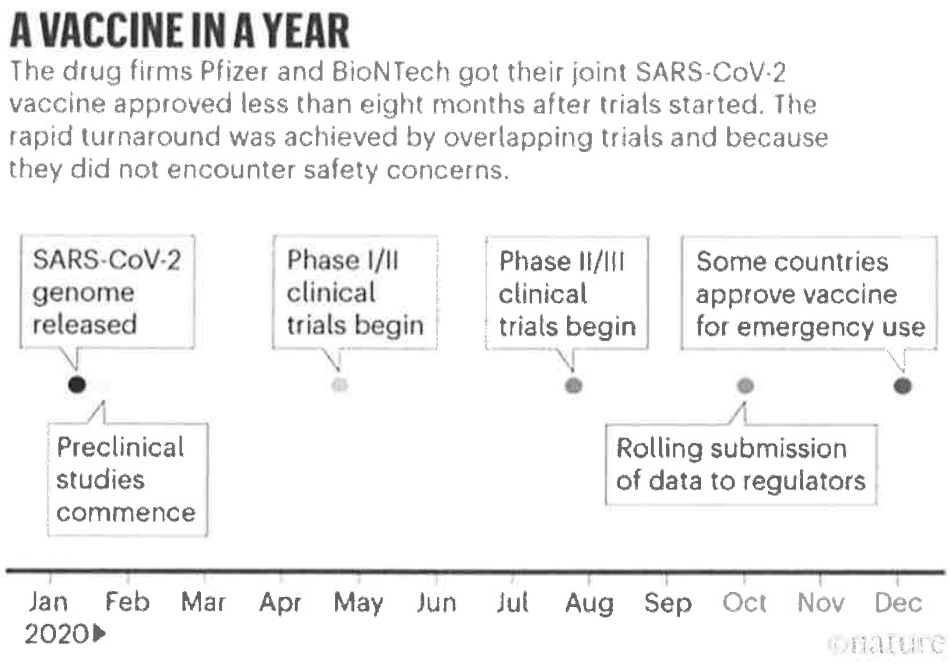
35. Research related to the two previous SARS outbreaks, coupled with the technology advancements in mRNA vaccine development, provided a basic approach and led to the rapid development of the vaccines for SARS-COV2

(Covid-19). An mRNA vaccine was previously developed to address SARS-COV1.

36. Vaccines based upon mRNA technology began research and development in the 1950's and 1960's. Moderna, specifically, had been working on the technology for a significant period of time and had recently developed a strategy to reduce immune response to allow humans to better tolerate mRNA vaccines. Additionally, there were other recent breakthroughs, including the development of a nano-lipid particle that allowed the mRNA to be labile and the ability to stabilize certain proteins' configuration to get optimum immune response, that allowed for the rapid development of these vaccines.

37. The Pfizer-BioNTech vaccine was manufactured for human use and Phase I/II and III trials were completed within a year (Figure 2). These successful trials were submitted to the FDA and the vaccine received emergency use authorization (EUA), and has subsequently received full FDA approval. The Moderna mRNA vaccine and the J&J adenovirus vectored vaccine were not far behind. All three vaccines were authorized in the US and ready for widespread use in early 2021.

38. Figure 2: Timeline for development of the Pfizer Covid mRNA vaccine



39. The speed of development of these vaccines was completely unprecedented, made possible by the coinciding of decades worth of development of mRNA technology and a surge of financial resources. This timeline is remarkable, particularly given the fact that these vaccines also underwent extraordinarily large clinical trials as compared to other vaccines. Typical vaccine clinical trials for FDA approval involve a few hundred participants. However, the clinical trials for these vaccines were upwards of 40,000 participants.

40. More important, the data coming from these trials showed that two doses of the mRNA vaccines were extraordinarily safe and highly effective. The study by Polack et al. which described the findings for the Pfizer-BioNTech mRNA vaccine was published in the New England Journal of Medicine on December 10, 2020. The information collected in this trial led to the FDA providing emergency use authorization on December 11, 2020. The study reports the results from vaccination in August 2020 until December 2020 during the period that the SARS-CoV2 alpha variant was circulating.

41. The study reported that a total of 43,548 participants, age 16 years or older, underwent randomization. 43,448 participants received injections: 21,720 with the Pfizer-BioNTech mRNA vaccine (BNT162b2) and 21,728 with a placebo. During the surveillance period of 100 days, there were eight cases of Covid-19 in the vaccine group and 162 cases among placebo recipients—establishing BNT162b2 was 95% effective in preventing Covid-19 which was highly statistically significant. The safety profile of BNT162b2 was characterized by short-term, mild-to-moderate pain at the injection site, fatigue, and headache.

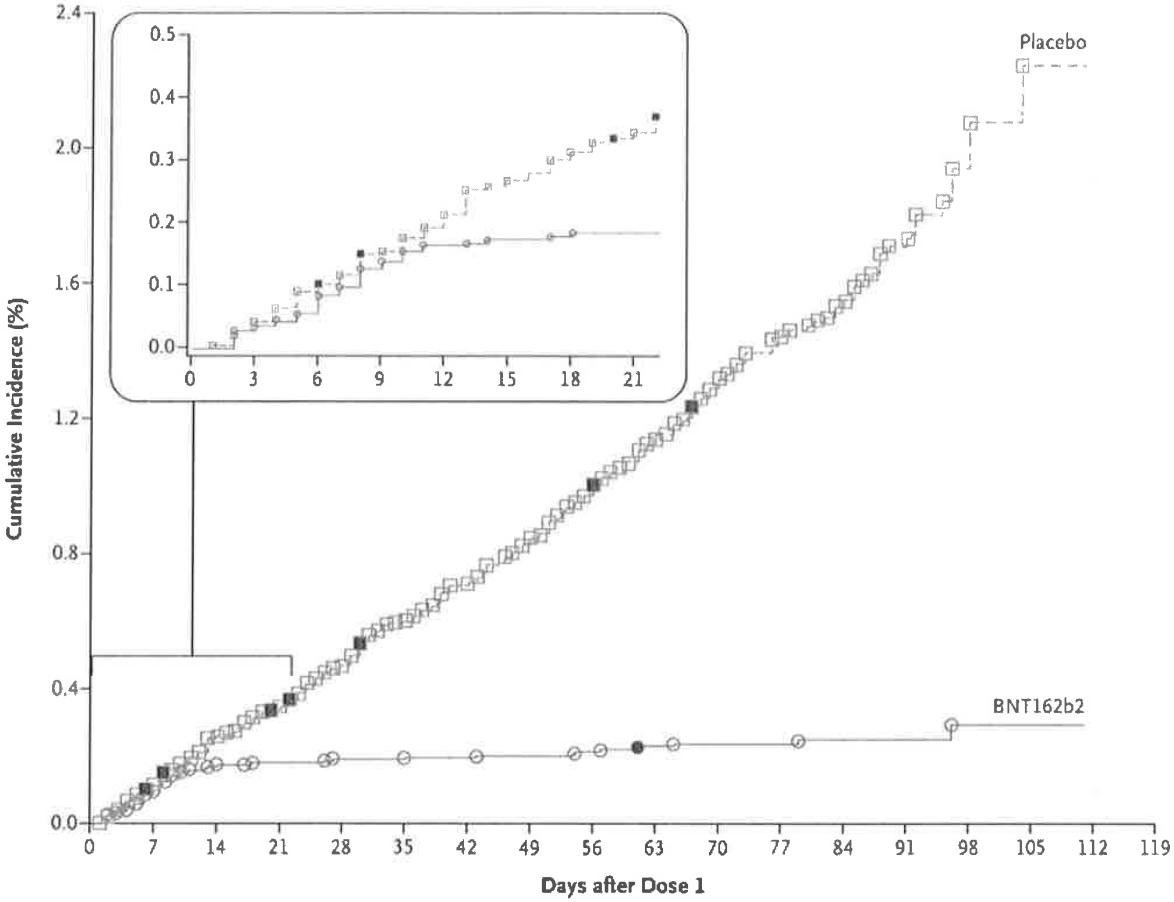
42. Figure 3 demonstrates the efficacy of BNT162b2 (Pfizer-BioNTech) against Covid-19 after the First Dose. Each symbol represents Covid-19 cases starting on a given day; filled symbols represent severe Covid-19 cases. Some symbols represent more than one case, owing to overlapping dates. Surveillance

time is the total time in 1,000 person-years for the given end point across all participants within each group at risk for the end point. The time period for Covid-19 case accrual is from the first dose to the end of the surveillance period.

> *See* Polack FP, Thomas SJ, Kitchin N, et al. Safety and Efficacy of the BNT162b2 mRNA Covid-19 Vaccine. N Engl J Med. 2020 Dec 31;383(27):2603-2615. Doi: 10.1056/NEJMoa2034577. Epub 2020 Dec 10. PMID: 33301246; PMCID: PMC7745181.

This figure illustrates that, for the first 7-10 days, the number of incidences of Covid-19 in vaccinated and unvaccinated individuals remained fairly similar. However, beginning about day 14 and continuing over time, the number of Covid-19 cases in vaccinated individuals remained low, while the number of Covid-19 cases in non-vaccinated individuals grew dramatically.

Figure 3:



Efficacy End-Point Subgroup	BNT162b2, 30 μg (N=21,669)		Placebo (N=21,686)		VE (95% CI)
	No. of participants	Surveillance time *person-yr (no. at risk)*	No. of participants	Surveillance time *person-yr (no. at risk)*	*percent*
Covid-19 occurrence					
After dose 1	50	4.015 (21,314)	275	3.982 (21,258)	82.0 (75.6–86.9)
After dose 1 to before dose 2	39		82		52.4 (29.5–68.4)
Dose 2 to 7 days after dose 2	2		21		90.5 (61.0–98.9)
≥7 Days after dose 2	9		172		94.8 (89.8–97.6)

43. The results from the Moderna vaccine trial were very similar to the Pfizer-BioNTech vaccine trial (Baden). In the Moderna trial, there were 30 cases of severe Covid in the placebo group compared to none in the vaccine group—demonstrating that, for the trial group, there was 100% efficacy for severe disease.

See Baden LR, El Sahly HM, Essink B, et al. Efficacy and Safety of the mRNA-1273 SARS-CoV-2 Vaccine. N Engl J Med. 2021 Feb 4;384(5):403-416. Doi: 10.1056/NEJMoa2035389. Epub 2020 Dec 30. PMID: 33378609; PMCID: PMC7787219.

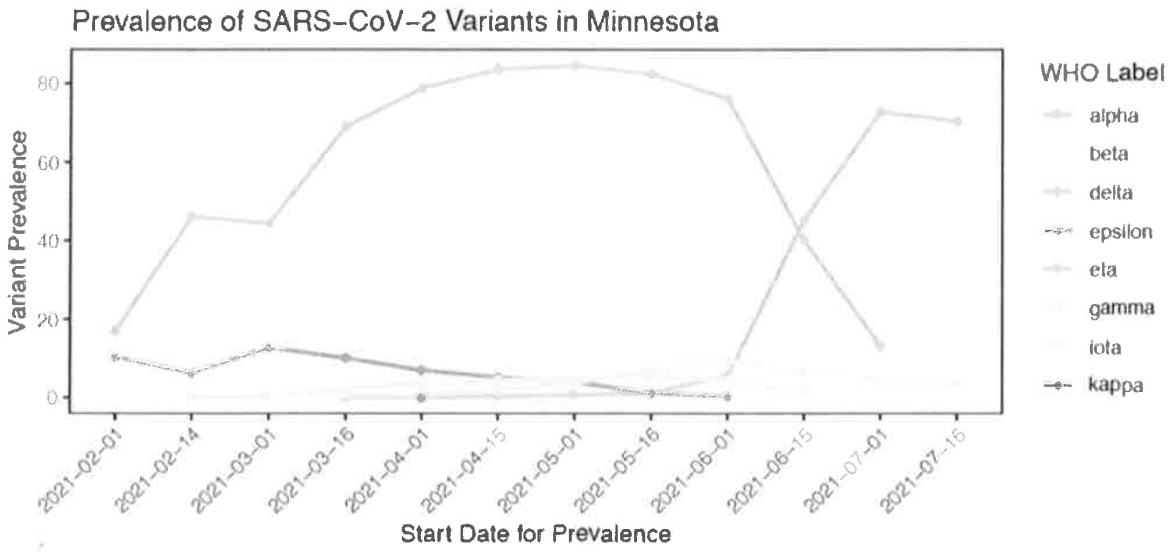
44. In the first 10 months after the authorization of the Covid-19 vaccines, the CDC reports that nearly 195 million people have been fully vaccinated in the US. The Pfizer-BioNTech vaccine accounted for 55% of those vaccinated, the Moderna vaccine accounted for 36%, and the Janssen/Johnson & Johnson vaccine accounted for 8% (table). As of May 17, 2022, 582 million doses have been given and 221 million persons are fully vaccinated. 67% of the US population is fully vaccinated. The highest vaccination rate is among persons 65 years and older at 86%.

https://covid.cdc.gov/covid-data-tracker/#vaccinations_vacc-total-admin-rate-total

45. The next wave of the pandemic occurred in July 2021 when the alpha variant was replaced by the delta variant. The delta variant started to increase in the US in May 2021 and quickly became the predominant strain in the US. Figure 4

below shows that, beginning in June 2021, the delta variant replaced the alpha variant over a period of only one month in Minnesota.

Figure 4:



Puranik A, Lenehan PJ, Silvert E, et al. Comparison of two highly-effective mRNA vaccines for COVID-19 during periods of Alpha and Delta variant prevalence. medRxiv [Preprint]. 2021 Aug 9:2021.08.06.21261707. doi: 10.1101/2021.08.06.21261707. PMID: 34401884; PMCID: PMC8366801.

46. The delta variant is of concern because it was more transmissible than the alpha variant. Since this summer the US underwent a resurgence of Covid illness due to the delta variant of SARS-CoV2. The increase in transmissibility meant that it was no longer possible to create herd immunity where those immunized would be able to protect the unimmunized. However, the vaccines

were still remarkably effective. Although the vaccines were significantly effective, they were not 100% effective, resulting in some breakthrough cases.

47. Figures 5 and 6 depict the rates of Covid-19 cases by vaccination status and the rates of Covid-19 deaths by vaccination status for the time period of April 4, 2021 through September 4, 2021, when the delta variant became prevalent. The black line on both figures represents the reported number of unvaccinated individuals, per 100,000, who contracted Covid-19 or died from Covid-19 during that time frame. The blue line on both figures represents the reported number of vaccinated individuals, per 100,000, who contracted Covid-19 or died from Covid-19 during that time frame. As illustrated by these figures, vaccinated individuals were much less likely to contract and/or die from Covid-19 than unvaccinated individuals. Unvaccinated persons were at a 6-fold greater risk of illness and an 11-fold greater risk of dying from Covid-19.

Figure 5:

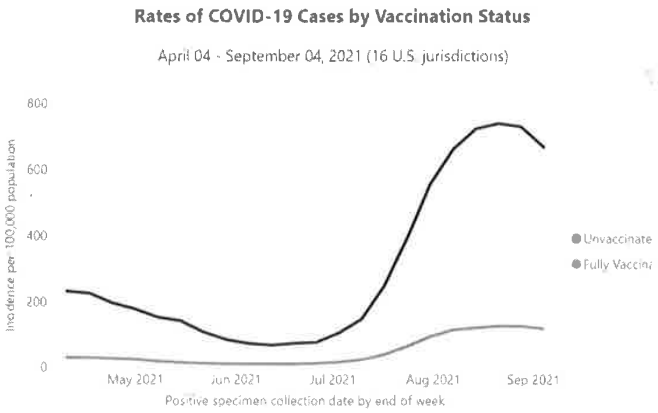
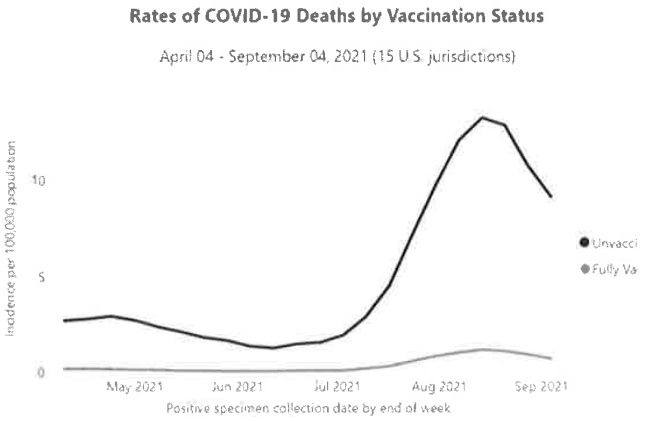


Figure 6:



Source: https://covid.cdc.gov/covid-data-tracker/#rates-by-vaccine-status, as of November 21, 2021.

48. In summary:

- For all adults aged 18 years and older, the cumulative COVID-19-associated hospitalization rate was about 12 times higher in unvaccinated persons.
- The cumulative rate of COVID-19-associated hospitalizations in unvaccinated adults ages 18-49 years was about 14 times higher than fully vaccinated adults aged 18-49 years.
- The cumulative rate of COVID-19-associated hospitalizations in unvaccinated adults ages 50-64 years was about 15 times higher than fully vaccinated adults aged 50-64 years.

49. The experience in Montana and other parts of the US is that the hospitals are full of Covid-19 patients who are unvaccinated. This is particularly true for persons under the age of 70, where vaccines are highly effective. The elderly do not have as robust an immune response after vaccination and are more

vulnerable to infection with the Covid-19 delta variant. The unvaccinated are a risk to themselves and a risk to others who, for a multitude of reasons, cannot produce a strong immune response after vaccination.

> Moline HL, Whitaker M, Deng L, et al. Effectiveness of COVID-19 Vaccines in Preventing Hospitalization Among Adults Aged ≥ 65 Years — COVID-NET, 13 States, February–April 2021. MMWR Morb Mortal Wkly Rep 2021;70:1088-1093.

50. The Covid-19 vaccines provide better protection than natural infection. For example, in Kentucky among people who were previously infected with COVID-19, unvaccinated persons were more than twice as likely to be reinfected with COVID-19 than those who were fully vaccinated after initially contracting the virus (Cavanaugh). These data further indicate that COVID-19 vaccines offer better protection than natural immunity alone and that vaccines, even after prior infection, help prevent reinfections. Observations such as these led to the recommendation that all persons should be vaccinated, regardless of previous COVID infection.

> Cavanaugh AM, Spicer KB, Thoroughman D, Glick C, Winter K. Reduced Risk of Reinfection with SARS-CoV-2 After COVID-19 Vaccination — Kentucky, May–June 2021. MMWR Morb Mortal Wkly Rep 2021;70:1081-1083.

51. In another study, the CDC examined data on 7,348 people hospitalized with a Covid-like illness at 187 hospitals in nine states from January 1 to September 2, 2021. All patients were ages 18 and older and had a Covid-19 test

between 14 days before hospital admission and 72 hours after. Unvaccinated people with a prior Covid-19 infection were more than five times as likely to test positive for Covid-19 than those who had been fully vaccinated and never had the disease.

> Bozio CH, Grannis SJ, Naleway AL, et al. Laboratory-Confirmed COVID-19 Among Adults Hospitalized with COVID-19–Like Illness with Infection-Induced or mRNA Vaccine-Induced SARS-CoV-2 Immunity — Nine States, January–September 2021. MMWR Morb Mortal Wkly Rep 2021;70:1539–1544.

52. These two studies show that vaccines are effective at preventing COVID-19 related hospitalizations among the highest risk age groups. As cases, hospitalizations, and deaths rise, the data reinforce that COVID-19 vaccines are the best way to prevent COVID-19.

53. COVID-19 vaccines remain safe and effective. They prevent severe illness, hospitalization, and death. Additionally, even among the uncommon cases of COVID-19 among the fully or partially vaccinated, vaccinated individuals are more likely to have a milder and shorter illness compared to those who are unvaccinated.

54. Most recently, Pfizer-BioNTech completed an efficacy trial among 2,268 children 5-11 years old. They were randomly assigned to receive two 10-µg doses of the BNT162b2 vaccine or placebo in a 2-to-1 ratio. The trial revealed that the vaccine was safe and produced a similar antibody response as had been

demonstrated in the older children and adults. Covid-19 with onset 7 days or more after the second dose was reported in three recipients of the BNT162b2 vaccine and in 16 placebo recipients (vaccine efficacy, 90.7%; 95% CI, 67.7 to 98.3). The study demonstrated that a Covid-19 vaccination regimen consisting of two 10-µg doses of BNT162b2 administered 21 days apart was found to be safe, immunogenic, and efficacious in children 5 to 11 years of age.

> Walter EB, Talaat KR, Sabharwal C, et al. Evaluation of the BNT162b2 Covid-19 Vaccine in Children 5 to 11 Years of Age. N Engl J Med. 2021 Nov 9. doi: 10.1056/NEJMoa2116298. Epub ahead of print. PMID: 34752019.

55. Individuals who are not vaccinated for vaccine preventable diseases pose a risk to themselves and to others, including "high risk" individuals. High risk individuals are those who cannot produce a robust immune response after vaccination—i.e. immunocompromised individuals, elderly individuals, etc.—and those who cannot, for a variety of reasons, receive vaccines—i.e. infants, individuals with severe allergic reactions to vaccines, individuals with health conditions that make vaccination medically contraindicated, etc. Health care workers are more likely to come into contact with these high risk individuals.

56. Vaccination and immunity status are important to know, as immunized individuals (either through vaccination or infections and recovery) are much less likely to become infected and, therefore, less likely to transmit the

diseases. Because non-immune individuals are more likely to become infected, they are more likely to spread pathogens through airborne, bloodborne, surface contamination, and other transmission mechanisms than immune individuals.

57. Covid-19 remains a fairly new virus, which has contributed to the confusion surrounding it and the vaccines for it. For example, one confusing area is the risk of Covid-19 transmission from vaccinated and unvaccinated persons. From the discussion above it should be clear that vaccinated persons are not as likely to become infected with Covid-19 as the unvaccinated. In the US as well as other parts of the world, the unvaccinated are responsible for most of the transmission because vaccinated persons are over five times less likely to contract the illness than the unvaccinated. You must have an infection to transmit the virus and vaccinated people are much less likely to be infected.

58. An outbreak in Provincetown, Massachusetts in July 2021 in which 74 percent of the 469 cases were in the fully vaccinated indicated that breakthrough infections can certainly occur with the delta variant, especially in indoor settings (Brown).

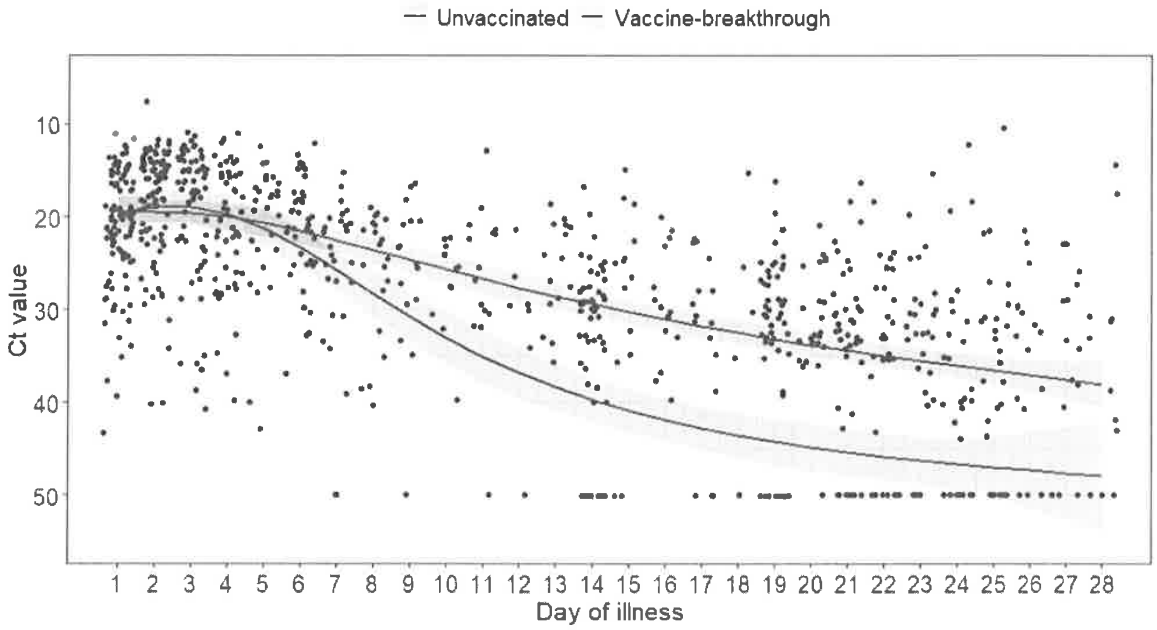
> Brown CM, Vostok J, Johnson H, et al. Outbreak of SARS-CoV-2 Infections, Including COVID-19 Vaccine Breakthrough Infections, Associated with Large Public Gatherings — Barnstable County, Massachusetts, July 2021. MMWR Morb Mortal Wkly Rep 2021;70:1059-1062.

59. In those instances where there is a breakthrough case in a vaccinated person, there is virus shedding which can be infectious. However, vaccinated persons are likely to be contagious for a shorter period of time and harbor less infectious virus compared to unvaccinated persons. Two studies illustrate these points.

60. First, Chia et al. studied 218 individuals with B.1.617.2 infection, 84 received an mRNA vaccine of which 71 were fully vaccinated, 130 were unvaccinated and four received a non-mRNA vaccine. These infections occurred in Singapore from April to June 2021. Figure 7 illustrates viral shedding identified by PCR as described for 30 days after the virus was first detected. PCR cycle time (CT) = 30 was used as the cutoff for viable or transmissible virus. In the first few days of infection, the viral load was similar in the vaccinated and unvaccinated groups. But the vaccinated group had a much more rapid decline in viral load over time. The vaccinated group reached the CT threshold of 30 at 8 days compared to 14 days for the unvaccinated. The amount of viral load correlates with transmission rates—those with a higher viral load are more likely to transmit the virus.

Chia PY, Ong SWX, Chiew CJ, et al. Virological and serological kinetics of SARS-CoV-2 Delta variant vaccine breakthrough infections: a multicentre cohort study. Clin Microbiol Infect. 2022 Apr;28(4):612.e1-612.e7.

Figure 7



61. A study from the Netherlands followed 24,706 vaccinated health care workers using sensitive methods of detection (PCR and viral culture), they identified 161 breakthrough infections. Ninety percent of the breakthrough infections were caused by the delta variant. All of the breakthrough infections were mild and did not require hospitalization. Infectious virus by culture was found in 68.6% of breakthrough infection in vaccinated vs. 84.9% in unvaccinated. The investigators concluded that vaccine breakthrough infections were rare (0.6%), usually mild and associated with a lower viral load in the respiratory tract.

Shamier MC, Tostmann A, Bogers S et al. Virological characteristics of SARS-CoV-2 breakthrough infections in health care workers. 2021 medRxiv preprint.

62. In conclusion, unvaccinated persons are six times more likely to become infected than vaccinated persons. While breakthrough infections occur, they are rare--occurring in less than one percent of vaccinated people. When vaccinated persons become infected they are likely to shed the virus at lower levels and for a shorter time than unvaccinated persons. These factors tend to reduce transmission. While vaccines are not perfect, they reduce the infection and transmission risk, and are by far the best tool we have in the fight against COVID-19 for protecting the community. Since there remains a number of unvaccinated individuals, masking and ventilation are still important ways to also continue to reduce the transmission risk of airborne pathogens.[1] These additional prevention methods should be used in conjunction with vaccination, not as a substitute for vaccination.[2]

63. While infections with the delta variant have waned in some areas, they have increased in other areas. SARS-CoV-2 may become like influenza showing an increase in the winter months when people are indoors. As of November 2021

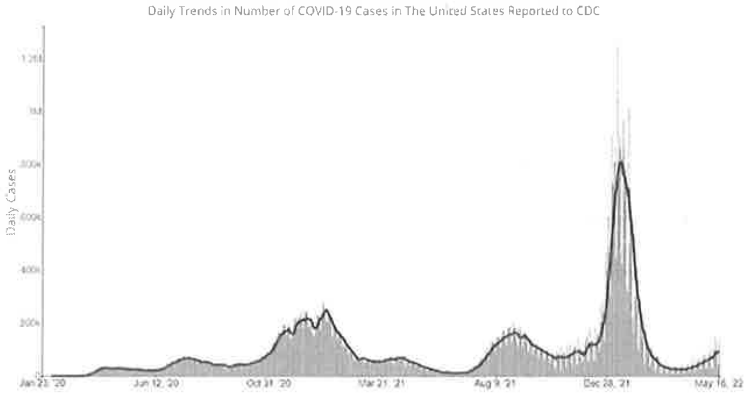
[1] These safeguards apply only to airborne pathogens as opposed to bloodborne.

[2] Other references used herein noted on Exhibit B

boosters shots are now recommended for all people in the US. This will strengthen our immunity which may be waning over time since the first vaccination. Further, unvaccinated individuals are being encouraged and more frequently mandated to receive their vaccines, which will strengthen immunity. Finally, new orally administered anti-viral agents have been tested and are likely to play an important role in reducing symptoms, decreasing secondary transmission, and decreasing the need for hospitalization.

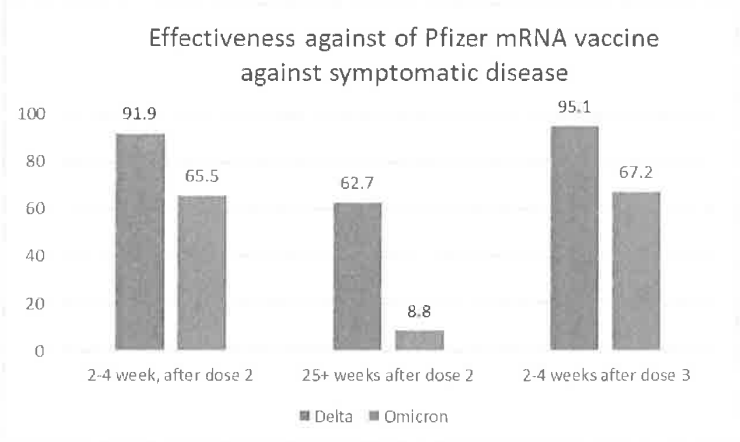
64. The Omicron outbreak:

As the outbreak with the delta variant began to wane in October 2021, another variant was identified in November 2021 in South Africa. This variant, designated the omicron, was more transmissible than delta. Omicron was identified in the US in early December and within a few weeks completely replaced the delta variant and caused a massive outbreak in the first 3 months of 2022 (Figure). Fortunately, the illness caused by omicron was less severe than the infections caused by the earlier Covid variants.



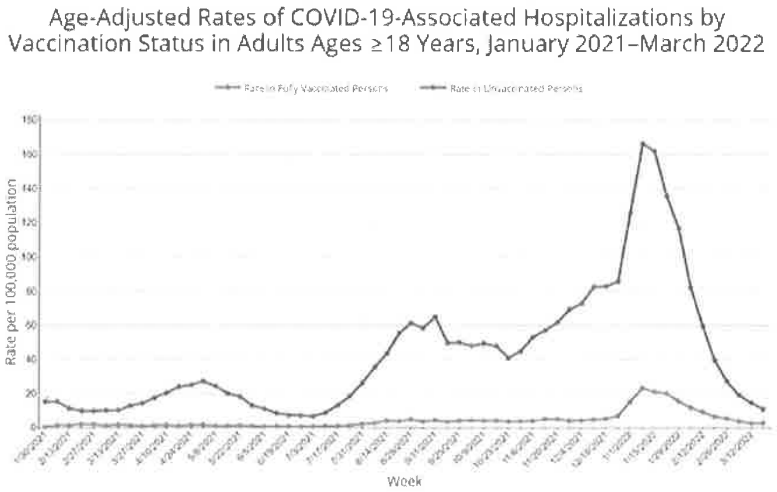
From CDC CDC COVID Data Tracker: Daily and Total Trends

Covid vaccination continued to play a significant protective role in protecting against symptomatic disease caused by the omicron variant. In a study from the United Kingdom the vaccine effectiveness was 65% in the period 2-4 weeks after the second dose. Protection decreased to less than 10% after 25 weeks but could be improved to 67% with a third vaccine dose (Figure).



From N. Andrews et al. N Engl J Med 2022; 386:1532-1546 DOI: 10.1056/NEJMoa2119451

Covid vaccination was also found to significantly reduce the severity of infection as measured by hospitalization rate. Data collected from a network of over 250 acute-care hospitals in 14 US states indicated that the risk of hospitalization was nearly 5-fold higher in unvaccinated adults aged 18 years and older (Figure).



Data from CDC Covid website

The omicron outbreak has emphasized that Covid epidemiology has not settled into a predictable pattern as has been the case with seasonal influenza. However, seasonal influenza may be the future model. Influenza vaccines are based on predicting the influenza strains that are likely to circulate in the next season and preparing a single dose vaccine given before the season starts.

65. Fighting viruses requires a multipronged approach. Vaccination can be combined with public health measures, such as social distancing and masking. Vaccination can also be constantly improved. The introduction of the mRNA Covid vaccines was a major advance and saved millions of lives. There is hope that future vaccines will be more effective against a wide variety of Covid strains. In summary, vaccines are a safe, effective and essential public health tool to insure the good health of our nation and world. Every effort should be made to promote their use.

DATED this 5th day of July, 2022.

David Taylor, M.D.

October 2021

CURRICULUM VITAE

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EDUCATION AND TRAINING

1970	B.S.	With honors in biology, Kenyon College, Gambier, Ohio
1972	DMS	Dartmouth Medical School, Hanover, New Hampshire
1974	M.D.	Harvard Medical School, Boston, Massachusetts
1978	MSc.	Medical Parasitology, London School of Hygiene and Tropical Medicine, London, England

Internship

1974-1975 State University of New York at Buffalo Affiliated Hospitals, Buffalo, New York

Residency

1975-1977 State University of New York at Buffalo Affiliated Hospitals, Buffalo, New York

Fellowship

1978-1980 Research Fellow in Geographic Medicine, Johns Hopkins University International Center for Medical Research (Panama)

CERTIFICATION

1975 Diplomate, National Board of Medical Examiners
1977 Diplomate, American Board of Internal Medicine
1988 Diplomate, American Board of Internal Medicine, Subspecialty of Infectious Diseases

2008	Advanced Vaccinology Course, Fondation Merieux & University of Geneva

MEDICAL LICENSURE

2021-present	Montana, 101045
1988-2021	Maryland, D35854

MILITARY SERVICE

1980-1982	Senior Assistant Surgeon, USPHS
1982-1987	Major, Medical Corps, U.S. Army
1987-1993	Lieutenant Colonel, Medical Corps, U.S. Army
1993-2002	Colonel, Medical Corps, U.S. Army

PROFESSIONAL EXPERIENCE

2021-	Director of Clinical Research, Bozeman Health, Bozeman, MT
2020-21	Independent Consultant, Healthcare technologies
2018-19	Chief Medical Officer, Vaxart Inc., S. San Francisco, CA
2016-18	Senior Medical Officer, Drug Development Global Program (DRG), PATH
2015-16	Senior Medical Officer, Vaccine Development Global Program, PATH
2013-14	Senior Medical Director, Vaccines, Takeda Vaccines
2007-13	Chief Medical Officer, VaxInnate Corporation
2004-06	Vice President Medical and Safety & Chief Medical Officer, Salix Pharmaceuticals
2002-04	Research Professor, Dept of International Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD
2001-02	Acting Director, Division of Communicable Diseases and Immunology, Walter Reed Army Institute of Research, Silver Spring, MD
2000-02	Research Coordinator, Prevention of Diarrheal Diseases, Military Infectious Diseases Research Program, US Army Medical Research and Materiel Command, Fort Detrick, MD
1997-02	Clinical Director, Dept. of Enteric Infections, Division of Communicable Diseases and Immunology, WRAIR
1995-2010	Adjunct Professor of Preventive Medicine/Biometrics, Uniformed Services University of the Health Sciences, Bethesda, MD
1994-97	Chief, Cholera Vaccine Project, Naval Medical Research Institute Detachment, Lima, Peru.
1992-94	Chief, Department of Clinical Trials, Walter Reed Army Institute of Research, Washington, D.C.
1990-92	Investigator, Department of Enteric Infections, Walter Reed Army Institute of Research, Washington, D.C.
1988-90	Investigator, Department of Bacterial Diseases, Walter Reed Army Institute of Research, Washington, D.C.
1983-88	Assistant Chief, Department of Bacteriology and Clinical, Laboratory Sciences, US Army Medical Component, Armed Forces Research Institute of Medical Sciences,

	Bangkok, Thailand
1980-82	Epidemic Intelligence Service Officer, Enteric Diseases Branch, Centers for Disease Control, United States Public Health Service, Atlanta, Georgia

PROFESSIONAL ACTIVITIES
Board of Directors, National Emergency Medicine Foundation (2015-present)

CONTINUING EDUCATION

1993 -- Good Clinical Practices Training, WRAIR, Washington DC
2000 – Effective Project Management, Center for Professional Advancement

1989 – 1st Conference of the International Society of Travel Medicine	Zurich
1991 – 2nd Conference of the International Society of Travel Medicine	Atlanta
1993 – 3rd Conference of the International Society of Travel Medicine	Paris
1995 – 4th Conference of the International Society of Travel Medicine	Acapulco
1997 – 5th Conference of the International Society of Travel Medicine	Geneva
1999 – 6th Conference of the International Society of Travel Medicine	Montreal
2003 – 8th Conference of the International Society of Travel Medicine	New York
2005 – 9th Conference of the International Society of Travel Medicine	Lisbon

PROFESSIONAL ACTIVITIES

Society membership

Fellow, American College of Physicians
Fellow, Infectious Diseases Society of America
Member, American Society of Microbiology
Member, American Epidemiological Society

International Experience

1972	Two month medical elective, Guatemala
1974	Two month medical elective, Colombia
1978-1980	Research Fellowship, Panama
1982	Two months research project, Chile
1983-1988	Thailand
1986-1987	WHO consultant to oral typhoid vaccine trial, Plagu, Sumatra, Indonesia
1994-1997	Peru
2002-4	Guatemala
2015-6	Vietnam and Serbia

LANGUAGE ABILITIES

Spanish, Thai

EDITORIAL ACTIVITIES

Peer Review Activities

Review for
Journal of Infectious Diseases
Clinical Infectious Diseases
Infection and Immunity
Journal of Clinical Microbiology
Annals of Internal Medicine
New England Journal of Medicine
Pediatrics
American Journal of Epidemiology
Pediatric Infectious Diseases
Vaccine

HONORS AND AWARDS

1988 Army Meritorious Service Medal
1995 Legion of Merit
1997 Navy Letter of Commendation
1998 Army Meritorious Service Medal (Second award)
2000 Certificate of Recognition for service during cold war (2 Sep 1945 to 26 Dec 1991).

PUBLICATIONS

Chapters, Reviews, and Editorials

1. Blaser MJ, Taylor DN, Feldman RA. Epidemiology of Campylobacter infections. In: Campylobacter infections in man and animals. CRC Press Inc., Boca Raton, FL, USA 1983:144-161

2. Sethabutr O, Echeverria P, Taylor DN, Pal T, Rowe B. DNA hybridization in the identification of enteroinvasive Escherichia coli and Shigella in children with dysentery. In Infectious Diarrhea in the Young, Elsevier Science Publishers, S Tzipori et al. eds. 1985

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4. Echeverria P, Taylor DN. New approaches to the diagnosis of enteric infections. In: Farthing MJG and Keusch GT, eds. Enteric Infection. Chapman and Hall, London. 1989:417-437

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9. Taylor DN, Shlim DR. Approach to recurrent and prolonged diarrhea in the traveler. In Travel Medicine Advisor. Eds Jong EC, Keystone JS. American Health Consultants, Atlanta, GA, 1991.

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PRESENTATIONS

Upon Request

EXHIBIT B

Other references
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**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION**

MONTANA MEDICAL ASSOCIATION, et al., Plaintiffs, and MONTANA NURSES ASSOCIATION, Plaintiff-Intervenor v. AUSTIN KNUDSEN, Montana Attorney General, and LAURIE ESAU, Montana Commissioner of Labor and Industry, Defendants.	Cause No. 9:21-cv-108 Hon. Donald W. Molloy **DECLARATION AND EXPERT REPORT OF GREG HOLZMAN, M.D., MPH**

I, Gregory S. Holzman, M.D., MPH, declare, pursuant to 28 U.S.C. § 1746 and under penalty of perjury, that the foregoing is true and correct:

1. The facts and opinions set forth in this Declaration are known to me

based on my personal knowledge and belief, and based upon my knowledge, training, research, education, and experience.

2. I have been retained by the Plaintiff-Intervenor in the above-captioned matter to render certain opinions as contained in this document. I am charging $500 per hour for my work on this matter. I reserve the right to modify, expand upon, or otherwise change these opinions as new or additional information is provided to me.

EXPERIENCE AND CREDENTIALS

3. I obtained my medical doctorate from the University of Florida, College of Medicine, and my Master of Public Health from the University of Washington, School of Public Health. I completed a residency in Family Medicine at the Carolina Medical Center and a Preventive Medicine residency at the University of Washington. I am board certified by the American Board of Family Medicine. I am also board certified by the American Board of Preventive Medicine. According to the American Board of Preventive Medicine, "Preventive Medicine is the specialty of medical practice that focuses on the health of individuals, communities, and defined populations. Its goal is to protect, promote, and maintain health and well-being and to prevent disease, disability, and death. Preventive medicine specialists have core competencies in biostatistics, epidemiology, environmental and occupational medicine, planning and evaluation

of health services, management of healthcare organizations, research into causes of disease and injury in population groups, and the practice of prevention in clinical medicine."

4. I have worked in clinical medicine, academia, and State and Federal governmental public health. I have held leadership positions in public health as the Chief Medical Executive for the Michigan Department of Community Health for the State of Michigan. I served with the Centers for Disease Control and Prevention as the Deputy Director for the Office for State, Tribal, Local and Territorial Support. Most recently, I served as the State Medical Officer for the State of Montana, Montana Department of Public Health and Human Services. I am currently working as a consultant on different public health issues. Attached as Exhibit 1 is my curriculum vitae, which further summarizes my credentials and professional and clinical education and experience.

5. I have not previously given deposition or trial testimony as a retained expert. However, I provided affidavit testimony in my capacity as State Medical Officer about the risk of COVID-19 transmission in polling places in a 2020 case called *Trump v. Bullock*, Case No. No. CV-20-67-H-DLC at the United States District Court for the District of Montana, Missoula Division. I also provided deposition testimony in my capacity as State Medical Officer in a 2020-2021 case called *Gallatin County v. Rocking R Bar* in state district court in Gallatin County.

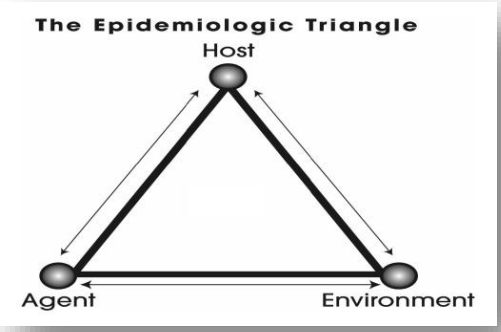
OPINIONS

6. It is well-settled in the fields of public health and preventive medicine that infectious diseases have been responsible for significant morbidity and mortality throughout the millennium. Even before the advent of life-saving antibiotics, antiviral, antifungal, and antiparasitic medications, scientists looked for ways to prevent infectious diseases and their spread within communities. Early interventions included tools like handwashing, source control such as masks for respiratory disease, and the concepts of isolation and quarantine. The advent of vaccines has significantly improved the ability to prevent the spread of disease, suffering, and deaths worldwide. A Centers for Disease Control and Prevention on April 2, 1999, Vol. 48, No 12 Morbidity and Mortality Weekly Report ("MMWR") identified vaccines as one of the Ten Great Public Health Achievements of the 20th century.[1] Some infectious diseases, such as smallpox, have been eradicated from the world, while diseases such as measles and polio have been eliminated from the U.S. due to vaccination programs. Many other vaccine-preventable diseases have been significantly reduced, leading to a decrease in suffering and premature death. In the MMWR report from May 20, 2011, the authors highlight an economic analysis by Zhou indicating "… that vaccinations of

[1] Centers for Disease Control and Prevention (CDC). Ten great public health achievements – United States, 1900 – 1999. MMWR Morb Mortal Wkly Rep. 1999 Apr 2;48(12): 241-3. PMID 10220250

each U.S. birth cohort with the current childhood immunization schedule prevents approximately 42,000 deaths and 20 million cases of the disease, with net savings of nearly $14 billion in direct costs and $69 billion in total societal cost."[2]

7. Public health and preventive medicine experts use a model called the Epidemiological Triangle to discuss the spread of, and ways to control, infectious disease.



The host is the "who" of the triangle. Public health and preventive medicine experts focus on how vulnerable the host (individual or population) is to the infectious disease. The Agent is the "what" of the triangle. Public health and preventive medicine experts focus on understanding the infectious disease's transmissibility and virulence within a given individual or population. The Environment is the "where" of the triangle. Public health and preventive medicine experts focus on understanding external factors that help support the spread of a

[2] Centers for Disease Control and Prevention (CDC). Ten great public health achievements – United States, 2001 - 2010. MMWR Morb Mortal Wkly Rep. 2011 May 20:60(19):619-23. PMID 2l597455

given contagious disease. Our goal in public health is to interrupt the triangle, at least on one of the sides, to stop the spread of diseases.

8. Acquiring an infectious disease is a recognized hazard to working within the medical field and in healthcare settings. This includes the acquisition of vaccine-preventable diseases. Healthcare workers, such as nurses, risk exposure to infectious diseases within their routine work requirements. Also, a healthcare worker who acquires an infectious disease can be a vector to spread that infection to others, including coworkers and patients, leading to an increased risk for longer hospital stays, increased medical cost, suffering, and even death.

9. Healthcare settings host vulnerable individuals at higher risk for morbidity and mortality if they acquire a vaccine-preventable infectious disease. Therefore, healthcare settings put forth significant resources to prevent the spread of diseases within their facilities through types of occupational health services.

10. Healthcare settings employ people, including nurses, who could be vulnerable or at higher risk for morbidity and mortality if they acquire a vaccine-preventable infectious disease.

11. Hospitals, clinics, and other healthcare settings implement evidence-based and standard of care practices such as using appropriate personal protective equipment, properly cleaning healthcare facilities and equipment, cohorting or isolating specific types of patients, and even limiting access to certain areas of the

facility or specific patients to limit the risk for disease transmission. Some precautions to prevent the spread of disease are universal throughout healthcare settings. At the same time, the risk of exposure to unique infectious diseases requires more specific prevention measures; for example, contact, bloodborne, droplet, or airborne precautions may be implemented.

12. In certain situations in healthcare settings, it is necessary to know the vaccination status of healthcare workers to prevent the spread of a vaccine-preventable disease. Likewise, there are situations in healthcare settings where it is essential to treat employees differently in the conditions of their employment based on their vaccination or immunity status in order to secure a safe workplace and protect patients. For example, a healthcare worker who is not immune to measles or varicella cannot be in direct contact with a patient who has an active infection of these diseases without creating a significant risk to the worker of infection. And because these viruses can be spread before an individual is aware they have measles or varicella, the risk can be compounded with the further spread of the disease to unknowing patients and/or healthcare workers.

13. It is well-established in the fields of public health and preventive medicine that vaccines can prevent or decrease the severity of vaccine-preventable diseases. High vaccination rates within a population can decrease the risk of the spread of disease within a population. High vaccination rates in a population can

decrease the risk of the nonimmune, such as individuals who are unable to be vaccinated or are immunosuppressed from possibly acquiring the infection. An example is the practice of vaccinating individuals against pertussis who are around a newborn who is too young to be vaccinated and is at the greatest risk for severe disease.

14. The CDC's Immunization of Health-Care Personnel – Recommendation of the Advisory Committee on Immunization Practice[3] (document) highlights that healthcare providers "… are considered to be at substantial risk for acquiring or transmitting hepatitis B, influenza, measles, mumps, rubella, pertussis, and varicella." These are all vaccine-preventable diseases. We would add COVID-19 to this list. Other vaccines are recommended to certain healthcare providers in certain situations.

15. In my opinion, other preventive measures are not a substitute for immunizations but are part of the comprehensive strategy to decrease the risk of disease spread in healthcare settings. For one reason, some infectious diseases can be spread without the host knowing they are infected. For example, a percentage of individuals actively infected with the SARS-CoV 2 virus has shown no overt symptoms of COVID-19. Other examples include measles which can spread up to

[3] Advisory Committee on Immunization Practices; Centers for Disease Control and Prevention (CDC). Immunization of health-care personnel: recommendations of the Advisory Committee on Immunization Practices (ACIP) MMWR Recomm Rep. 2011 Nov 25;60(RR-7):1-45. PMID: 22108587

four days before a rash appears and varicella up to two days before the rash onset. Another example is influenza, where an individual could start spreading the virus a day before symptoms. Another reason is that none of the other prevention measures are foolproof. Human error can decrease their effectiveness, such as incorrectly wearing a mask, not appropriately washing one's hands, or even having an accidental needle stick. Immunizations are also not 100% effective at preventing infection or reducing disease spread in all circumstances. Rather, it is through a comprehensive program that includes immunizations that healthcare setting can best minimize the risk of the spread of vaccine-preventable diseases to patients and healthcare workers.

16. Actual knowledge of a healthcare worker's immunization status allows a healthcare setting to assess not only the risk to the individual in certain situations, but the risk to others in a population. Passive assumptions about an individual's vaccination status are no substitute for actual knowledge of their vaccination status. In medicine and public health, we take a medical history or use investigative tools to gather pertinent information to help us understand risk and implement treatment and/or prevention plans.

17. In my opinion, to care for patients and employees in certain situations, public health and preventive medicine require healthcare settings to treat immune and unimmune individuals differently. Medically recommended intervention may

be different for an immune or non-immune individual. For example, a healthcare provider may need to move quickly with post-exposure prophylaxis to decrease the risk of an individual acquiring the disease. Infection Control Preventionists use the knowledge of vaccine status when determining quarantine or possible work restriction to help prevent risk to others and further spread of disease.

18. I understand that House Bill 702 does not allow healthcare settings to treat employees differently based on their vaccination status. Based on my experience and knowledge in the fields of public health and preventive medicine, it is my opinion that in specific scenarios, healthcare settings must be able to treat employees differently in the conditions of their work and employment based on their vaccination status to secure a work environment free from known hazards for healthcare workers and their patients.

19. I also understand that it HB 702 allows certain health care facilities to assume that some employees are not vaccinated and make accommodations. As described above, assumptions about immunity or vaccination status are no substitute for actual knowledge of immunity or vaccination status when a healthcare setting is responding to an active transmission of vaccine-preventable disease, or developing and implementing plans to prevent further transmission of disease. It is my opinion that in order to provide a workplace free from known hazards, healthcare settings must be able to treat employees differently based on

knowledge of a healthcare worker's actual immunity status—and that in certain situations, this is the only option that does not jeopardize workplace safety.

20. Healthcare workers have an increased risk of exposure to vaccine-preventable diseases. Healthcare workers also pose the risk of transmitting vaccine-preventable diseases to vulnerable patients, and other healthcare workers, among others. It is my opinion that all healthcare workers that can, should be vaccinated in accordance with the Advisory Committee for Immunization Practices recommendation for healthcare personnel. It is my further opinion that healthcare settings must have the flexibility to require immunizations described by the Advisory Committee—or to treat employees differently based on actual knowledge of their immunization status—in order to address the recognized workplace hazard of vaccine-preventable disease and to provide a safe environment for workers and patients at risk.

21. Based on my knowledge and experience, it is my opinion that healthcare workers in long term care settings face the same or similar workplace risks associated with vaccine-preventable diseases as those who do not work in long term care settings.

Greg Holzman, M.D., MPH

Holzman Report – Exhibit 1

GREGORY SCOTT HOLZMAN MD, MPH

PERSONAL

Home Address:	1311 E Broadway St Helena, MT 59601
Telephone	517-488-7161
Email	Holzmangreg99@gmail.com
Citizenship	USA

EDUCATION

University of Washington	2000 – 2002	MPH Preventive Medicine Residency
Maniilaq Health Center, Kotzebue, Alaska	1998 (March)	One-month clinical rotation
Carolina Medical Center, Department of Family Practice	1995 – 1998	Family Medicine Residency
University of Florida College of Medicine	1990 – 1995	MD with Honors
Michigan State University	1985 – 1988	BS with High Honors
Tulane University	1984 – 1985	

LICENSES

Michigan	Active
Montana	Active

CERTIFICATIONS

Advanced Trauma Life Support	2018
Advanced Cardiac Life Support	2021
Basic Life Support	2021
American Board of Preventive Medicine – Re-Certification	2016
American Board of Preventive Medicine - Certification	2005
American Board of Family Practice – Re-Certification	2004, 2014
American Board of Family Practice – Certification	1998

LEADERSHIP TRAINING

2017 Physician Leadership Effectiveness Program	2016 - 2017
Public Sector Leadership: Values, Vision & Vital Strategies: The Federal Executive Institute	September 9 - 13, 2012

PROFESSIONAL EXPERIENCE

Consulting Contracts	
Montana Primary Care Association	2021 – present
Association of State and Territorial Health Officials	2022 – present
Senior Leadership Reserve Corp	
Montana Medical Association	2021 – 2022
Montana Department of Public Health and Human Services	
State Medical Officer	2015 – 2021
State Health Officer	2020 – 2021
State Health Officer Designee	2018 – 2020
Medicaid Medical Director	2015 – 2021
State Refugee Health Coordinator	2015 – 2017
Michigan State University	
Adjunct Associate Professor of Epidemiology	2007 – 2020, 2022 – present
Associate Professor, Department of Family Medicine	2007 – 2015
Associate Chair for Preventive Medicine, Family Medicine	2013 – 2015
Director Healthy Campus Initiative – MSU	2014 – 2015
Medical Director, Family Medicine Residency Network	2013 – 2014
Acting Co-Director GRIN (Great Lakes Research into Practice Network)	2013 – 2014
Institute for Health Policy	2013 – 2014
Sparrow Residency Program, Educator	2013 – 2014
University of Michigan	
Preventive Medicine Residency	
Residency Advisory Committee	2006 – 2017
Chair	2010 – 2013
Adjunct Associate Professor of Health Management and Policy	2007 – 2014
Deputy Director – Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention	2011 – 2013
Chief Medical Executive – State of Michigan	2006 – 2011
BioWatch Advisory Committee	2010 – 2011
Executive Medical Director	
Michigan's WISEWOMAN program – Medical Oversight	2008 – 2011
Michigan Resource Allocation Ethics Advisory Committee	2008 – 2011
Institutional Review Board – Signatory Official	2007 – 2011
Michigan Primary Care Consortium	2007 – 2009
Member of Steering Committee	
Michigan Advisory Committee on Immunizations	2006 – 2011
Ex-Officio Member	
Michigan Public Health Institute – Preventive Medicine	2006 – 2011
Residency Site Director	
University of Michigan School of Public Health Practice	2006
Lindblad Expeditions – Ship Doctor 1- 4 weeks per year	2002 – present

PROFESSIONAL EXPERIENCE– Continued

Consulting Contracts

Wyoming Diabetes Prevention and Control Program	2006 (Misc. Events)
University of North Dakota School of Medicine and Health Sciences	Aug 2005 – June 2006
Montana Department of Public Health and Human Services	
Montana Tobacco Use Prevention Program	Nov 2005 – Oct 2006
Maternal and Child Health	June 2005 – Sept 2006

Central Maine Medical Center

Faculty, Family Practice Residency Program	2004 – 2005

University of Minnesota, School of Public Health

Adjunct Assistant Professor, Public Health Practice	2003 – 2005
Midwest Center for Life-Long-Learning in Public Health Advisory Cooperative Board, North Dakota Educational Liaison	2002 – 2004

University of North Dakota School of Medicine and Health Sciences

Clinical Adjunct Associate Professor, Department of Community Medicine	2004 – 2006
Associate Professor, Department of Community Medicine	2002 – 2004
Associate Professor, Department of Family Medicine	2003 – 2004
Visiting Associate Professor accompanying UND Clerkship Students, B.P. Koirala Institute of Health Science, Dharan, Nepal	2005 (April)
Co-director of Block 5, Introduction to Patient Care, Evidence Based Medicine	Fall 2002, 2003, 2004, 2005
Center for Health Promotion and Translation Research (CHPTR)	
Director of Asthma Studies	2002 – 2004
Consultant to Diabetes Studies	2002 – 2004
Medical Director, Physician Assistant Program	2002 – 2003

Indian Health Service, Browning Montana

Staff Physician, Blackfeet Community Hospital	1998 – 2000
Medical Director, Blackfeet Nursing Home	1998 – 2000

Berkeley Preparatory School, Tampa, Florida

High School Teacher	1989 – 1990
Honors Biology 9th Grade / Chemistry 11th & 12th Grade	
JV Girls' Basketball Coach	

HONORS

Professional	2020 Governor's Award for Excellence in Performance, State of Montana 2020 Vivian A. Paladin Award, Montana The Magazine of Western History Award of Merit, Montana Medical Association, 2020 Award of Excellence, Montana Department of Justice, Division of Criminal Investigation, 2018 Public Health Leadership Award, Michigan State Medical Society, 2011 Mosquito Award, Tobacco-Free Michigan, 2008 Presidential Citation, Michigan State Medical Society, 2008 Outstanding Block Instructor Award, Block 5, 2003 -2004 Outstanding Block Instructor Award, Block 5, 2002 -2003 Rookie Physician of the Year 2000, Indian Health Service Outstanding Service Provider of the Quarter, Blackfeet Community Hospital
Residency	Resident Award 2003 – American College of Preventive Medicine
Medical School	American School Health Association Scholarship Samuel D. Harris Scholarship Award – Pulmonary Alpha Omega Alpha
College	Dean's List every quarter enrolled as a full-time student Phi Kappa Eta Golden Key Honor Society Overseas Study Scholarship

ORGANIZATIONS

Montana Medical Association	2015 – present
American College of Preventive Medicine	2001 – present
American Academy of Family Physicians	1992 – present
Michigan Association of Preventive Medicine	2009 – 2016
Public Health Physicians	

NATIONAL COMMITTEES

ASTHO, Tobacco Issues Forum	2019 - 2021
Co-Chair	2019 - 2021
ASTHO, Community Health and Prevention Committee	2017 - 2021
American College of Preventive Medicine	2013 - 2019
Policy Committee	
Chair	2013 - 2017

APPOINTMENTS

Governor's Coronavirus Taskforce	2020 - 2021
Violent Death Reporting System Advisory Board	2019 - 2021
Governor's Challenge to Prevent Suicide Among Servicemembers, Veterans, and Their Families	2018 - 2021
Montana Public Health Systems Work Group	2017 - 2021
Montana Medical Association (MMA)	2016 - 2021
MMA Substance Use Disorder Committee	2016 - 2021
Legislative Committee, Ex-Officio	2016 - 2021
MMA Public Health Committee	2017 - 2021
Substance Use Disorder Taskforce	2016 - 2021
Montana Mortality Review Committee	2015 - 2021
Public Health and Safety Division – Communication Work Group	2015 - 2021
Montana Central Tumor Registry Data Use Committee	2015 - 2021
Graduate Medical Education Council, Ex-Officio	2015 – 2021
Public Health Institute – Design Team	2019 – 2020
MSU Faculty Health Care Council (Ex-Officio Member)	2013 – 2015
MSU CHM Public Health Search Committee	2013 – 2015
MSU Family Medicine Executive Committee	2013 – 2015
MSU CHM Admissions Committee	2013 – 2015
Board for Michigan Quality Improvement Consortium	2013 – 2014
ICMS – Board of Trustees – Executive Committee at Large (Elected Position)	2009 – 2011
Michigan Health & Hospital Association (MHA) Keystone Center Advisory Group	2008 – 2011
Animal Agriculture and the Environment Team - MSU	2007 – 2011
Michigan Health Council Board of Trustees	2007 – 2011
Michigan State University (MSU) Master of Public Health Program - Steering Committee Member	2007 – 2011
Tomorrow's Child Board Member	2007 – 2011

PLANNING COMMITTEES

2019 Preventive Medicine Conference, (Policy Track Chair)	2018 – 2019
Montana – Canada Conference on Addressing The Opioid Crisis, (Planning Coordinator)	2019
Big Sky Pulmonary Conference	2017, 2018, 2019, 2020
Montana's Diabetes Professional Conference	2016, 2017, 2018, 2019
2018 Montana Public Health Association	2017 – 2018

INTERVIEW TEAMS

Bureau Chief, Family and Community Health	2017
Toxicologist	2017

THESIS

Evaluating a media campaign to promote pneumococcal immunizations: Is a random digit dial telephone survey an effective strategy? (University of Washington School of Public Health)

GUEST EDITORIAL

Tobacco Control and the Ill Effects of Smoking. Michigan Journal of Public Health, Volume 1, Issue 2, Summer 2007

SELECTED PRESENTATIONS

Event	Topic	Date(s)
Montana Medical Association "The Future of Medicine after COVID" series, Virtual, Helena, MT	State Public Health: What we learned, where are we headed, and where to find help	09/2020
2020 Big Sky Pulmonary Conference, Fairmont, MT	Continuum of Care Where Healthcare & Public Health Meet – What's the Mission, and Are We Using the Right Tools to Get There?	03/2020
Healthcare Training and Delivery for Rural and Minority Underserved: An Interprofessional Perspective, Whitefish, MT	Montana Public Health Trends: Where Clinical Medicine and Public Health Meet	10/2019
Governor's Conference on Workers Compensation, Big Sky, MT	Opioid Transition Care	09/2019
2019 Preventive Medicine Conference, Pittsburgh, PA	Are E-Cigarettes the Solution to the Tobacco Use Epidemic or a Wolf in Sheep's Clothing? (Co-presented)	05/2019
REACT - Montana's teen-led Movement Against Big Tobacco, Anaconda, MT	The Tobacco Epidemic: Déjà vu all over again	04/2019
Montana – Canada Conference on Addressing the Opioid Crisis, Helena, MT	Setting the Context: The Opioid Crisis in the US and Canada (Co-presented)	03/2019
American Cancer Society – Cancer Action Network – Day at the Capitol Legislative Briefing, Helena, MT	E-Cigarettes: What We Know in 2019	03/2019

SELECTED PRESENTATIONS – Continued

Event	Topic	Date(s)
Big Mountain Medical Conference, Whitefish, MT	"No More War; No More Plague" The Spanish Influenza Pandemic Toll on Montana	01/2019
2018 ASTHO's Senior Deputies Annual Meeting, Washington, D.C.	Overcoming Stigma: Normalization Medication Assisted Treatment (Co-presented)	06/2018
ASTHO Expert Panel Meeting on Systems Level Change: Behavioral Health and Public Health, Atlanta, GA	Systems Level Changes Use of Data, Montana's Experience	06/2018
ASTHO National Webinar	Reflections on the 1918 Influenza Pandemic (Co-presented)	04/2018
MT Colorectal Cancer Roundtable Meeting, Helena, MT	Colorectal Cancer Screening: Improving Rates and Quality	03/2018
2018 Montana Pharmacy Association Winter Conference, Big Sky, MT	Cost, Access and Outcomes: The Struggle Continues	01/2018
2017 Montana Substance Use Disorder Summit, Helena, MT	Directions for Action in Montana – Summary of Themes and Opportunities for Action (Panel Discussion including Dr. Vivek Murthy, Former US Surgeon General)	11/2017
2017 Montana Public Health Association Conference, Missoula, MT	Public Health: What's in it for Me? What's in it for My Community?	09/2017
2017 Preventive Medicine Conference, Portland, OR	The Broad Street Pump: That was then, what is now? (Co-presented)	05/2017
For Pills to Heroin: A Montana Opioid Health Threat, Bozeman, MT	Opioid Health Crisis Solutions: A Community Model (Panel Discussion)	10/2016
2016 Montana Pediatric Round Up, Chico Hot Springs, Pray, MT	Suicide in Montana: Let's Stop the Pain	10/2016
Public Health and Safety Division Summer Institute	History of Public Health (Abridged)	07/2016

SELECTED PRESENTATIONS – Continued

Event	Topic	Date(s)
Public Health and Safety Division Summer Institute	Overview of the US Federal Public Health System	07/2016
2016 Montana Employer Conference, Billings, MT	Health, Me, My Job, My Community	05/2016
American Indian Tobacco Prevention Specialist's Planning Meeting, Great Falls, MT	Tobacco's Targeting of American Indians: Selling Dependence, Ill-Health and Death	03/2016
Council on Healthcare Innovation and Reform Meeting, Helena, MT	Health in Big Sky Country: Cost, Access, Outcomes, Oh My	01/2016
2015 Montana Public Health Association Conference, Bozeman, MT	Why Clinical Medicine Can Not Fix the Health System Alone	10/2015
Pediatric Roundup 2015, Big Sky, MT	Immunizations: Putting the Odds in Your Favor	09/2015
Your Health Lecture Series – Multiple locations throughout MI	Why Medicine cannot fix the Health Care System Alone? Does Your Community Impact Your Health	Multiple dates 2014
Michigan State University College of Human Medicine Alumni Weekend 2013, Grand Rapids, MI	Overview of the Affordable Care Act: How did we get here and where might we go?	10/2013
Sparrow Pediatrics Grand Rounds Lansing, MI	Vaccinations: Protecting Ourselves and Our World	08/2013
Family Medicine Senior Resident Retreat, Tustin, MI	Leading Change Through Practice Transformation and the Affordable Care Act	05/2013
2012 Keynote Address, University of Florida, College of Medicine Graduation, Gainesville, FL	What Kind of Doctor are You Going to Be...A Good One	05/2012
2013 Preventive Medicine Conference, Phoenix – Scottsdale, AZ	Unique Careers in Preventive Medicine and Public Health (Co-presented)	02/2012
Association of State and Territorial Health Officers Annual Meeting, Portland, OR	*Rediscovering Our Roots: Physicians and Public Health*	10/2011

SELECTED PRESENTATIONS – Continued

Event	Topic	Date(s)
28th National Indian Health Board Annual Consumer Conference, Anchorage, AK	*CDC & Tribes: Working Together to Improve the Health of American Indians and Alaska Natives*	09/2011
2010 Andrew D. Hunt Memorial Lecture, Lansing, MI	Happiness is … Finding a Fulfilling Career in Medicine	10/2010
Shaping the Future of Family Medicine, Lansing, MI	Issues in Healthcare	10/2010
Michigan Osteopathic Association (MOA) Annual Scientific Convention, Dearborn, MI	It Takes a Community to Have an Effective Patient-Centered Medical Home	05/2009
MSU College of Nursing 2007 Case Mgt. Conference, Kellogg Ctr. – East Lansing, MI	Evidence-Based Medicine (EBM): Why do we need EBM and what does EBM mean?	11/2007
Michigan's Premier Public Health Conference, Dearborn, MI	Building Bridges – Clinical Medicine, Public Health and the Community	10/2007
Sinai-Grace Hospital's Research Day 2007, Detroit, MI	Research: A Crucial Part of the Medical Question	08/2007
4th International Bird Flu Summit, Washington, D.C.	Preparing for the Pandemic: MI Flu Focus – A Novel, Comprehensive Influenza Surveillance System	03/2007

Additional list of national, state, and local conferences and classroom presentations – including poster presentations – available upon request

NEWSLETTERS

Holzman GS, Sahmoun AE, Brosseau JD, Helgerson SD, Pickard SP. Arthritis is the Leading Cause of Disability, 2005;1(7):1-2

Holzman GS, Sahmoun AE, Brosseau JD, Helgerson SD. The Number One Killer: Smoking. Healthy North Dakota-Highlights, 2004; 1(1):1-2

Holzman GS, Sahmoun AE, Brosseau JD, Helgerson SD. Misuse of Alcohol: North Dakota is Nationally Ranked (#2) and Needs to Get Out of the Top Ten. Healthy North Dakota-Highlights, 2004:1(3):1-2

Holzman GS, Sahmoun AE, Brosseau JD, Helgerson SD, Pickard SP. Older North Dakotans Need to be Vaccinated Against Influenza, 2004;1(4):1-2

NEWSLETTERS – Continued

Smoking Cessation: An Essential Part of Diabetes Care, Quality Improvement Report, Department of Community Medicine, University of North Dakota School of Medicine and Health Sciences 2003;1(2): Page 1

Assessing and Improving Asthma Care in Provider Practices: The CHPTR Approach. Center for Health Promotion and Translation Research, University of North Dakota School of Medicine and Health Sciences 2002;1(3): Page 3

Additional Newsletters – available upon request

ARTICLES IN REFEREED JOURNALS

Williamson LL, Harwell TS, Koch TM, Anderson SL, Scott MK, Murphy JS, Holzman GS, Tesfai H. 2021. COVID-19 Incidence and Mortality among American Indian/Alaska Native and White Persons – Montana, March 13–November 30, 2020. MMWR Morb Mortal Wkly Rep. 2021;70:510-513.

Williamson L, Nelson D, Zimmerman H, Cook-Shimanek M, Harwell T, Holzman G. 2020. High incidence of brain and other nervous system cancer identified in two mining counties, 2001-2015: insufficient evidence to support association with heavy metal exposure. *Spatial and spatio-temporal epidemiology*, *35*, 100378. https://doi.org/10.1016/j.sste.2020.100378

Harwell TS, Anderson SL, Holzman GS, Helgerson SD. "The Biggest Public Health Experiment Ever" The polio pioneers and Montana's contribution to the elimination of polio in the United States. Montana - The Magazine of Western History. 2019;69(3):47-69, 94-96.

Harwell TS, Holzman GS, Helgerson SD. "No more war, no more plague" The Spanish influenza pandemic toll on Montana. Montana – The Magazine of Western History. 2018;68(2):27-44, 93-94

Neuberger M, Dontje K, Holzman G, Corser W, Keskimaki A, Chant E. (2014). "An Examination of Office Visit Patient Preferences for the After-Visit Summary (AVS)." Sept, 2014. Perspect Health Inform Management.

Dontje K., Corser WD, Holzman G. (2014). "Understanding Patient Perceptions of the Electronic Personal Health Record." J Nurse Pracit. 10(10): 824-828.

Devlin HM, Desai J, Holzman GS, Gilbertson DT, Trends and disparities among diabetes-complicated births in Minnesota, 1993-2003. AM J Public Health 2008 Jan;98(1):59-62

Harwell TS, Lee L, Haugland C, Wilson SM, Campbell SL, Holzman GS, Gohdes D, Helgerson SD; Utilization of a tobacco quit line prior to and after a tobacco tax increase. J Public Health Manag Pract 2007 November/December; 13(6):637-641.

Folden DV, Machayya JA, Sahmoun AE, Beal JR, Holzman GS, Helgerson SD, Lo TS, Estimating the proportion of community-associated methicillin-resistant Staphylococcus aureus: two definitions used in the USA yield dramatically different estimates. J Hosp Infect. 2005 Aug;60(4):329-32.

ARTICLES IN REFEREED JOURNALS – Continued

Holzman GS, Harwell TS, Johnson E, Goldbaum G, Helgerson SE, A media campaign to promote pneumococcal vaccinations: is a telephone survey an effective evaluation strategy? J Public Health Manag Pract. 2005 May-Jun;11(3):228-34.

Moum KR, Holzman GS, Harwell TS, Parsons SL, Adams SD, Spence MR, Helgerson SD, Gohdes D, Increasing Rate of Diabetes in Pregnancy among American Indian and White Mothers in Montana and North Dakota, 1989-2000. Maternal and Child Health Journal 8(2):71-76, June 2004.

Johnson E, Harwell TS, Donahue P, Weisner MA, McInerney MI, Holzman GS, Helgerson SD, Promoting pneumococcal immunizations among rural Medicare beneficiaries using multiple strategies. J Rural Health 2003; 19:506-510.

Holzman GS, Muus K, Haugland B, Blueshield M, Hefta C, Morin B, Helgerson SD, Asthma Prevalence and Care for American Indian Youth in North Dakota, IHS Primary Care Provider. 2003; 28:20-223.

BOOK REVIEWS

Helgerson SD, Holzman GS, Clinical epidemiology. How to Do Clinical Practice Research, 3rd edition, by DL Sackett, GH Gordon, and P Tugwell. JAMA 2006; 295:446.

CHAPTERS

Holzman GS, Harwell TS, Gohdes D, Helgerson SD. Smoking Cessation for American Indians: The Need is Great and the Opportunity Clear. In: Roberts AR, Yeager KR, eds. Evidence-Based Practice Manual: Research and Outcome Measures in Health and Human Services, New York, NY: Oxford University Press; 2004:389-396.

Television, radio, and written interviews including public information commercials – available on request

AWAY ROTATIONS DURING MEDICAL SCHOOL TRAINING

Glasgow, Scotland	Pediatrics	6 weeks
Honolulu, Hawaii	OB/GYN	1 month
Jerusalem, Israel	OB/GYN	1 month
London, England	Cardiology	1 month
Zimbabwe, Chiredzi	General Practice	3 weeks
Zimbabwe, Harare	Pediatrics	1 month

PAST REVIEWER

Journal of Public Health Management and Practice
American Journal of Kidney Diseases
American Journal of Preventive Medicine

PROFESSIONAL INTERESTS

Better Integration of Public Health and Clinical Medicine, Epidemiology, Health Promotion and Disease Prevention, Evidence Based Medicine, Health Equity, Chronic Disease Management, Tobacco Cessation and Control, Social Determinants of Health, Medical and Public Health History

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Attorneys for Plaintiffs

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION

MONTANA MEDICAL ASSOCIATION, et al.,

Plaintiffs,

and

MONTANA NURSES ASSOCIATION,

Plaintiff-Intervenors,

v.

AUSTIN KNUDSEN, et al.,

Defendants.

Case No. CV 21-00108-DWM

DECLARATION AND EXPERT REPORT OF BONNIE STEPHENS, M.D.

EXHIBIT 21
Bonnie Stephens
Mon, Aug 15, 2022
Reported by:
Mary Sullivan, RMR, CRR

Exhibit 4 - 1

Exhibit 3 - 1

I, Bonnie Stephens, M.D., declare, pursuant to 28 U.S.C. § 1746 and under penalty of perjury, that the foregoing is true and correct:

1. The facts and opinions set forth in this Declaration are known to me based on my personal knowledge and belief, and based upon my knowledge, training, research, education, and experience.

2. I have been retained by the Plaintiffs in the above-captioned matter to render certain opinions as contained in this document. I am charging $500 per hour for my work on this matter. I reserve the right to modify, expand upon, or otherwise change these opinions as new or additional information is provided to me.

EXPERIENCE AND CREDENTIALS

3. I obtained my medical doctorate from Northwestern University Medical School. I performed a pediatric residency at Children's Memorial Hospital in Chicago, IL, and a neonatal/perinatal medicine fellowship and a developmental/behavioral pediatrics fellowship at Brown University Women/Infants' Hospital/Rhode Island Hospital. I am board certified in Pediatrics, Neonatal-Perinatal Medicine, as well as Developmental-Behavioral Pediatrics.

4. I have approximately 10 years' experience as a neonatal intensivist and medical director of the NICU at Community Medical Center. I have worked in

a number of intensive care settings, including the neonatal intensive care unit (NICU) and pediatric intensive care unit (PICU). I currently serve as the Chief Medical Officer for Community Medical Center. Attached as Exhibit A is my curriculum vitae, which further summarizes my credentials and professional and clinical education and experience.

OPINIONS

5. NICUs provide around-the-clock care to infants who need intensive medical care due to critical illness, a need for specialized care, being premature, or other reasons. Infants in a NICU setting are particularly vulnerable to infectious disease. These infants have compromised immune systems and are too young to receive vaccinations to protect them from vaccine preventable illness. For these reasons, infectious disease prevention is critical in intensive care settings. It is standard of care in a NICU setting to confirm the vaccination and/or immunity status of all individuals working in, and providing care to, patients in the NICU.

6. For the safety of these patients, providers in the NICU setting should have current vaccination for Measles, Mumps, and Rubella (MMR), Pertussis (through the Tetanus-Diptheria-Petussis, or TDaP vaccine), Chickenpox/varicella, influenza and COVID. Remaining current on all other available vaccines is crucial for patient safety.

7. Current vaccination also protects fellow staff members from contracting infectious disease and passing them on to the infants for whom they are providing care. This includes vaccination against airborne diseases (such as measles, influenza, and COVID), as well as blood-borne diseases such as Hepatitis.

8. In particular, pertussis is a highly contagious disease that can cause death in infants. Pertussis is vaccine-preventable, and pertussis vaccination is routinely required for staff in NICU settings. Other diseases, such as measles, also pose a direct threat to infants in these intensive care settings. Infants are more likely to suffer serious harm or death from illnesses than adults. This is even more true for infants being treated in the NICU setting. It is critical that these vulnerable patients be treated by vaccinated staff.

9. Infants are unable to obtain common vaccination against these and other diseases until they reach a certain age. The typical minimum age for obtaining vaccines is as follows:

a. MMR (measles, mumps, rubella) – 12 months

b. DTaP (diptheria, tetanus, pertussis) – 2 months,

c. Varicella (Chicken pox) – 12 months

d. Influenza – 6 months

10. Other intensive care settings, as well as cancer care settings, are places where particularly vulnerable and immunocompromised patients seek care.

It is important to protect these patients by observing all available infection control measures, including vaccination of caregivers and staff and tracking vaccination or immunity status of caregivers and staff.

11. Providers and staff who are not currently vaccinated against these diseases should not be permitted to treat vulnerable patients in a NICU or cancer care setting. Patients in the NICU and cancer care settings will most often fall under the protections of the ADA because of their underlying disease processes and disabilities. Their conditions make them more susceptible to vaccine-preventable illnesses and increase their risk of serious harm or death from such illnesses. Faced with a situation where an employee is unvaccinated, a facility needs to be informed, so that they can perform an individualized assessment of whether a reasonable accommodation under the ADA is available, absent an undue hardship or direct threat to the hospital's operations, including the safety of its patients. In order to do that analysis, facilities need to know the vaccination status of the healthcare workers, and be able to take appropriate steps to address such status.

12. The standard of care requires an individual assessment of a patient care encounter and determination of whether the particular patient requires treatment only by vaccinated staff members. If so, then the facility needs to be able to ensure that the patient is only treated by vaccinated staff members. This

would require the facility to treat vaccinated staff members differently than unvaccinated staff members.

13. Requirements for vaccination and immunization status has been a common feature of healthcare in hospitals. Hospitals routinely require individuals be vaccinated prior to being allowed to treat patients in the NICU and settings treating particularly vulnerable patients.

14. I have experienced both firsthand and through my position at the hospital, occasions in which patients have specifically requested to be treated by vaccinated staff. It is my opinion that these request from patients should be honored. In order to honor these requests, hospitals would be required to treat vaccinated and non-vaccinated staff differently.

15. Vaccination is safe and effective. In my opinion, every eligible healthcare provider should be vaccinated against vaccine preventable diseases. Risk of side effects from vaccines are extremely low compared to the risks caused by infection with vaccine preventable diseases. Lower vaccination rates place individuals at unnecessary risk. In particular, lower rates of immunity lead to increased presence of variants of the COVID virus, which will perpetuate the pandemic and place people at unnecessary risk. COVID vaccination and other long-standing and well-accepted vaccinations are critical to protect the safety and health of our community's kids

16. Montana has a relatively high rate of exemption from the COVID vaccine requirements. When staff are not vaccinated against COVID, more staff will contract COVID. Staff who contract COVID are at risk of injury and possibly death from the infection. Staff who contract COVID are required to quarantine, exacerbating the shortage of needed healthcare workers.

17. As CMO, I am very aware of the importance of hospitals complying with CMS conditions of participation to participate in the Medicare and Medicaid systems. This includes remaining current and compliant on all general infectious disease prevention (i.e. following national standards of care), as well as complying with the new COVID vaccine requirements, or risk losing CMS funding, which would result in hospital closures due to inadequate funding

18. If the current injunction is lifted, Montana HB 702 directly conflicts with the CMS conditions of participation.

MD

Bonnie Stephens, M.D.

CURRICULUM VITAE
BONNIE STEPHENS, MD

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Missoula MT 59804
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Education

Fellowship	Women and Infants' Hospital/ Rhode Island Hospital Fellowship, Neonatal/Perinatal Medicine 2003-2008 Fellowship, Developmental/Behavioral Pediatrics, 2003-2008
Residency	Children's Memorial Hospital, Chicago, Illinois Pediatric Resident, 1997-2000
Medical School	Northwestern University Medical School, Chicago, Illinois MD, 1993-1997
Undergraduate	Northwestern University, Evanston, Illinois BA, Biology/Neurobiology, 1990-1993

Hospital Appointments

Community Medical Center, Missoula, MT

Chief Medical Officer, May 1, 2022 - present

Medical Staff President, January 1, 2021 – May 1, 2022

- Lead the re-write of the Medical Staff Bylaws, Rules and Regulations
- Lead the Medical Staff through a transition in senior leadership including the replacement of our CEO and CNO
- Co-chair of the Hospital Patient Safety and Clinical Quality Program

Pediatric Section Chief, October 3, 2017 – December 31, 2020

- Established and ran a Pediatric Section after the reorganization of Medical Staff Departments led to the combination of Obstetric and Pediatric Departments into a joint Women and Children's Department

Medical Director of NICU, Nov 1, 2011-present

- Implemented infection control measures including hand washing policy, VAP protocol, PICC line team, visitor policies, that reduced rates of sepsis, CLABSI, VAP. Last CLABSI > 5 years ago
- Implemented nutrition protocol for VLBW infants that includes exclusive breast milk feeds for all VLBW infants, reduced sepsis and NEC rates

EXHIBIT 22
Bonnie Stephens
Mon, Aug 15, 2022
Reported by:
Mary Sullivan, RMR, CRR

- Introduced developmental care including the training and staffing of a team of Neonatal therapists in our NICU
- Implemented 24/7 neonatal respiratory therapy coverage for our NICU
- Overhaul and re-engagement of neonatal transport program
- Built our practice from 2 FTE neonatologist to 3 FTE neonatologist and 4 FTE NNP, increased annual admissions by 15%
- Trained and hired a team of Neonatal Nurse Practitioners to become the first NICU in Montana to provide 24/7 in-house provider coverage
- Held a NICU Strategic planning session with a multidisciplinary group for the NICU including MDs, NNPs, RNs, RTs, NTs, administration.
- Built and maintained outreach/referral relationships throughout western MT to increase admissions to our unit from ~ 200/year to ~ 250/year
- Assisted with development of Pediatric/NICU PSCQ dashboards

Staff Neonatologist Aug 1, 2011-present
Staff Developmental-Behavioral Pediatrician Aug 1, 2011-present

- Developed the only multidisciplinary clinic in Montana for children with complex developmental and behavioral problems

Providence St Patrick's Hospital, Missoula, MT
Staff Neonatologist, July 1, 2020 - present
Medical Director of Level 2 NICU, July 1, 2020 - present

Kootenai Health, Coeur d'Alene, ID
Locums Neonatologist, August 1, 2014 – December 31, 2016

Women and Infants Hospital, Providence, RI
Staff Neonatologist, Department of Pediatrics, Sept 17, 2007 – June 30, 2011
Courtesy Staff Neonatologist, Department of Pediatrics, July 1, 2011-2013

Southcoast Healthcare System, Southeastern MA
House Physician, Neonatology, May 2004-June 2011

Kent County Hospital, Warwick, RI
House Physician, Department of Pediatrics, Dec 2003-June 2011

Evanston Northwestern Healthcare, Evanston, IL
Staff Physician, Division of Neonatology, July 2000-July 2006

Children's Memorial Hospital, Chicago, IL
Program Associate, Behavioral/Developmental Pediatrics, May 2001-June 2002
In House Physician, NICU, Jan 2000-June 2003
In House Physician, Transitional Care Unit, June 2001-June 2003
Transport Team Physician, June 1999-June 2001

Academic Appointments
University of Washington School of Medicine, Seattle, WA
Clinical Assistant Professor, July 2013-present

Brown University Medical School, Providence, RI
Clinical Instructor, Pediatrics, July 2003-July 2008
Assistant Professor, Pediatrics, August 2008-June 2011
Adjunct Assistant Professor, Pediatrics, July 2011-June 2017

Northwestern University Medical School, Chicago, IL
Clinical Instructor, Pediatrics, 2000-2003

Other Appointments
Healthy Foundations Steering Committee
2020 - present

Ronald MacDonald House, Missoula MT
Board of Directors Feb 2016-present

Montana Medical Association
Executive Committee Member/Board of Directors, Sept 2015-Sept 2017

Child Development Center, Missoula MT
Medical Director, Aug 2013-present

Mother's Milk Bank of Montana, Missoula, MT
Medical Director of Inpatient Services, Aug 2013-present

Fetal, Infant, Child, Maternal Mortality Review Committee, Missoula County
Committee Member, 2013-present

Hospital Committees
Medical Executive Committee, Community Medical Center, 2017-present
Bylaws Committee (chair), Community Medical Center, 2020
Pediatric Service Line Committee, Community Medical Center, 2016-present
Perinatal Executive Committee, Community Medical Center, 2015-present
Infection Control Committee, Community Medical Center, 2014-present
PICC Line Committee, NICU, Community Medical Center, 2014-present
Physician Leadership Counsel, Community Medical Center, 2016-2020
Community Physician Group Executive Committee, Community Medical Center, 2017-2018
Complex NICU Discharges Committee, Chair, Women and Infants' Hospital, 2010-2011
Pharmacy and Therapeutics Committee, Women and Infants' Hospital, 2010-2011
Millennium Neonatal Symposium Planning Committee, 2009-2010
Family Centered Care Committee, Women and Infants' Hospital, 2007-2011
Indomethacin Task Force, Women and Infants' Hospital, 2007
Pulse Oximetry Clinical Practice Guideline, Women and Infants' Hospital, 2007

Medical Model for new NICU, Women and Infants' Hospital, 2006-2009
Trophic Feeding Protocol Committee, Women and Infants' Hospital, 2006-2007
Fellow/Assistant Nurse Manager Liaison, Women and Infants' Hospital, 2003-2006
Limits of Viability Committee, Women and Infants' Hospital, 2003-2005

Professional Memberships
Montana Medical Association 2013-present
American Academy of Pediatrics 1997-present
American Medical Student's Association 1993-97

Honors
Honor's Program in Medical Education 1990-1997
Young Investigator Travel Award, SPR 2005
Young Investigator Travel Award, ESPR 2006
Young Investigator Travel Award, ESPR 2007
Young Investigator Travel Award, SPR-RC 2007
NIH-Loan Repayment Program Grant, 08/2009-08/2011

Professional Licenses
Montana 12488 – current
Idaho M-12543 - inactive
Rhode Island MD11634 - inactive
Illinois 036-100894 - inactive
Massachusetts 219759 - inactive

Certification
National Board of Medical Examiners
American Board of Pediatrics, General Pediatrics - current
American Board of Pediatrics, Developmental-Behavioral Pediatrics - current
American Board of Pediatrics, Neonatal-Perinatal Medicine – current
Autism Diagnostic Observation Schedule 2010-current
Prectl General Movements Assessment 2019-present

Peer Review Activities
1. Journal of Pediatrics, reviewer, 2010-present
2. Journal of the American Medical Association, reviewer, 2010-present
3. Pediatrics, reviewer, 2010-present
4. American Journal of Perinatology, reviewer, 2011-present
5. Clinical Nutrition, reviewer, 2011-present

Peer Reviewed Publications
1. Stephens BE, Bann CM, Poole WK, Vohr BR for the NICHD Neonatal Research Network. Neurodevelopmental Impairment – Predictors of Its Impact on the Families of Extremely Low Birth Weight Infants at 18 Months. Infant Mental Health Journal. 2008 Nov 1;29(6):570-587

2. Stephens BE, Gargus RA, Vogt R, Mance M, Nye J, McKinley L, Tucker R, Vohr BR. Fluid Regimen in the First Week of Life Increases Risk of Patent Ductus Arteriosus in Extremely Low Birth Weight Infants. Journal of Perinatology. 2008 Feb;28(2):123-8.

3. Stephens BE, Walden R, Gargus RA, Tucker R, McKinley L, Mance M, Nye J, Vohr BR. First Week Protein and Calorie Intake is Associated with 18 Month Developmental Outcomes in Extremely Low Birth Weight Infants. Pediatrics. 2009 May;123(5):1337-43.

4. Stephens BE, Liu J, Lester B, Lagasse L, Shankaran S, Bada H, Bauer C, Das A, Higgins R. Neurobehavioral Assessment Predicts Motor Outcomes in ELBW Infants. Journal of Pediatrics. 2010 Mar;156(3):366-71.

5. Stephens BE, Tucker R, Vohr BR. Special Health Care Needs of Infants Born at the Threshold of Viability. Pediatrics. 2010;125:1152-1158.

6. Balakrishnan A, Stephens B, Burke R, Yatchmink Y, Alksninis B, Tucker R, Cavanaugh E, Collins A, Vohr B. Impact of Very Low Birth Weight Infants on the Family at 3 Months Corrected Age. Early Human Development. 2011 Jan;87(1):31-5.

7. Balakrishnan M, Tucker R, Stephens BE, Bliss JM. Blood urea nitrogen and serum bicarbonate in extremely low birth weight infants receiving higher protein intake in the first week after birth. Journal of Perinatol. 2011 Aug;31(8):535-9.

8. Caskey M, Stephens B, Tucker R, Vohr B. Importance of Parent Talk on the Development of Preterm Infant Vocalizations. Pediatrics. 2011 Nov;128(5):910-916.

9. Vohr BR, Yatchmink YY, Burke RT, Stephens BE, Cavanaugh EC, Alskinis B, Nye JH, Bacani D, McCourt MF, Collinc AM, Tucker R. Factors Associated with Rehospitalizations of Very Low Birthweight Infants: Impact of a Transition Home Support and Education Program. Early Human Development. 2011.

10. Vohr BR, Stephens BE, Higgins R, Hintz S, Bann CM. Are Outcomes of extremely preterm infants improving? Impact of Bayley Assessment on Outcomes. J Pediatr, Mar 14 2012

11. Stephens BE, Bann CM, Watson VE, Peralta M, Vohr BR, Higgins R for the NICHD Neonatal Research Network. Screening for Autism Spectrum Disorder in Extremely Preterm Infants. J Dev Behav Pediatr. 2012 Sep;33(7):535-41

12. Laptook AR, McDonald SA, Shankaran S, Stephens BE, Vohr BR, Guillet R, Higgins RD, Das A; Extended Hypothermia Follow-up Subcommittee of the National Institute of Child Health and Human Development Neonatal Research Network. Elevated temperature and 6- to 7-year outcome of neonatal encephalopathy. Ann Neurol. Jan 29 2013

13. Vohr BR, Stephens BE, McDonald SA, Ehrenkranz RA, Laptook AR, Pappas A, Hintz SR, Shankaran S, Higgins RD, Das A; Extended Hypothermia Follow-up Subcommittee of the National Institute of Child Health and Human Development Neonatal Research Network Cerebral Palsy and Growth Failure at 6-7 years of Age. Pediatrics. 132(4):e905-14, Oct 2013.

14. Caskey M, Stephens B, Tucker R, Vohr B. Adult talk in the NICU with preterm infants and developmental outcomes. Pediatrics. 133(3):e578-84, 2014

15. Balakrishnan M, Jennings A, Przystac L, Phornphutkul C, Tucker R, Mance M, Vohr B, Stephens BE, Bliss JM. Growth and Neurodevelopmental Outcomes of Early, High Dose Parenteral Amino Acid Intake in Very Low Birth Weight Infants: A Randomized Controlled Trial. Journal of Parenteral and Enteral Nutrition. Accepted for publication, publication pending

Invited Articles/Chapters

1. Stephens BE, Vohr BR. Neurodevelopmental Outcome of the Premature Infant. Pediatric Clinics of North America. 2009 June;56(3):631-46.

2. Vohr BR and Stephens BE. Normal and Abnormal Neurodevelopmental and Behavioral Outcomes of Preterm Infants. In G. Buonocore, R. Bracci, M Weindling (Eds), Textbook of Neonatology. Springer-Verlag 2009

3. Vohr, Stephens. Neurodevelopmental Follow-up and Outcomes. In: Elzouki AY (Ed). Textbook of Clinical Pediatrics, Second Edition. Springer. Chapter 36, page 431

4. Stephens BE, McKinley L, Vohr BR. Medical Care of Neonatal Intensive Care Unit Graduates. Dr Oh's Handbook of Neonatology.

5. Vohr, Stephens. Follow-up Assessment of Preterm Infants. Dr Oh's Handbook of Neonatology.

6. Vohr, Stephens, Tucker. Thirty-five Years of Neonatal Follow-up in Rhode Island. Med Health R I. 2010 May;93(5):151-3

7. Stephens BE, Vohr BR. Protein and Neurodevelpmental Outcomes. Clinics in Perinatology. 2014 June; 41(2):323-9

Abstracts

1. Berger S, Stephens BE, Glusman M. Understanding others by learning about ourselves: A training exercise in child development, behavior, & parenting. Poster Presentation, Pediatric Academic Societies, Seattle, WA, May 2003.

2. Berger S, Stephens BE, Paine A, et al. Every picture tells a story when you know where to look. Poster Presentation, Pediatric Academic Societies, San Francisco,CA, May 2004.

3. Gargus RA, Vogt R, Stephens BE, Tucker R, McKinley L, Mance M, Nye J, Vohr BR. Outcome at 18months in AGA ELBW Infants with Postnatal Growth Restriction. Poster Presentation, Pediatric Academic Societies, Washington DC, May 15, 2005.

4. Gargus RA, Stephens BE, Vogt R, Tucker R, Mance M, Nye J, Vohr BR. SNAPPE-II Score: Prediction of NICU and 18month Outcomes. Poster Presentation, Pediatric Academic Societies, Washington DC, May 16, 2005

5. Stephens BE, Bann CM, Poole WK, Vohr BR for the NICHD Neonatal Research Network. Impact on the family of Neurodevelopmental Impairment in ELBW infants at 18 months. Platform Presentation, Pediatric Academic Societies, Washington DC, May 16, 2005.

6. Stephens BE, Gargus RA, Vogt R, Mance M, Nye J, McKinley L, Tucker R, Vohr BR. Do Current Fluid Regimens in the First Week of Life Increase Morbidity in ELBW Infants? Poster Presentation, Pediatric Academic Societies, Washington DC, May 17, 2005.

7. Gargus RA, Vogt R, Stephens BE, Tucker R, McKinley L, Mance M, Nye J, Vohr BR. Impact of Gender on 18-22 month Outcome in ELBW Infants. Platform Presentation, Society of Developmental and Behavioral Pediatrics Annual Meeting, San Diego, CA, Sept 25, 2005.

8. Stephens BE, Tucker R, Vohr, BR. Special Health Care Needs Of Infants Born at the Threshold of Viability. Poster Presentation, Pediatric Academic Societies, San Francisco, CA, May 2, 2006.

9. Stephens BE, Liu J, Lester B, Lagasse L, Shankaran S, Bada H, Bauer C, Das A, Higgins R. Neurobehavioral Assessment Predicts Motor Outcomes in ELBW Infants. Poster Presentation, Pediatric Academic Societies, Toronto, ON, May 5, 2007.

10. Stephens BE, Vogt R , Gargus RA, Tucker R, McKinley L, Mance M, Nye J, Vohr BR. Adequate First Week Protein and Calorie Intake is Critical for 18 month Developmental Outcome in ELBW Infants. Poster Presentaton, SPR-RC, Woodlands, TX, Oct, 17, 2007

11. Balakrishnan M, Tucker R, Stephens BE, Bliss JM. Protein Safety in Extremely Low Birth Weight Infants. Poster Presentation, Pediatric Academic Societies, Baltimore, MD, May 5, 2009

12. Stephens BE, Miller R, Bigsby R, Tucker R, Lester B. Normative Neurobehavior of Extremely Low Birth Weight Infants on the Neonatal Intensive Care Unit Network Neurobehavioral Scale. Poster Presentation, Pediatric Academic Societies, Vancouver, BC, May 3, 2010

13. Vohr BR, Stephens BE, Alksninis B, Yatchmink YE, Burke RT, Tucker R. Plagiocephaly in Preterm Infants: An Early Marker of Motor Dysfunction. Poster Presentation, Pediatric Academic Societies, Vancouver, BC, May 3, 2010

14. Vohr BR, Stephens BE, Higgins R, Hintz S, Bann CM. Are Outcomes of extremely preterm infants improving? Impact of Bayley Assessment on Outcomes. Poster Presentation, Pediatric Academic Societies, Vancouver, BC, May 3, 2010

15. Caskey M, Stephens BE, Tucker R, Vohr BR. Impact of Language Exposure in the NICU on the Development of Vocalizations in Preterm Infants. Poster Presentation, Pediatric Academic Societies, Vancouver, BC, May 3, 2010

16. Caskey M, Stephens B, Tucker R, Vohr B. Adult-Infant Conversations in the NICU and Language and Cognitive Outcomes in Preterm Infants. Platform Presentation, Pediatric Academic Societies, Denver, CO, April 30, 2011

17. Stephens B, Watson V, Tucker R, Sheinkopf S, Vohr B. Screening for Autism Spectrum Disorder at 18 vs. 30 months in Extremely Preterm Infants. Poster Symposium, Pediatric Academic Societies, Denver, CO, May 1, 2011

18. Stephens B, Bann C, Watson V, Peralta-Carcelen M, Sheinkopf S, Higgins R, Vohr B, for NICHD NRN. Screening for Autism Spectrum Disorder in Extremely Preterm Infants. Poster Symposium, Pediatric Academic Societies, Denver, CO, May 1, 2011

19. Johnson K, Stephens B, Tucker R, Vohr, B. Very Early Language Skills of Late Preterm Compared to Term Infants at Birth and 44 Weeks Corrected Age. Poster Presentation, Pediatric Academic Societies, Denver, CO, May 2, 2011

20. Johnson K, Stephens B, Tucker R, Vohr, B. Reciprocal Vocalizations between Female Caregivers and their Infants Surpass those of Male Caregivers in the First Months of Life. Poster Presentation, Pediatric Academic Societies, Denver, CO, May 2, 2011

21. Stephens B, Bann C, Higgins R, Vohr B, for NICHD NRN. Autism Spectrum Disorder Phenotype in Extremely Preterm Infants. Poster Presentation, Pediatric Academic Societies, Denver, CO, May 3, 2011

22. Sommers R, Vohr B, Stephens B, Tucker R, Laptook A. Does the Amplitude Integrated EEG (aEEG) at 36 Weeks Post-Menstrual Age Correlate with Bayley Scores at 18 Months Corrected Age? Poster Presentation, Pediatric Academic Societies, Denver, CO, May 3, 2011

23. Vohr B, Stephens B, McDonald S, Ehrenkranz R, Laptook A, Das A, Higgins R, ShankaranS. Associations between Disability and Growth at 7 years of age for Children who Experienced Perinatal Hypoxia Ischemia and Participated in the Hypothermia Trial.

24. Laptook A, McDonald S, Shankaran S, Stephens B, Vohr B, Guillet R, Higgins R. Outcome at 6-7 years of Infants with Elevated Temperatures Following Hypoxia-Ischemia. Platform Presentation, Pediatric Academic Societies, Boston, MA, May 1, 2012

25. Balakrishnan M, Przystac LE, Jennings AV, Phornphutkal C, Tucker R, Mance MJ, Stephens BE, Vohr BR, Bliss JM. Growth Outcomes following Early, High Dose Parenteral Amino Acids in Very Low Birth Weight Infants: A Randomized Trial. Pediatric Academic Societies, Vancouver, BC, May 2014

Invited Presentations

1. Neural Tube Defects, Perinatal Management Conference, Women and Infants' Hospital, Providence, RI, October, 2003.

2. Neural Tube Defects, Pediatric Grand Rounds, Rhode Island Hospital, Providence, RI, February 20, 2004.

3. Do Current Fluid Regimens in the First Weeks of Life Increase Morbidity in ELBW Infants? New England Regional Perinatal Conference, Chatham, MA, October 7, 2004.

4. Congenital Lymphatic Disorders, Perinatal Management Conference, Women and Infants' Hospital, Providence, RI, December 22, 2004.

5. Perinatal Asphyxia, Perinatal Management Conference, Women and Infants' Hospital, Providence, RI, March 2, 2005.

6. Do Current Fluid Regimens in the First Weeks of Life Increase Morbidity in ELBW Infants? Pediatric Research Colloquium, Women and Infants' Hospital, Providence, RI, April 1, 2005.

7. Impact on the Family of Neurodevelopmental Impairment in ELBW infants at 18months. Pediatric Academic Societies, Washington DC, May 16, 2005.

8. Do Current Fluid Regimens in the First Weeks of Life Increase Morbidity in ELBW Infants? Poster Presentation, Pediatric Academic Societies, Washington DC, May 17, 2005.

9. Impact on the Family of Neurodevelopmental Impairment in ELBW infants at 18months. Harvard Poster Symposium, Sept 20, 2005

10. Impact on the Family of Neurodevelopmental Impairment in ELBW infants at 18months. New England Regional Perinatal Conference, Chatham, MA, Sept 30, 2005

11. Neonatal Gastroesophageal Reflux Disease, Perinatal Management Conference, Women and Infants' Hospital, Providence, RI, Nov 9, 2005

12. Do Current Fluid Regimens in the First Weeks of Life Increase Morbidity in ELBW Infants? Platform Presentation, Neonatal Nutrition and Gastrointestinal Symposium, Key Biscayne, FI, Dec 10, 2005

13. Prematurity, Lecture to RIC Master's Program in Special Education, Feb 14, 2006

14. Special Health Care Needs of Infants Born at the Threshold of Viability, Platform Presentation, Eastern Society for Pediatric Research, March 18, 2006

15. Special Health Care Needs of Infants Born at the Threshold of Viability, Poster Presentation, Pediatric Academic Societies, San Francisco, CA, May 2, 2006

16. Special Health Care Needs of Infants Born at the Threshold of Viability, Platform Presentation, New England Regional Perinatal Conference, Newport, RI, Sept 28, 2006.

17. Neurobehavioral Assessment of the Preterm Infant, Perinatal Management Conference, Women and Infants' Hospital, Providence, RI, Nov 1, 2006

18. Predicting Motor Outcomes in Extremely Low Birth Weight Infants, Pediatric Research Colloquium, Women and Infants' Hospital, Providence, RI, Nov, 17, 2006.

19. Stephens BE, Liu J, Lester B, Lagasse L, Shankaran S, Bada H, Bauer C, Das A, Higgins R. Neurobehavioral Assessment Predicts Motor Outcomes in ELBW Infants. Poster Presentation, Eastern Society for Pediatric Research, March 10, 2007.

20. Predicting Motor Outcomes in ELBW Infants, Platform Presentation, ByConn, April 11, 2007

21. Stephens BE, Liu J, Lester B, Lagasse L, Shankaran S, Bada H, Bauer C, Das A, Higgins R. Neurobehavioral Assessment Predicts Motor Outcomes in ELBW Infants. Poster Presentation, Pediatric Academic Societies, Toronto, ON, May 5, 2007

22. Educational Workshop, Favorite Interactive Teaching Methods for Resident Education. Society for Developmental and Behavioral Pediatrics, Providence, RI, Sept 28, 2007

23. Stephens BE, Liu J, Lester B, Lagasse L, Shankaran S, Bada H, Bauer C, Das A, Higgins R. Neurobehavioral Assessment Predicts Motor Outcomes in ELBW Infants. Poster Presentation, Society for Developmental and Behavioral Pediatrics, Providence, RI, Sept 30, 2007

24. Stephens BE, Vogt R , Gargus RA, Tucker R, McKinley L, Mance M, Nye J, Vohr BR. Adequate First Week Protein and Calorie Intake is Critical for 18 month Developmental Outcome in ELBW Infants. Poster Presentaton, SPR-RC, Woodlands, TX, Oct, 17, 2007

25. Developmental Delay and Mental Retardation, Resident Noon Conference, Hasbro Children's Hospital, Providence, RI, Nov 9. 2007

26. Early TPN, Are We Doing Enough?, Perinatal Management Conference, Women and Infants' Hospital, Providence, RI, April 23, 2008

27. Autism Spectrum Disorder in Extremely Preterm Infants, Pediatric Research Colloquium, Women and Infants' Hospital, Providence, RI, Oct 30, 2009

28. Stephens BE, Miller R, Bigsby R, Tucker R, Lester B. Normative Neurobehavior of Extremely Low Birth Weight Infants on the Neonatal Intensive Care Unit Network Neurobehavioral Scale. Poster Presentation, Pediatric Academic Societies, Vancouver, BC, May 3, 2010

29. Stephens BE, Alksninis B, Yatchmink YE, Burke RT, Tucker R, Vohr BR. Plagiocephaly in Preterm Infants: An Early Marker of Motor Dysfunction. Platform Presentation, New England Regional Perinatal Conference, Chatham, MA, Oct 18, 2010

30. Discharge of the Medically Complex Infant, Perinatal Management Conference, Women and Infants' Hospital, Providence, RI, January 5, 2011

31. Pharmacovigilance: A multidisciplinary approach to perinatal medication safety, Perinatal Management Conference, Women and Infants' Hospital, Providence, RI, January 12, 2011

32. Caskey M, Stephens B, Tucker R, Vohr B. Adult-Infant Conversations in the NICU and Language and Cognitive Outcomes in Preterm Infants. Platform Presentation, Pediatric Academic Societies, Denver, CO, April 30, 2011

33. Stephens B, Watson V, Tucker R, Sheinkopf S, Vohr B. Screening for Autism Spectrum Disorder at 18 vs. 30 months in Extremely Preterm Infants. Poster Symposium, Pediatric Academic Societies, Denver, CO, May 1, 2011

34. Stephens B, Bann C, Watson V, Peralta-Carcelen M, Sheinkopf S, Higgins R, Vohr B, for NICHD NRN. Screening for Autism Spectrum Disorder in Extremely Preterm Infants. Poster Symposium, Pediatric Academic Societies, Denver, CO, May 1, 2011

35. Stephens B, Bann C, Higgins R, Vohr B, for NICHD NRN. Autism Spectrum Disorder Phenotype in Extremely Preterm Infants. Poster Presentation, Pediatric Academic Societies, Denver, CO, May 3, 2011

36. Late Preterm Infants, Grand Rounds, St Joseph's Hospital, Polson, MT, June 11, 2013

37. Neonatal Abstinence Syndrome, Grand Rounds, St Joseph's Hospital, Polson, MT, Aug 27, 2013

38. Developmental Care, the role of the Physical Therapist in the NICU and beyond, University of Montana, Physical Therapy Student Lecture Nov 13, 2013

39. Developmental Care in the NICU, March of Dimes Prematurity Summit, Missoula, MT, Nov 15, 2013

40. Interpretation of ABG's in the Neonate, Grand Rounds, Bozeman Deaconess Hospital, Bozeman, MT, May 9, 2014

41. Complex Congenital Heart Disease Screening, Grand Rounds, St Joseph's Hospital, Polson, MT, July 18, 2014

42. Developmental Follow-up Care of the NICU Graduate, Timely Topics, Kalispell, MT, Sept 12, 2014

43. Neonatal Abstinence Syndrome, Rocky Mountain Childbirth Conference, Missoula, MT, Oct 3, 2014

44. Neurobehavioral Assessment in the NICU and Its Role in Predicting Outcomes in High Risk Neonates, National Association of Neonatal Therapists, Phoenix, AZ, April 10, 2015

45. Therapeutic Hypothermia for Neonatal Hypoxic Ischemic Encephalopathy. Grand Rounds, Bozeman Deaconess Hospital, Bozeman, MT, June 5, 2015

46. Therapeutic Hypothermia for Neonatal Hypoxic Ischemic Encephalopathy. Timely Topics, Missoula, MT, Oct 23, 2015

47. Neonatal Abstinence Syndrome, Workshop, St Joseph's Hospital, Polson, MT, Oct 29, 2015

48. New NRP Guidelines, Overview and Mock Codes, St James Healthcare, Butte, MT, Jan 13, 2016

49. Developmental and Behavioral Pediatrics in Primary Care, Montana AAFP Conference, Whitefish, MT, Jan 28, 2016

50. Survival is Not Enough: Improving Outcomes of Extremely Preterm Infants. Annual Sauer Lecture, Pediatric Ground Rounds, Evanston Hospital, NorthShore University HealthSystem, Evanston, IL, Apr 12, 2016

51. Individualizing Care at the Limits of Viability. Timely Topics. Missoula, MT. Oct 27, 2017.

52. Common Developmental Disorders: Screening, Diagnosis and Management. Montana AAFP Winter Conference. Whitefish, MT. January 25, 2018

53. Priorities for Safe and Secure Care After Birth. First 1000 Days Conference. Missoula, MT. June 13, 2018

54. Therapeutic Hypothermia for Hypoxic Ischemic Encephalopathy. Montana AAP Roundup. Pray, MT Oct 6, 2018

55. Individualizing Care at the Limits of Viability. Rocky Mountain Childbirth Conference. Fairmont Hot Springs, MT. Oct 12, 2018

56. Therapeutic Hypothermia for Hypoxic Ischemic Encephalopathy. Rocky Mountain Childbirth Conference. Fairmont Hot Springs, MT. Oct 12, 2018

57. Abdominal Wall Defects, A Multi-Disciplinary Approach. Timely Topics. Missoula, MT. Sept 13, 2019

58. Updates in Neonatal Care. BCBS. Helena, MT. March 6, 2020.

59. Eat, Sleep and Console. Multiple neonatal/perinatal conferences

Conference Moderator/Invited Participant

1. Moderator, Neonatology – Epidemiology and Follow-up, Platform Session, ESPR, Philadelphia, PA, March 27, 2010

2. Moderator, PAS/SPR, Boston, MA, 2012

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UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MONTANA, MISSOULA DIVISION

MONTANA MEDICAL ASSOCIATION, ET. AL., *Plaintiffs,* and MONTANA NURSES ASSOCIATION, *Plaintiff-Intervenors*, v. AUSTIN KNUDSEN, ET AL., DEFENDANTS.	No. CV-21-108-M-DWM **EXPERT REPORT OF DR. JAYANTA BHATTACHARYA**

EXPERT REPORT OF DR. JAYANTA BHATTACHARYA

EXPERIENCE & CREDENTIALS

1. I am a former Professor of Medicine and current Professor of Health Policy at Stanford University School of Medicine and a research associate at the National Bureau of Economic Research. I am also the Director of Stanford's Center for Demography and Economics of Health and Aging. I hold an M.D. and Ph.D. from Stanford University. I have published 160 scholarly articles in peer-reviewed journals in the fields of medicine, economics, health policy, epidemiology, statistics, law, and public health, among others. My research has been cited in the peer-reviewed scientific literature more than 13,300 times. My curriculum vitae is attached to this declaration as Exhibit A.

2. I have dedicated my professional career to analyzing health policy, including infectious disease epidemiology and policy, and the safety and efficacy of medical interventions. I have studied extensively and commented publicly on the necessity and safety of vaccine requirements for those who have contracted and recovered from COVID-19 (individuals who have "recovered immunity,"

sometimes called "natural immunity"). I am familiar with the emergent scientific and medical literature on this topic and pertinent government policy responses to the issue both in the United States and abroad.

3. My assessment of vaccine immunity is based on studies on the efficacy and safety of the two vaccines to receive full approval from the Food and Drug Administration (FDA) and the one vaccine for which the FDA has granted Emergency Use Authorization (EUA) for use in the United States. These include two mRNA-technology vaccines (manufactured by Pfizer-BioNTech and Moderna) and an adenovirus-vector vaccine technology (manufactured by Johnson & Johnson). Of those, the Pfizer vaccine, also known as Comirnaty, and Moderna vaccine have full FDA approval.

4. I have been asked to provide my opinion on several matters related to the use of one of the COVID-19 vaccines above:

- Based on current medical and scientific knowledge, the risk SARS-CoV-2 virus poses to different population groups;
- Whether, based on the current medical and scientific

knowledge, vaccines effectively protect against infection (and therefore disease spread);

- Whether, based on the current medical and scientific knowledge, immunity after COVID recovery is categorically inferior to vaccine immunity to prevent reinfection and transmission of the SARS-CoV-2 virus;
- Whether, based on the existing medical and scientific understanding of SARS-CoV-2 transmission and recovery, there is any categorical distinction between recovered immunity and vaccine immunity;
- Whether there is scientific evidence to support the notion that immunity provided by COVID recovery should not be considered as a reason to be excused from a vaccine mandate;
- Whether, based on the current medical and scientific knowledge, Omicron presents a grave danger to the population; and

- Whether, based on the current medical and scientific knowledge, vaccines are effective at preventing Omicron infections.
- Whether, based on the current medical and scientific knowledge, healthcare staff and the public's vaccination status affects the spread and transmission of COVID-19 within healthcare settings.

5. I can summarize my opinions briefly. The scientific evidence strongly indicates that for the vast majority of children and young adults, COVID-19 infection poses less mortality risk than seasonal influenza; while the COVID vaccines are effective at protecting vaccinated individuals against severe disease, they provide only short-lasting and limited protection versus infection and disease transmission; the recovery from COVID disease provides strong and lasting protection against severe disease (hospitalization or death) if reinfected, at least as good and likely better than the protection offered by the COVID vaccines; requiring vaccines for COVID recovered patients, thus, provides only a limited benefit while exposing them to the risks associated with the

vaccination; Omicron does not present a grave danger to most of the population; and vaccines are ineffective at preventing Omicron infections.

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

OPINIONS

I. COVID-19 Infection Fatality Risk

7. SARS-CoV-2, the virus that causes COVID-19 infection, entered human circulation in 2019 in China. The virus itself is a member of the coronavirus family of viruses, several of which cause typically mild respiratory symptoms upon infection in humans. The SARS-CoV-2 virus, by contrast, induces a wide range of clinical responses upon infection. These presentations range from entirely

asymptomatic infection to mild upper respiratory disease with unusual symptoms like loss of sense of taste and smell, hypoxia, or a deadly viral pneumonia that is the primary cause of death due to SARS-CoV-2 infection.

8. The mortality danger from COVID-19 infection varies substantially by age and a few chronic disease indicators.[1] For most of the population, including the vast majority of children and young adults, COVID-19 infection poses less mortality risk than seasonal influenza. By contrast, for older people – especially those with severe comorbid chronic conditions – COVID-19 infection poses a high infection fatality risk, on the order of 5%.

9. The best evidence on the infection fatality rate from SARS-CoV-12 infection (that is, the fraction of infected people who die due to the infection) comes from seroprevalence studies. The definition of seroprevalence of COVID-19 is the fraction of people in a population who have specific antibodies against SARS-CoV-2 in

[1] Public Health England (2020) Disparities in the Risk and Outcomes of COVID-19. August 2020. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf

their bloodstream. A seroprevalence study measures the fraction of a population with antibodies produced specifically by people infected by the SARS-CoV-2 virus. Specific antibodies in blood provide excellent evidence that an individual was previously infected.

10. Seroprevalence studies provide better evidence on the total number of people who have been infected than do case reports or positive reverse transcriptase-polymerase chain reaction (RT-PCR) test counts. PCR tests are the most common test used to check whether a person currently has the virus or viral fragments in their body (typically in the nasopharynx). The PCR test should not be used to count the total number of people infected to date in a population. Case reports and PCR test counts both miss infected people who are not identified by the public health authorities or who do not volunteer for RT-PCR testing. That is, they miss people who were infected but recovered from the condition without coming to the attention of public health authorities. Because they ignore unreported infections, fatality rate estimates based on case reports

or positive test counts are substantially biased toward reporting a higher fatality rate.

11. According to a meta-analysis[2] by Dr. John Ioannidis of every seroprevalence study conducted to date of publication with a supporting scientific paper (74 estimates from 61 studies and 51 different localities worldwide), the median infection survival rate—the inverse of the infection fatality rate—from COVID-19 infection is 99.77%. For COVID-19 patients under 70, the meta-analysis finds an infection survival rate of 99.95%. A separate meta-analysis[3] by other scientists independent of Dr. Ioannidis' group reaches qualitatively similar conclusions.

12. A study of the seroprevalence of COVID-19 in Geneva, Switzerland (published in *The Lancet*)[4] provides a detailed age

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[2] John P.A. Ioannidis , *The Infection Fatality Rate of COVID- 19 Inferred from Seroprevalence Data*, Bulletin of the World Health Organization BLT 20.265892.

[3] Andrew T. Levin, et al., *Assessing the Age Specificity of Infection Fatality Rate for COVID- 19: Meta-Analysis & Public Policy Implications* (Aug. 14, 2020) MEDRXIV, http://bit.ly/3gplolV.

[4] Silvia Stringhini, et al., *Seroprevalence of Anti-SARS-CoV-2 lgG Antibodies in Geneva, Switzerland (SEROCoV-POP): A Population Based Study* (June 11, 2020) THE LANCET, https://bit.ly/3187S13.

breakdown of the infection survival rate in a preprint companion paper:[5] 99.9984% for patients 5 to 9 years old; 99.99968% for patients 10 to 19 years old; 99.991% for patients 20 to 49 years old; 99.86% for patients 50 to 64 years old; and 94.6% for patients above 65.

13. I estimated the age-specific infection fatality rates from the Santa Clara County seroprevalence study[6] data (for which I am the senior investigator). The infection survival rate is 100% among people between 0 and 19 years (there were no deaths in Santa Clara in that age range up to that date); 99.987% for people between 20 and 39 years; 99.84% for people between 40 and 69 years; and 98.7% for people above 70 years.

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[5] Francisco Perez-Saez, et al. *Serology- Informed Estimates of SARS-COV-2 Infection Fatality Risk in Geneva, Switzerland* (June 15,2020) OSF PREPRINTS, http://osf.io/wdbpe/

[6] Eran Bendavid, et al., *COVID- 19 Antibody Seroprevalence in Santa Clara County, California* (April 30,2020) INT J EPIDEMIOL. 2021 May 17;50(2):410-419. doi: 10.1093/ije/dyab010. PMID: 33615345; PMCID: PMC7928865. https://pubmed.ncbi.nlm.nih.gov/33615345/

14. Those numbers are consistent with what the US CDC has reported. A US CDC report[7] found between 6 and 24 times more SARS-CoV-2 infections than cases reported between March and May 2020. Correspondingly, the CDC's estimate of the infection fatality rate for people ages 0-19 years is 0.003%, meaning infected children have a 99.997% survivability rate. For people ages 20-49 years, it was 0.02%, meaning that young adults have a 99.98% survivability rate. For people ages 50-69 years, it was 0.5%, meaning this age group has a 99.5% survivability rate. Finally, for people ages 70+ years, it was 5.4%, meaning seniors have a 94.6% survivability rate.[8] There is, thus, no substantial qualitative disagreement about the infection fatality rate reported by the CDC and other sources in the scientific literature. This should come as no surprise since they all rely on seroprevalence studies to estimate infection fatality rates. All of these mortality rate estimates are

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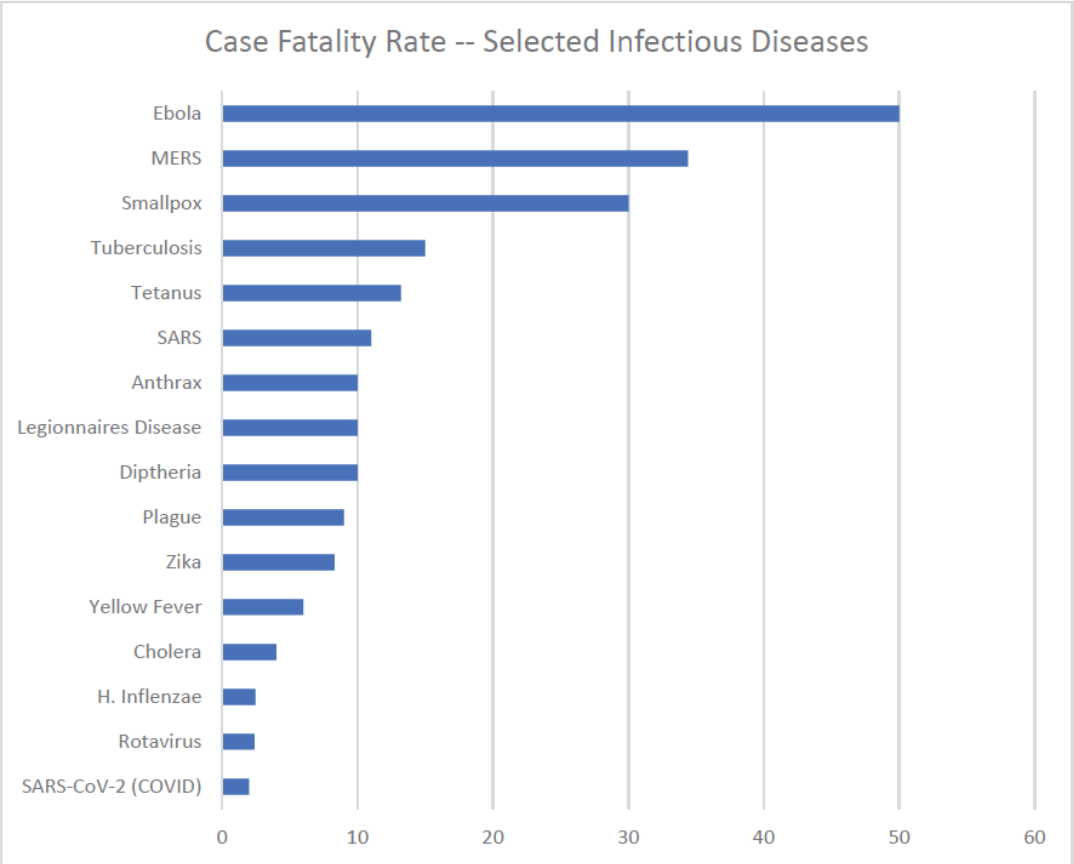
[7] Fiona P. Havers, et al., *Seroprevalence of Antibodies to SARS-CoV-2 in 10 Sites in the United States, March 23-May 12, 2020* (Jul. 21, 2020) JAMA INTERN MED., https://bit.ly/3goZUgy.

[8] COVID- 19 Pandemic Planning Scenarios, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html.

derived from data before the emergence of the Omicron variant, which has caused lower mortality per infection than previous variants.

15. It is helpful to provide some context for how large the mortality risk COVID infection poses relative to the risk posed by other infectious diseases. Since seroprevalence-based mortality estimates are not readily available for every disease, I plot case fatality rates in the figure immediately below, defined as the number of deaths due to the disease divided by the number of identified or diagnosed cases of that disease. The case fatality rate for SARS-CoV-2 is ~2% (though that number has decreased with the availability of vaccines and effective treatments). By contrast, the case fatality rate for SARS is over five times higher than that, and for MERS, it is 16 times higher.



16. Perhaps the most important implication of these estimates is that they identify two distinct populations of people who face a very different risk from COVID infection. One segment – the elderly and others with severe chronic disease – faces a higher mortality risk if infected (especially if unvaccinated and not COVID recovered). A second segment – typically non-elderly people – faces a low mortality risk if infected. Instead, it faces much greater harm from lockdowns, school closures, and other non-pharmaceutical

interventions than COVID infection. The right strategy, then, is focused protection of the vulnerable population by prioritizing them for vaccination while lifting lockdowns and other restrictions on activities for the rest since they cause harm without corresponding benefit for the non-vulnerable. The Great Barrington Declaration, of which I am a primary co-author, describes an alternate policy of focused protection. This policy would lead to fewer COVID-related deaths and fewer non-COVID-related deaths than universal lockdowns or a strategy that lets the virus rip through the population. My co-authors of this Declaration include Prof. Martin Kulldorff of Harvard University and Prof. Sunetra Gupta of Oxford University. Over 15,000 epidemiologists and public health professionals and 50,000 medical professionals have co-signed the Declaration.[9]

II. Recovered immunity Provides Durable Protection Against Reinfection and Against Severe Outcomes If Reinfected; COVID-19 Vaccines Provide Limited Protection Against Infection but Durable Protection Against Severe Outcomes if Infected.

[9] Bhattacharya J, Gupta S, Kulldorff M (2020) Great Barrington Declaration. https://gbdeclaration.org

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

18. Both types of immunity are based on the same basic immunological mechanism—stimulating the immune system to generate an antibody response. In clinical trials, the efficacy of those vaccines was initially tested by comparing the antibody levels in the blood of vaccinated individuals to those who had recovered immunity. Later Phase III studies of the vaccines established 94%+ clinical efficacy of the mRNA vaccines against symptomatic COVID

illness.[10] [11] A Phase III trial showed 85% efficacy for the Johnson & Johnson adenovirus-based vaccine against symptomatic disease.[12]

19. Immunologists have identified many immunological mechanisms of immune protection after recovery from infections. Studies have demonstrated prolonged immunity with respect to

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

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

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

memory T and B cells,[13] bone marrow plasma cells,[14] spike-specific neutralizing antibodies,[15] and IgG+ memory B cells[16] following naturally-acquired immunity.

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

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

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

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

[16] Cohen, K. W., Linderman, S. L., Moodie, Z., Czartoski, J., Lai, L., Mantus, G., Norwood, C., Nyhoff, L. E., Edara, V. V., Floyd, K., De Rosa, S. C., Ahmed, H., Whaley, R., Patel, S. N., Prigmore, B., Lemos, M. P., Davis, C. W., Furth, S., O'Keefe, J., McElrath, M. J. (2021). Longitudinal analysis shows durable and broad immune memory after SARS-CoV-2 infection with persisting antibody responses and memory B and T cells. *medRxiv*, Preprint. (study of 254 recovered COVID patients over 8 months "found a predominant broad-based immune memory response" and "sustained IgG+ memory B cell response, which bodes well for rapid antibody response upon virus re-exposure." "Taken together, these results suggest that broad and effective immunity may persist long-term in recovered COVID-19 patients").

21. Specifically, studies confirm the efficacy of recovered immunity against reinfection of COVID-19[17] and show that the vast

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

majority of reinfections are less severe than first-time infections.[18]

For example, an Israeli study of approximately 6.4 million

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protects against reinfection, even in the absence of detectable antibodies. *The Journal of Infection*, *83*(2), 237-279. doi: 10.1016/j.jinf.2021.05.024 (0.86% of previously infected population in London became reinfected); Tarke, A., Sidney, J., Methot, N., Yu, E. D., Zhang, Y., Dan, J. M., Goodwin, B., Rubiro, P., Sutherland, A., Wang, E., Frazier, A., Ramirez, S. I., Rawlings, S. A., Smith, D. M., da Silva Antunes, R., Peters, B., Scheuermann, R. H., Weiskopf, D., Crotty, S., Grifoni, A. & Sette, A. (2021). Impact of SARS-CoV-2 variants on the total $CD4^+$ and $CD8^+$ T cell reactivity in infected or vaccinated individuals, *Cell Reports Medicine 2*(7), 100355 (an examination of the comparative efficacy of T cell responses to existing variants from patients with recovered immunity compared to those who received an mRNA vaccine found that the T cell responses of both recovered COVID patients and vaccines were effective at neutralizing mutations found in SARS-CoV-2 variants).

[18] Abu-Raddad, L. J., Chemaitelly, H., Coyle, P., Malek, J. A., Ahmed, A. A., Mohamoud, Y. A., Younuskunju, S., Ayoub, H. H., Kanaani, Z. A., Kuwari, E. A., Butt, A. A., Jeremijenko, A., Kaleeckal, A. H., Latif, A. N., Shaik, R. M., Rahim, H. F. A., Nasrallah, G. K., Yassine, H. M., Al Kuwari, M. G., Al Romaihi, H. E., Al-Thani, M. H., Al Khal, A., Bertollini, R. (2021). SARS-CoV-2 antibody-positivity protects against reinfection for at least seven months with 95% efficacy. *EClinicalMedicine*, *35*, 1-12. doi: 10.1016/j.eclinm.2021.100861 (finding that of 129 reinfections from a cohort of 43,044, only one reinfection was severe, two were moderate, and none were critical or fatal); Hall, V. J., Foulkes, S., Charlett, A., Atti, A., Monk, E. J. M., Simmons, R., Wellington, E., Cole, M. J., Saei, A., Oguti, B., Munro, K., Wallace, S., Kirwan, P. D., Shroti, M., Vusirikala, A., Rokadiya, S., Kall, M., Zambon, M., Ramsay, M., Hopkins, S. (2021). SARS-CoV-2 infection rates of

individuals demonstrated that recovered immunity provided equivalent if not better protection than vaccine immunity in preventing COVID-19 infection, morbidity, and mortality.[19] Of the 187,549 unvaccinated persons with recovered immunity in the study, only 894 (0.48%) were reinfected; 38 (0.02%) were hospitalized, and 16 (0.008%) were hospitalized with severe disease, and only one died, an individual over 80 years of age. Another study analyzing data from Italy found that only 0.31% of

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antibody-positive compared with antibody-negative health-care workers in England: a large, multicentre, prospective cohort study. *The Lancet*, *397*(10283), 1459-1469. doi: 10.1016/S0140-6736(21)00675-9 (finding "a 93% lower risk of COVID-19 symptomatic infection… [which] show[s] equal or higher protection from natural infection, both for symptomatic and asymptomatic infection"); Hanrath, A. T., Payne, B., A., I., & Duncan, C. J. A. (2021). Prior SARS-CoV-2 infection is associated with protection against symptomatic reinfection. *The Journal of Infection*, *82*(4), e29-e30. doi: 10.1016/j.jinf.2020.12.023 (examined reinfection rates in a cohort of healthcare workers and found "no symptomatic reinfections" among those examined and that protection lasted for at least 6 months).

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

COVID-recovered patients experienced reinfection within a year after the initial infection.[20]

22. Before the emergence of the Omicron variant, variants did not escape the immunity against infection provided by prior infection or vaccination.[21] [22] In a study of a large population of patients in Israel, *vaccinated* people who had not been previously infected had 13 times higher odds of experiencing a breakthrough infection with the Delta variant than patients who had recovered

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

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

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

from COVID but were never vaccinated.[23] They had 27 times higher odds of experiencing subsequent symptomatic COVID disease and seven times higher odds of hospitalization. The design of this Israeli study was particularly strong – it tracked large cohorts of people over time from the time of vaccination or initial infection and thus carefully distinguished the effect of time since initial exposure or vaccination in estimating its effect estimates. This is important because both vaccine-mediated and infection-mediated protection against subsequent infection diminish with time.

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

24. In contrast to the concrete findings regarding the robust durability of recovered immunity, the immunity provided by

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

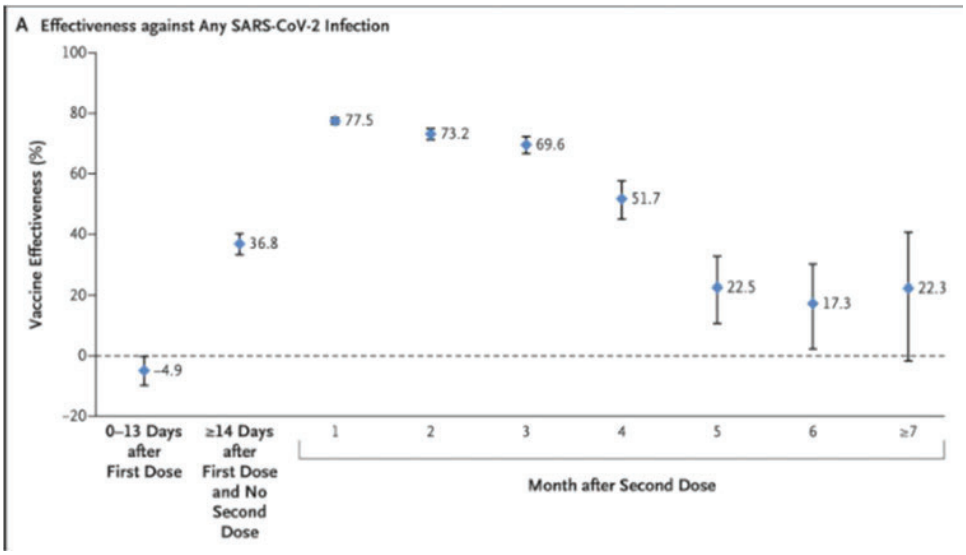
vaccination against infection appears to be short-lived, especially in the Omicron era.

25. A study from Qatar by Chemaitelly and colleagues (recently published in the New England Journal of Medicine), which tracked 927,321 individuals for six months after vaccination, concluded that the Pfizer vaccine's "induced protection against infection appears to wane rapidly after its peak right after the second dose, but it persists at a robust level against hospitalization and death for at least six months following the second dose."[24]

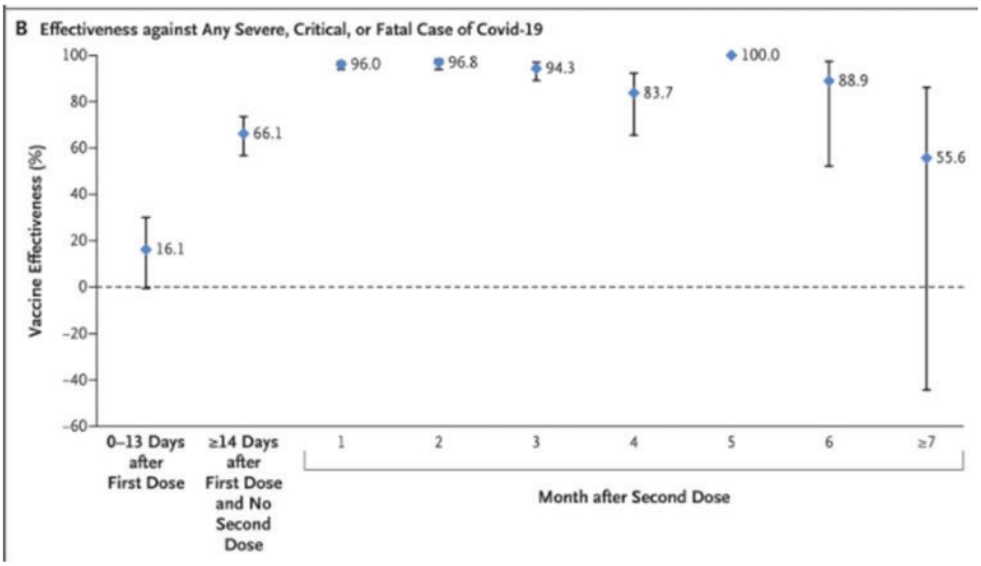
26. The key figures from the Qatari study are reproduced immediately below. Panel A shows that vaccine-mediated protection against infection peaks at 77.5% one month after the second dose, and then declines to 22.5%, five months after the second dose. According to this result, vaccines effectively protect

[24] Chemaitelly H, Tang P, Hasan MR, AlMukdad S, Yassine HM, Benslimane FM, Al Khatib HA, Coyle P, Ayoub HH, Al Kanaani Z, Al Kuwari E, Jeremijenko A, Kaleeckal AH, Latif AN, Shaik RM, Abdul Rahim HF, Nasrallah GK, Al Kuwari MG, Al Romaihi HE, Butt AA, Al-Thani MH, Al Khal A, Bertollini R, Abu-Raddad LJ. Waning of BNT162b2 Vaccine Protection against SARS-CoV-2 Infection in Qatar. N Engl J Med. 2021 Oct 6:NEJMoa2114114. doi: 10.1056/NEJMoa2114114. Epub ahead of print. PMID: 34614327; PMCID: PMC8522799.

against infection (and therefore disease spread) for a short period of time after the second dose of the mRNA vaccines.



27. On the other hand, Panel B shows that protection versus severe disease is long lasting after vaccination—even though the person will no longer be fully protected against infection and, presumably, disease spread. At six months after the second dose, the vaccine remains 88.9% efficacious versus severe disease. While it appears to dip at seven months to 55.6% efficacy, the confidence interval is so wide that it is consistent with no decrease whatsoever even after seven months.



28. The Qatari study is no outlier. A large study in California tracked the infection rates for nearly 5 million patients vaccinated with two doses of the Pfizer mRNA vaccine. The study tracked both SARS-CoV-2 infections as well as COVID-19 related hospitalizations. The figure immediately below plots the trend in vaccine efficacy over time for different age groups in the population cohort. **Panel A** on the right plots effectiveness versus SARS-CoV-2 *infections*.[25] Though the drop in effectiveness is not as steep as in

[25] Tartof SY, Slezak JM, Fischer H, Hong V, Ackerson BK, Ranasinghe ON, Frankland TB, Ogun OA, Zamparo JM, Gray S, Valluri SR, Pan K, Angulo FJ, Jodar L, McLaughlin JM. Effectiveness of mRNA BNT162b2 COVID-19 vaccine up to 6

the Qatari study, there is, nevertheless, a sharp drop. While in the first month, vaccine effectiveness is near 90% for all age-groups, by month 5, it drops to nearly 50% for all the groups. By contrast, **Panel B** plots vaccine efficacy versus *hospitalizations*. It remains high with no decline over time –near 90% throughout the period. The vaccine provides durable private protection versus severe disease, but declining protection versus infection (and hence transmission).

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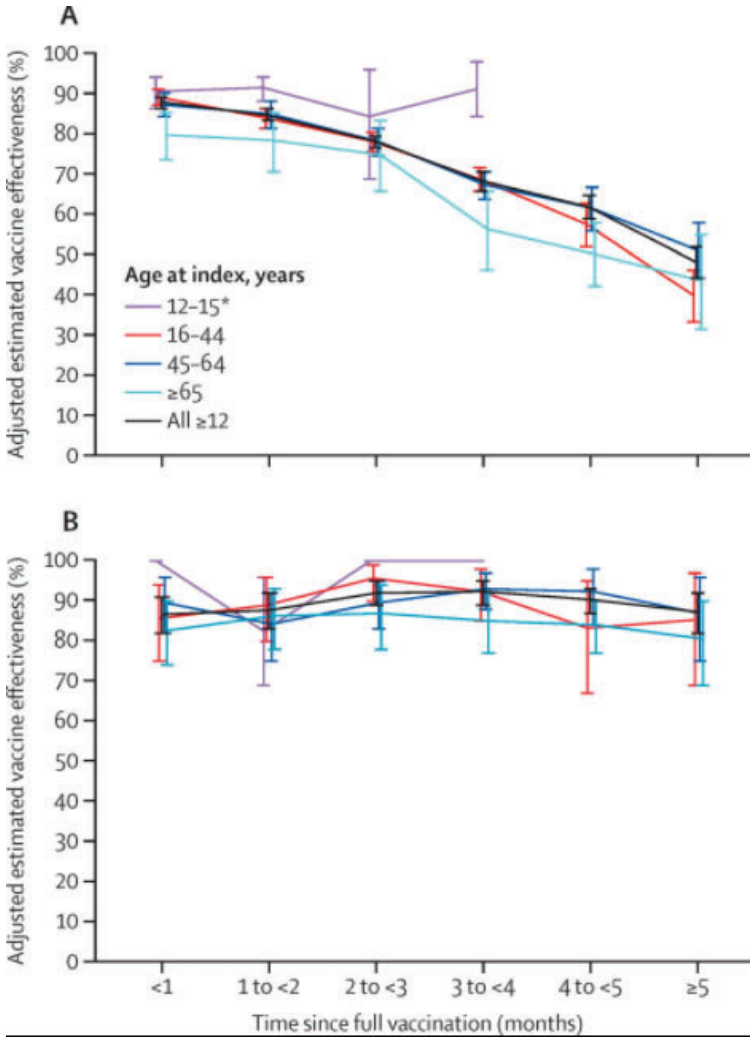
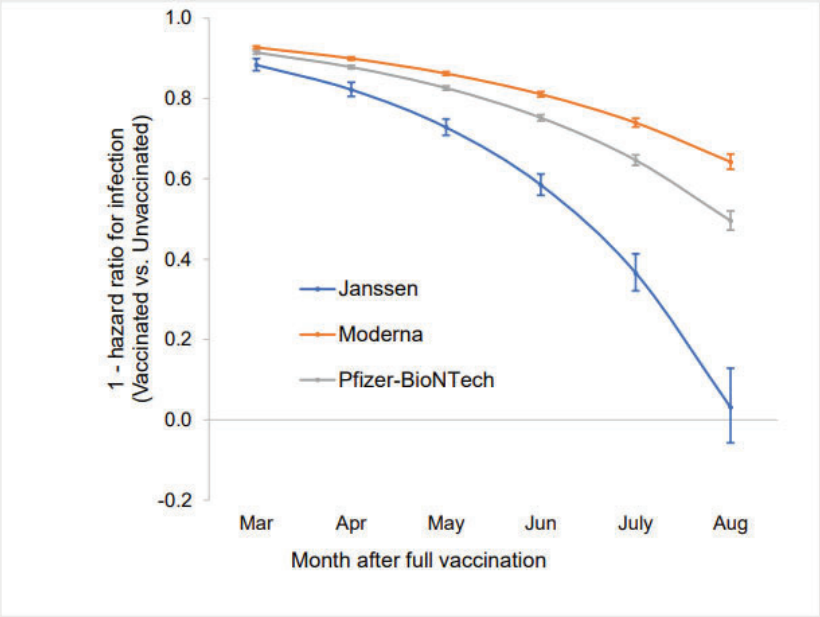
months in a large integrated health system in the USA: a retrospective cohort study. *Lancet*. 2021 Oct 16;398(10309):1407-1416. doi: 10.1016/S0140-6736(21)02183-8. Epub 2021 Oct 4. PMID: 34619098; PMCID: PMC8489881.



29. Another recent study tracked 620,000 vaccinated U.S. veterans to measure breakthrough infections for the three vaccines in common use in the U.S.[26] Like the other studies, the authors of the study found a sharp decline in vaccine effectiveness versus infection. Five months after vaccination, the effectiveness of the

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

J&J vaccine dropped from ~90% to less than 10%; the Pfizer vaccine dropped from ~90% to ~50%; and the Moderna dropped from ~90%



to ~65%. The figure on this page tracks the decline in effectiveness of the vaccines against infection over time documented in this study. This study corroborates yet another study that documented declining vaccine efficacy in the first three months after vaccination against disease transmission in the era of the Delta variant.[27]

30. Yet another study conducted in Wisconsin confirmed that vaccinated individuals can shed infectious SARS-CoV-2 viral

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

particles.[28] The authors analyzed nasopharyngeal samples to check whether patients showed evidence of infectious viral particles. They found that vaccinated individuals were at least as likely as unvaccinated individuals to be shedding live virus. They concluded:

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

31. A study in the U.K. during its wave of delta COVID cases compared the likelihood of a vaccinated individual passing on the disease to someone within their same household relative to unvaccinated patients.[29] This study tracked these groups of patients over time to the point they tested positive for COVID. At

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

[29] Singanayagam A, Hakki S, Dunning J, et al. Community transmission and viral load kinetics of the SARS-CoV-2 delta (B.1.617.2) variant in vaccinated and unvaccinated individuals in the UK: a prospective, longitudinal, cohort study [published online ahead of print, 2021 Oct 29]. Lancet Infect Dis. 2021;doi:10.1016/S1473-3099(21)00648-4

that point, study investigators measured levels of the SARS-CoV-2 virus in the patients, and observed whether the patients passed on the disease to other household members. The authors find that while vaccination does reduce the fraction of time that a patient passes the disease on to household members from 38% [95% confidence interval: 24-53] to 25% [95% confidence interval: 18-33], there was no statistically significant difference (p=0.17). They conclude:

> Vaccination reduces the risk of delta variant infection and accelerates viral clearance. Nonetheless, fully vaccinated individuals with breakthrough infections have peak viral load similar to unvaccinated cases and can efficiently transmit infection in household settings, including to fully vaccinated contacts.

32. The CDC recognizes the importance of recovered immunity in its updated science brief analyzing the difference in immunity from infection-induced and vaccine-induced immunity.[30] The CDC noted that "confirmed SARS-CoV-2 infection decreased risk of subsequent infection by 80–93% for at least 6–9 months,"

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

with some studies showing "slightly higher protective effects (89-93%)." It also noted that "researchers have predicted that the immune response following infection would continue to provide at least 50% protection against reinfection for 1–2 years following initial infection with SARS-CoV-2 or vaccination. This would be similar to what is observed with seasonal coronaviruses."

33. The CDC science brief does claim that vaccine-induced immunity is stronger than immunity from natural infection.[31] The study the CDC relies on to support this claim is not determinative, however, for several reasons.[32] First, its result is contrary to the weight of other evidence, as set forth above. Second, the study compared hospitalization of those infected—and had recovered immunity—90-225 days after their infection while against those who had completed their RNA vaccine regime 45-213 days before reinfection. Because immunity—regardless of how gained—wanes

[31] *Id.*

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

over time, the failure to adequately compare like periods means that the study's conclusions are biased in favor of vaccine-induced immunity. Indeed, the study admits this weakness. Third, the study design itself does not permit it to address the critical question of interest – whether COVID-recovery without vaccination or vaccination without COVID-recovery provides stronger protection against COVID-related hospitalization. The study analyzes only patients who are already in the hospital. To obtain an accurate answer to the question of interest, it would need to include and analyze patients before entering the hospital. As it is, the study implicitly and incorrectly assumes that the set of hospitalized patients with COVID-like symptoms is representative of the population at large, which is untrue.

34. In summary, the evidence to date strongly suggests that, while vaccines—like recovered immunity—protect against severe disease, they, unlike recovered immunity, provide only short-lasting protection against subsequent infection and disease spread. In short, there is no medical or scientific reason to believe

that vaccine immunity will prove longer-lasting immunity than recovered immunity, much less more durable immunity.

35. The United States government is an outlier relative to other developed countries in its refusal to recognize the efficacy of recovered immunity. For instance, the Netherlands recently extended the duration of its "recovered immunity certificate," which can be used in lieu of a vaccine passport from 180 days to 365 days.[33] A similar exemption was made for recovered immunity in vaccine passports in the U.K. when the country required them.[34]

III. OMICRON DOES NOT PRESENT A GRAVE DANGER

36. The Omicron variant now represents substantially all new SARS-COV2 infections in the United States. This fact renders any remaining basis for a vaccine mandate obsolete.

37. An analysis from the South African government's National Institute for Communicable Diseases provides reason for

[33] Block J. Vaccinating people who have had covid-19: why doesn't recovered immunity count in the US? BMJ. 2021 Sep 13;374:n2101. doi: 10.1136/bmj.n2101. Erratum in: BMJ. 2021 Sep 15;374:n2272. PMID: 34518194.

[34] Diver T. Vaccine passports will show 'recovered immunity' for people who have had Covid. MSN News. June 6, 2021.

optimism: S-Gene Target Failure (presumptive Omicron) cases are 80% less likely to be hospitalized.[35]

Table 1. Multivariable logistic regression analysis evaluating the association between S gene target failure (SGTF) infection, compared to non-SGTF infection, and hospitalisation, South Africa, 1 October – 30 November 2021[a] (N=11,255)

		Hospital admission[b] n/N (%)	Adjusted odds ratio (95% CI)	P-value
SARS-CoV-2 variant		N=11,495		
	SGTF	256/10,547 (2)	0.2 (0.1-0.3)	<0.001
	Non-SGTF	121/948 (13)	Ref	-

38. Data from Scotland also strongly suggests the same optimistic conclusion: "early national data suggest that Omicron is associated with a two-thirds reduction in the risk of COVID-19 hospitalisation when compared to Delta."[36]

Table 3: Observed vs expected analysis for risk of hospital admission by S gene status

Omicron — Risk of hosp 68% lower controlling for vax, reinfections)

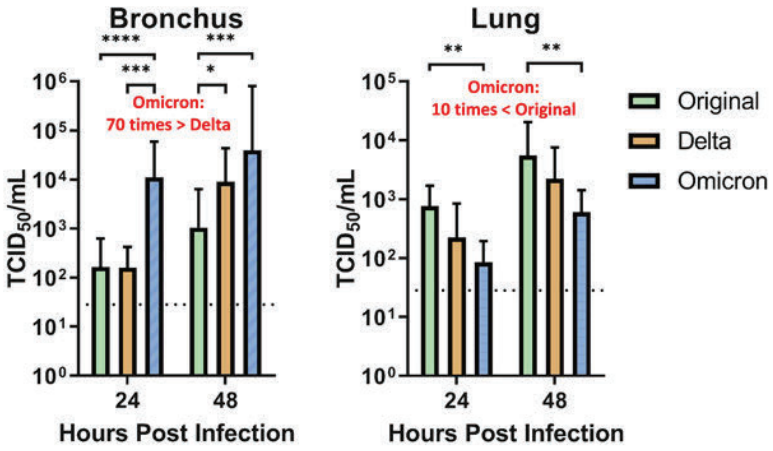
	S Gene Status	N	Person Years	Hospital Admissions	Expected Admissions	Observed/ Expected	LCL	UCL
All cases linking into the EAVE II dataset	S Positive	119100	4375.1	856	856.9	1	0.93	1.07
	S Negative	22205	413.4	15	46.6	0.32	0.19	0.52
	Weak S Positive	2199	57.3	7	6.9	1.02	0.45	2
	Other	990	33.8	*	*	0.79	0.26	1.88
	Unknown	1647	58.2	14	14.8	0.94	0.54	1.54

35 https://www.medrxiv.org/content/10.1101/2021.12.21.21268116v1.full.pdf

36 https://www.research.ed.ac.uk/en/publications/severity-of-omicron-variant-of-concern-and-vaccine-effectiveness-

39. Denmark's data shows Omicron cases were three times less likely to end up with hospital admissions than the previous dominant variant, Delta.[37]

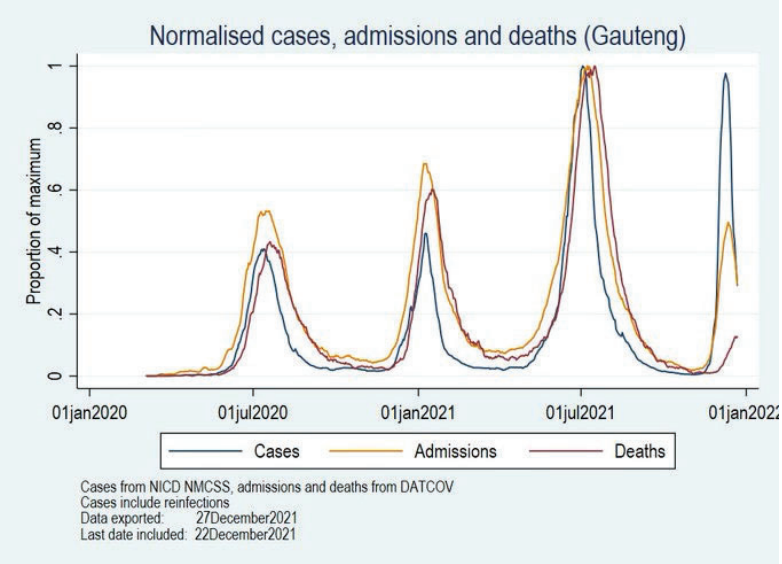
40. Hong Kong University researchers pointed to the likely reason, or mechanism, for Omicron's increased infectiousness but reduced virulence: it replicates far more efficiently in the bronchus and upper respiratory tract than Delta, but less efficiently in the lungs:[38]



[37] https://arstechnica.com/science/2021/12/omicron-cases-less-likely-to-require-hospital-treatment-studies-show/

[38] http://www.med.hku.hk/en/news/press/20211215-omicron-sars-cov-2-infection

41. Compelling evidence of Omicron ending any grave danger from SARS-CoV2 comes from South Africa, particularly the Gauteng province (population 18 million) where the first recognized Omicron wave occurred. According to Dr. Harry Moultrie of the South African government's National Institute for Communicable Diseases, Gauteng cases peaked on December 9 at 97 percent of the delta wave. Even more reassuringly, deaths were only 13 percent of the delta peak:[39]



42. A recently published working paper by a South African team of scientists who were conducting a sero-epidemiological

[39] https://twitter.com/hivepi/status/1475383429403484163

survey in the Gautang Province confirms the conclusion that Omicron infection is substantially less likely to require hospitalization or induce mortality than infection with other strains. While cases may rise sharply as a wave of Omicron sweeps through a region, hospitalizations and deaths do not follow. The authors conclude:[40]

> "We demonstrate widespread underlying SARS-CoV-2 seropositivity in Gauteng Province prior to the current Omicron-dominant wave, with epidemiological data showing an uncoupling of hospitalization and death rates from infection rate during Omicron circulation."

43. Based on their Omicron experience, some South African scientists have effectively declared the pandemic over, stating:[41]

> "All indicators suggest the country may have passed the peak of the fourth wave at a national level… While the Omicron variant is highly transmissible, there has

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[40] Shabir A. Madhi, Gaurav Kwatra, Jonathan E. Myers, Waasila Jassat, Nisha Dhar, Christian K. Mukendi, Amit J. Nana, Lucille Blumberg, Richard Welch, Nicoletta Ngorima-Mabhena, Portia C. Mutevedzi (2021) *South African Population Immunity and Severe Covid-19 with Omicron Variant*. medRxiv 2021.12.20.21268096; doi: https://doi.org/10.1101/2021.12.20.21268096

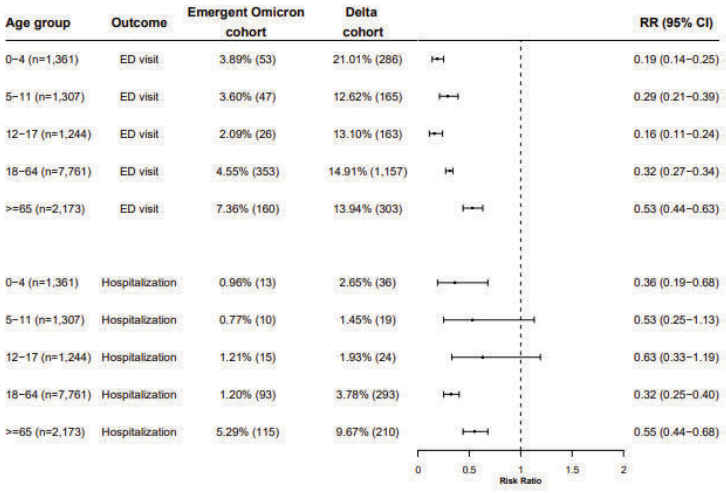
[41] https://sacoronavirus.co.za/2021/12/30/media-release-cabinet-approves-changes-to-covid-19-regulations/

> been lower rates of hospitalisation than in previous waves. This means that the country has a spare capacity for admission of patients even for routine health services."

44. In other words, the first country to experience an Omicron wave unambiguously concluded that the dominant variant presents no grave danger.

45. Early U.S. data was available in a preprint from a team at Case Western Reserve University, which used propensity matched-cohort analysis to find markedly reduced disease severity during the period from December 14 to December 24, 2021. On an age and risk-matched basis, they found E.R. visits were 70% lower than earlier cohorts, hospitalizations were 56% lower, ICU admissions were 67% lower, and ventilation were 84% lower.

Age−stratified comparison of 3−day acute outcomes in matched patients with SARS−CoV−2 infections
Emergent Omicron cohort (12/15−12/24) vs. Delta cohort (9/1−11/15)



46. As good as they appear, these reductions substantially *understate* the reduction of risk represented by Omicron, because this cohort included a non-negligible number of Delta infections. According to the authors:

> "The estimated prevalence of the Omicron variant during 12/15-12/24 was only 22.5-58.6%, suggesting that the outcomes for the Omicron variant may be found to be even milder than what we report here as the prevalence of the Omicron variant increases."

47. Quite simply, the Omicron variant is now a *normal respiratory virus,* not an unusual, extraordinary, or grave danger. There is no evidence specific to Omicron to support a grave danger finding.

IV. VACCINES ARE INEFFECTIVE AT PREVENTING OMICRON INFECTIONS

48. Pfizer and BioNTech are the manufacturers of the current leading vaccine. They recently admitted that the existing vaccine does not provide robust protection against Omicron, saying:

> "Sera from individuals who received two doses of the current COVID-19 vaccine did exhibit, on average, more than a 25-fold reduction in neutralization titers against the Omicron variant compared to wild-type, indicating that two doses of BNT162b2 may not be sufficient to protect against infection with the Omicron variant."[42]

49. Moderna, the second-leading manufacturer, similarly admitted that its vaccine does not provide acceptable efficacy against Omicron, stating:

> "All groups had low neutralizing antibody levels in the Omicron PsVNT assay prior to boosting."[43]

50. Similarly, NIH-funded researchers at Duke university found in vitro that: "neutralizing titers to Omicron are 49-84 times

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[42] https://www.pfizer.com/news/press-release/press-release-detail/pfizer-and-biontech-provide-update-omicron-variant

[43] https://investors.modernatx.com/news/news-details/2021/Moderna-Announces-Preliminary-Booster-Data-and-Updates-Strategy-to-Address-Omicron-Variant/default.aspx

lower than neutralization titers to D614G [wild-type SARS-CoV2] after 2 doses of mRNA-1273 [Moderna], which could lead to an increased risk of symptomatic breakthrough infections."[44]

51. Real-world evidence from at least four countries with significant experience with Omicron — Denmark, the United Kingdom, Germany, and Canada, all of which provide more detailed and transparent data than has been made available in the United States — evidences that these vaccines have *substantially zero efficacy* at preventing Omicron transmission, undermining the central rationale for mandating them in the workplace.

52. The Statens Serum Institut in Copenhagen, Denmark analyzed Danish data and found vaccine efficacy turned *negative* after 91 days following the second dose was administered. In other words, vaccinated Danes were *even more likely* than unvaccinated

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[44] https://www.medrxiv.org/content/10.1101/2021.12.15.21267805v1.full-text

Danes to be infected with Omicron after 3 months.[45] This may be due to unvaccinated, COVID-recovered patients having better[46] protection versus Omicron than vaccinated patients who never previously had COVID.

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[45] https://www.medrxiv.org/content/10.1101/2021.12.20.21267966v2.full.pdf

[46] Sivan Gazit, Roei Shlezinger, Galit Perez, Roni Lotan, Asaf Peretz, Amir Ben-Tov, Dani Cohen, Khitam Muhsen, Gabriel Chodick, Tal Patalon (2021) *Comparing SARS-CoV-2 recovered immunity to vaccine-induced immunity: reinfections versus breakthrough infections*, medRxiv 2021.08.24.21262415; doi: https://doi.org/10.1101/2021.08.24.21262415

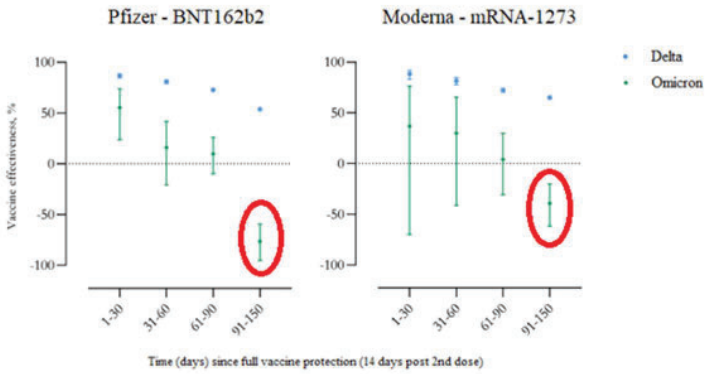

Figure Vaccine effectiveness against SARS-CoV-2 infection with the Delta and Omicron variants, shown separately for the BNT162b2 and mRNA-1273 vaccines. Vertical bars indicate 95% confidence intervals.

Table Estimated vaccine effectiveness for BNT162b2 and mRNA-1273 against infection with the SARS-CoV-2 Omicron and Delta variants during November 20 – December 12, 2021, Denmark.

	Pfizer – BNT162b2				Moderna - mRNA-1273			
	Omicron		Delta		Omicron		Delta	
Time since vaccine protection	Cases	VE, % (95% CI)	Cases	VE, % (95% CI)	Cases	VE, % (95% CI)	Cases	VE, % (95% CI)
1-30 days	14	55.2 (23.5; 73.7)	171	86.7 (84.6; 88.6)	4	36.7 (-69.9; 76.4)	29	88.2 (83.1; 91.8)
31-60 days	32	16.1 (-20.8; 41.7)	454	80.9 (79.0; 82.6)	8	30.0 (-41.3; 65.4)	116	81.5 (77.7; 84.6)
61-90 days	145	9.8 (-10.0; 26.1)	3,177	72.8 (71.7; 73.8)	48	4.2 (-30.8; 29.8)	1,037	72.2 (70.4; 74.0)
91-150 days	2,851	-76.5 (-95.3; -59.5)	34,947	53.8 (52.9; 54.6)	393	-39.3 (-61.6; -20.0)	3,459	65.0 (63.6; 66.3)
1-30 days after booster vaccination protection	29	54.6 (30.4; 70.4)	453	81.2 (79.2; 82.9)	-	-	5	82.8 (58.8; 92.9)

CI = confidence intervals; VE = vaccine effectiveness. VE estimates adjusted for 10-year age groups, sex and region (five geographical regions). Vaccine protection was assumed 14 days post 2nd dose. Insufficient data to estimate mRNA-1273 booster VE against Omicron.

53. In Germany, the most recent detailed report from the Robert Koch Institute (the German equivalent of the CDC) found that 78.6 percent (4,020 of 5,117) of sequenced Omicron cases were in *vaccinated* Germans,[47] despite a population vaccination rate of just 70 percent.[48]

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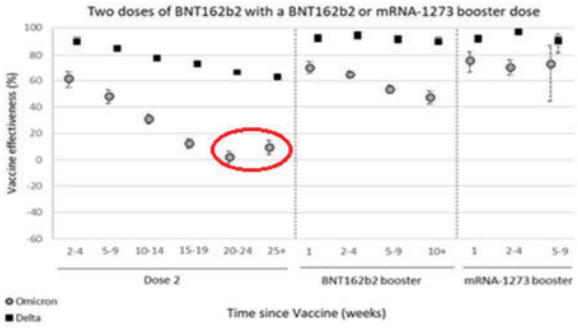
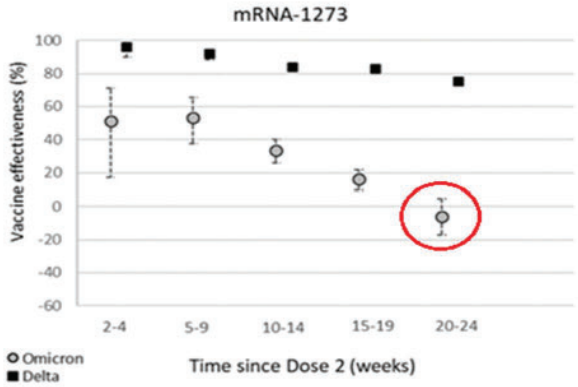
47 https://www.rki.de/DE/Content/InfAZ/N/Neuartiges_Coronavirus/Situationsberichte/Wochenbericht/Wochenbericht_2021-12-30.pdf?__blob=publicationFile

48 https://ourworldindata.org/covid-vaccinations

54. In the United Kingdom, the U.K. Health Security Agency calculated preliminary vaccine effectiveness estimates remarkably like the Danish findings, with *near-zero vaccine efficacy* for both Pfizer-BioNTech and Moderna vaccines after 20 weeks following the second dose:[49]

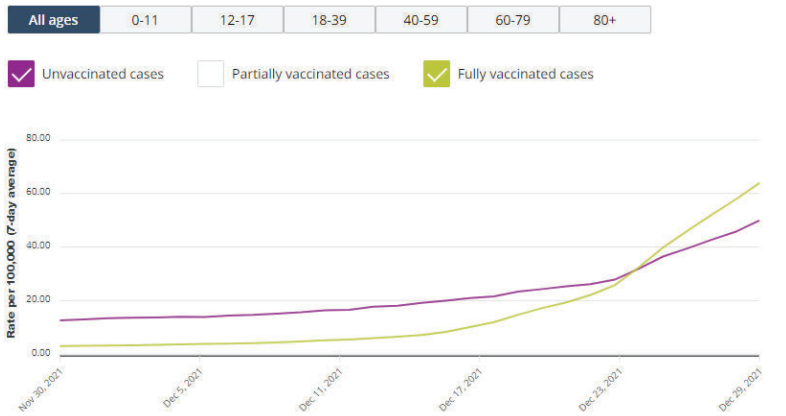




49 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1043807/technical-briefing-33.pdf

55. Although the U.K. Health Security Agency clarifies "[t]hese results should be interpreted with caution due to the low counts and the possible biases related to the populations with highest exposure to Omicron (including travelers and their close contacts) which cannot fully be accounted for," these results are consistent with the epidemiological patterns we are seeing in the United States and globally.

56. In Ontario, Canada, the case rate per 100,000 fully *vaccinated* Ontarians has risen sharply above the case rate per 100,000 unvaccinated Ontarians, again suggesting *negative vaccine efficacy*:[50]



[50] https://covid-19.ontario.ca/data/case-numbers-and-spread

57. A test-negative control analysis of Ontario test data by researchers from Public Health Ontario and leading Canadian universities found: "observed *negative* VE against Omicron among those who had received 2 doses compared to unvaccinated individuals" (emphasis added).

58. As the following table shows, the Ontario researchers found that after day 60 following the second dose, vaccine effectiveness was *negative*, meaning a vaccinated person was *more likely* to be infected than an unvaccinated person:

Table 2. Vaccine effectiveness against infection by Omicron or Delta among adults aged ≥18 years by time since latest dose

Doses	Vaccine products	Days since latest dose	SARS-CoV-2 negative controls, n	Omicron-positive cases, n	Vaccine effectiveness against Omicron (95% CI)	Delta-positive cases, n	Vaccine effectiveness against Delta (95% CI)
First 2 doses	≥1 mRNA vaccine	7-59	14,288	63	6 (-25, 30)	204	84 (81, 86)
		60-119	34,741	214	-13 (-38, 8)	562	81 (79, 82)
		120-179	282,977	2,257	-38 (-61, -18)	4,342	80 (79, 81)
		180-239	47,282	522	-42 (-69, -19)	635	74 (72, 76)
		≥240	10,285	46	-16 (-62, 17)	203	71 (66, 75)
Third dose	Any mRNA vaccine	0-6	10,208	50	2 (-35, 29)	71	88 (85, 90)
		≥7	36,500	114	37 (19, 50)	138	93 (92, 94)
	BNT162b2	0-6	8,461	42	2 (-39, 30)	64	87 (83, 90)
		≥7	30,269	106	34 (16, 49)	116	93 (91, 94)
	mRNA-1273	0-6	1,747	8	5 (-94, 54)	7	93 (86, 97)
		≥7	6,231	8	59 (16, 80)	22	93 (90, 96)

59. In the United States, studies and data from last summer showing higher viral transmission in less vaccinated southern states is now completely obsolete. As the following CDC table demonstrates, in the Omicron wave there is no observable reduction in case rates based on vaccination rates:[51]

[51] https://data.cdc.gov/Case-Surveillance/United-States-COVID-19-Cases-and-Deaths-by-State-o/9mfq-cb36

Difference in Cases in the Month of December: Most Vaccinated States Compared to Least Vaccinated

State	Cases in December 2021	2020	Difference	Fully Vaccinated
Vermont	11,120	2,932	279%	77.4%
Rhode Island	34,434	32,625	6%	76.5%
Maine	25,029	12,225	105%	75.8%
Connecticut	80,792	68,413	18%	74.6%
Massachusetts	176,728	149,046	19%	74.6%
New York	645,476	332,116	94%	71.8%
New Jersey	242,649	160,001	52%	70.5%
Maryland	113,299	79,084	43%	70.4%
Virginia	129,377	114,703	13%	68.0%
Washington	67,731	76,819	-12%	67.9%
Dist. Columbia	25,133	7,431	238%	67.6%
New Hampshire	35,412	23,034	54%	67.2%
Oregon	27,234	38,478	-29%	66.5%
New Mexico	33,567	45,769	-27%	66.2%
Colorado	80,691	100,744	-20%	66.2%
California	308,923	1,018,584	-70%	66.1%
Minnesota	103,065	96,539	7%	65.4%
MOST VACCINATED STATES			45%	70.2%

State	Cases in December 2021	2020	Difference	Fully Vaccinated
Ohio	281,594	279,317	1%	55.2%
West Virginia	30,720	37,492	-18%	55.1%
Kentucky	66,912	88,994	-25%	54.2%
Montana	6,049	19,357	-69%	54.0%
Oklahoma	37,452	105,592	-65%	53.5%
South Carolina	47,894	97,200	-51%	53.1%
Missouri	88,356	111,450	-21%	53.0%
North Dakota	10,403	13,115	-21%	52.6%
Indiana	133,734	172,712	-23%	52.0%
Tennessee	82,063	211,266	-61%	51.4%
Arkansas	28,713	67,779	-58%	51.2%
Georgia	127,565	194,889	-35%	51.1%
Louisiana	45,334	82,861	-45%	50.3%
Mississippi	24,681	63,076	-61%	48.1%
Alabama	43,257	111,713	-61%	47.6%
Wyoming	4,153	11,104	-63%	47.5%
Idaho	11,613	39,379	-71%	46.2%
LEAST VACCINATED STATES			-44%	51.5%

60. The published evidence in the Omicron era comparing vaccine-mediated immunity and recovered immunity continues to find that recovered immunity provides good protection versus severe disease on subsequent infection.[52] A pre-print by the same team of Qatari researchers concludes that COVID recovered patients are very unlikely to cause severe disease or death at least 15 months after initial infection in data spanning the Omicron era.

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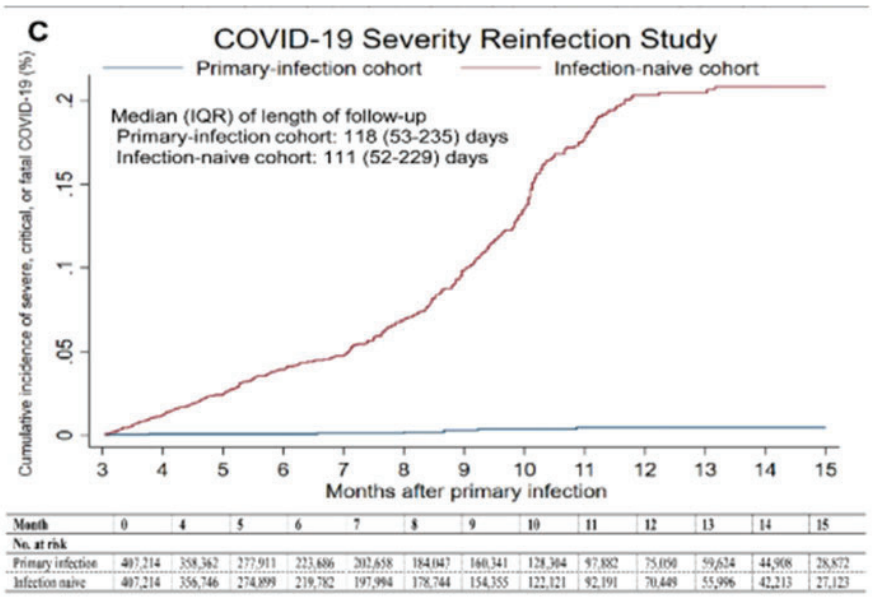
https://covid.cdc.gov/covid-data-tracker/COVIDData/getAjaxData?id=vaccination_data

[52] Altarawneh HN, Chemaitelly H, Ayoub HH, Tang P, Hasan MR, Yassine HM, Al-Khatib HA, Smatti MK, Coyle P, Al-Kanaani Z, Al-Kuwari E, Jeremijenko A, Kaleeckal AH, Latif AN, Shaik RM, Abdul-Rahim HF, Nasrallah GK, Al-Kuwari MG, Butt AA, Al-Romaihi HE, Al-Thani MH, Al-Khal A, Bertollini R, Abu-Raddad LJ. Effects of Previous Infection and Vaccination on Symptomatic Omicron Infections. N Engl J Med. 2022 Jul 7;387(1):21-34. doi: 10.1056/NEJMoa2203965. Epub 2022 Jun 15. PMID: 35704396; PMCID: PMC9258753.

The graph below, reproduced from that paper compares the cumulative incidence of severe reinfection in the study of people who had never had COVID versus those with recovered immunity. At 15 months, the likelihood of severe reinfection for the COVID-recovered group was near zero, while those in the "infection-naïve" cohort was 0.2% of the population.[53]



[53] Chemaitelly H et al. (2022) Duration of immune protection of SARS-CoV-2 natural infection
against reinfection in Qatar. *medRxiv*. July 7, 2022. https://www.medrxiv.org/content/10.1101/2022.07.06.22277306v1.full.pdf

V. Conclusion

61. Based on the scientific evidence to date, for most of the population, COVID-19 infection poses less of a mortality risk than seasonal influenza.

62. Based on the scientific evidence to date, vaccines effectively protect against infection (and therefore disease spread) for only a short period of time.

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

64. Based on my analysis of the existing medical and scientific literature, any policy regarding vaccination that does not

recognize recovered immunity is irrational, arbitrary, and counterproductive to community health.[54]

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

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

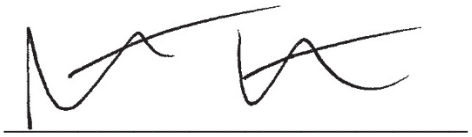
66. Since a large fraction of the unvaccinated population of health care staff are COVID recovered and hence pose little to no more risk of transmission of the virus than vaccinated workers, mandatory healthcare staff vaccination, or proof of immunity, does not have an appreciable effect on COVID-19 transmission within the healthcare setting.

67. Substantial new factual developments related to the Omicron variant substantially undermines any possible justification for the vaccine mandates. Even if SARS-CoV-2 did present a grave danger justifying the mandates at the time they were announced — a highly controversial assertion in its own right — at this time, the Omicron virus that presently dominates the field does not even arguably present a grave danger. Nor could its transmission be substantially reduced through mandatory vaccination even if it did present a grave danger.

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

Executed this 15th day of July, 2022, at Stanford, California.

Respectfully submitted,



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RESEARCH INTERESTS

Health economics, health policy, and outcomes research

A. ACADEMIC HISTORY:

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

B. EMPLOYMENT HISTORY:

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

C. SCHOLARLY PUBLICATIONS:

PEER-REVIEWED ARTICLES (161 total)

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8. **Bhattacharya J** and Richmond P "On Work and Health Among the American Poor" in Pathways to Self-Sufficiency: Getting Ahead in an Era Beyond Welfare Reform John Karl Scholz and Carolyn Heinrich (eds), New York, NY, Russell Sage Foundation (2009).
9. **Bhattacharya J**, Garber A, MaCurdy T "The Narrowing Dispersion of Medicare Expenditures 1997-2005" in Research Findings in the Economics of Aging, D. Wise (ed.), Chicago, IL, University of Chicago Press (2010)
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15. MaCurdy T and **Bhattacharya J** "Challenges in Controlling Medicare Spending: Treating Highly Complex Patients" in Insights in the Economics of Aging, David Wise (ed.) Chicago, IL, University of Chicago Press (2015).

ABSTRACTS (3)

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2. Nguyen C, Hernandez-Boussard T., Davies S, **Bhattacharya J**, Khosla R, Curtin C. *Cleft Palate Surgery: Variables of Quality and Patient Safety*. Presented at the 69th Annual American Cleft-Palate Craniofacial Association (2012). [abstract]
3. Patel MI, Ramirez D, Agajanian R, Bhattacharya J, Milstein A, Bundorf MK. "The effect of a lay health worker-led symptom assessment intervention for patients on patient-reported outcomes, healthcare use, and total costs." Journal of Clinical Oncology 36(15 Suppl):6502 [abstract]

D. PUBLIC AND PROFESSIONAL SERVICE:

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

SERVICE ON SCIENTIFIC REVIEW AND ADVISORY COMMITTEES (Selected)

- Standing member of the Health Services Organization and Delivery (HSOD) NIH review panel, 2012-2016
- NIH reviewer (various panels, too numerous to list) 2003-present
- NIH Review Panel Chair: 2018 (P01 review), 2020 (DP1 review).
- Invited Reviewer for the European Research Council, ERC Advanced Grant 2015 RFP
- NIH Stage 2 Challenge Grant Review Panel, July 2009
- Appointed a member of an Institute of Medicine (IOM) panel on the regulation of work hours by resident physicians, 2007-8.
- Standing member of the NIH Social Science and Population Studies Review Panel, Fall 2004-Fall 2008
- Invited Reviewer for National Academy of Sciences report on Food Insecurity and Hunger, November 2005.

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

TESTIMONY TO GOVERNMENTAL PANELS AND AGENCIES (9)

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

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

REFEREE FOR RESEARCH JOURNALS

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

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

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

Dissertation Committee Memberships

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

E. GRANTS AND PATENTS

PATENT (2)

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

GRANTS AND SUBCONTRACTS (42)

CURRENT (6)

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

PREVIOUS (36)

2016-2018	Funder: University of Kentucky Title: Food acquisition and health outcomes among new SNAP recipients since the Great Recession Role: PI

2015-2019	Funder: Alfred P. Sloan Foundation Title: Public versus Private Provision of Health Insurance Role: PI
2015-2019	Funder: Natural Science Foundation Title: Health Insurance Competition and Healthcare Costs Role: Investigator (PI: Levin)
2014-2015	Funder: The Centers for Medicare and Medicaid Services Title: Effect of Social Isolation and Loneliness on Healthcare Utilization Role: PI
2014-2015	Funder: AARP Title: The Effect of Social Isolation and Loneliness on Healthcare Utilization and Spending among Medicare Beneficiaries Role: PI
2013-2019	Funder: National Bureau of Economic Research Title: Innovations in an Aging Society Role: PI
2013-2014	Funder: Robert Wood Johnson Foundation Title: Improving Health eating among Children through Changes in Supplemental Nutrition Assistance Program (SNAP) Role: Investigator (PI: Basu)
2011-2016	Funder: National Institutes of Health (R37) Title: Estimating the Potential Medicare Savings from Comparative Effectiveness Research Role: PI Subaward (PI: Garber)
2011-2016	Funder: National Institute of Aging (P01) Title: Improving Health and Health Care for Minority and Aging Populations Role: PI Subcontract (PI: Wise)

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

	Title: The HIV Epidemic in Africa and the Orphaned Elderly Role: PI
2007	Funder: University of Southern California Title: The Changes in Health Care Financing and Organization Initiative Role: PI
2006-2010	Funder: National Institute of Aging (K02) Title: Health Insurance Provision for Vulnerable Populations Role: PI
2006-2010	Funder: Columbia University/Yale University Title: Dummy Endogenous Variables in Threshold Crossing Models, with Applications to Health Economics Role: PI
2006-2007	Funder: Stanford Center for Demography and Economics of Health and Aging Title: Obesity, Wages, and Health Insurance Role: PI
2005-2009	Funder: National Institute of Aging (P01 Subproject) Title: Medical Care for the Disabled Elderly Role: Investigator (PI: Garber)
2005-2008	Funder: National Institute of Aging (R01) Title: Whom Does Medicare Benefit? Role: PI Subcontract (PI: Lakdawalla)
2002	Funder: Stanford Center for Demography and Economics of Health and Aging Title: Explaining Changes in Disability Prevalence Among Younger and Older American Populations Role: PI
2001-2003	Funder: Agency for Healthcare Research and Quality (R01) Title: State and Federal Policy and Outcomes for HIV+ Adults Role: PI Subcontract (PI: Goldman)
2001-2002	Funder: National Institute of Aging (R03) Title: The Economics of Viatical Settlements Role: PI
2001-2002	Funder: Robert Woods Johnson Foundation Title: The Effects of Medicare Eligibility on Participation in Social Security Disability Insurance Role: PI Subcontract (PI: Schoenbaum)
2001-2002	Funder: USDA Title: Evaluating the Impact of School Breakfast and Lunch Role: Investigator
2001-2002	Funder: Northwestern/Univ. of Chicago Joint Center on Poverty Title: The Allocation of Nutrition with Poor American Families Role: PI Subcontract (PI: Haider)
2000-2002	Funder: National Institute on Alcohol Abuse & Alcoholism (R03) Title: The Demand for Alcohol Treatment Services Role: PI

2000-2001 Funder: USDA
Title: How Should We Measure Hunger?
Role: PI Subcontract (PI: Haider)

F. SCHOLARSHIPS AND HONORS

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

G. LIST OF CASES IN WHICH I PREVIOUSLY OFFERED EXPERT WITNESS TESTIMONY

- *R.K., et al. v. Lee*, No. 3:21-cv-00725 (M.D. Tenn. 2021)
- *SID BOYS CORP. d/b/a Kellogg's Diner, and 143 Cafe Inc. d/b/a Toscana v. Cuomo, et al.*, No. 1:20-cv-6249 (E.D.N.Y. 2020)
- *Tandon v. Newsom*, No. 5:20-cv-07108-LHK (N.D.Cal. 2020)
- *Kane v. De Blasio,* No. 21-CV-7863 (VEC), 2021 U.S. Dist. LEXIS 239124 (S.D.N.Y. Dec. 2021)
- *Netzer Law Office, P.C. and Donald L. Netzer v. Montana*, DV-2021-089 (Mont. Seventh Jud. Dist. 2021).
- *UnifySCC v. Cody*, No. 22-cv-01019-BLF, 2022 U.S. Dist. LEXIS 116386 (N.D. Cal. June 30, 2022)
- *Calvary Chapel of Ukiah v. Newsom*, 524 F. Supp. 3d 986, 1000 (E.D. Cal. 2021)
- *Gateway City Church v. Newsom*, 516 F. Supp. 3d 1004, 1020 (N.D. Cal. 2021)
- *Brach v. Newsom*, No. 2:20-cv-06472-SVW-AFM, 2020 U.S. Dist. LEXIS 232008 (C.D. Cal. 2020)
- *S. Bay United Pentecostal Church v. Newsom*, 494 F. Supp. 3d 785 (S.D. Cal. 2020)
- *Hernandez v. Grisham*, 494 F. Supp. 3d 1044 (D.N.M. 2020)
- *DeSantis v. Fla. Educ. Ass'n,* 306 So. 3d 1202 (Fla. Dist. Ct. App. 2020)
- *Cty. of L.A. Dep't of Pub. Health v. Superior Court,* 61 Cal. App. 5th 478, 275 Cal. Rptr. 3d 752 (2021) and *California Restaurant Association, Inc. v. County of Los Angeles Department of Public Health*, No. 20STCP03881 (Cal.Super. 2020)
- *Cross Culture Christian Ctr. v. Newsom*, 445 F. Supp. 3d 758, 763 (E.D. Cal. 2020)

DATED this 15th day of July, 2022.

Austin Knudsen
Montana Attorney General

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CERTIFICATE OF SERVICE

I certify a true and correct copy of the foregoing was delivered by email to the following:

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Dia C. Lang

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Attorneys for Defendants

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MONTANA, MISSOULA DIVISION

MONTANA MEDICAL ASSOCIATION, ET. AL.,

Plaintiffs,

and

MONTANA NURSES ASSOCIATION,

Plaintiff-Intervenors,

v.

AUSTIN KNUDSEN, ET AL.,

DEFENDANTS.

No. CV-21-108-M-DWM

EXPERT REPORT OF RAM DURISETI MD, PHD

Expert Report of Ram Duriseti MD, PhD

July 15th, 2022

I, Ram Duriseti, MD, PhD, declare as follows:

I am a clinical associate professor at the Stanford Emergency Department. I have been a practicing Board Certified Emergency Physician for over 20 years. My PhD background is in computational decision modeling, simulation, and optimization algorithms. I have personal knowledge of the facts set forth below and could testify competently to them if called to do so. A true and correct copy of my *curriculum vitae* is attached to this declaration.

I am being compensated $300.00 per hour for my effort in this case. My compensation is in no way contingent upon my conclusions in this case.

COVID-19 is the disease caused by infection with the SARS-CoV-2 virus. The current generation of COVID-19 vaccines do not significantly limit transmission. Transmission of an infectious disease is both a function of behavior and presence of infection. A vaccine mandate with

the purpose of limiting transmission must not simply decrease the risk of infection, but must do so by a substantial margin.

We must first acknowledge, using the Pfizer COVID-19 mRNA vaccine as a canonical example, that the vaccine trials were never designed to test for preventing transmission. Pfizer themselves pointed this out to the FDA.[1] The "data gaps" identified by Pfizer were:

- Duration of protection
- Effectiveness in certain populations at high risk of severe COVID-19
- Effectiveness in individuals previously infected with SARS-CoV-2
- Future vaccine effectiveness as influenced by characteristics of the pandemic, changes in the virus, and/or potential effects of co-infections
- Vaccine effectiveness against asymptomatic infection
- Vaccine effectiveness against long-term effects of COVID-19 disease

[1] https://www.fda.gov/media/148542/download#page=38

- Vaccine effectiveness against mortality
- Vaccine effectiveness against transmission of SARS-CoV-2

It's important to remember that the original Pfizer trial supporting its FDA approval was never structured to test for transmission reduction and this is part of the record in the Emergency Use Authorization (EUA) review. As noted by Dr. Patrick Moore of the University of Pittsburgh Cancer Institute,

> "One question that addresses these two discussion items, I find is really, really central, and important, is that FDA did not ask in its guidance and Pfizer has presented no evidence in its data today that the vaccine has any effect on virus carriage or shedding, which is the fundamental basis for herd immunity (page 342 of transcription)." [2]

While many COVID-19 immune naïve individuals (no prior infection by SARS-CoV-2 which is the virus that causes COVID-19) likely benefitted from having their immune systems primed by a vaccine prior to a subsequent infection thereby increasing their protection from more severe disease progression, any imputed impact on disease transmission has been fleeting at best.

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[2] https://www.fda.gov/media/144859/download

As early as Summer 2021, emerging data suggested that vaccinated individuals' net reduction in "viral load" during an infection was no more than 30%.[3] Since that time, between waning efficacy and partial "immune escape" from SARS-CoV-2 variants, it's become clear that even that degree of reduction is not sustained. In a more recent study, researchers used longitudinal sampling of nasal swabs for determination of viral load, sequencing, and viral culture in outpatients with newly diagnosed coronavirus disease 2019 (Covid-19). From July 2021 through January 2022 and concluded that, "we did not find large differences in the median duration of viral shedding among participants who were unvaccinated, those who were vaccinated but not boosted, and those who were vaccinated and boosted".[4]

When discussing the topic of transmission in a health care setting and staff vaccination rates, a July 2021 paper examined infection rates among different vaccinated patient cohorts in a nursing home at different levels of staff vaccination. The most telling table was in the supplement.

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[3] https://www.medrxiv.org/content/10.1101/2021.08.20.21262158v1.full-text

[4] https://www.nejm.org/doi/full/10.1056/NEJMc2202092

In table S3, there was no association between staff vaccination rates and transmission to residents regardless of the residents' vaccination status.[5] As this study was pre-Delta and pre-Omicron, given increased escape from vaccine induced immunity with both Delta and Omicron variants, there is no reason to believe that this trend would not hold.

NURSING HOME VACCINATIONS 8

Table S3. Incident SARS-CoV-2 infections in residents living in nursing homes with low, moderate, and high staff vaccination rates

	Low staff vaccination (Less than 58.7% of staff vaccinated)		Moderate staff vaccination (58.7 - 69.2% of staff vaccinated)		High staff vaccination (69.3 - 95.7% of staff vaccinated)	
	Total	Percent (%) asymptomatic	Total	Percent (%) asymptomatic	Total	Percent (%) asymptomatic
Residents vaccinated with at least dose 1, n	5691		6291		6260	
Tested positive 0-14 days after dose 1, n(%)	266 (4.7%)	71.1%	267 (4.2%)	74.2%	289 (4.6%)	69.2%
Tested positive 15-28 days after dose 1, n(%)	83 (1.5%)	75.9%	50 (0.8%)	62.0%	117 (1.9%)	72.6%
Residents vaccinated with doses 1 & 2, n	4001		4579		4468	
Tested positive 0-14 days after dose 2, n(%)	46 (1.1%)	80.4%	32 (0.7%)	87.5%	52 (1.2%)	86.5%
Tested positive >14 days after dose 2, n(%)	18 (0.4%)	72.2%	8 (0.2%)	75.0%	12 (0.3%)	83.3%
Unvaccinated residents	1629		1296		1065	
Tested positive 0-14 days after clinic 1 held, n(%)	73 (4.5%)	65.8%	65 (5.0%)	66.2%	35 (3.3%)	68.6%
Tested positive 15-28 days after clinic 1 held, n(%)	31 (1.9%)	64.5%	15 (1.2%)	46.7%	23 (2.2%)	65.2%
Tested positive 29-42 days after clinic 1 held, n(%)	6 (0.4%)	83.3%	4 (0.3%)	75.0%	6 (0.6%)	83.3%
Tested positive >42 days after clinic 1 held, n(%)	6 (0.4%)	83.3%	3 (0.2%)	66.7%	3 (0.3%)	100.0%

Notes. Nursing homes stratified by tertiles of staff vaccination rates as of February 17, 2021. Staff vaccinations occurred simultaneously with resident vaccinations and rates were tracked by the organization.

What about transmission and vaccination/booster status with Omicron? An early December 2021 paper in Danish Households demonstrated a roughly 40% reduction in household secondary attack rate (SAR) with boosting when compared to the unvaccinated or

5 https://www.nejm.org/doi/suppl/10.1056/NEJMc2104849/suppl_file/nejmc2104849_appendix.pdf

vaccinated.[6] Most importantly, there was no such reduction in susceptibility to infection when comparing vaccinated alone compared to the vaccinated. Focusing on table 2, during the early December 2021 study period, booster vaccination cut the risk of contracting Omicron by roughly 45%+ and passing on Omicron by roughly 40%.[5] While this appeared promising for boosters, the subsequent ecological waves from late December 2022 forward in heavily boosted countries previously lauded for the "COVID success" demonstrated otherwise. Denmark, Iceland, Norway, New Zealand, Australia, Hong Kong, South Korea all experienced per-capital COVID waves larger than any experienced by the United States.[7] So the advantage of boosting, while demonstrable in an 8-week time frame, appears to rapidly devolve over time.

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6 https://www.medrxiv.org/content/10.1101/2021.12.27.21268278v1.full.pdf

7 https://ourworldindata.org/explorers/coronavirus-data-explorer?zoomToSelection=true&time=2020-03-01..latest&facet=none&pickerSort=asc&pickerMetric=location&Metric=Confirmed+cases&Interval=7-day+rolling+average&Relative+to+Population=true&Color+by+test+positivity=false&country=USA~ISL~DNK~NOR~KOR~NZL~AU

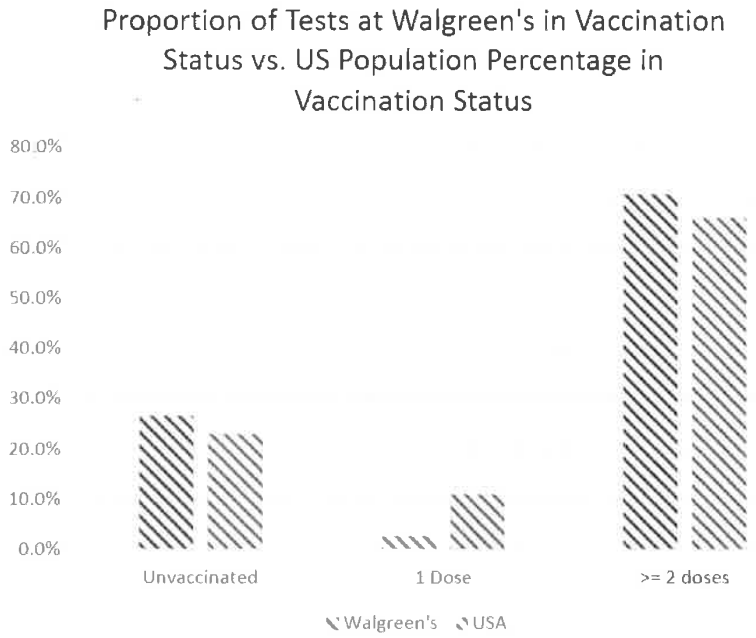
Indeed, we are seeing this effect even more so now across multiple data sets: both national and local.

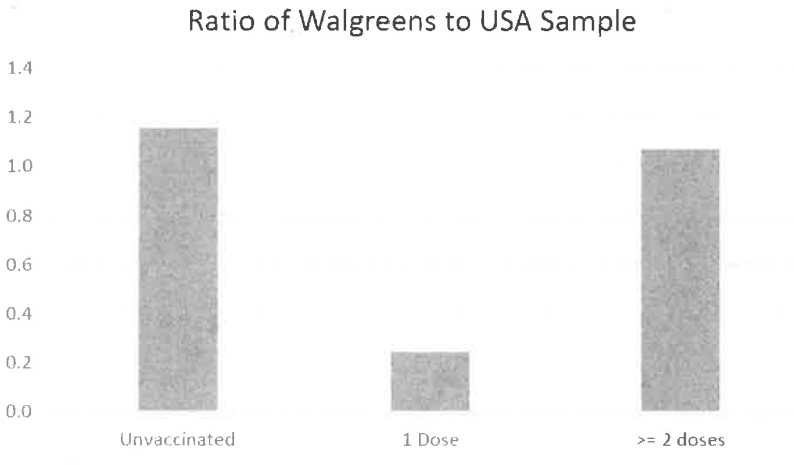
Walgreens is a leading nationwide provider of COVID vaccination and testing provider. They maintain a remarkable COVID dashboard that details test positivity by vaccination status broken down by age cohort.[8] Correcting for vaccination rates and population representation. The data show that vaccinated and boosted individuals are testing positive for COVID-19 at a higher rate than unvaccinated individuals. While there is a chance this reflects the fact that unvaccinated individuals are more likely to have had protection from a prior infection and more likely required to obtain surveillance testing, this does not impact our discussion here as the vast majority of Americans, vaccinated or not, have had a COVID-19 infection (approximately 75% through February 2022 alone).[9]

The Walgreen's data is not excessively sampling vaccinated patients. In fact, the population tested by Walgreens has a small number of single-dose vaccinated than the USA population, with higher

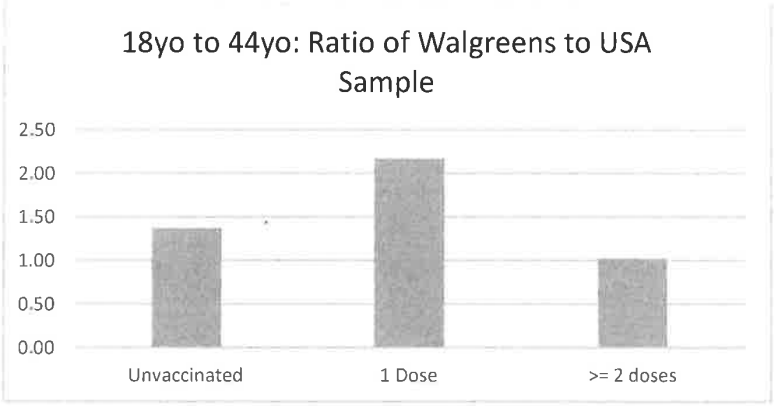
[8] https://www.walgreens.com/businesssolutions/covid-19-index.jsp
[9] https://covid19serohub.nih.gov/

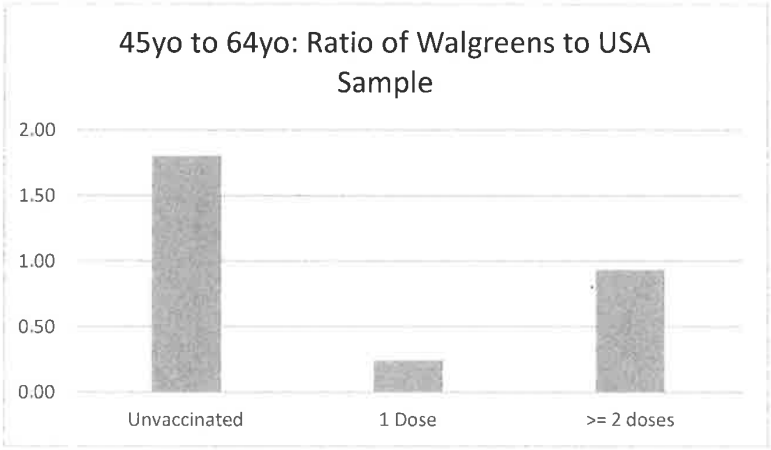
proportions of vaccinated and unvaccinated patients – particularly the unvaccinated.

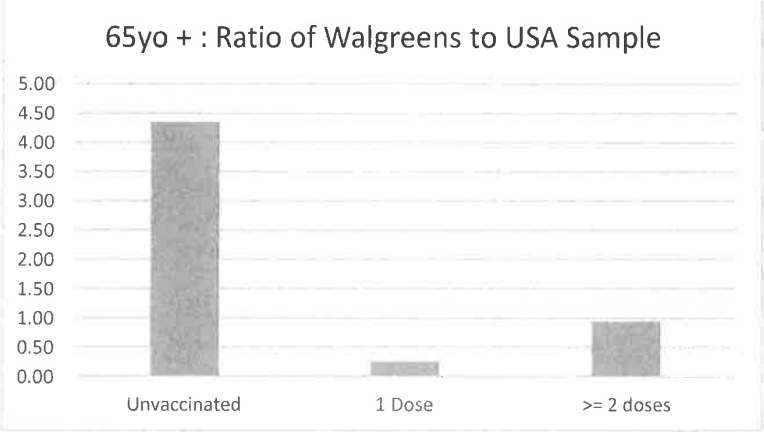




In fact, in the over 18-year-old age cohorts, Walgreen's tests unvaccinated patients at significantly higher rate than their representation in the USA population:

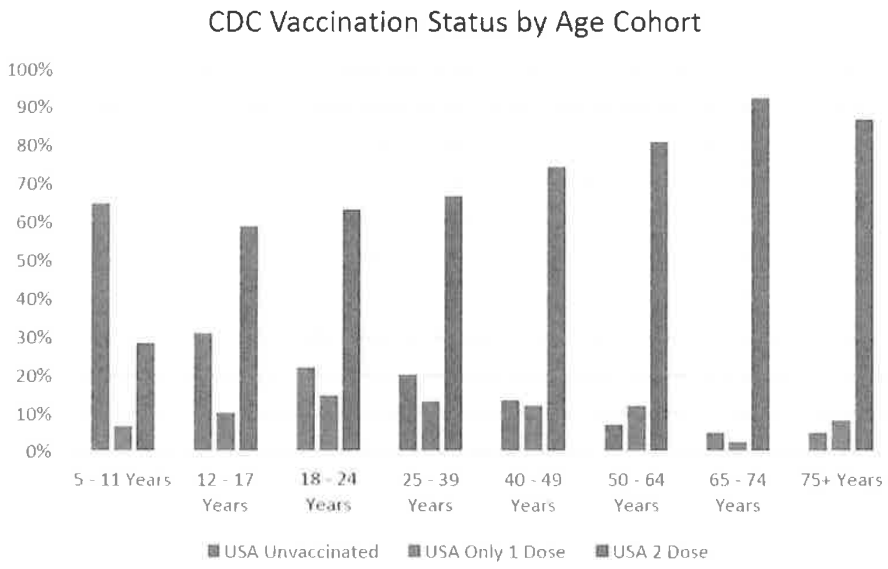




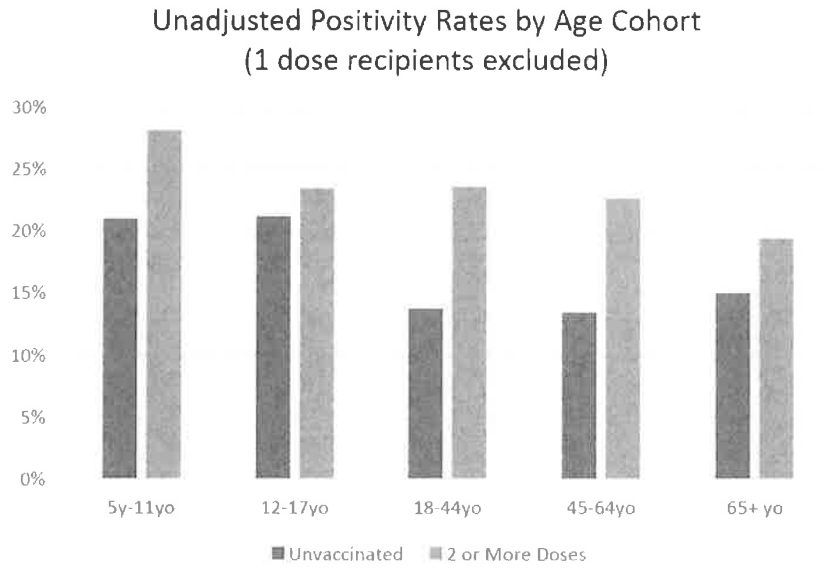


When collecting Walgreens data for a testing week April 28th, 2022, for every age cohort, vaccinated individuals are testing positive at a *higher rate*. It's important to understand that these are rates so there is no "base rate fallacy". In other words, just because vaccinated individuals are a larger percentage of the population, they will not register a higher rate of positivity.

CDC data by dose per age cohort through April 2022:

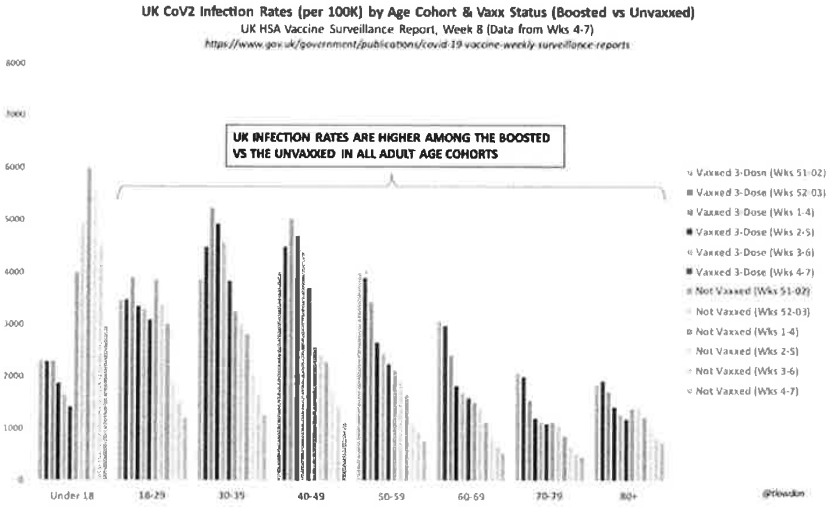


Consolidating fully vaccinated and boosted individuals into a "2 or more doses" category to correspond to the CDC data above, we see the following across all age cohorts from Walgreens:

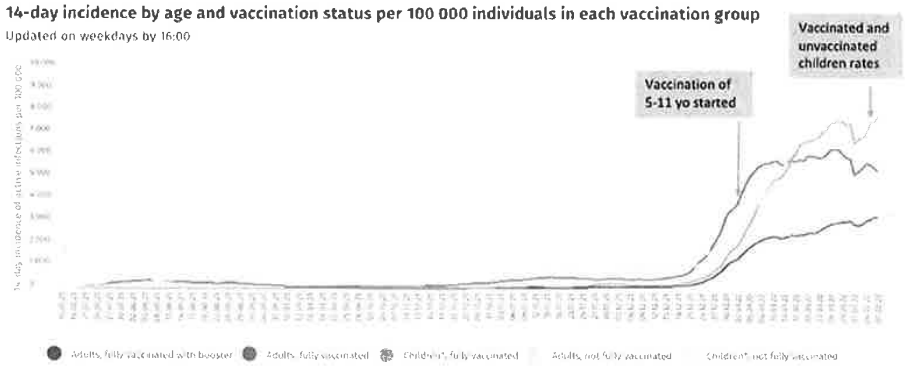


These high positivity rates in vaccinated individuals are duplicated across multiple countries.

The United Kingdom[10]:



Iceland:



[10] https://www.gov.uk/government/publications/covid-19-vaccine-weekly-surveillance-reports

And the high infection rates in vaccinated, and even near universally boosted populations is evident in multiple local data sets such as the University of California campuses.

The University of California at Irvine:[11]

Daily snapshot: 5/27/2022 6:04:04 AM

Positive cases reported yesterday

57

All Students: 53
Students in Campus Housing 36
Students not in Campus Housing 17
Staff and Faculty/Academics: 4

Cumulative positive cases

5,426

All Students: 4,563
Students in Campus Housing: 2,336
Students not in Campus Housing: 2,227
Staff and Faculty/Academics: 863

Total number of people testing positive starting September 5, 2021

Active positive cases

429

All Students: 390
Students in Campus Housing 256
Students not in Campus Housing 134
Staff and Faculty/Academics: 39

Those who are currently recuperating

Cumulative recovered cases

4,997

All Students: 4,173
Students in Campus Housing: 2,080
Students not in Campus Housing: 2,093
Staff and Faculty/Academics: 824

Those cleared to return to normal daily activity

Isolation and quarantine beds available

257

Out of 362 total beds

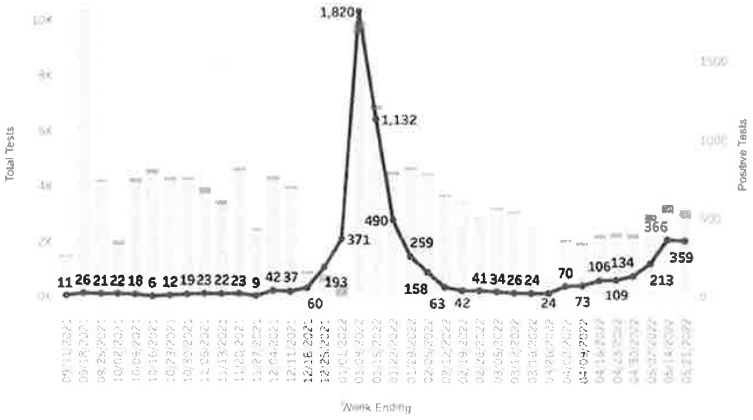
Vaccination and Booster Data

	% Vaccinated	% Boosted*	Total Vaccinated	Total Population
All Students	98%	97%	33,711	34,484
Students in Campus Housing	99%		14,074	14,214
Students not in Campus Housing	97%		19,637	20,270
Staff and Faculty/Academics	95%	99%	6,683	7,007

* % boosted is a subset of total vaccinated who are eligible to be boosted

Symptomatic and asymptomatic testing

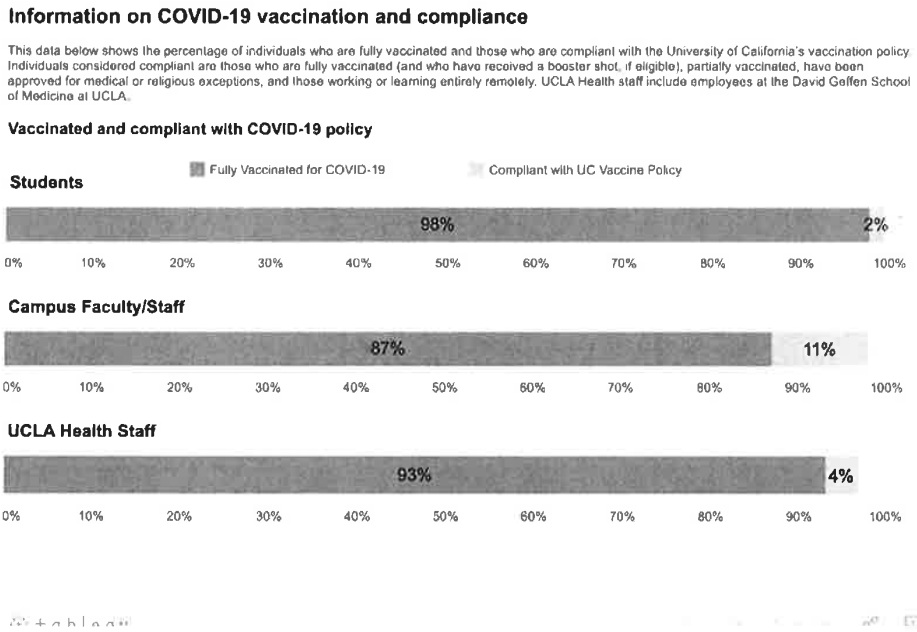
Testing since September 5, 2021. The following chart combines asymptomatic and symptomatic results.



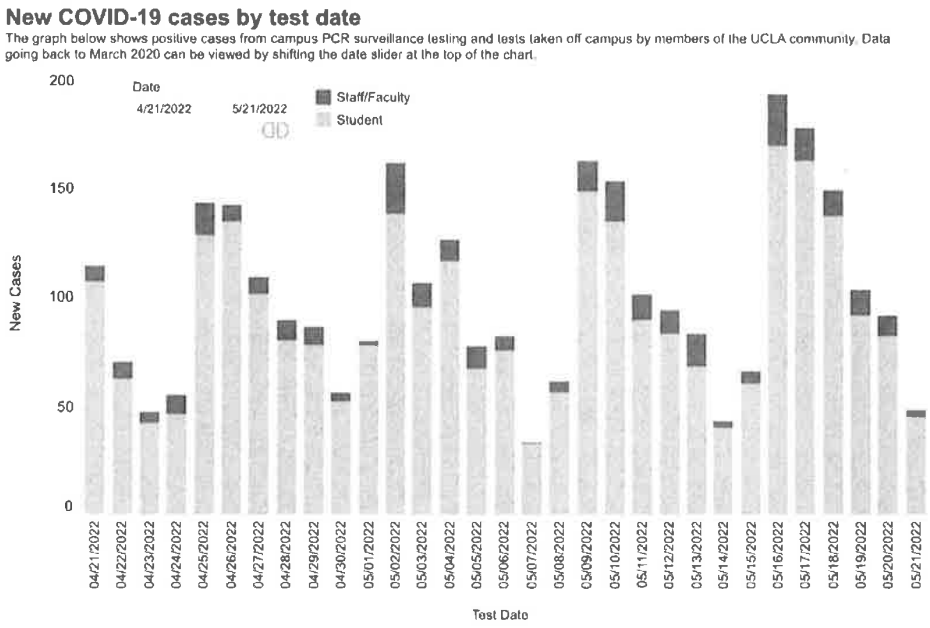
[11] https://uci.edu/coronavirus/dashboard/index.php

Exhibit 5 - 16

University of California at Los Angeles:[12]



[12] https://covid-19.ucla.edu/confirmed-cases-of-covid-19-among-the-ucla-campus-community/



Coming back to Danish research on transmission with the BA.2 Omicron variant (dominant now) versus the BA.1 Omicron variant (dominant through the winter of 2021-22), they noted:[13]

> Both unvaccinated, fully vaccinated and booster-vaccinated individuals had a higher susceptibility for BA.2 compared to BA.1, indicating an inherent increased transmissibility of BA.2 (Table 3). However, the relative increase in susceptibility was significantly greater in vaccinated individuals compared to unvaccinated individuals (appendix Figure 6, which points towards immune evasive properties of the BA.2 conferring an even greater advantage for BA.2 in a highly vaccinated population such as Denmark. Because previous studies of the Omicron VOC has focused on the BA.1 (Pearson et al., 2021; Planas et al., 2021), new studies are needed to further investigate these properties for BA.2.

[13] https://www.medrxiv.org/content/10.1101/2022.01.28.22270044v1

Vaccine mandates for COVID-19 vaccines were an ill-conceived policy more than a year ago. As noted by Dr. Patrick Moore during the original Pfizer FDA review meeting, "FDA did not ask in its guidance and Pfizer has presented no evidence in its data today that the vaccine has any effect on virus carriage or shedding" (page 342 of the transcript).[14]

Having said the above, it is well past time to reconsider our approach to COVID-19 especially as it pertains to COVID-19 vaccine mandates even if one truly believes that *any* reduction in transmission is demonstrable. When considering the susceptibility of the general population to COVID-19 in May of 2022, at least 97% of Americans are no longer immune-naïve to SARS-CoV-2 through either vaccination, infection, or hybrid immunity.[15] As noted by FDA voting member Dr. Paul Offitt, it is clear that neither vaccination or mass testing will stop COVID-19, but both vaccination and prior infection will confer resistance to severe disease.[16] This "herd resistance to severe disease " will not confer iron-clad protection from an "infection" moving forward, but it's

[14] https://www.fda.gov/media/144859/download (page 342)
[15] https://covid19serohub.nih.gov/
[16] https://www.inquirer.com/health/expert-opinions/covid-19-pandemic-immunity-boosters-normal-20220304.html?

main value will be protection from severe disease and there is historical precedent for this belief.[17] By July 13th, 2022, with likely well over 97% of Americans (was 97% through February 18th, 2022) falling into a category of prior vaccination and/or prior infection, as a population, we have achieved as much meaningful population level protection as is possible. Moving forward, every individual, based upon their individual age, metabolic risks, immune status, and personal preferences, will have to decide how best to proceed with future vaccine doses or therapeutics.[18]

Influenza

This brings us full circle to Influenza as the parallels are dramatic. Both are RNA viruses of roughly the same size, both are transmitted by droplets and aerosols, and the impacts of vaccination are quite similar. COVID-19 has followed the path of Influenza: now, as with influenza, cases of COVID-19 will continue to appear, but the number and severity of those infections will be significantly reduced even while neither vaccination or prior infection represents an impenetrable shield to

[17] https://www.eurekalert.org/news-releases/694958
[18] https://www.nature.com/articles/s41574-021-00608-9

subsequent infection.[19,20] In fact, a 2018 study positively correlated amount of virus in exhaled breath with vaccination status thereby suggesting that in the study population, those vaccinated with the Influenza vaccine were spreading more viral particles.[21] It is well established that the benefits of Influenza vaccination extend to the individual receiving the vaccination which is traditionally why Influenza vaccination in health care settings has been recommended and not mandated (until recently at some institutions). Indeed, a 2017 study established that patient benefit from healthcare worker was not established:

> "The impression that unvaccinated HCWs place their patients at great influenza peril is exaggerated. Instead, the HCW-attributable risk and vaccine-preventable fraction both remain unknown and the NNV to achieve patient benefit still requires better understanding. Although current scientific data are inadequate to support the ethical implementation of enforced HCW influenza vaccination, they do not refute approaches to support voluntary vaccination or other more broadly protective practices, such as staying home or masking when acutely ill." [22]

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[19] https://www.eurekalert.org/news-releases/694958
[20] https://www.thelancet.com/journals/lanmic/article/PIIS2666-5247(21)00180-4/fulltext
[21] https://www.pnas.org/doi/10.1073/pnas.1716561115
[22] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0163586

This has led Dr. Michael Osterholm, formerly a member of the Biden Administration's COVID Task Force to state:

> "We have to make public health recommendations based on good science," Osterholm added, "but we do not have the justification to take punitive action against healthcare workers if they don't get vaccinated [for Influenza]." [23]

"Sterilizing Vaccines" and Mandates

When we refer to "sterilizing vaccines", we are referring to vaccines that confer both protection from infection thereby effectively eliminating infection risk as well as providing protection from severe illness. Traditionally, as canonical examples of "sterilizing vaccines", we consider the Measles/Mumps/Rubella (MMR) vaccine as it pertains to Measles and the Hepatitis B vaccine. Measles, like Influenza and SARS-CoV-2 (the virus that causes COVID-19) are respiratory viruses. Measles transmission while through droplets and aerosols, is more droplet mediated than with COVID-19 or Influenza, and yet remains highly contagious. In the case of Measles and Hepatitis B, there is a major component of the infection that is bloodborne (unlike SARS-CoV-2 or

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[23] https://www.cidrap.umn.edu/news-perspective/2017/01/health-worker-flu-vaccine-data-insufficient-show-protection-patients

Influenza) such that blood-borne vaccine or infection induced antibodies can perform a pivotal role in preventing infection. But even in the context of Measles and Hepatitis B vaccines, "sterilizing" is a relative term.

Numerous studies have shown that those vaccinated against Measles can develop infections, even as the primary value remains protection from severe illness. In a recent 2018 study of an outbreak in a French Psychiatric ward, 14% of fully vaccinated index cases from a primary unvaccinated case developed Measles. 2 of the cases had 2 Measles vaccinations and one even had vaccination with a prior infection in the preceding 6 years.[24] A less contained outbreak in New York was traced to a vaccinated index case.[25]

All of this said, an outbreak of Measles in the Marshall Islands demonstrated that non-vaccine eligible infants were more likely to be infected as secondary contacts than adults (46% versus 13%).[26] In this outbreak, the largest in the United States or associated area in more than a decade, 41% of cases were reported to have been previously vaccinated.

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[24]https://journals.lww.com/pidj/FullText/2019/09000/Measles_Transmission_in_a_Fully_Vaccinated_Closed.27.aspx

[25] https://academic.oup.com/cid/article/58/9/1205/2895266

[26] https://pubmed.ncbi.nlm.nih.gov/16392073/

Given that Measles vaccine is not recommended under 12 months of age, the biggest lesson of the Marshall Islands outbreak was the susceptibility of vulnerable non-vaccine eligible populations. It is thought that 90% vaccine coverage is required for the prevention of such outbreaks.

In the case of Hepatitis B, transmission is through body fluid contact. Vaccination, or infection, followed by documented threshold antibody levels is highly effective in preventing infection and transmission. Once again, "sterilizing immunity" in this context remains "relative" with documented Hepatitis B cases in previously vaccinated individuals. In one study, roughly 10% of previously vaccinated individuals with no evidence of prior infection had detectable Hepatitis B virus through DNA-testing suggesting evidence of an undetected "breakthrough" infection.[27] Once again, as with protection from a Measles vaccination, the benefit accrued to the vaccinated individual is substantial. In East Asian countries, Hepatitis B is endemic (spreads at baseline through the population). With the advent of universal Hepatitis B vaccination of newborns in Taiwan, the infant mortality rate from

[27] https://journals.lww.com/md-journal/fulltext/2016/12060/hepatitis_b_viremia_in_completely_immunized.92.aspx

hepatitis B dropped by 3-fold and severe hepatitis almost disappeared in older children.[28,29,30]

Summary

While we can establish significant distinctions between "sterilizing vaccines" and vaccines such as the ones for COVID-19 and Influenza, it remains the case that the main benefit of vaccination is accrued to the individual receiving the vaccination. For vaccines such as the COVID-19 and Influenza vaccines where there is minimal prevention of subsequent infection and transmission, it's extremely difficult to supplant individual bodily autonomy particularly at threat of unemployment or violation of one's religious beliefs.

However, for "sterilizing vaccines", even while they do not absolutely prevent subsequent infection, clearly demonstrated reduction in transmission with high community vaccination rates requires more consideration than one's personal autonomy. Specifically, nuance is required when considering populations that are at risk of disease, but are

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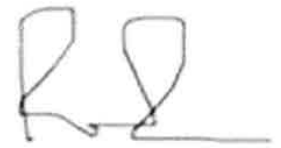
[28] https://pubmed.ncbi.nlm.nih.gov/11562612/
[29] https://pubmed.ncbi.nlm.nih.gov/14752823/
[30] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3630933/

not eligible, either through age or circumstance, to receive a particular "sterilizing vaccine". In these cases, caregivers who do not accept such "sterilizing vaccines" where said vaccination can markedly attenuate transmission when community vaccine coverage is more than 90%, may need to accept special precautions when caring for vulnerable populations. While one might argue that these precautions should be entertained regardless of vaccination status, community vaccination rates for such "sterilizing vaccines" will affect the risk of infection and transmission irrespective of any one individual's vaccination status. These special precautions may include, but are not limited to, use of fit-tested N95 masking, enhanced barrier precautions, and even surveillance testing.

I declare under penalty of perjury, under the laws of the State of Montana, that the foregoing is true and correct.



Ram Duriseti MD, PhD
July 15th, 2022

Ram Duriseti, M.D., Ph.D.
(650) 521-4517
ramduriseti@gmail.com

Educational Background:

Engineering:

- 9/01-5/07: Doctoral degree from the Stanford University School of Engineering with a concentration in Decision/Risk Analysis, Machine Learning, and Clinical Decision Support. Coursework included Decision and Risk Analysis, Probability and Statistical Inference, Bayesian Networks, Machine Learning, Computer Science, and Clinical Informatics. Funded through a VA Medical Informatics Fellowship.
  - Computing Background: C++, Java, Matlab, C, Ruby On Rails, Javascript and HTML with Ajax, Drools (JBoss Rules Engine), controlled medical terminology deployment (IMO services, SNOMED-CT, RxNorm, and other UMLS resources), Apelon server deployment, LISP, PostGreSQL, MySQL, JBoss application server, UNIX environment, Visual Basic (Excel Modules), Git, Subversion and Mercurial version control

Medical and Undergraduate:

- 11/97-11/2001: Residency training in Emergency Medicine at Stanford Medical Center.
- 5/96: M.D. with highest honors, University of Michigan Medical School
- 6/92: B.S. in Biololgy, and B.A in Political Economy, with distinction Stanford University.

Select Relevant Employment Experience:

11/00 – Present: Clinical Associate Professor, Stanford Emergency Department. Contacts: Dr. Bernard Dannenberg and Dr. Matthew Strehlow. Numbers available upon request.

3/01- Present: Mills Peninsula Emergency Medical Associates shareholder. President and CEO until 6/2017

6/08 – Present: Founder, CEO, and Product Engineer (principle algorithm and product design architect) for ShiftRx, L.L.C. ShiftRx provides the ShiftGen service that provides a cloud based enterprise workforce management tool. Key elements: machine learning algorithms, schedule optimization, workforce management, revenue cycle management with payroll integration, Java, Ruby on Rails, MySQL, SaaS on ec2.

10/08 – Present: Special consultant and subject matter expert to Sutter Health for Epic EHR implementation. Provided technical design for the billing extracts to migrate clinical information into a file sharing framework for billing companies supporting Sutter Emergency Medicine groups. Contacts: Multiple. Numbers available upon request.

4/15 – 3/2017: CEO and subsequently CTO and CMO of LifeQode Inc. which provides the Lifesquare product. Helped craft and secure 4 different patents, with continuations, around the central business processes for the product. Contacts: Larry Leisure and Steve Shulman. Numbers available upon request.

7/09 – 10/09: Technical consultant to Rise Health, Inc.. Contacts: Eric Langshur, Forrest Claypool, and Inder-Jeet Gujral. Numbers available upon request.

1/07 – 9/08: Chief Medical Officer and Director of Medical Informatics for Enfold, Inc. Responsibilities include design and implementation of intelligent medical functionality and a taxonomy engine as well as oversight of medical content driving the system. Implementation

EXHIBIT A

details: Java, Ruby on Rails, Drools, Apelon Server, Oracle 10g Database, MySQL. Contacts: Inder-jeet Gujral, Kimberly Higgins-Mays. Numbers are available upon request.
10/06 – 3/08: Medical Informatics Director Working Group Stanford University Hospitals and Clinics CIS Initiative. Particular emphasis on hand held technology integration into the Epic Initiative and organizing patient encounter level reportable data on clinical documentation events. Contacts: Kevin Tabb, President and CEO Beth Israel Deaconess Medical Center. Contact information is available upon request.
6/05 –12/06: Design and implementation of an attribute matching expert system in Java as a consultant to Wellnet Inc. Implemented in a Java environment with Hibernate DBMS and MySQL. Contacts: Kimberly Higgins-Mays. Number available upon request.

Select Research Experience:
7/11-Present: Design and implementation of a computational model for stochastic stimulation of the cost-effectiveness of various strategies to diagnose pediatric appendicitis (manuscript in progress).
10/05-Present: Design and implementation of an asymmetric cost Support Vector Machine to evaluate a large clinical database on chest pain patients presenting to the University of Pennsylvania Hospital Emergency Department (manuscript in progress).
09/02-9/04: Medical Informatics Fellow, Palo Alto Veteran's Administration Hospital.
04/03-Present: Development of Bayesian decision network for evaluation of the clinical utility of the quantitative Vidas ELISA Ddimer Assay. Published work listed.
02/04-Present: Bayesian decision network implementation modeling reasoning in the clinical domain of chest pain and associated pathology in the Emergency Department.
6/05-3/06: Using portable digital devices to generate a standard electronic medical record that can be downloaded directly to a relational database to facilitate data mining for prospective clinical research.
11/99 – 4/00: Retrospective chart review to examine the incidence of electrolyte and cardiac enzyme abnormalities in patients presenting to the Stanford Emergency Department with Supraventricular Tachycardia.

Select Administrative Experience:
6/09 – Present: CEO and Founder of ShiftRx, LLC
6/09 – Present: Regional Information Services Steering Committee for Sutter Health
6/08 – 6/18: President of CEO of Mills Peninsula Emergency Medical Associates
9/12 – 3/17: Acting CMO and CEO of Lifesquare, Inc.
6/07 – 9/08: Chief Medical Officer and Director of Medical Informatics at Enfold, Inc.
5/05-9/08: Member of Medical Informatics Director Working Group and RFP phase of evaluation for the Epic initiative at Stanford University Hospitals and Clinics
4/05-6/06: Served on the Mills-Peninsula Health Information Management and Medical Records Committee.

Current Volunteer Activities
3/22 – Present: Board of Director of Restore Childhood which is a non-profit focused on research initiatives quantifying risks to children in schools in the 'COVID Era". The goals are both legal and scientific. The scientific goal is to generate novel research and support mitigation measures that are both effective and maintain in person education.

EXHIBIT A

12/21 – Present: Co-author of Urgency of Normal. We are a group of physicians focused on collating and presenting data as it pertains to children and COVID. We help facilitate safe school openings.
Guest Lecturer at the Wharton School of Business (University of Pennsylvania) 2007/2008/2009 for health economics and information technology course

Select Honors and Distinctions:

- Guest Lecturer at the Wharton School of Business (University of Pennsylvania) 2007/2008/2009 for health economics and information technology course
- VA Medical Informatics Fellowship
- Alpha Omega Alpha Medical Honor Society
- Graduation with Distinction from the University of Michigan Medical School (top 5%)
- Recommended for Graduation with Distinction from Stanford University
- National Merit Scholarship Recipient
- Telluride Foundation Fellow

Select Papers and Publications:

- Lowe, T., Brown, I., Duriseti, R. "Emergency Department Access During COVID-19: Dis parities in Utilization by Race/Ethnicity, Insurance, and Income", Western Journal of Emergency Medicine; April, 2021

- Duriseti, R., Brandeau M. "Cost-Effectiveness of Strategies for Diagnosing Pulmonary Embolism Among Emergency Department Patients Presenting with Undifferentiated Symptoms", Annals of Emergency Medicine; October, 2010

- Duriseti, R., Wu, T. "Gastrointestinal introduction and abdominal pain – Pediatric Abdominal Pain in the Emergency Department", A Practical Guide to Pediatric Emergency Medicine, Cambridge University Press, Cambridge, 2010

- Duriseti, R. "Musculoskeletal Trauma: fractures", A Practical Guide to Pediatric Emergency Medicine, Cambridge University Press, Cambridge, 2010

- Duriseti, R. "Using Influence Diagrams in Cost Effectiveness Analysis for Medical Decisions", Optimization in Biology and Medicine, Auerbach Press, New York, 2008

- Duriseti, R. "Non-Bayesian Classification to Obtain High Quality Clinical Decisions", Optimization in Biology and Medicine, Auerbach Press, New York, 2008

- Duriseti, R., Shachter R., Brandeau M. "Implications of a Sequential Decision Model on the Use of Quantitative D-Dimer Assays in the Diagnosis of Pulmonary Embolism", Academic Emergency Medicine; July, 2006

- Duriseti R, VanderVlugt T. Paroxysmal supraventricular tachycardia is not associated with clinically significant coronary ischemia. ACEP Abstracts. ACEP Scientific Assembly 10/2001

EXHIBIT A

•VanderVlugt T., Duriseti R. Electrolyte findings in patients with paroxysmal supraventricular tachycardia. ACEP Abstracts. ACEP Scientific Assembly 10/2001

•Contributing Editor for Trauma Reports for the topic, "Trauma in Pregnancy"; published 2/2001

•Duriseti R. Cost Effective Management of Common Infections in the Emergency Department. Resident Reporter. Wyeth Ayerst Resident Scholars Program. March, 2000

Select Professional Lectures:

- Commonly Encountered Statistical Concepts in the Emergency Medicine Literature
- Medical Decision Making, Clinical Information Systems, and Cost Control: Complexity Collides with Uncertainty

Previous Expert Witness Testimony

- *Elijah Brown, et al. v. Mills-Peninsula, et al.*, No. CIV536321 (Cal. Super. Ct. Cty of San Mateo 2015)
- *Julia Sullivan v. The Superior Court of Santa Clara*, No. 18FL001837 (Cal. Super. Ct. Cty of Santa Clara 2018)
- *UNIFYSCC, et al. v. Sara H. Cody, et al.*, No. 22-cv-01019-BLF (N.D. Cal. 2022)
- *Vincent Tsai, et al. v. County of Los Angeles*, No. 21STCV36298 (Cal. Super. Ct. Los Angeles Cty 2021)
- *Jennifer Guilfoyle et al. v. Austin Beutner et al.*, No. 2:2021-cv-05009-VAP (C.D. Cal. 2021)

EXHIBIT A

Raph Graybill
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Email: rgraybill@silverstatelaw.net

Attorney for Plaintiff-Intervenor

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION

MONTANA MEDICAL ASSOCIATION, et al., Plaintiffs, and MONTANA NURSES ASSOCIATION, Plaintiff-Intervenor v. AUSTIN KNUDSEN, Montana Attorney General, and LAURIE ESAU, Montana Commissioner of Labor and Industry, Defendants.	Cause No. 9:21-cv-108 Hon. Donald W. Molloy **DECLARATION AND EXPERT REPORT OF LAUREN WILSON, M.D.**

I, Lauren Wilson, M.D., declare, pursuant to 28 U.S.C. § 1746 and under penalty of perjury, that the foregoing is true and correct:

1. The facts and opinions set forth in this Declaration are known to me

based on my personal knowledge and belief, and based upon my knowledge, training, research, education, and experience.

2. I have been retained by the Plaintiff-Intervenor in the above-captioned matter to render certain opinions as contained in this document. I am charging $400 per hour for my work on this matter. I reserve the right to modify, expand upon, or otherwise change these opinions as new or additional information is provided to me.

EXPERIENCE AND CREDENTIALS

3. I was granted a medical doctorate from McGill University in Montreal, Canada. I completed residency training in pediatrics at the University of Vermont, after which I served as Chief Resident for Vermont Children's Hospital. I have been board certified in Pediatrics since 2010 and additionally became board certified in the subspecialty of Pediatric Hospital Medicine in 2019. I am licensed to practice medicine in Montana.

4. I have approximately 12 years of experience as a practicing pediatric hospitalist. I currently take care of hospitalized pediatric patients in a general pediatric inpatient unit, as well as in a pediatric intensive care unit (PICU) and in the newborn nursery. I have recently served as Medical Director for the Pediatric Service Line at Community Medical Center.

5. I have been credentialed to provide care at three hospitals in Seattle

(Seattle Children's, Harborview Medical Center, and EvergreenHealth) as well as both hospitals in Missoula (Community Medical Center and Providence St. Patrick's Hospital). At Community Medical Center, I serve on the Credentialing Committee, which reviews the medical staff membership applications of other physicians.

6. I currently hold the rank of Clinical Associate Professor of Pediatrics at the University of Washington School of Medicine.

7. I was elected by my peers to serve in a voluntary position as Vice President of the Montana Chapter of the American Academy of Pediatrics.

8. Further information about my education, training and clinical responsibilities as well as my publications can be found in my curriculum vitae, attached (Exhibit 1).

9. I testified before in court in a case called *Montana Smoke Free Association v. Montana Department of Public Health and Human Services*, Ravalli County District Court, on behalf of the State of Montana about the risks associated with flavored e-cigarette products.

OPINIONS

10. Vaccination is an effective way of preventing the transmission of disease and of preventing death from disease. Historical data shows that vaccines have led to enormous declines in disease burden. As two examples: (1) pertussis

vaccination led a greater than 92% decline in pertussis cases and greater than 99% decline in deaths, when comparing the average number of pre-vaccine cases and deaths to those in post-vaccine years, and (2) measles vaccination led to a greater than 99% decline in cases when comparing average pre-vaccine measles cases to those in post-vaccine years.[1]

11. Serious adverse effects from vaccines are rare. The benefit of vaccination in preventing disease outweighs the risk of vaccination.

12. Outbreaks of vaccine preventable diseases are much less common than they once were. However, cases of measles, varicella, pertussis and hepatitis B continue to occur. Additionally, there is ongoing transmission of COVID-19, and seasonal transmission of influenza.

13. Measles can be transmitted via aerosol or contact with contaminated surfaces. It is extremely transmissible; transmission can occur up to 2 hours after an infected individual has left a room. Influenza and pertussis can be transmitted via respiratory droplets or contact with contaminated surfaces. Varicella and COVID-19 can be transmitted via respiratory droplets or contact with contaminated surfaces, and also via aerosol. Hepatitis B can be transmitted vertically from mother to child, via blood transfusion or needlestick injury, via

[1] Roush SW, Murphy TV, Vaccine-Preventable Disease Table Working Group AT. Historical Comparisons of Morbidity and Mortality for Vaccine-Preventable Diseases in the United States. *JAMA.* 2007;298(18):2155–2163. doi:10.1001/jama.298.18.2155

intravenous drug use or sexually.[2]

14. There have been pertussis outbreaks in Montana while I have been practicing here, and I have cared for patients with pertussis. I have had patients I have cared for in Montana who were affected by a measles outbreak in Washington state as well, because some Montana patients are cared for in Washington hospitals.

15. There was a measles outbreak primarily in Flathead County in 1989-1990. In many places in Montana, vaccination rates are now lower than the 95% which is generally felt to be the threshold to prevent outbreaks. Due to areas with lower vaccine rates, areas of Montana would be considered at risk during future measles outbreaks in the U.S.

16. Vaccine-preventable diseases can cause severe consequences. Measles can cause pneumonia and encephalitis, which can be fatal during the acute illness, as subacute sclerosing pan encephalitis (SSPE), which is a fatal complication that can occur years later. Pertussis is most commonly fatal in young infants less than 6 months of age. It can also cause severe illness and hospitalization in older children and adults, often due to pneumonia or complications of cough. Varicella can lead

[2] Centers for Disease Control. Type and Duration of Precautions Recommended for Selected Infections and Conditions: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007). https://www.cdc.gov/infectioncontrol/guidelines/isolation/appendix/type-duration-precautions.html. Accessed 7/15/2022.

to skin superinfections with bacteria, as well as encephalitis or cerebellar infection in the brain, and can cause children to die. Hepatitis B can cause liver failure and death. Influenza can cause respiratory failure and death. COVID can cause respiratory failure and death.[3]

17. Vaccine preventable diseases are often more severe in patients who are very young, very old, or lack functioning immune systems. These special populations require more frequent care in hospitals and making that setting safe for them is an important focus for me as a pediatrician.

Several examples from my current practice include:

a. Babies in the newborn nursery or NICU who are < 2 months old cannot yet be immunized. Due to their age, they are also more vulnerable to severe outcomes from many diseases, including pertussis and influenza.

b. Children who have undergone transplantation (heart, kidney, lung) are especially vulnerable to viral infections with varicella and measles, among others. Their immune systems are not normal because they must take immunosuppressive medication. If

[3] Kimberlin DW, Barnett ED, Lynfield R, Sawyer MH. *Red Book : 2021-2024 Report of the Committee on Infectious Diseases / Committee on Infectious Diseases, American Academy of Pediatrics ; David W. Kimberlin, Editor ; Elizabeth D. Barnett, Associate Editor ; Ruth Lynfield, Associate Editor ; Mark H. Sawyer, Associate Editor.* 32nd ed. (Kimberlin DW, Barnett ED (Elizabeth D, Lynfield R, Sawyer MH, eds.). American Academy of Pediatrics; 2021.

exposed, they may require an intervention such as post-exposure prophylaxis with immune globulin. Nonetheless, fatal outcomes can still occur.

c. Children undergoing chemotherapy are also vulnerable to viral and bacterial illness because they have fewer white blood cells to fight infection.

d. Children undergoing invasive procedures (surgeries, blood draws) are at risk for transmission of a blood borne illnesses like Hepatitis B, should a needle stick occur from an infected caregiver.

18. Verifying vaccination or providing proof of immunity is a standard part of the onboarding process for hospital workers. Every hospital in which I have been credentialed to work as a physician has required me to submit proof of vaccination or immunity (in the form of antibody measurements, for example) for vaccine preventable diseases as part of my credentialing for medical staff membership in order to protect healthcare workers and patients from the risks associated with vaccine-preventable diseases.

19. A health care worker who is unvaccinated against measles, pertussis, varicella, influenza, COVID-19 or hepatitis B presents an increased risk to patients and to other co-workers.

20. There are no adjunctive measures (hand washing, mask wearing) that

can completely mitigate the risk an unvaccinated caregiver could present to patients or co-workers in the course of his or her usual clinical duties in a hospital. Several examples:

a. Needlestick injuries are not entirely preventable, and can transmit Hepatitis B.

b. Measles is primarily transmitted via airborne particles, so a standard surgical mask would not be sufficient to prevent transmission. Rooms in which someone with measles have been sitting must be closed off for 2 hours before being used again, as cases of transmission have been reported even after a patient has left a hospital room. The same would be true of a staff member – even if he or she were no longer present in a room, there is the potential for transmission if a patient or co-worker were to enter afterwards.

c. Masks are helpful in preventing droplet transmission of disease (for example, COVID-19, influenza, varicella, pertussis) but not 100% effective.

d. For infections transmitted via contact with infected surfaces, wearing gloves and gowns is helpful but not 100% effective.

21. During an outbreak of disease, unvaccinated health care workers

exposed to a disease may be recommended to quarantine (i.e. not work) by current CDC guidance.

22. Accordingly, it is my opinion that healthcare settings must have actual knowledge of the immunity status of their workers. It is also my opinion that healthcare settings must be able to condition and treat healthcare workers differently based on actual knowledge of their immunity status in order to secure a safe work environment and to secure a safe environment for patients.

23. The risk presented by the transmission of vaccine-preventable diseases is greatest for patients typically found in the newborn nursery, NICU, oncology, or transplant services. In the pediatric unit in which I work, we care for newborns, children with cancer and children with organ transplants. It is my opinion that in order to secure a safe work environment and a safe environment for patients in this setting, the healthcare setting must have actual knowledge of a worker's immunization status and must have the flexibility to condition the worker's employment in ways that respond to their actual immunity status.

Lauren Wilson, M.D.

Wilson Report – Exhibit 1

LAUREN WILSON, MD

1. CONTACT INFORMATION

Office Address: Community Medical Center
Pediatrics
2827 Fort Missoula Road
Missoula, MT 59804
Email: lswilson@communitymed.org

2. EDUCATION

B.A., *summa cum laude*, German and Mathematics 8/1999-5/2003
Rice University, Houston, TX

M.D.C.M., McGill University, Montreal, Quebec 8/2003-5/2007

3. POSTGRADUATE TRAINING

Pediatric Resident 6/2007-6/2010
University of Vermont, Burlington, VT

Pediatric Chief Resident 7/2010-7/2011
University of Vermont, Burlington, VT

4. FACULTY POSITIONS HELD

Clinical Instructor 7/2007-6/2011
University of Vermont College of Medicine, Burlington, VT

Clinical Assistant Professor 7/2011-10/2014
University of Washington School of Medicine, Seattle, WA

Acting Assistant Professor 11/2014-12/2015
University of Washington School of Medicine, Seattle, WA

Associate Program Director, Pediatric Residency Program 7/2014-12/2015
Seattle Children's Hospital, Seattle, WA
Clinical Assistant Professor 12/2015-7/2018
University of Washington School of Medicine, Seattle, WA

Clinical Associate Professor 7/2018-present
University of Washington School of Medicine, Seattle, WA

Adjunct Faculty 12/2015-present
University of Montana, Missoula, MT

6. HOSPITAL POSITIONS HELD

Attending Physician, Division of Inpatient Medicine 7/2010-6/2011
Vermont Children's Hospital at Fletcher Allen Health Care, Burlington, VT

Member, Neonatal Intensive Care Transport Team 7/2012-6/2011
Vermont Children's Hospital at Fletcher Allen Health Care, Burlington, VT

Attending Physician, Division of Hospital Medicine 7/2011-12/2015
Seattle Children's Hospital, Seattle, WA

Pediatric Hospitalist 7/2014-12/2015
Evergreen Health, Kirkland, WA

Pediatric Inpatient Attending 7/2015-12/2015
Harborview Medical Center, Seattle, WA

Pediatric Hospitalist 12/2015-present
Community Medical Center, Missoula, MT

Pediatric Hospitalist 12/2015-present
Providence St. Patrick's Hospital, Missoula, MT

Medical Director, Pediatric Service Line 5/2017-present
Community Medical Center, Missoula, MT

7. HONORS

Herbert Allen (Half Tuition) Scholarship, Rice University School of Humanities	1999-2003
Institute for International Education of Students Excellence in Sciences Award	1/2002
Phi Beta Kappa	5/2003
Mark Nickerson Prize in Pharmacology, McGill University	4/2005
Osler Medical Aid Foundation Scholarship, McGill University	6/2005
Quebec Medical Association Scholarship and Prix Robert-Gourdeau	4/2006
P.E.O. (Philanthropic Educational Organization) Scholar Award	6/2006
James McGill Prize (Top 5% of class), McGill University	2005-2006
Dean's Honor List (Top 10% of class), Faculty of Medicine, McGill University	2003-2007
Alexander D. Stewart Prize (Top graduate, selected by peers), McGill University	5/2007
Resident Outstanding Teacher Award (Three times), University of Vermont	2008-2010
Montana Medical Association Healthcare Leadership Program selectee	2019-2020

8. BOARD CERTIFICATION

Diplomate, American Board of Pediatrics, General Pediatrics, 10/18/2010
Diplomate, American Board of Pediatrics, Pediatric Hospital Medicine, 11/13/2019

9. CURRENT LICENSE TO PRACTICE

Montana Medical License, #MED-PHYS-LIC-42164

10. PROFESSIONAL ORGANIZATIONS

Montana Chapter of American Academy of Pediatrics – 1/2016-present
Neonatal Resuscitation Program, 5/2010-5/2012 and 10/2015 to present
Pediatric Advanced Life Support (American Heart Association), Provider, 6/2007-present
Pediatric Fundamental Critical Care Support, 10/2016-present
Pediatric Fundamental Critical Care Support Instructor, 2/2018-present
AAP Section on Hospital Medicine, Member, 6/2011-present
AAP Council on Quality Improvement and Patient Safety (COQIPS), Member, 11/2013-8/2017
Quality Improvement Innovation Networks (QuIIN), Member, 6/2013-present
Academic Pediatric Association, Member, 1/2014-12/2014
American Academy of Pediatrics, Member, 6/2007-8/2013, Fellow, 8/2013-present
Society of Hospital Medicine, 1/2016-present

11. TEACHING RESPONSIBILITIES

Small Group Leader, McGill University College of Medicine 3/2007
Helped lead “Physicianship” course for first-year medical students

Pediatric Grand Rounds, “Cystinosis: Failure to Thrive and Really Big Diapers” 12/2007
University of Vermont College of Medicine

Pediatric Grand Rounds (1/2009), Obstetric Grand Rounds (2/2009) 1/2009-2/2009
“Neonatal Alloimmune Thrombocytopenia”, University of Vermont College of Medicine

Resident Education Committee, University of Vermont College of Medicine 06/2009-6/2011
Help review the pediatric residency curriculum and evaluate program changes.

Pediatric Professor Rounds, University of Vermont College of Medicine 7/2010-6/2011
As Pediatric Chief Resident, led bi-weekly didactic sessions for “Pediatric Professor Rounds”, a case-focused morning conference attended by faculty, community physicians, and house staff. 98 sessions total, with 55 presented entirely by me and the remainder with 30% contribution. Attendees eligible for CME credits.

Resident Night Curriculum, Seattle Children’s Hospital 6/2011- 12/2015
Helped to develop and lead interactive teaching cases based on typical on-call scenarios for night float residents. Occurred weekly when on service.

Medical Student Observership Preceptor, Seattle Children's Hospital 1/2012-5/2012
Introduced first year medical student to pediatrics; directly observed patient interactions.

Resident Noon Lectures, Seattle Children's Hospital 5/2012-12/2015
"Bronchiolitis", "Pertussis", "Cellulitis", "Childhood Exanthems" (repeat yearly)

Pediatric Medicine Inpatient Service, Seattle Children's Hospital 7/2013-12/2015
Clinical preceptor for pediatric residents and medical students.

Clinical Competency Committee, Seattle Children's Hospital 7/2014-12/2015
Evaluate and mentor residents to enable progression along learning milestones.

Residency Committee, Seattle Children's Hospital 7/2014-12/2015
Help review the pediatric residency curriculum and evaluate program changes.

WWAMI Pediatric Clerkship Site Co-Coordinator, University of Washington 12/2015-9/2019
Responsible for overseeing pediatric core clerkship in Missoula, MT

Family Medicine Residency of Western Montana, University of Montana 12/2015-present
Instruct family medicine residents in clinical pediatrics

Coordinator, Community Hospital Medicine Elective, University of Washington 6/2017-present
Design and coordinate elective for third year pediatric residents

12. EDITORIAL RESPONSIBILITIES

Reviewer, Hospital Pediatrics 2015

13. SPECIAL NATIONAL RESPONSIBILITIES

Legislative Affairs Intern, American Medical Student Association (AMSA) 11/2006-12/2006
Washington, DC

14. SPECIAL LOCAL RESPONSIBILITIES

Member, Family Centered Rounding Quality Improvement Committee 06/2009-06/2010
Fletcher Allen Health Care, Burlington VT
Improve the ability of rounding teams to communicate effectively with patients and families about their care, while simultaneously allowing the team to make treatment plans and educate trainees.

Visioning Committee, Division of Hospital Medicine 12/2011-2/2013
Seattle Children's Hospital
Participate in the development of a vision, mission, and strategic plan for the division. Designed and implemented faculty satisfaction survey for the division.

Bronchiolitis Clinical Pathway Owner 7/2012-12/2015
Seattle Children's Hospital
Manage established evidence-based clinical pathway for patients with bronchiolitis. Develop a new pathway for treatment of patients in the Emergency Department and acute care wards with High Flow Nasal Cannula; develop and track metrics to ascertain quality of care.

Cellulitis and Abscess Clinical Pathway Owner 9/2012-12/2015
Seattle Children's Hospital
Develop new evidence-based clinical pathway for patients in both the Emergency Department and acute care wards with skin and soft tissue infections; develop and track metrics to ascertain quality of care.

Inpatient Medicine Reaggregation Project Leader 8/2014-12/2015
Help design changes to medical unit structure to take advantage of geographic-based teams and improve inpatient work flow. Apply Lean Methodology to improve efficiency.

Executive Committee 10/2018-present
Montana Chapter, American Association of Pediatrics
Secretary-Treasurer 10/2018-10/2020, Vice President 10/2020-present
As a member of the executive committee of the MT AAP, help with minutes, finances, as well as advocacy priorities and chapter conferences and activities.

Physician Advisory Council Member 1/2019-present
Blue Cross Blue Shield of Montana
Help advise Montana's major private insurer with regards to policy priorities in the state.

Legislative Committee Member 12/2018-present
Montana Medical Association

Board of Trustees Member 12/2020-present
Montana Medical Association

Legislative Committee Chair 12/2018-present
Montana Chapter, American Academy of Pediatrics

Medical Executive Committee 1/2020-1/2022
Community Medical Center

Bylaws Committee 1/2020-present
Community Medical Center

Credentials Committee 7/2021-present
Community Medical Center

15. RESEARCH FUNDING

Completed: PI, AAP Community Access to Child Health (CATCH) Grant, "Parenting Support Groups for Somali Bantu Refugees", 1/2009 – 6/2010, $3,000 with 100% effort

Completed: Co-PI (with D Caglar), Academic Enrichment Fund Award, Seattle Children's Hospital. "Impact of a comprehensive clinical protocol on outcomes for patients with skin and soft tissue infections", 1/2015 – 1/2017. $37,250 with 50% effort.

16. BIBLIOGRAPHY

Manuscripts in Refereed Journals

1. Davis-Kirsch S, **Wilson L**, Albin D, Harkins M, Del Beccaro M. "A Feasibility Study Using a Pediatric Call Center as Part of a Readmission Prevention Strategy." *J Pediatr Nursing.* In press. Published online 19 Aug 2014. S0882-5963(14)00239. PMID: 25193689.

2. **Wilson L.** "Index of Suspicion: Recurrent vomiting and a 60 lb weight loss in a 17-year-old girl." *Pediatr Rev.* 2016 Jun; 37(6):264-6.

3. Bryan M, Desai A, **Wilson L,** Wright D, Mangione-Smith R. "Association of Bronchiolitis Clinical Pathway Adherence with Length of Stay and Costs." *Pediatrics* Feb 2017, e20163432; DOI: 10.1542/peds.2016-3432.

Book Chapters

1. Taxier R, **Wilson L**. (2015) Imperforate Anus. In EK Chung (Ed.) *Visual Diagnosis and Treatment in Pediatrics, 3rd Edition*. (pp. 43-47) Philadelphia, PA: Wolters Kluwer.

2. **Wilson L**, Taxier R. (2015) Hand Swelling. In EK Chung (Ed.) *Visual Diagnosis and Treatment in Pediatrics, 3rd Edition*. (pp. 337-342) Philadelphia, PA: Wolters Kluwer.

Abstracts

1. **Wilson L**, Reincke K, Fondacaro K, Green A. "Parenting Groups for Somali Bantu Refugees". Poster Presentation. Pediatric Academic Societies Annual Meeting, Vancouver, B.C. 5/2010

2. **Wilson L**, Foti J, Ringer C, Magin J, Spencer S, Roberts J, Slater A, Beardsley E. "Effects of a Clinical Pathway for High Flow Nasal Cannula Therapy in Bronchiolitis Outside of the Intensive Care Unit." Poster Presentation. National Conference and Exhibition. American Academy of Pediatrics. San Diego, CA. 10/2014.

3. Bryan M, **Wilson L**, Desai A, Wright D, Mangione-Smith R. "Adherence to a Bronchiolitis Clinical Pathway is Associated with Decreased Length of Stay and Costs." Poster Presentation. 5th Annual Advancing Quality Improvement Science for Children's Health Care Research Conference, Academic Pediatric Association. 4/24/15. San Diego, CA.

4. Bryan M, **Wilson L**, Desai A, Wright D, Mangione-Smith R. "Adherence to a Bronchiolitis Clinical Pathway is Associated with Decreased Length of Stay and Costs." Platform Presentation. Pediatric Academic Societies Annual Meeting. 4/25-4/28/2015. San Diego, CA.

5. Collins C, Chan T, Haaland W, Roberts J, Spencer S, **Wilson L,** Wright D. "Simulating the Economic Effects of a Ward-Based High Flow Nasal Cannula Protocol." Poster Presentation. Pediatric Academic Societies Annual Meeting. 4/30 – 5/3/2016. Baltimore, MD.

6. Caglar D, **Wilson L,** Kronman M, Vora S, Lion C, Rutman L. "Effect of a Clinical Pathway on Treatment of Skin and Soft Tissue Infections." American Academy of Pediatrics National Conference & Exhibition. 10/21-10/25/16. San Francisco, CA.

7. **Wilson L**, Caglar D, Rutman L, Lion C, Kronman M, Vora S. "Standardizing Care for Skin and Soft Tissue Infections in Children: Impact on Antimicrobial Stewardship." Pediatric Academic Societies Annual Meeting. 4/30 – 5/3/2016. Baltimore, MD.

8. **Wilson L,** Caglar D, Rutman L, Lion C, Kronman M, Vora S. "Standardizing Care for Skin and Soft Tissue Infections in Children: Impact on Antimicrobial Stewardship." Pediatric Hospital Medicine Conference. 7/28-7/31/2017. Chicago, IL.

Workshops

1. McPhillips H, Kendermore D, Batra M, Olson S, **Wilson L**, Konecki K, Grow M, Quitiquit C, Wild J, Schook C, Dixon S. Enhancing Teamwork in Your GME Office: A Workshop for Program Directors and Coordinators. 3/25-3/28/2016. Orlando, FL.

2. Beck J, Rooholamini S, **Wilson L**, McDaniel C, Griego E, Long M, Shen M, Ravid N, Kupono B, Kinkel H, Blankenburg B. Choose Your Own Adventure: Leading Effective Case-Based Learning Sessions Using Evidence-based Strategies. Pediatric Hospital Medicine Conference. 7/28-7/31/2016. Chicago, IL.

3. Beck J, Rooholamini S, **Wilson L,** Long M, Shen M, Louden D, Gribben V, Peterson J, Blankenburg B. Choose Your Own Adventure: Leading Effective Case-Based Learning Sessions Using Evidence-based Strategies. Workshop presented at: Pediatric Academic Societies Annual Meeting. 4/30 – 5/3/2016. Baltimore, MD.

4. Russo C, Hodo L, **Wilson L**, Bachta S, Fletcher C, Hofmann M, Joseph-Griffin M., Krugman S., Marek S, Marlow L, Rowinsky P, and Snow C. It Doesn't Take a Village, It

Takes a Community: How to Design and Improve Your Educational Program for Trainees in a Community Hospital. Workshop presented at: Pediatric Academic Societies; May 2016; Baltimore, MD.

5. Russo C, Hodo L, **Wilson L**, Bachta S, Fletcher C, Hofmann M, Joseph-Griffin M., Krugman S., Marek S, Marlow L, Rowinsky P, and Snow C. It Doesn't Take a Village, It Takes a Community: How to Design and Improve Your Educational Program for Trainees in a Community Hospital. Workshop presented at: Pediatric Hospital Medicine; July 2016; Chicago, IL.

17. OTHER ACTIVITIES

Member, McGill International Health Initiative	9/2003-5/2007
Leader, McGill International Health Initiative	8/2004-6/2005
Co-Organizer, World AIDS Day lecture and rally, McGill Campus	9/2003-5/2007
Conference Co-Organizer, “Global Health Equality”, McGill University	3/2004
Organizer, Community dengue prevention campaign, Santa Lucia, Honduras	7/2005-8/2005
Volunteer, “Dans La Rue”, program for homeless street youth in Montreal	10/2005-9/2006
Physician Volunteer, Partners in Health, Port au Prince, Haiti	4/2011

Local Invited Lecture:

Invited speaker, “Dengue Prevention in Rural Honduras.” 9/2005
Osler Medical Aid Foundation Scholar Lecture, McGill University. Montreal, Canada.

National Invited Lectures:

Invited speaker (co-presenter with Kenneth Roberts), “Visual Diagnosis” 7/25/2014
Pediatric Hospital Medicine Conference, Orlando, FL.

Invited speaker, “Bronchiolitis: Improving Care after the New Guidelines” 11/6/2015
UW Continuing Nursing Education Advanced Practice in Primary and Acute Care Conference, Seattle, WA.

Montana Medical Association, et al. v
Austin Knudsen, et al.

David N. Taylor, MD
August 4, 2022

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION

MONTANA MEDICAL ASSOCIATION, ET AL.,
Plaintiffs,
and
MONTANA NURSES ASSOCIATION,
Plaintiff-intervenors,
vs.
AUSTIN KNUDSEN, ET AL.,
Defendants

Cause Number CV-21-108-M-DWM

VIDEORECORDED DEPOSITION UPON ORAL EXAMINATION OF DAVID N. TAYLOR, MD

BE IT REMEMBERED, that videorecorded deposition upon oral examination of DAVID N. TAYLOR, MD, appearing at the instance of Defendants, was taken at the offices of Fisher Court Reporting, 442 E. Mendenhall, Bozeman, Montana, on Tuesday, August 4th, 2022, beginning at the hour of 9:00 a.m., pursuant to the Federal Rules of Civil Procedure, before Deborah L. Fabritz, Court Reporter - Notary Public.

APPEARANCES

ATTORNEY APPEARING ON BEHALF OF THE PLAINTIFFS, MONTANA MEDICAL ASSOCIATION:
Mr. Justin K. Cole, Esq.
Garlington, Lohn & Robinson, PLLP
350 Ryman Street
Missoula, MT 59807-7909
and
ATTORNEYS APPEARING VIA ZOOM ON BEHALF OF THE DEFENDANTS, AUSTIN KNUDSEN, ET AL.:
Mr. Brent Mead, Esq.
Mr. Christian B. Corrigan, Esq.
Mr. David M.S. Dewhirst, Esq.
PO Box 201401
Helena, MT 59620-1401

ALSO PRESENT:
Nate Trejo, videographer

I N D E X

E X H I B I T S

WHEREUPON, the following proceedings were had and testimony taken, to-wit:

* * * * * * *

THE VIDEOGRAPHER: This is the videorecorded and videoconferenced deposition of David Taylor, MD, taken in the United States District Court of Montana, Missoula Division. Cause Number CV-21-180-M-DWM [sic]. Montana Medical Association, et al. and Montana Nurses Association verse Austin Knudsen, et al.

Today is August 4th, 2022. The time is 9:09. We are present with the witness at Bozeman Health Deaconess Hospital, 915 Highland Boulevard, Bozeman, Montana 59715.

The court reporter is Deb Fabritz, and the video operator is Nate Trejo of Fisher Court Reporting. The deposition is being taken pursuant to notice.

I would now ask the attorneys to identify themselves, who they represent, and whoever else is present. For those attending remotely, please note from where you are appearing.

MR. MEAD: Brent Mead representing defendants Austin Knudsen and Laurie Esau, appearing remotely from Helena, Montana. I also have Christian

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Corrigan and David Dewhirst also -- with the attorney general's office also appearing remotely from Helena, Montana.

MR. COLE: Justin Cole from Garlington, Lohn, and Robinson representing the plaintiffs, appearing in person.

THE VIDEOGRAPHER: The court reporter will now administer the oath.

DAVID N. TAYLOR, MD,

called as a witness, having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. MEAD:

Q. Good morning, Dr. Taylor.

A. Good morning.

Q. As I said, my name is Brent Mead, an assistant solicitor general for the State of Montana. What that means in this case, I'm one of the lawyers representing the defendants.

So I want to start by going over just a few general guidelines for this morning to hopefully make this go as easy as possible. My goal here today is just to learn about you and what you've stated in your report.

I'm going to be asking you questions.

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We're both on Zoom. I'm sure you're aware by now that that format does create some issues occasionally. So I will try to speak as slow as I can. I will -- I can't promise I won't speed up at times, but the idea I'll speak as slow as I can, as clear as I can, pause and allow you to answer. I want to avoid that we talk over each other as much as possible. So, again, it -- it's going to happen, but we'll try and make this easy as we can.

If I ask you a question and you don't understand it, please ask me to rephrase it or tell me that you don't understand it. And I'll try and reword it so that I can -- so I can get the answer to the question I'm looking at.

If you need to take a break, please just ask. The only thing is that if we're in the middle of answering a question, I'd ask that you complete answering the question, and then we'll step away for a break. And on that, as a general rule, I'll try and make sure that we take a break for five or ten minutes every hour. I believe Justin will let us know -- Mr. Cole I should say. Mr. Cole let us know that you're on call. So if there's a need for you to step away, again please just let us know, and we'll pick up when you're available. Does that all sound good?

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A. Sounds good.

Q. So I would like to start with the easy question. Could you please state and spell your name.

A. David Taylor, D-A-V-I-D, T-A-Y-L-O-R.

Q. Where is your residential address?

A. Bozeman, Montana.

Q. Do you have the street address?

A. 518 South 3rd Avenue.

Q. And, Dr. Taylor, where are you currently employed?

A. Bozeman Health, Bozeman, Montana.

Q. Have you ever participated in a deposition before?

A. No, I haven't.

Q. Have you ever testified as an expert witness before?

A. No, I haven't.

Q. Dr. Taylor, are you under the influence of any substance that could affect your ability to provide true and accurate testimony today?

A. No, I am not.

Q. I want to ask you just a little bit about your preparation for today. What did you do to prepare for your deposition this morning?

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A. I reread my deposition and the deposition of the two opposing depositions or expert testimony.

Q. Did you discuss your deposition today with anyone other than the attorneys for plaintiffs, Mr. Cole or Ms. Mahe?

A. No, I did not.

Q. Now, Dr. Taylor, in your career, have you ever been subject to a malpractice lawsuit?

A. No, I have not.

Q. Have you ever been the subject of an ethical complaint or ethics investigation in your professional or academic career?

A. No, I have not.

Q. Okay. So, Dr. Taylor, I -- want to start -- can you just -- can you please describe what your day-to-day responsibilities are at Bozeman Deaconess?

A. I'm the medical director for the Department of Clinical Research. I in that role provide medical expertise for the clinical work that we're doing and also support work on COVID surveillance in collaboration with Montana State University.

And I also have a role in teaching medical students at our medical school here.

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upper respiratory tract rather than in the -- in the lungs which is where the original strains were. So it's a -- it's a less severe infection, but it's highly transmissible. And so I think that we will see a new vaccine directed at the Omicron strains coming out in the fall.

MR. MEAD: So Justin, Dr. Taylor, I think now is a good time to take a break before I jump into my next set of questions. Would it be good to break until say 10:05?

MR. COLE: Works for us.

MR. MEAD: Okay. Thank you.

THE WITNESS: Thank you.

THE VIDEOGRAPHER: We're going off the record. The time is 9:57.

(Whereupon, a break was then taken.)

THE VIDEOGRAPHER: We are back on the record. The time is 10:06.

BY MR. MEAD:

Q. Dr. Taylor, I want to start -- can you please describe to me the conclusions that you reach in your report?

MR. COLE: Objection. Vague and overly broad.

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THE WITNESS: May I refer to those?

BY MR. MEAD:

Q. So, Dr. Taylor -- yes. And, again, Dr. Taylor, if you don't understand a question that I ask, please ask me and I will try to rephrase it for you.

So, Dr. Taylor, can you please just describe the -- the main conclusions that you reach in your report? And if it helps you to sort of number them out and refer me to those paragraphs, please do so.

MR. COLE: And same objection. Overbroad and vague.

THE WITNESS: Well, I'll start out with the last paragraph, Mr. Mead, paragraph 65 on page 37.

BY MR. MEAD:

Q. Are there -- Dr. Taylor, are there other subconclusions that you reached in your expert report?

MR. COLE: Object. Vague.

THE WITNESS: Well, I think every paragraph I try to make a statement, provide the information that supports that statement and then conclude, you know, what the importance of that is.

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So we could go through all 65 paragraphs and -- and -- and determine what those conclusions are for each paragraph.

BY MR. MEAD:

Q. Dr. Taylor, I'm trying to understand what you view the scope of your expert report to be. Is it fair to categorize that your expert report is limited to, one, the safety of vaccine trials, and, two, the overall public policy behind vaccination campaigns?

MR. COLE: Object to the form of the question. It misstates Dr. Taylor's report, and it misstates his testimony.

BY MR. MEAD:

Q. Can you please answer, Dr. Taylor?

A. I'm -- my report is based on the idea that vaccines are a major cornerstone of public health, that they have been since the inception of vaccine development, which really started in the 1940s, an absolutely key part of public health. We would not have the healthy population that we have now without vaccination.

In my view reading the law HB 702, I -- I think that this law has the effect of trying to decrease the importance of vaccines as a public

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health tool. What in my view happens is that if we say that it's up to the individual -- in other words, there's a personal freedom issue here -- that that's abdicating our duty to the community.

And so I think that it's our -- an important duty of the state to educate the -- the population in the state on the importance of vaccines and other public health measures and that we should do everything we can to encourage our -- people in our state to -- to receive vaccines and to embrace other public health measures that would keep them healthy.

So by saying that -- that it's an individual decision and not giving the individuals the tools to make an informed decision, I think, is -- is a problem with the law. I think that the other problem is that it doesn't address the common good that is part of vaccination. We vaccinate to protect ourselves, but we also vaccinate to -- to protect our community.

Q. So, Dr. Taylor, it's fair to say that you are familiar with House Bill 702?

A. I'm not a lawyer, obviously, and so I'm -- I'm familiar with the wording of it. I may not understand all the nuances of the law.

vaccines are -- you know, that's a -- that's a hard question for a layperson to come to.

And so, again, I think that, you know, the state has some duty to advocate for these vaccines in terms of promoting community welfare.

Q. So, Dr. Taylor, you -- you just mentioned laypeople, and I -- I want to be clear that the sentence we're discussing, is that your opinion about health care workers in that sentence, that COVID vaccine exemptions in health care facilities were approximately twice as high? So I want to be clear --

A. Sorry about that. I thought what you were saying was how do you know that this is going to have an impact on childhood immunizations. I was looking at it from that point of view.

Q. So Dr. -- Dr. Taylor, then I guess in that sentence in paragraph 23, the COVID vaccine exemptions in health care facilities were approximately twice as high as the national average. In that last part, in part is caused by the opposing state and federal mandates.

Specific to health care workers, what do you mean by opposing state and federal mandates?

MR. COLE: I'm going to object. Vague.

It's paragraph 24 and you may answer the question.

THE WITNESS: So I look at HB 702 as an opposing state mandate which indicates that it is a personal decision to -- to decide whether you want to get vaccinated. Is that the essence of that law in your opinion?

Q. Dr. Taylor, please just answer the question.

A. So that's how I would answer the question, that -- that I believe that that, you know, has a negative impact on -- on getting people vaccinated.

Q. So, Dr. Taylor, it's your opinion, then, that the state allowing individuals to choose to become vaccinated, that is a mandate?

MR. COLE: Objection to the extent it mischaracterizes testimony.

THE WITNESS: How would you characterize a law if not a mandate? I could say opposing state laws. Would that be -- clarify that?

BY MR. MEAD:

Q. So, Dr. Taylor, again, going to HB 702, would you agree that the law allows for the recommendation of vaccines?

MR. COLE: Objection. Calls for a legal

conclusion.

THE WITNESS: I see no language in there that calls for a recommendation of vaccines.

BY MR. MEAD:

Q. So, Dr. Taylor, in paragraph 24, the last sentence, you use a phrase "safe care environment." What do you mean by that?

A. We want to create a workplace where our patients and our staff are protected from diseases. This is done in any number of ways. Bozeman Health, for example, has had a mask mandate since the beginning of the -- of the pandemic and we still have it, you know. And we do that in order to create a safe care environment.

We also to the best extent we can try and get everybody vaccinated. That's an important tool in providing a safe care environment. The worst thing that could happen is that one of our cancer patients, for example, or someone debilitated would catch a disease in the hospital, such as COVID, you know. We -- we certainly do not want that to ever happen, and we want to take measures to protect our patients from -- from disease. And that is a safe care environment.

Q. So, Dr. Taylor, what -- what data or

studies do you cite in your report to form that opinion?

A. I would say that this is common knowledge.

Q. So, Dr. Taylor, you -- you don't cite any specific data or studies that -- to reach that opinion of what constitutes a safe care environment?

MR. COLE: I'm going to object that it mischaracterizes the balance of the report.

THE WITNESS: So I think that the hospital personnel here that are -- do the best we can to -- to try and make everything as safe as possible for our patients. That's our responsibility and our obligation to them.

We will look at the information available. If COVID didn't exist right now, we would not recommend COVID vaccines, because they do not make the environment any safer.

If we had a vaccine, for example, for some other disease that our patients might get in the hospital, we would advocate that that vaccine be used. We also advocate hand washing. We advocate, you know, gloves and PPE when working with a patient who is infected with COVID or some other infectious disease. So we have any number of safeguards that we -- we utilize to provide that safe environment.

Q. So, Dr. Taylor, are you aware of why the FDA paused administration of that vaccine?
A. I believe it was due to blood clots being seen in some of the recipients of the vaccine.
Q. Okay. And, Dr. Taylor, are you aware that the FDA has limited the scope of the emergency use authorization since it was initially authorized?
MR. COLE: I'm going to object. It's vague. If you understand it, you may answer.
THE WITNESS: Are you still referring to the J&J vaccine, Mr. Mead?
BY MR. MEAD:
Q. Yes, Dr. Taylor. Thank you for the helpful clarification. For the next series of questons unless I specify otherwise, I will be referring to the Johnson & Johnson vaccine.
So, again, to clarify, are you aware that the FDA has limited the scope of the emergency use authorization since it was initially issued?
MR. COLE: I'm going to object as to vague.
THE WITNESS: So I don't think they've -- what I was trying to clarify, Mr. Mead, was that the scope of emergency use authorization hasn't changed, but the scope of the use of the vaccine has changed,

the J&J vaccine. So it's now recommended only for certain people.
It's, you know, essentially been determined to be a vaccine where, you know, if for some reason you can't get the MRNA vaccine, you're allergic to it or some other reason, that that would be an option open to you. But otherwise, it's not on the first line at this point.
BY MR. MEAD:
Q. Dr. Taylor, why is it not on the first line anymore?
A. Because of the adverse events that were observed.
Q. So, Dr. Taylor, looking back to the J&J's vaccine trial, were these types of adverse events cited during the vaccine trial?
MR. COLE: Objection. Foundation.
THE WITNESS: I don't know the extent of the adverse event profile that was seen in those trials. Sorry. I just don't recall.
BY MR. MEAD:
Q. So, Dr. Taylor, you would -- you would agree, though, that the FDA's pause of administering the J&J vaccine in April 2021, that came fairly recently after it was initially authorized under its

emergency use authorization?
MR. COLE: I'm going to object to foundation and vague.
THE WITNESS: This is the -- how the system works. You know, the -- there is a -- one of the obligations of manufacturers when they have a vaccine under emergency use authorization is that they continue to monitor safety of that vaccine.
BY MR. MEAD:
Q. Dr. Taylor, the video feed -- the video feed cut out and -- at the start of your answer, so --
A. Oh.
MR. COLE: For the record, we just lost Brent Mead on the video.
THE WITNESS: Here he comes again.
MR. COLE: He may want to -- we can go off record. Brent, oh, go ahead.
THE VIDEOGRAPHER: We are going off the record. The time is 11:20.
(Whereupon, a break was then taken.)
THE VIDEOGRAPHER: We are back on the record. The time is 11:21.
BY MR. MEAD:

Q. Dr. Taylor, it's true that the FDA's pause of the J&J vaccine, that occurred shortly after it was initially authorized under its emergency use authorization. Right?
MR. COLE: Objection. Vague. Foundation.
THE WITNESS: Well, the -- the importance is not the timing of it but when there is sufficient information to make the call. This is not the first time that a vaccine has been licensed or been used in emergency use authorization and found to have side effects that are unacceptable.
So if the J&J vaccine was the only vaccine available for COVID, then, you know, the FDA's recommendation would be different than what it is now. But since we have alternatives, the Pfizer and the Moderna vaccine and now the Novavax vaccine, that have now a safety record that is pretty rock solid after some 600 million doses have been given and so I think the FDA's feeling was why expose people to potential side effects when they can be avoided by using the other vaccines.
BY MR. MEAD:
Q. Dr. Taylor, you said that this is not the first time this has happened with a vaccine. To your knowledge, what are other examples when the FDA has

pulled back a vaccine?

MR. COLE: Objection. Overly broad.

THE WITNESS: Well, one example was the -- the first rotavirus vaccine. So rotavirus is a diarrhoeal disease in children. All of our kids had rotavirus when they were young, and so it's very common.

And so the first vaccine which was made and -- and tested went through all of the safety testing in the initial trials and passed. And then later on when it was -- when millions of doses were given, there was an increase in a condition called intussusception. And this is essentially when the -- the intestine of an infant is -- is loose and it has the ability to kind of telescope on itself. And that's what an intussusception is.

So that can be a condition that doesn't resolve without surgery, et cetera, and so there's a certain background intussusception level in the population of infants. And so I believe that, you know, what finally led to the vaccine being taken off the market was that even though there was a background that there was a temporal association between the immunization, which was an oral immunization, and -- and -- and having

intussusception. And I've forgotten what the rate was, 1 in 100,000 children or something like that, but it was enough that -- that they felt that -- that the vaccine should be pulled.

Oral polio vaccine, you know, which was used for decades in the United States, was pulled because there was a 1-in-1 million chance that a child could get paralytic polio from the -- from the vaccine. And so that was thought to be unacceptable. And so in the United States for the last 20 years we've been using exclusively IPV, you know, the injectible polio vaccine.

BY MR. MEAD:

Q. So, Dr. Taylor, turning back to the blood clotting side effect caused by the J&J vaccine, what were the consequences of that side effect?

MR. COLE: Objection. Foundation. Overly broad.

THE WITNESS: Well, I -- I think it depended on where the blood clot was. You know, if you have a blood clot in your -- one of your extremities, you know, you might see a redness, a swelling, et cetera. So those -- those might be symptoms associated with a blood clot.

BY MR. MEAD:

Q. Dr. Taylor, is it possible that the blood clotting caused by the J&J vaccine could lead to death?

MR. COLE: Objection. Calls for speculation. Foundation.

THE WITNESS: I don't recall. I mean, that's something that is an obtainable piece of data. I just don't happen to have it myself.

BY MR. MEAD:

Q. Okay. So, Dr. Taylor, again, with the J&J vaccine, were the -- were the side effects of blood clotting -- were they more prevalent in some population subgroups than others?

MR. COLE: Objection. Foundation.

THE WITNESS: Yes. I believe they were.

BY MR. MEAD:

Q. What populations were those?

MR. COLE: Objection. Foundation.

THE WITNESS: Females, I believe, under 40 is the way I remember it, but I don't have a lot of clarity around that.

BY MR. MEAD:

Q. So, Dr. Taylor, going back to the timing of the J&J vaccine and House Bill 702. Did the publicized side effects of the J&J vaccine coincide

with the debate over House Bill 702?

MR. COLE: Objection. Vague. Calls for speculation. Lack of foundation.

THE WITNESS: I have no idea.

BY MR. MEAD:

Q. So, Dr. Taylor, are you aware of when House Bill 702 was passed?

A. I don't have the exact date, no. I'd say over a year ago. Right?

Q. Dr. Taylor, is it true to say that House Bill 702 was passed in April and May of 2021?

MR. COLE: Objection. Foundation.

THE WITNESS: You'll have to provide me with that information.

BY MR. MEAD:

Q. So, Dr. Taylor, if your opinion would publicized reports of the side effects of the J&J vaccine, would that lead to vaccine hesitancy?

MR. COLE: Objection. Calls for speculation. Lack of foundation and it's vague.

THE WITNESS: Well, I think it depends on how broadly you want to paint with a brush. So if -- say one model of car is removed because the gas tank blows up or something. Does that mean you're going to stop driving?

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the hospital could inquire as to an employee's vaccination status and treat a nonanswer as if that employee is not vaccinated. Correct?

MR. COLE: Objection. This calls for a legal conclusion. Lack of foundation.

THE WITNESS: To my knowledge, vaccination status was completely unknown prior to the federal bill or federal mandate.

BY MR. MEAD:

Q. Okay. And, Dr. Taylor, I -- I want to return to the scope of your expert report. Can you please state with particularity the opinions you're expressing?

MR. COLE: Objection. His opinions are set forth in his report.

You can answer the question.

THE WITNESS: Well, I would summarize my report as saying that the COVID epidemic is highly consequential. It's led to 90 million cases, a million deaths. The estimates on the number of deaths and cases averted are enormous numbers. You know, on the order of, you know, 2 million deaths were averted by the use of the vaccines.

You know, that's --- if we had to look at this in the opposite way, what would be the

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consequences in the United States if the vaccines had not been introduced in -- in as timely a manner as they were. I think that we'd all be arguing that the -- that the government was in arrears by not providing vaccines.

Vaccines are important in the control of disease. We have not seen a disease of this magnitude in our lifetimes. You know, perhaps you have to go back to the 1918 epidemic of influenza to find something with as severe as impact as this disease. Under those circumstances, I believe that the state has an obligation to try and control that disease as best as they can, using all the scientific and preventive medicine approaches that can possibly be used.

We, you know, want to be able to stop this epidemic. We do that by looking at this as something that affects us all and that we have a responsibility, you know, a community or a larger responsibility to -- you know, as a -- as a nation to be compliant to the things that -- that our nation feels will interrupt this outbreak.

And that information is very important for everyone to understand and to understand also that you're not only doing this for your own personal

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safety, but you're doing it for the safety of the community. And so it's that -- that feeling that -- that we need to get back to the importance of coming together as a -- as a state and as a nation to do the right thing that I think is so important.

Maybe there were other ways to roll out this vaccine. I think that, you know, we all look back now and say, you know, could we have done a better job in explaining the importance of this vaccine? Could we have done it in a way that would have allayed the fears of people? What if our two great parties had come together and said with one voice this is how we're going to save America. Would that have not been the right choice to make under these circumstances? I think it would have been.

And so, you know, I think those are the important points of my report.

BY MR. MEAD:

Q. Thank you, Dr. Taylor. And so I want to -- you just said that the state has an obligation to control disease as best they can. And so I just -- could you please clarify what you mean by the state's obligation?

A. The -- the state is composed of elected officials, is it not? These are the representatives

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of the people. They are there to understand matters that are beyond the individual to understand. They're our representatives.

I believe that if everyone understood the importance of vaccination in regards to the COVID epidemic and could understand also the, you know, fears that people have and figure out how to allay those fears so that they would be less reluctant to get the vaccine, less hesitant, that that would be to all of our welfare. So I think that, you know, that's -- that's what I think the state, you know, and the nation -- all of our elected officials need to do.

We need to take the best information that we have and apply it as best we can. And I think that, you know, just like in a -- in a, you know, force majeure, you know, where we're in the middle of a -- of a war and we have to recruit individuals to go to battle or whatever, that this is, you know, that kind of -- of requirement to -- to really fight this epidemic.

Q. Dr. Taylor, the elected officials, are they the ones that get to determine what's in the public welfare?

MR. COLE: Objection. Calls for a legal

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conclusion.
THE WITNESS: Well, the elected officials pass laws. That's one of their jobs. If they pass laws that are antithetical to public health, I think that we have to call them out on that and to find a way where we can come together and create a better law. If -- if the reason that the -- you know, we have to, I think, sit down with the creators of this law and find out what their underlying concerns were.
The other thing about this law that I think it's -- it's so narrow and associated with -- with really the COVID period here and that, you know, at some point in time that will pass, and there will be other problems.
Perhaps there will be researching some polio. Perhaps it will be monkey pox. Who knows what it's going to be? Perhaps it will be not the elderly that will be impacted. You know, there's plenty of flu outbreaks that impacted 20-year-olds.
So we -- we -- can't say that the epidemiology of COVID is always going to match what we have in the future. This law, you know, doesn't allow for the best medical practice, the best preventive medicine practice to be used. It -- it -- it sets -- it shackles best practices in my view.

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BY MR. MEAD:
Q. And so, Dr. Taylor, on that, who gets to determine the best medical practices?
MR. COLE: Objection. Calls for a legal conclusion.
THE WITNESS: I would say the best qualified.
BY MR. MEAD:
Q. Who are the best qualified?
MR. COLE: Same objection. Go ahead.
THE WITNESS: So we have federal agencies such as the Centers for Disease Control, the National Institute of Health, and the FDA, Food and Drug Administration. They provide this. We also have our legislature, national legislature opining on -- on various cases that come in and various ways to craft laws and -- and -- and our judicial body also.
So, you know, I think that -- that isn't it a mix of all of these things that -- that are important in -- in providing the justification for laws and for mandates. So in the -- in the case of -- of trying to get people vaccinated against COVID, we used part of the Health and Human Services to do that. So that's where those mandates came out of.
So the state also, you know, certainly has

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a say in what's going on. You know, for example, if we had a situation where, you know, Montana didn't have the same problem as New York state, you know, we say there was a -- something that said you had to be vaccinated against Lyme disease and, you know, there's no Lyme disease in Montana. You know, it would not be appropriate for a -- a mandate for Lyme disease to be used in Montana.
So the state health people or -- might, you know, provide that scientific information to suggest that the -- you know, there shouldn't be a national mandate to immunize against Lyme disease. You should only do it in endemic areas or and those who travel to endemic areas.
So that would be a situation where the state would have the ability to change the course of national policy.
BY MR. MEAD:
Q. Dr. Taylor, your report and testimony today, you are not testifying to any standard of care that Bozeman or any hospital in Montana posed to patients. Is that correct?
MR. COLE: I'm going to object. It's been asked and answered and it mischaracterizes the witness's testimony and his report.

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THE WITNESS: I'm thinking a minute about the best way to answer this. What I'm advocating for is transparency, that medical knowledge of who's vaccinated, who's not vaccinated, trying to figure out the reasons that people are not vaccinated, et cetera, and addressing those issues is -- is where we need to be.
We need to be able to work out the issues as an informed body of experts and people representing various groups and to, you know, make the best decision based on the information that's available. And then also reassure the people that, you know, these are not punitive kinds of mandates. We're not trying to chase people down in the streets and -- and immunize them. We're telling them that this is the best thing they can do for themselves and for their communities, you know, and to get that across.
And I think that if our elected officials, if our -- you know, anyone that -- that is a figure of respect in the community who advocates for vaccines, you know, is a plus, just like anything else. I mean, you know, if we want to have kids, you know, not smoke, if we want to have kids not, you know, indulge in -- in drugs or whatever, you know,

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we need to have, you know, public service approaches to -- to making sure they understand the dangers of that.

I think that when you have a divisive kind of situation that we have now in politics, you know, something like the COVID vaccine, you know, has become a political football, which is the last thing that you want to happen.

You know, what if this was cancer treatment and -- and the Republicans or the GOP had one opinion and the -- and the Democrats had another opinion? You know, you would say, well, who cares. Let's let the oncologists -- the cancer doctors determine what's best for that patient and -- and discuss that with the patient.

So, you know, I -- I think I would look at it like that. It's -- we -- we need to depoliticize this and make it a public health issue rather than a political issue.

BY MR. MEAD:

Q. So, Dr. Taylor, a couple questions based on that. Is it your opinion, then, that it was a positive for the medical community to advocate for the J&J vaccine prior to knowing its side effects?

MR. COLE: Objection. The question is

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vague. I think it mischaracterizes the witness's testimony at least.

THE WITNESS: I think that what we need to do is advocate what is the best policy. You know, right now, you know, we would say that the MRNA vaccines are by far the -- the best choice here. There is an overwhelming amount of safety data with the 500 million doses that have been given, and, you know, I think that -- that we can be reassuring to the public.

I myself, you know, have been double vaxed and double boosted and, you know, look forward to the next recommendations in my age group. I imagine that you're the same, you know. It's because we're two informed adults. What we need to do is be able to inform the rest of our state's people, you know, of the advantages of getting that vaccine.

BY MR. MEAD:

Q. Dr. Taylor, was it a positive good for the medical community to advocate for the J&J vaccine prior to acknowledgement of its complications?

MR. COLE: Objection. Asked and answered and I restate my objections.

THE WITNESS: You see I would say that as nonmedical people or nonpublic health people, that

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the -- the important statement is to say is to get vaccinated and then leave it up to the medical people or the public health people to say what's the best alternative to get vaccinated.

BY MR. MEAD:

Q. So, Dr. Taylor, can you please answer? Was it a good thing for the medical community to advocate for the J&J vaccine prior to knowledge of its complication?

MR. COLE: Objection. Because it's been asked and answered now three times.

THE WITNESS: So you're asking me why would we advocate for a vaccine that's been pulled off the market or -- or -- or, you know, reduced in its availability? We wouldn't.

BY MR. MEAD:

Q. So, Dr. Taylor, thank you. Thank you for that answer.

Why -- why did it occur last spring? Why did the medical community advocate for the J&J vaccine prior to the knowledge of those complications?

MR. COLE: I object to the form of the question and reassert all prior objections.

THE WITNESS: So are you saying that

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because the vaccine was licensed under EUA that that was an effication of it, or do you have other -- other advocacy that you're thinking of besides the emergency use authorization?

BY MR. MEAD:

Q. Dr. Taylor, was it a positive good for the medical community to advocate for the J&J vaccine last spring prior to what we now know about its side effects and complications?

MR. COLE: Same objection and at this point argumentative.

THE WITNESS: I think that's the way our system works, that the FDA and -- and their group of experts look at the data and make a decision on the use of the vaccine. It was not licensed fully, as you know. It was given an emergency use authorization because the -- the data looked good, you know, from a point of view of side effects as well as efficacy.

The -- I think the remarkable thing about how our system works is that we have a network to follow symptoms. And so oftentimes, you know, when you're talking about a rare complication, you won't see it until millions of people have received the vaccine, and that was the case in this particular

So, you know, when a child goes to their pediatrician, the pediatrician is -- is a person that the family has come to trust. And if the pediatrician says, you know, it's in your best interests to receive these immunizations, there's usually little pushback, on the order of 2 percent as we have seen in the -- in the publication that we just reviewed.

So I think that that could have happened with the COVID vaccines also. If they would been rolled out so that -- you know, as part of your going, you know, to your -- your physician, perhaps that would be a better way to improve the acceptance of the vaccine. You know, and that's obviously what's done now, you know, for influenza vaccines and for pneumoccal vaccines.

You know, you go to your internist, and they suggest things that you can do to, you know, protect your health, including vaccinations. And so that oftetimes is very important.

I think also is, you know, how much trouble is it that -- you know, if you -- if your internist suggests getting the COVID vaccine and he says by the way we have it just down the hall here in room 3, that would be -- also decrease the barrier.

You know, you don't have to make an appointment and, you know, go to some vaccine clinic someplace. You know, so all of those things, you know, might be helpful in improving our vaccination acceptance.

BY MR. MEAD:

Q. So, Dr. Taylor, one last question. How does HB 702 specifically prevent a doctor from recommending any vaccine to one of their patients?

MR. COLE: Objection. Calls for a legal conclusion.

THE WITNESS: I -- I think that -- that the problem as I see is that doctors in practices, you know, that are not allowed to determine if people are vaccinated. So that's -- that's the stipulation in the law, is that they're not allowed to determine if their personnel, you know, are vaccinated. So that's one step beyond recommendation. That's another step that says, you know, for me to ensure a safe working place, I need to know whether you're vaccinated. That's different from saying, you know, I'm going to fire you if you're not vaccinated, you know. That's -- that's completely different than that.

And I think that in my view if -- if there was a way to -- you know, can this law be made into a

better law? I think there are ways that it could be. And that might be one way is just to say, you know -- you know, we're not looking at punitive actions here. We're looking at best practices.

BY MR. MEAD:

Q. Dr. Taylor, where specifically in House Bill 702 does it prohibit a doctor from asking their patient their vaccination status?

MR. COLE: Objection. Calls for a legal conclusion, and this question has been asked and answered several times.

THE WITNESS: All I can say is that that's the way I interpret it, you know, is that, you know, hospitals are exempted, but doctors' offices are not exempted. They're under the law, and the law specifically says you can't ask about vaccination status. Am I misinterpreting it?

MR. MEAD: I think we're going to have again leave it that I -- I don't believe I got a complete answer, but we're going around a little bit in circles, I think. So I'd just like to note for the record that it's our position we don't believe the question has been asked -- answered.

MR. COLE: And we certainly disagree.

MR. MEAD: Yeah. So, Justin, that's my

last question. Excuse me. Strike that. Mr. Cole, that is my last question.

MR. COLE: We'll reserve all questions for trial.

MR. MEAD: Okay.

THE VIDEOGRAPHER: That concludes this deposition. The time is 12:46.

(Whereupon, the deposition concluded at 12:46 p.m.)

SIGNATURE RESERVED.

* * * * * * * * *

DEPONENT'S CERTIFICATE

I, DAVID N. TAYLOR, MD, the deponent in the foregoing deposition, DO HEREBY CERTIFY, that I have read the foregoing - 112 - pages of typewritten material and that the same is, with any changes thereon made in ink on the corrections sheet, and signed by me a full, true and correct transcript of my oral deposition given at the time and place hereinbefore mentioned.

_____
DAVID N. TAYLOR, MD

Subscribed and sworn to before me this _____day of _____, 2022.

_____
PRINT NAME: _____
Notary Public, State of Montana
Residing at: _____
My commission expires: _____

C E R T I F I C A T E

STATE OF MONTANA)
: ss
COUNTY OF GALLATIN)

I, Deborah L. Fabritz, Registered Professional Reporter and Notary Public for the State of Montana, residing in Bozeman, do hereby certify:

That I was duly authorized to and did swear in the witness and report the deposition of DAVID N. TAYLOR, MD, in the above-entitled cause; that the foregoing pages of this deposition constitute a true and accurate transcription of my stenotype notes of the testimony of said witness, all done to the best of my skill and ability; that the reading and signing of the deposition by the witness have been expressly RESERVED.

I further certify that I am not an attorney nor counsel of any of the parties, nor relative or employee of any attorney or counsel connected with the action, nor financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal on this 17th day of August, 2022.

Montana Medical Association, et al. v
Austin Knudsen,et al.

Carter Anderson 30(b)(6)
August 18, 2022

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION

MONTANA MEDICAL ASSOCIATION, et al.,
Plaintiff, No. CV-21-00108-DWM
and
MONTANA NURSES ASSOCIATION,
Plaintiff-Intervenors,
v.
AUSTIN KNUDSEN, et al.,
Defendants.

VIDEOCONFERENCE/VIDEOTAPED DEPOSITION
UPON ORAL EXAMINATION OF
DPHHS 30(b)(6) DESIGNEE CARTER ANDERSON

BE IT REMEMBERED, that the videoconference/videotaped deposition upon oral examination of DPHHS 30(b)(6) Designee Carter Anderson, appearing at the instance of the Plaintiffs Montana Medical Association, et al., was taken at 800 North Last Chance Gulch, #101,

Helena, Montana, on Thursday, August 18, 2022, beginning at the hour of 9:21 a.m., pursuant to the Federal Rules of Civil Procedure, before Mary R. Sullivan, Registered Merit Reporter, Certified Realtime Reporter, and Notary Public.

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I N D E X

EXHIBITS:

INDEX: (Contd.)
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S T I P U L A T I O N S

It was stipulated by and between counsel for the respective parties that the deposition be taken by Mary R. Sullivan, Freelance Court Reporter and Notary Public for the State of Montana, residing in Missoula, Montana.

It was further stipulated and agreed by and between counsel for the respective parties that the deposition be taken in accordance with the Federal Rules of Civil Procedure.

It was further stipulated and agreed by and between counsel for the respective parties and the deponent that the reading and signing of the deposition would be expressly reserved.

THURSDAY, AUGUST 18, 2022

THE VIDEOGRAPHER: This is the video-recorded and videoconference deposition of Carter Anderson, 30(b)(6) representative of the Department of Health and Human Services, taken in the United States District Court for the District of Montana, Missoula Division. Cause No. CV-21-00108-DWM, Montana Medical Association, et al., and Montana Nurses Association vs. Austin Knudsen, et al.

Today is August 18th, 2022. The time is 9:21 a.m.

We are present with the witness at the offices of Fisher Court Reporting at 800 North Last Chance Gulch, No. 101 in Helena, Montana.

The court reporter is Mary Sullivan, and the video operator is Nicole Tomac of Fisher Court Reporting.

The deposition is being taken pursuant to notice.

I would now ask the attorneys to identify themselves, who they represent, and whoever else is present. For those attending remotely, please note from where you are appearing.

MS. MAHE: My name is Katie Mahe, and

with me today is Justin Cole, and we represent the plaintiffs.

MR. GRAYBILL: My name is Raph Graybill on behalf of the Montana Nurses Association.

MR. MEAD: Brent Mead on behalf of defendant Austin Knudsen and Laurie Esau in their official capacities. On the line appearing remotely from Helena, Montana is David Dewhirst also representing the defendants.

MR. KRASKE: And Justin Kraske representing Department of Public Health and Human Services.

THE VIDEOGRAPHER: The court reporter will now administer the oath.

Thereupon,

DPHHS 30(b)(6) DESIGNEE CARTER ANDERSON, a witness of lawful age, having been sworn to tell the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MS. MAHE:

Q. Mr. Anderson, we met a little bit before we began today. Have you ever had your deposition taken before?

A. No.

Q. Okay. So before we get started, I'm just gonna to go over some kind of the ground rules about the deposition to help you understand what's happening here today.

We have our court reporter. She's taking down everything that we're saying, and so we want to make sure that we get a clear record. So it's important for you and I not to talk over each other if we can.

Do you understand that?

A. We're good.

Q. Well, that brings me to my next point that it's very important that you answer verbally to my questions because the transcript can't pick up hand gestures and things like you did.

Can you answer verbally for me today?

A. Yes.

Q. And I'm not trying to trick you today. I'm -- I'm trying to get your full and complete testimony. I want to make sure you understand my questions, so if you don't understand my question, will you let me know?

A. Yes.

Q. And if you answer my question, is it safe for me to assume that you understood what I was

asking?

A. Yes.

Q. And this is not an endurance contest. If you need a break at any time, you just let me know, okay?

A. Thank you.

Q. The only thing I ask is if I have a question pending, that you will answer that question before we take a break. Is that okay?

A. Yes.

Q. And if I ask you a question today and during the course of your deposition you think of additional information or clarification, will you provide that to me?

A. Yes.

Q. Is there any reason that you're prevented from giving complete and accurate answers today?

A. No.

EXHIBIT:

(Deposition Exhibit 34 marked for identification.)

BY MS. MAHE:

Q. The court reporter has handed you what has been marked as Deposition Exhibit 34. Have you seen this document before?

A. Yes.
Q. And is this the subpoena to testify at the deposition for the Department of Public Health and Human Services?
A. Yes.
Q. And you're -- you're here today, so I'm assuming that you are coming in response to this subpoena?
A. Yes.
Q. And there's also a Subpoena Duces Tecum, which is a fancy word for a subpoena to produce documents, in this document as well. Do you see that there?
A. Yes.
Q. And were you part or did you participate in compiling the documents that were produced in response to the subpoena?
A. I'm not exactly sure what all they submitted. I did submit some information to my attorneys, but I'm not sure what they submitted in response. I can't answer that.
Q. Well, yesterday we got about a thousand -- 1,153 documents from DPHHS. Does -- Have you seen those documents?
A. I can't say I've seen them all, but I've

-- I've seen quite a few.
MS. MAHE: And we'll have that marked as Exhibit 35.
EXHIBIT:
(Deposition Exhibit 35 marked for identification.)
BY MS. MAHE:
Q. The court reporter has handed you what's been marked as Exhibit 35. That's the privilege log that we received in response to the subpoena. Have you seen that document before?
A. Yes.
Q. Okay. And I might have given away all my copies. I didn't.
I just have some quick questions for you on this.
Did you help create this document?
A. No.
Q. Okay. So when it says "Author(s)" and then it has an author and then says "and recipients," do you know what that means? Is that all of the people listed in the box next to it? That's my -- That's my question.
MR. MEAD: Objection. Vague.
///

BY MS. MAHE:
Q. Did you understand my question?
A. Not really.
Q. Okay. What I'm trying to figure out is you see under the "Author" box. Let's just look at the first one.
A. Yes.
Q. It says "Robert Lishman and recipients."
A. Mm-hmm.
Q. Does that "recipients" reference the box next to it, do you know?
A. Okay. Yeah.
Q. Okay. And I don't know, so that's why I'm asking you.
A. And I -- And I don't really know either. I mean, I understand the way this reads it looks like these -- this person wrote it and these people received it.
Q. Okay. And is Robert Lishman an attorney?
A. Yes.
Q. Okay. Is Paula Stannard -- Stannard an attorney?
A. Yes.
Q. Okay. You have been designated by the Montana Department of Public Health and Human

Services to testify on its behalf related to the topics in the 30(b)(6) subpoena. Correct?
A. Yes.
Q. And you were informed that you were going to be testifying on behalf of DPHHS?
A. Yes.
Q. And if I say "DPHHS," do you know what I'm talking about?
A. Yes.
Q. If I also say "the department," would you know that I was talking about DPHHS?
A. Yes.
Q. Did DPHHS gather all the information known or reasonably known to it regarding the topics in the 30(b)(6) subpoena?
MR. MEAD: Objection. DPHHS objected to those topics.
You can answer subject to those objections.
A. To my knowledge, yes.
BY MS. MAHE:
Q. And describe the process that DPHHS did to make sure that you have all of the information and knowledge of DPHHS on those topics for which you are designated to testify.

MR. MEAD: Before you answer, I'm going to make sure that you're not to discuss anything that was between you and an attorney.

You can go ahead and answer.

A. Can you re -- Can you -- Could you ask the question again, then?

BY MS. MAHE:

Q. Sure. Can you describe the process that DPHHS did to make sure that you have all of the information and knowledge of DPHHS on the topics for which you have been designated to testify?

A. Most of the information was emailed to me for me to review, and we had two phone calls to discuss it.

Q. And were those phone calls with the attorneys?

A. There were attorneys on the call, yes.

Q. What documents did you review in order to prepare?

A. That -- That list is way -- way too long for me to actually quote. There was a -- There was quite a few documents sent to me. I couldn't quote you which ones, all they were.

Q. Okay. Well, do you know generally what kind of documents?

MR. MEAD: Objection. Vague.

BY MS. MAHE:

Q. You get to answer.

A. Generally documents related to information that was produced related to the vaccine requirements out there. Documents that we received from the Center for Medicaid Services, Medicare, CMS that we received in the certification bureau that was related to vaccine requirements. Also documents related to the state hospital -- Montana State Hospital.

Q. Did you review the CMS conditions of participation?

MR. MEAD: Objection. Vague as to conditions of participation is broad.

BY MS. MAHE:

Q. You can answer.

A. No.

Q. Did you review PowerPoint presentations that DPHHS provided to us in response to the subpoena?

A. Yes.

Q. Did you review correspondence that DPHHS provided to us in response to the subpoena?

MR. MEAD: Vague as to what you mean by

"correspondence."

BY MS. MAHE:

Q. You understand what "correspondence" means?

A. I understand what "correspondence" means, but I don't recall reviewing any direct correspondence between attorneys.

Q. Okay. And that's not what I'm asking. I'm asking did you review any DPHHS correspondence? Internal emails, letters, memos?

A. Yes.

Q. And other than the attorneys, who did you speak with to prepare?

A. No one.

Q. Did you review the discovery responses provided in this case?

A. Yes.

MR. MEAD: Objection. Which discovery responses are you referring to?

MS. MAHE: Well, I don't know what he's reviewed.

BY MS. MAHE:

Q. So what -- what discovery responses did you review?

A. I'd have to see them in writing what

you're talking about 'cause I don't -- I reviewed so much stuff I can't really distinguish between whether it was a discovery response or this, that, or the other.

Q. Did you review the discovery responses from the defendants that they had created? Did you review those?

A. Again, I'd ask you to show me what you're asking me if -- if I reviewed it or not. I reviewed so many documents it's hard for me to tell you if it was a discovery document or this document. I'm not a lawyer.

Q. Did you review all the documents that were produced in response to the subpoena?

A. I reviewed all the documents I was supplied.

Q. Is there an email that would list through the documents that you were supplied?

A. There were emails that supplied me documents, but I don't -- couldn't tell you if it was a master list for those or not.

Q. And were those documents all provided by attorneys?

A. Yes.

Q. Other than the attorneys, has anyone with

DPHHS done anything to make you aware of documents in this case?
A. No.
Q. Are you confident that you possess the relevant and discoverable information to testify on topics for which you've been designated?
A. Yes, with a caveat as long as I have the documents in front of me that you're -- that I'm questioned on, then I would feel confident to make sure that I'm refreshing my memory.
Q. And you understand that today you're testifying as to the collective knowledge of DPHHS?
A. Yes.
Q. You understand you have an affirmative duty to be prepared to testify fully and knowledgeably on behalf of DPHHS today on the topics upon which you have been designated to testify?
A. Yes.
Q. And you understand that your testimony here today is not in your individual capacity.
A. Yes.
Q. And that when you're answering my questions, you are answering on behalf of DPHHS.

A. Yes.
Q. Are you an employee of DPHHS?
A. Yes.
Q. Okay. What is your job title?
A. Currently the acting CEO of the Montana State Hospital.
Q. And what were you -- we talked a little bit before your deposition, but what did you do before that?
A. Prior to that assignment I was the inspector general for the OIG office.
Q. And how long have you been the CEO of Montana State Hospital?
A. Since May 9th.
Q. And, I'm sorry, before that you said you were?
A. The inspector general for -- the office of the inspector general with DPHHS.
Q. And how long did you hold that position?
A. It started as the division administrator of quality assurance in June of -- of 2018, and then it was converted -- the same job was converted to the OIG office about a year and a half ago. Roughly. I couldn't give you an exact date.

Q. And prior to that did you hold a position with DPHHS?
A. No. Prior to 2018, no.
Q. And what did you do before that?
A. I've been the CEO of Acadia Hospital, and I worked for AWARE as a COO for 16 years. I've done various other things prior to that.
Q. How much time did you spend preparing for this deposition?
A. Six hours, possibly.
Q. And how much time do you think you spent reviewing documents?
A. Four hours, maybe.
Q. You understand today that when I say "you" when I'm referring to these questions, I'm referring to DPHHS?
A. I understand that now.
Q. Okay. What is DPHHS's role in relation to determining whether healthcare facilities are in compliance with the conditions of participation for Medicare and Medicaid?
A. DPHHS has a contract with the Center for Medicaid -- as far as CMS to provide certification services.
Q. And we need to make sure that we're

really articulating 'cause I think the court reporter's having a hard time. I talk very fast --
A. Mm-hmm.
Q. -- so I'm going to work on that, and if you can work on articulating, hopefully we won't have her throwing things at us.
A. Yes.
Q. You mentioned that you had a contract with CMS?
A. Mm-hmm.
Q. Is that a yes?
A. Yes.
Q. And as part of that contract you -- DPHHS performs compliance reviews and surveys?
A. Yes.
MR. MEAD: Objection. Compound.
BY MS. MAHE:
Q. Did you understand my question?
A. The terminology's not right, but the answer is yes.
Q. Well, give me the correct terminology.
A. We did recertification surveys as well as complaint surveys as well as initial surveys for CMS.

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Q. I'm sorry, was that a yes?
A. Yes. This would have been in an effort to help providers to understand what -- what their expectations would be under the CMS guidance that was issued.
Q. And do you know when this was created?
A. No.
Q. Do you know who created it?
A. No.
Q. Do you know who would know that information?
A. Maybe.
Q. And who would that be?
A. I would say Charlie Brereton was most -- most likely involved in this type of a -- of a documentation that would go out. I would assume that our legal team would have reviewed it.
Q. And, I'm sorry, you said Charlie Britton [phonetic]?
A. Britton, yeah. Bareton, Brereton. Charlie Brereton. He's our current director. At the time I would say he was either at the governor's office or he was our chief operating officer. I'm not sure what his role was when this was produced.

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Q. And did you speak with him to get his information about the topics in the 30(b)(6) notice before today?
A. No.
Q. And you mentioned the legal team. Is there anyone else with DPHHS that would know information about this guidance?
A. Possibly Jon Ebelt, our public information officer.
Q. Jon?
A. Ebelt. E -- Just like it says. Ebelt.
Q. Did you speak with Jon before coming today in preparation for this deposition?
A. No.
Q. So I have some questions about this guidance. Are you the person with DPHHS that is most knowledgeable about this document?
A. No.
Q. So you have not been prepared to testify about this document today? And by "this document," I'm just talking about the guidance, not the FAQs.
A. I understand what's written in here if that's what you're asking.
Q. Would you have information about why it was written?
A. No.
Q. Because, for example, you know, it talks about the OSHA standard in here. Do you see that on page 1?
A. Yeah. Yes.
Q. DPHHS isn't responsible for anything related to OSHA, is it?
MR. MEAD: Objection. Calls for a legal conclusion.
A. No.
BY MS. MAHE:
Q. So you don't know why that was included in here?
A. It was -- The initial information that we received from CMS included this documentation. This is right out of what was written from the -- the Biden administration on why they were implementing vaccine requirements.
Q. Okay. So this is a direct quote from what the Biden administration provided?
A. Yes.
Q. On page -- it's going to be page 6 of Exhibit 36, but it's page 2 of the guidance?
A. Mm-hmm.

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Q. There's a bunch of bullet points, and following that is a paragraph. Do you see that? It starts with "Religious Nonmedical"?
A. Yes.
Q. Okay. The second sentence of that paragraph says "The CMS mandate also does not apply to Assisted Living Facilities, Group Homes, physician offices, noncertified therapy providers," et cetera.
Do you see that there?
A. Yes.
Q. And is that because assisted living -- living -- I can't talk today, sorry -- assisted living facilities are not covered by the conditions of participation for facilities under Medicare and Medicaid?
A. Yes.
MR. MEAD: Objection. Calls for a legal conclusion.
BY MS. MAHE:
Q. I want to make sure we got your answer on the record there.
A. Yes.
Q. On the -- It's the second full paragraph from the bottom of that page. It starts with "CMS

Q. Okay.
A. -- if you guys are good. Ask me in ten minutes.
Q. All right. Before we mark these for an exhibit, it might make more sense for me to just ask you which one is current, so I'm gonna ask you about the QSOs. Do you know what those are?
A. Yes.
Q. Okay. So there is a QSO from January 14th, and you can look at both of these. I'm pretty sure the revised QSO is the current one, but if you want to just peek at those and tell me.
A. The revised one would be your current QSO.
Q. Okay. Then we won't muck up the record with the noncurrent one.
EXHIBIT:
(Deposition Exhibit 38 marked for identification.)
BY MS. MAHE:
Q. The court reporter has handed you what has been marked Deposition Exhibit 38. Have you seen this document before?
A. Yes.

Q. And is this the current QSO from CMS related to the COVID CMS vaccine mandate?
A. Yes.
Q. Okay. And it looks like this one is dated January 14th, 2022, but revised April 5th, 2022. Is that right?
A. Yes.
Q. And in the memorandum summary, that section, is this guidance that CMS provides to the state survey agency directors related to the COVID vaccine mandate?
A. Yes.
Q. And it's for the procedures for assessing and maintaining compliance with the regulatory requirements?
A. Yes.
Q. And in that box there it says that this one applies to Montana?
A. Yes.
Q. Under the second page of Exhibit 38, there's a paragraph entitled "Vaccination Enforcement - Surveying For Compliance."
Do you see that?
A. Yes.
Q. And we talked a little bit before about some of the potential penalties for failing to comply with the conditions of participation. That last sentence in that paragraph says "The sole enforcement remedy for non-compliance for hospitals and certain other acute and continuing care providers is termination."
Do you see that there?
MR. MEAD: Objection. That's not the whole sentence.
BY MS. MAHE:
Q. Do you see that there?
A. Yes.
Q. Thanks. And then it says "however, CMS's primary goal is to bring health care facilities into compliance." Correct?
A. Yes.
Q. So this -- but the sole penalty is termination if they don't come into compliance. Correct?
A. The ultimate penalty.
Q. And in that next paragraph in bolded letters it says "Facility staff vaccination rates under 100% constitute non-compliance under this rule." Is that accurate?
A. Yes.

Q. And your surveyors, when they go out, they are looking for compliance with this QSO. Correct?
A. Yes.
Q. And on page 4 there it says "Within 90 days and thereafter following issuance of this memorandum, facilities failing to maintain compliance with the 100% standard may be subject to enforcement action."
Do you see that?
A. Yes.
Q. Okay. And then there is a list of the provider-specific guidance, and I did not include all those attachments in your exhibit today, but I am going to ask you some questions about some of them.
So I'm assuming that the revised QSO hospital attachment is the most current version. Is that accurate?
A. Yes.
Q. Again, I won't muck the record with the other one.
EXHIBIT:
(Deposition Exhibit 39 marked for identification.)

BY MS. MAHE:
Q. The court reporter has handed you what has been marked Deposition Exhibit 39. Have you seen this before?
A. Yes.
Q. And what is this document?
A. It's a supplemental attachment with some guidance on -- for our surveyors on the process for reviewing vaccine compliance and other things.
Q. So this is guidance that your surveyors use when they go and do on-site compliance --
A. Yes.
Q. -- surveys? And this particular one is for hospitals. Correct?
A. Correct.
Q. If you turn to page -- well, it's marked at the bottom DPHHS 67.
A. Okay.
Q. The paragraph says "The policy must also ensure." Do you see where I'm reading? It's under "Policies" --
A. Yes.
Q. Says [As Read]: "The policies must also ensure those staff who are not yet fully vaccinated, or who've been granted an exemption or

accommodation as authorized by law, or who have a temporary delay, adhere to additional precautions that are intended to mitigate the spread of COVID-19."
Do you see that?
A. Yes.
Q. So when your surveyors go in, are they making sure that those staff who are not vaccinated are required to have additional precautions?
A. Yes.
Q. And some of those precautions are listed there below in those bullet points. Is that correct?
A. Yes.
Q. And some of them can be requiring at least weekly testing for those nonvaccinated staff?
A. That's an option.
Q. Another option would be requiring the nonvaccinated staff to wear an N95 mask?
A. Yes.
Q. Or a higher level respirator?
A. Yes.
Q. And the hospitals also have to provide a

process for how they're ensuring their contracted staff are compliant with the vaccine requirement. Correct? You can look at page DPHHS 72.
A. Yes.
Q. On the next page, page 73 --
A. Mm-hmm.
Q. -- it goes through what are acceptable forms of proof of vaccination. Do you see that there?
A. Up top?
Q. Yep. So it says "For each individual identified by the hospital as vaccinated."
A. Yeah.
Q. Then it says "surveyors will: Review hospital records to verify vaccination status." Correct?
A. Yes.
Q. So your surveyors are actually having to look at the records. Right?
A. Yes.
Q. And the records that they can look at are the CDC COVID-19 vaccination record card. That's one, right?
A. Mm-hmm. Yes.
Q. Or documentation of vaccination from a

healthcare provider or an electronic health care record. That's another.
A. Yes.
Q. And then the only other one is the state immunization information system.
A. Yes.
Q. And they also have to have that proof from their contract staff as well.
A. Yes.
Q. Same question with the critical access hospital attachment. The revised one is the most current?
A. Yes.
EXHIBIT:
(Deposition Exhibit 40 marked for identification.)
BY MS. MAHE:
Q. The court reporter has handed you what has been marked as Exhibit 40. Do you know what that document is?
A. Yes.
Q. What is it?
A. It's the critical access hospital guidance from CMS for vaccine requirements.
Q. So, again, this is some guidance that

Q. How?
A. We do -- We do surveys based on either recertification dates, initial requests, or on complaints, so -- and complaints generate us -- have a -- a scale of -- of severity, which generate us doing surveys based on timeframes. So seemed relevant that we have not had any complaints come in about the vaccine requirement to me.
Q. So it seemed relevant for you to include it in this declaration, right?
A. At the time.
Q. But it didn't seem relevant for you to prepare on that topic for the DPHHS deposition today?
A. I think I am prepared short of being beyond May 9th. I can't tell you what happened after May 9th. I've been on another assignment that's a full-time job.
Q. And May 9th is a little over three months ago?
A. Yeah.
EXHIBIT:
(Deposition Exhibit 42 marked for identification.)

BY MS. MAHE:
Q. The court reporter has handed you what has been marked Deposition Exhibit 42. Have you seen this before?
A. Yes.
Q. Okay. And is this another QSO that is sent to state survey agency directors from CMS regarding surveys that are performed by DPHHS?
A. Well, yes, but it's regarding the vaccination expectations for surveyors.
Q. Correct. And -- And what is -- what is the vaccination expectation for surveyors in this QSO?
A. Generally that they have received the vaccination or they have an exemption similar to would be in the requirement for the other facilities.
Q. And so on the second page of that under the "Guidance For State Survey Agency and Accrediting Organization Surveyors" --
A. Mm-hmm.
Q. -- do you see where it says [As Read]: "Surveyors who are not fully vaccinated (unless vaccination is medically contraindicated or the individual is legally entitled to a reasonable

accommodation under federal civil rights laws because they have a disability or sincerely held religious beliefs, practices, or observations that conflict with the vaccination requirement) should not participate as part of the we do that survey team performing federal oversight of certified providers and suppliers (including accreditation surveys performed under an AO's deeming authority."
Do you see that sentence?
A. Yes.
Q. And did DPHHS comply with this provision while this QSO was in effect?
MR. MEAD: Objection. That calls for a legal conclusion.
A. Yes.
BY MS. MAHE:
Q. So you required your surveyors to have vaccination to go on-site?
A. Or an exemption.
Q. And this QSO was in effect looks like from January 25th, 2022, and I think it was rescinded in June of this year. Is that right?
A. Yes.
Q. So DPHHS describes itself as improving

and protecting the health, well-being, and self-reliance of all Montanans. Correct?
A. Correct.
Q. And you'd agree with me that infection prevention protocols and healthcare facilities are designed to protect the health of patients and staff. Right?
MR. MEAD: Objection. Vague.
A. Yes.
BY MS. MAHE:
Q. And infection prevention protocols promote public health. Correct?
A. Yes.
Q. I want to turn to the state hospital now. I know that you're currently the CEO. Correct?
A. Yes.
Q. And you haven't been in that role very long. Correct?
A. Since May 9th.
Q. It might feel like a long time to you.
A. Been a couple years now.
Q. And in April of this year, CMS terminated the state hospitals provider agreement for failure to comply with the conditions of participation. Correct?

A. Yes.
Q. That was prior to your tenure there.
A. Yes.
EXHIBIT:
(Deposition Exhibit 43 marked for identification.)
BY MS. MAHE:
Q. The court reporter has handed you what has been marked Exhibit 43. Have you seen this document before?
A. Yes.
Q. And what is this document?
A. It's an involuntary termination of the Medicare provider disagreement with Medicaid between the Montana State Hospital and Center for Medicare and Medicaid Services.
Q. And it looks like here that it goes through sort of the process that DPHHS went through with the survey. Correct?
A. Yes.
Q. So it looks like the original complaint survey was in February of 2022?
A. Correct.
Q. And then on February 18th CMS issued a statement of deficiencies regarding noncompliance.

Is that correct?
A. Yes.
Q. And one of the reasons it was out of compliance was related to 42 CFR 482.42, which is the infection control. Correct?
A. Yes.
Q. And that was related to infection control related to COVID. Right?
A. Yes.
Q. Then it looks like there was a revisit survey that occurred in February 23rd of 2022. Is that right?
A. Yes.
Q. And that survey found that those previously cited deficiencies, which resulted in immediate jeopardy, were still not corrected. Correct?
A. Correct.
MR. MEAD: Objection. This -- So long as this is limited to the infection control IJs, not the other IJ findings. Those other IJ findings are irrelevant.
MR. GRAYBILL: Is your objection relevance?
MR. MEAD: Yes.

BY MS. MAHE:
Q. Okay. You can answer.
A. Could you ask the question again?
Q. Maybe. The revisit survey --
A. Yes.
Q. -- February 23rd, 24th --
A. Yeah.
Q. -- found that those previous deficiencies which resulted in immediate jeopardy had still not been corrected. Correct?
A. Yes, but I believe they were related more to the -- the psychotropic medications, right?
Q. Well, there was an additional --
A. Okay.
Q. -- immediate jeopardy that was related to the psychotropic medications. Right?
A. Correct.
Q. And --
A. That's right. So yes, you're right.
Q. And then they did a second revisit on March 9th, 2022, right?
A. Correct.
Q. And all three of those deficiencies that resulted in immediate jeopardy were still there. Right?

A. Correct.
Q. Okay. And then it looks like there was another survey that was a complaint survey that happened on March 24th and 25th of 2022. Right?
MR. MEAD: Objection. Relevance.
A. Yes.
BY MS. MAHE:
Q. Yeah. And in that investigation they found that the three other previously cited deficiencies, which were immediate jeopardy level deficiencies, remained. Correct?
A. Yes.
Q. And ultimately the state hospital lost the ability to participate in Medicare and Medicaid under this letter. Correct?
A. Yes.
Q. And how much to date has the state hospital lost in reimbursement?
MR. MEAD: Objection. Speculation.
A. The -- The stated amount was about 7 million. What we determined so far, it's a little -- somewhat less than that, but I don't have exact numbers. But it was closer to about 6 million is what I've come up with.
///

BY MS. MAHE:
Q. Have you done any projections about what the future loss of reimbursement will be?
MR. MEAD: Objection. Speculation.
MS. MAHE: I asked has he done any.
BY MS. MAHE:
Q. Have you?
A. Yes.
Q. And what is the projected loss?
MR. MEAD: Same objection.
A. I really can't answer that accurately because there's too many variables of things that would happen. In other words, I've done projections in my head of if this, then that would equal into different dollar amounts. And those if then and then thats are -- are -- are not really relevant to anything, they're just my hypotheticals of well, if we do this, we do that, what will happen, and some of those things are determined that they're not eligible to do. We looked at the options of trying to get Medicaid eligibility for our group homes, but we didn't meet the -- the actual setting rules, and the projection there would have been close to about 4 million that -- that we could have generated, but

we didn't -- we were outside of the settings rule, if you understand the settings rule and the -- the way CMS determines things. So I've done some projections that didn't work out, but right now I think had we not lost that, that's hard to say too because you have the -- the IMD exclusion and did that -- that didn't come to fruition as a result of losing that, so there's a whole different set of projections that you would do based on that.
BY MS. MAHE:
Q. Is the state hospital currently being subsidized through the general fund?
MR. MEAD: Objection. Vague as to what you mean by "subsidized."
A. I'm not -- I'm not sure what you mean by "subsidized," but our revenue does come from general fund and other areas throughout state government. We might get -- I call -- I call tax money. I -- You'd have to talk to BFSD about how they're funding things.
BY MS. MAHE:
Q. Has that -- Has that loss of reimbursement made it difficult to operate the state hospital?
MR. MEAD: Objection. Vague.

A. Not yet.
BY MS. MAHE:
Q. Do you think it's coming?
MR. MEAD: Objection. Speculation.
BY MS. MAHE:
Q. You can answer.
A. Yes.
Q. That's the problem when preparing late last night. All over the place.
EXHIBIT:
(Deposition Exhibit 44 marked for identification.)
BY MS. MAHE:
Q. The court reporter has handed you what has been marked as Deposition Exhibit 44, and I'll represent to you that this is part of a PowerPoint presentation that was provided to us by DPHHS in response to the subpoena. So I just want to make sure I understand. Assisted living facilities are not Medicare or Medicaid certified facility providers. Correct?
A. Correct.
Q. So they are not subject to the CMS conditions of participation. Correct?
A. Correct.

Q. Okay. And they are not surveyed under those conditions of participation.
A. That's correct.
Q. And they don't risk losing funding from Medicare and Medicaid based on not complying with the conditions of participation.
A. Correct.
EXHIBIT:
(Deposition Exhibit 45 marked for identification.)
BY MS. MAHE:
Q. The court reporter has handed you what has been marked Exhibit 45. Have you seen that document before?
A. Yes.
Q. And is -- what is this document?
A. It's the House Bill 702 guidance for -- It's the House Bill 702 guidance.
Q. From DPHHS.
A. Yes.
Q. And is it dated on September 1st, 2021? It's at the very bottom.
A. Yes.
Q. Okay. It says it was updated on that date. Do you know what it said prior to

September 1st, 2021?
A. No.
Q. Did you create this document?
A. No.
Q. Do you know who created the document?
A. Well, it says it was sent out by Jon Ebelt, our public information officer. I assumed that he would be part of the creation of the document.
Q. Did you talk to Jon Ebelt in preparation for your deposition today?
A. No.
Q. Who was this document given to?
A. It was posted publicly for anyone who needed -- who was interested.
Q. Why was -- Why did DPHHS put out guidance on House Bill 702?
MR. MEAD: Objection. Deliberative process.
MS. MAHE: What is your objection?
MR. MEAD: To the extent you're asking him to enunciate the views of why the department chose to do something, the DPHHS has lodged objections based on deliberative -- excuse me, deliberative process.

MS. MAHE: You know that that only applies to federal agencies, right?
MR. GRAYBILL: There is no such privilege in Montana government. The state has taken the position in O'Neill v. Gianforte that no Montana court has ever recognized such a privilege. It's not a thing. The very purpose of a 30(b)(6) deposition is to find out why the government agency did what it did. That is why we are here.
MR. MEAD: Restating the privilege objections that are found within DPHHS's letter to you.
MS. MAHE: Are you instructing him not to answer?
MR. MEAD: He can answer as to the nonprivileged portion.
BY MS. MAHE:
Q. Why -- Why did DPHHS create this document?
A. So the public, in general, would understand how to comply with the -- the House Bill 702.
Q. So does DPHHS determine compliance with House Bill 702?
A. No.

Q. Did DPHHS put out written guidance for hospitals about how they can comply with 702 and the CMS vaccine mandate?
MR. MEAD: Objection. Compound.
A. No. We did hold public meetings with conversations about it, but I don't recall any -- any written documentation.
BY MS. MAHE:
Q. And how -- how do you make the decision of whether to give written documentation versus a public meeting?
MR. MEAD: Objection. That that -- that's again going into the privilege that's been noted by DPHHS in their letter to counsel.
MS. MAHE: Are you instructing him not to answer?
MR. MEAD: He can answer as to the nonprivileged portion.
MR. GRAYBILL: And I'll just reiterate this is a privilege that the state of Montana has taken the position that no court has ever recognized as to the state of Montana.
BY MS. MAHE:
Q. You can answer.
A. Do you want to ask the question again?

Q. I can't remember it.
MS. MAHE: Mary, could you read it?
THE COURT REPORTER: "How do you make the decision of whether to give written documentation versus a public meeting?"
A. When we feel like that there needs to be information out there for people to have, we try to put it out there publicly as much as possible such as developing the PowerPoints that -- that your -- so that people can have those. As far as public meetings are there to help clarify if there's questions about what we've put out there. So when we feel it's important the people have the guidance we -- we place it out there for them to have that, and if they have questions about the guidance to get clarification, we'll have public meetings or conversations about those things.
BY MS. MAHE:
Q. Okay. So in this particular instance why wasn't there written guidance provided to hospitals about how they can comply with 702 and the CMS vaccine mandate?
MR. MEAD: Objection. Compound.
A. I think the guidance applied that we did put out -- put out covers for everyone. It wasn't

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specific to any one provider.
BY MS. MAHE:
Q. And what is the guidance of DPHHS on how hospitals could comply with the CMS vaccine mandate and House Bill 702?
MR. MEAD: Objection. Compound; vague.
A. They should review QSO 22-09, the guidance produced by CMS.
BY MS. MAHE:
Q. So they should comply with the federal conditions of participation guidance?
A. Correct.
Q. On Exhibit 45, the second paragraph under the "Considerations For Local Government."
Do you see that?
A. Mm-hmm.
Q. There's a sentence, it's the last sentence of that paragraph, it says [As Read]: "Additionally, depending on the circumstances, unvaccinated individuals who do not quarantine or isolate despite having knowledge of having come into close contact with an infected person or being infected could potentially be subject to claims of legal liability from individuals -- individuals they infect within the community."

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Do you see that there?
A. Yes.
Q. So when you're talking about unvaccinated individuals, would that also apply to unvaccinated individuals who are employees of hospitals?
A. I would think so if it -- if they didn't have an exemption.
Q. Okay. And same thing for critical access hospital employees.
MR. MEAD: Objection. The document that you are quoting from says "Considerations For Local Government," not critical access hospitals.
A. Again, I would assume this is generated by one of the legal team 'cause it talks about legal liability. So in my view of this, it -- it would apply to all.
BY MS. MAHE:
Q. How are you doing? Do you need a break?
A. I'm good. How are you?
Q. I'm doing fine. Thank you.
A. Okay. I'm worried about you.
Q. You're the first person who ever has.
EXHIBIT:
(Deposition Exhibit 46 marked for identification.)

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BY MS. MAHE:
Q. The court reporter has handed you what has been marked Exhibit 46. Again, this was part of the production DPHHS gave us in response to the subpoena.
A. Mm-hmm.
Q. It's an email chain, and whenever we print these out, they work backwards. So if we start on the last page, that'll be the first email in the chain, and then we go backwards through it.
A. Mm-hmm.
Q. So have you seen this document before?
A. Yes.
Q. And it looks like it's an email -- It starts off with email correspondence to you from Duane Preshinger?
A. Mm-hmm.
Q. Is that a yes?
A. Yes.
Q. And who is Duane?
A. Duane Preshinger works for the Montana Hospital Association. He's the vice president, I guess.
Q. Okay. And that -- We didn't actually get the original email with the attachment, but it

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says "Hi Carter, here is the document that was being shared with Bitterroot Health regarding their survey."
Do you see that?
A. Yes.
Q. Do you recall what document that was?
A. No.
Q. Okay. Then there's some -- some conversations there if you look starting on page 2 on to page 3, looks like another email from Duane to you. If you want to just take a second to read that.
A. Which one are you looking at?
Q. Yeah. I'm starting the one that starts at the very bottom of page 2. Says "Yes, Bitterroot is a CAH."
A. Okay. I've read it.
Q. Okay. So he mentions that "Other issues that were apparently discussed during the survey are that N95 masks need to be worn throughout the facility, weekly testing of all staff and that non-vaccinated staff should be reassigned."
Do you see that?
A. Yes.
Q. Okay. Do you recall what he was talking

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BY MS. MAHE:
Q. The court reporter has handed you what has been marked Deposition Exhibit 48. This was a document that was produced by DPHHS in response to the subpoena. It appears to be an email from Erika Baldry to Heath Hall and Susan Woods. Have you seen this document before?
A. No.
Q. It's a June 30th, 2022 -- It's dated June 30th, 2022. Correct?
A. Correct.
Q. From Erika who is with Department of Public Health and Human Services?
A. Correct.
Q. And she says [As Read]: "As a CAH, you must apply House Bill 702 which means you can't discriminate based on vaccination status."
Do you see that?
A. Yes.
Q. So is DPHHS taking the position that critical access hospitals are not subject to the injunction that has been entered in in this case?
MR. MEAD: Objection. Calls for a legal conclusion.
A. I really don't know how to answer that.

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I don't really understand the question --
BY MS. MAHE:
Q. Sure.
A. -- to tell you the truth. I'm not a lawyer, so...
Q. Are you aware of that there has been an injunction in this case that healthcare facilities who are subject to the conditions of participation are -- cannot -- Let me start over. There's an injunction in place that enjoins the state from applying House Bill 702 to healthcare facilities that are subject to the conditions of participation related to the CMS vaccine mandate?
A. Yes.
Q. And do you know whether it's DPHHS's position that critical access hospitals are subject to that?
A. Yes.
Q. So do you know why Erika said this to Heath on June 30th, 2022?
A. I do not.
Q. Let's go ahead and take a quick break.
A. Okay.
THE VIDEOGRAPHER: We are going off the record. The time is 11:16 a.m.

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(Recess taken from 11:16 a.m. to 11:27 a.m.)
THE VIDEOGRAPHER: We are back on the record. The time is 11:28 a.m.
BY MS. MAHE:
Q. Mr. Anderson, have you answered all my questions today truthfully and accurately?
A. Yes.
Q. I don't have anything further at this time.
EXAMINATION
BY MR. GRAYBILL:
Q. All right. We have -- I have just a couple questions for you, Mr. Anderson.
MR. GRAYBILL: We're on Exhibit 49, correct?
THE COURT REPORTER: Yes.
MR. GRAYBILL: All right.
EXHIBIT:
(Deposition Exhibit 49 marked for identification.)
BY MR. GRAYBILL:
Q. Court reporter's handed you what's been marked as Exhibit 49. Do you remember you were asked earlier about a system for public reporting

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and deficiencies called QCOR?
A. Mm-hmm.
Q. Is that a yes?
A. Yes.
Q. The document in front of you, Exhibit 49, does this appear to be a QCOR report?
A. Yes. I've never actually printed one out, but, yes.
Q. Okay. And if you look in about the middle of the document it says [As Read]: "Surveys for -- for FY 22."
Do you see that?
A. Yes.
Q. Okay. And then below there's a little table. Do you see that?
A. Yes.
Q. And the table, in the third from the left bottom row, says "COVID-19 Vaccination of Facility Staff."
Do you see that?
A. Yes.
Q. Okay. Do you have any reason to doubt whether or not this is a QCOR report?
A. No.
Q. Okay. The court reporter will now hand

you what's marked Exhibit 50.
EXHIBIT:
(Deposition Exhibit 50 marked for identification.)
BY MR. GRAYBILL:
Q. Does this appear to be a QCOR report?
A. Yes.
Q. I'd like to direct your attention to the same place in this document, a little table in the middle. Do you see that?
A. Yes.
Q. And it reads "COVID-19 Vaccination of Facility Staff" under "Deficiency Description."
A. Yes.
Q. Did I read that accurately?
A. Yes.
MR. GRAYBILL: No further questions.
EXAMINATION
BY MR. MEAD:
Q. So Carter, I -- staying with the documents you have in front of you --
A. Yes.
Q. -- the document marked No. 49 first, in that box labeled "Deficiency Description," does that deficiency description state the nature of

what would create the violation?
A. Not --
Q. Like the specifics of it.
A. No.
Q. And with document No. 50, does -- again, looking at that box labeled Deficiency Description, does that state with any specificity what would have led to the deficiency?
A. No.
Q. So it could have been a -- a failure to -- staff could have failed to have their masks worn in appropriate areas?
MS. MAHE: Object to the form.
MR. GRAYBILL: Join.
BY MR. MEAD:
Q. So let -- let me rephrase that. Is there a -- Is it fair to say that there is a large universe of facts that could have -- that could exist that would have led to that deficiency description?
MS. MAHE: Object to the form.
MR. GRAYBILL: Join.
A. There -- There's numerous things that could have created these types of citations. I'd have to read the report to actually know what they

-- what they were citing.
BY MR. MEAD:
Q. Thanks. And so now I want to go to the document that was marked Exhibit No. 38, which was QSO 22-09 revised April 5th.
A. Mm-hmm.
Q. And I believe this is -- Well, I can't remember exactly which one this refers to, but I want to turn to page 3 of that document.
So that first full paragraph, do you see the bolded sentence, "Facility Staff Vaccination Rates"?
A. Yes.
Q. Can you read the sentence that follows that one that starts "Non-compliance"?
A. "Non-compliance does not necessarily lead to termination, and facilities will generally be given opportunities to return to compliance."
Q. In your experience, does CMS generally afford facilities noncompliance opportunities to return to compliance prior to termination?
A. A hundred percent of the time.
Q. Okay. Thank you. And now I just want to turn to DPHHS's role in enforcing House Bill 702. Is it your understanding that DPHHS does not levy

any civil or criminal penalties related to House Bill 702?
MS. MAHE: Object to the form.
MR. GRAYBILL: Join.
A. Yes.
BY MR. MEAD:
Q. And when DPHHS surveys CMS-covered facilities, when you are conducting those survey activities, you check for whether -- Strike that.
So regarding the CMS vaccine mandate, you look to see whether the covered facility has granted medical or religious exemptions. Correct?
MS. MAHE: Object to the form.
MR. GRAYBILL: Join.
A. Yes.
BY MR. MEAD:
Q. Does DPHHS investigate as to the validity of a granted religious request?
MS. MAHE: Object to the form.
MR. GRAYBILL: Join.
A. No.
MR. MEAD: Okay. I think that is all the questions I have.
///
///

EXAMINATION

BY MS. MAHE:

Q. I have a quick follow-up.

Exhibit 49 and 50, these are the QCOR reports.

A. Mm-hmm.

Q. In the deficiency description where it says "COVID-19 Vaccination of Facility Staff."

A. Mm-hmm.

Q. Do you see that part?

A. Yes.

Q. Is that a reference to the CMS vaccine mandate?

A. Yes.

MS. MAHE: I don't have any further questions.

MR. GRAYBILL: None from me.

MR. MEAD: We'll reserve any.

THE VIDEOGRAPHER: That concludes the deposition. The time is 11:34 a.m.

(Deposition concluded at 11:34 a.m. Deponent excused; signature reserved.)

DEPONENT'S CERTIFICATE

I, DPHHS 30(b)(6) DESIGNEE CARTER ANDERSON, the deponent in the foregoing deposition, DO HEREBY CERTIFY, that I have read the foregoing pages of typewritten material and that the same is, with any changes thereon made in ink on the corrections sheet, and signed by me, a full, true and correct transcript of my oral deposition given at the time and place hereinbefore mentioned.

DPHHS 30(b)(6) DESIGNEE CARTER ANDERSON, Deponent.

Subscribed and sworn to before me this day of , 2022.

PRINT NAME:
Notary Public, State of
Residing at:
My commission expires:

MRS - Montana Medical Association, et al. vs. Austin Knudsen, et al.

C E R T I F I C A T E

STATE OF MONTANA)
: ss
COUNTY OF MISSOULA)

I, Mary R. Sullivan, RMR, CRR, and Notary Public for the State of Montana, residing in Missoula, do hereby certify:

That I was duly authorized to and did swear in the witness and report the deposition of DPHHS 30(b)(6) DESIGNEE CARTER ANDERSON in the above-entitled cause; that the foregoing pages of this deposition constitute a true and accurate transcription of my stenotype notes of the testimony of said witness, all done to the best of my skill and ability; that the reading and signing of the deposition by the witness have been expressly reserved.

I further certify that I am not an attorney nor counsel of any of the parties, nor a relative or employee of any attorney or counsel connected with the action, nor financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal on August 21, 2022.

Montana Medical Association, et al. v
Austin Knudsen, et al.

John Elizandro 30(b)(6)
August 18, 2022

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION

MONTANA MEDICAL ASSOCIATION, et al.,
Plaintiffs, Case No. CV-21-00108-DWM
and
MONTANA NURSES ASSOCIATION,
Plaintiff-Intervenors,
v.
AUSTIN KNUDSEN, et al.,
Defendants.

VIDEOCONFERENCE/VIDEOTAPED DEPOSITION
UPON ORAL EXAMINATION OF
DEPARTMENT OF LABOR AND INDUSTRY 30(b)(6) DESIGNEE
JOHN ELIZANDRO

BE IT REMEMBERED, that the videoconference/videotaped deposition upon oral examination of Department of Labor and Industry 30(b)(6) Designee John Elizandro, appearing at the instance of the Plaintiffs Montana Medical

Association, et al., was taken at 800 North Last Chance Gulch, #101, Helena, Montana, on Thursday, August 18, 2022, beginning at the hour of 12:57 p.m., pursuant to the Federal Rules of Civil Procedure, before Mary R. Sullivan, Registered Merit Reporter, Certified Realtime Reporter, and Notary Public.

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Also Present: Graden Marcelle

I N D E X

INDEX: (Contd.)

EXHIBITS: (Contd.)

S T I P U L A T I O N S

It was stipulated by and between counsel for the respective parties that the deposition be taken by Mary R. Sullivan, Freelance Court Reporter and Notary Public for the State of Montana, residing in Missoula, Montana.

It was further stipulated and agreed by and between counsel for the respective parties that the deposition be taken in accordance with the Federal Rules of Civil Procedure.

It was further stipulated and agreed by and between counsel for the respective parties and the deponent that the reading and signing of the deposition would be expressly reserved.

THURSDAY, AUGUST 18, 2022

Thereupon,

DEPARTMENT OF LABOR AND INDUSTRY 30(b)(6) DESIGNEE JOHN ELIZANDRO,

a witness of lawful age, having been sworn to tell the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MS. MAHE:

Q. And Mr. Elizandro, my name is Katie Mahe.

A. Okay.

Q. I represent the plaintiffs in this action. We met just before. Is it all right if I call you Mr. Elizandro?

A. John's fine.

Q. John's fine?

A. Whatever you prefer.

Q. Okay. Have you ever had your deposition taken before?

A. No.

Q. Before we get going, I'm just going to go over some ground rules. Okay?

A. Mm-hmm.

Q. So the first one is we have to answer verbally because the court reporter is here taking

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down everything that we're saying. So mm-hmms and hmm-mms don't translate well on the record, so if you could answer verbally for me, that would be great.
A. No problem.
Q. Can you do that?
A. Yes.
Q. The other thing is we have to be careful not to talk over one another because that makes the transcript really messy. So I'll try to remember to take a good pause and let you take a pause before you answer too. Can we do that?
A. Sure.
Q. And I'm not trying to trick you today. I want you to understand what I'm asking you. If you don't understand my questions, can you tell me?
A. Yes.
Q. And if you do answer my questions, is it safe for me to assume that you understood them?
A. Yes.
Q. If you need a break at any point today, just let me know and we'll take one. The only thing that I ask is that if I have a question pending, you answer that before we break. Is that okay?

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A. Sure.
Q. And if I ask you a question today and during the course of your deposition you think of additional information or clarification, will you provide that to me?
A. Yes.
Q. Is there any reason that you're prevented from giving truthful and accurate answers today?
A. No.
EXHIBIT:
(Deposition Exhibit 51 marked for identification.)
BY MS. MAHE:
Q. The court reporter has handed you what has been marked Deposition Exhibit 51. Have you seen that document before?
A. Let me take a look quick, and I'll tell you.
Q. Sure.
A. Yes.
Q. That's the notice of 30(b)(6) deposition for the Department of Labor and Industry. Correct?
A. Yes.
Q. And you've been designated by the Montana Department of Labor and Industry to testify on its

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behalf related to the 30(b)(6) deposition notice topics?
A. Correct.
Q. And you were informed you would be testifying on behalf of DLI on those topics?
A. That's correct.
Q. And if I say "DLI," do you know what I'm talking about?
A. I sure do.
Q. If I say "department," do you understand I'm talking about the Department of --
A. I do.
Q. -- Labor?
A. If I have a question, I'll ask for clarification.
Q. Okay. So we need to make sure that I finish asking before you answer, just for the record.
Did the Department of Labor & Industry gather all information known or reasonably known to it regarding the topics in the 30(b)(6) deposition designation?
A. Yes.
Q. Can you describe the process the Department of Labor & Industry did to make sure

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that you have all the knowledge and information from the DLI on these topics?
A. Conducted a search of documents and communications responsive to the requests.
Q. What documents did you review?
A. Did I review?
Q. Yes.
A. In terms of in -- in trying to be responsive to the request?
Q. In preparing for this deposition.
A. The documents that we produced in response to the document ahead of me.
Q. Okay. Well, that's -- that's a deposition notice. So are you talking about the documents that were produced in discovery?
A. Correct, yes, I'm sorry. I'm not an attorney, so I don't know the exact...
Q. That's fine, and I -- I'm just trying to figure out what you looked at, so --
A. Understood.
Q. -- I'll help as much as I can through that process.
Did you also look at the discovery responses?
A. Yes.

Q. Okay. Did you look at any documents that were not produced in discovery?
A. In preparation for this or just in general?
Q. In preparation to testify on behalf of the Department of Labor.
A. No.
Q. Did you speak to anyone within the Department of Labor to prepare for the deposition? And I'm not asking about attorneys.
A. Not to prepare, no. I let others know I was doing it more as a scheduling matter than anything else. Just that I would be out of pocket for a while this afternoon, so...
Q. So did you talk to Commissioner Esau? Am you saying that right?
A. Esau.
Q. Esau. Did you talk to Commissioner Esau about the information that she may have relevant to the topics in the deposition notice?
A. Not specifically, no, but I'm prepared to speak about them.
Q. Did you talk to her in preparation for the deposition today?
A. I let her know I was doing it, again, as

a scheduling matter that I wouldn't be around this afternoon.
Q. Is there anybody that you did talk to to get information in order to be prepared to testify as to the topics in Exhibit 51?
A. No, I think I have a pretty good handle on topics we talked about.
MR. DEWHIRST: Can I just clarify the record? It's okay for you to say that you talked to attorneys.
THE DEPONENT: Oh, okay.
MR. DEWHIRST: It's just --
THE DEPONENT: Yeah, I'm sorry. She said outside of attorneys, so...
MR. DEWHIRST: Yeah.
THE DEPONENT: Okay.
MR. DEWHIRST: Just what you talked about.
THE DEPONENT: Yeah.
BY MS. MAHE:
Q. So did you talk to attorneys, then?
A. Yes.
Q. And did you talk to attorneys for -- attorneys of record in this case? Do you know what that means?

MR. DEWHIRST: Objection. Form; compound; legal conclusion.
BY MS. MAHE:
Q. You get to answer still.
A. Yes.
Q. Okay. And did you also speak to internal attorneys with the Department of Labor?
A. Yes.
Q. Are you confident that you possess all relevant and discoverable information regarding the topics on which you've been identified to testify?
A. Yes.
Q. And you understand that you are testifying as to the collective knowledge of DLI today?
A. Yes.
Q. You understand you have an affirmative duty to be prepared to testify fully and knowledgeably on behalf of DLI on the topics upon which you have been designated?
A. Yes.
Q. You mentioned reviewing the information that has been provided in discovery. Would that include the final investigative reports that were provided? I think we got them yesterday.
A. I have not reviewed those, no.

Q. And were you involved in the redaction process of those documents?
A. No.
Q. Do you know who was?
A. No.
Q. Did DLI contact any of the parties to those final investigative reports to determine whether they objected to providing the information?
A. I would not be in a position to know that. I did not see the reports and was not aware of the contents prior to that, and that would be a question for the Human Rights Bureau who will be in here next week.
Q. And since you mentioned the Human Rights Bureau, can you explain to me the relationship between the Department of Labor and the Human Rights Bureau?
A. Sure. The Human Rights Bureau is a functional unit of the Department of Labor & Industry tasked with enforcing the Montana Human Rights Act and the statutes involved there. DLI is the umbrella organization to the Human Rights Bureau. Their process is, while supported by DLI, largely independent of DLI, and takes place internally among that unit.

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Q. So that was a big answer, so I want to break it down a little bit.
Is it fair to say that the HRB is the enforcement arm of DLI related to the Montana Human Rights Act?
A. That's correct.
Q. Okay. And so questions related to that enforcement of the Montana Human Rights Act are better asked to the HRB?
A. That's correct.
Q. So you're being presented as the 30(b)(6) witness today on behalf of the Department of Labor & Industry. Are you an employee of DLI?
A. I am.
Q. And what is your job title?
A. I'm the department's chief of staff.
Q. And how long have you held that position?
A. I started with DLI early last year as the department's head of communications, and was promoted to chief of staff about three months ago.
Q. So when last year did you start with DLI?
A. I believe it was the end of March.
Q. So end of March 2021?
A. 2021, that's correct.
Q. Did you work for DLI before that?

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A. No.
Q. What did you do before that?
A. I worked as a congressional aide on Capitol Hill in Washington.
Q. A congressional what?
A. Aide in Capitol Hill in Washington.
Q. I'm hard of hearing.
A. That's okay.
Q. I apologize.
A. No problem.
Q. And how much time did you spend preparing for the 30(b)(6) deposition today?
A. The -- Quite a bit of time over the last several days reviewing the documents that were produced in discovery as well as conversing with attorneys.
Q. And how much is "quite a bit of time"?
A. Several hours.
Q. More than five?
A. Cumulatively, yes.
Q. Okay. Less than ten?
A. Between five and ten.
Q. And you understand when I say "you" in my questions, that I'm referring to DLI from this point forward?

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A. Okay.
Q. Well, actually I asked that question too soon. I'm going to ask you a personal question --
A. Okay.
Q. -- first. Have you ever been deposed before?
A. No.
Q. Now when I say "you," I'm referring to DLI.
A. Okay.
Q. You're familiar with House Bill 702?
A. Yes.
Q. And you understand that House Bill 702 was codified as Montana Code Annotated 49-2-312 and 313?
A. I don't have the citation in front of me, but I understand it was codified, yes.
Q. Okay.
EXHIBIT:
(Deposition Exhibit 52 marked for identification.)
BY MS. MAHE:
Q. The court reporter has handed you what has been marked Deposition Exhibit 52, and this is Montana Code Annotated 49-2-312 and 313. Looking

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at those, do you understand that that's where 702 was codified?
A. Yes.
Q. Okay. Does Exhibit 52, so 49-2-312, only apply to the COVID-19 vaccine?
MR. DEWHIRST: Objection. Calls for a legal conclusion.
BY MS. MAHE:
Q. You get to answer.
A. I'm not in a position to determine that.
Q. And why not?
A. Those kind of determinations are made by the department's Human Rights Bureau. Specifically has responsibility for that.
Q. DLI has certain obligations that are imposed upon it by statute. Correct?
A. Yes.
Q. And so does the commissioner of labor and industry. Correct?
A. Yes.
Q. And it's important for DLI to be able to understand those obligations. Right?
A. Yes.
Q. So that DLI can carry them out. Correct?
A. Yes.

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Q. What is DLI's role in enforcement of Montana Code Annotated 49-2-312 and 313?
MR. DEWHIRST: Objection. Calls for a legal conclusion.
A. DLI possesses within it the Human Rights Bureau which is tasked with enforcement of the Human Rights Act including 49-2-312.
BY MS. MAHE:
Q. Are you aware of any other state agency that is tasked with enforcing 49-2-312 and 13?
A. No.
Q. And complaints that are brought under the statute are filed with the Department of Labor & Industry?
A. With the department.
MR. DEWHIRST: Objection.
THE DEPONENT: I'm sorry.
MR. DEWHIRST: Just objection to form on that.
A. With the department's Human Rights Bureau.
BY MS. MAHE:
Q. And the department's Human Rights Bureau gets to determine whether those complaints are timely filed. Correct?

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A. That would be part of the process that they would undertake, I believe, yes.
Q. And if a complaint is not timely filed, the department, through the Human Rights Bureau, must dismiss the complaint on a finding of no reasonable cause. Correct?
MR. DEWHIRST: Objection. Calls for a legal conclusion.
A. I would defer to them for the answers to their process questions.
BY MS. MAHE:
Q. Okay.
EXHIBIT:
(Deposition Exhibit 53 marked for identification.)
BY MS. MAHE:
Q. So Exhibit 53 is Montana Code Annotated 49-2-501, 503, 504, 505, 506, 508, 511, 512, and 601.
A. Thank you.
Q. So the question that I asked, I think, before we got Exhibit 52 is if a complaint isn't timely, the department through the Human Rights Bureau, must dismiss the complaint on a finding of no reasonable cause. I asked you that question.

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And what was your answer?
A. I'm sorry, could you --
Q. Sure.
A. Was that a statement or a question?
Q. That was a question, and then I was asking what your answer was.
A. Okay. What was --
Q. Sure.
A. -- the question itself?
Q. If a complaint is not timely filed, the department, through the Human Rights Bureau, must dismiss the complaint on a finding of no reasonable cause. Correct?
MR. DEWHIRST: Objection. Calls for a legal conclusion.
A. I would say that I'm not in a position to speak on behalf of the Human Rights Bureau's process.
BY MS. MAHE:
Q. Okay. Well, let's look at Exhibit 52.
MR. DEWHIRST: 53 or 52?
MS. MAHE: Isn't this 52?
MR. DEWHIRST: The one you just handed is 53, yes.
///

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BY MS. MAHE:
Q. Well, then let's look at 53. I've been saying 52.
MR. DEWHIRST: Do you have it as 53?
THE DEPONENT: I've got it 53.
MS. MAHE: So for the record, the statutes were 53. I think I said 52. One of those days.
MR. DEWHIRST: Well, 52 is also statutes, but that was 702 codified. Right?
MS. MAHE: Correct.
MR. DEWHIRST: Okay. Do you want the paperclip for your --
THE DEPONENT: Sure.
MR. DEWHIRST: -- exhibit?
THE DEPONENT: Even better.
BY MS. MAHE:
Q. So if you look at 49-2-501(5) says if the department determines that a complaint is untimely, it shall dismiss the complaint on a finding of no reasonable cause. Do you see that?
A. I do.
Q. So that's an obligation that's imposed on the department by statute?
MR. DEWHIRST: Objection. Calls for a

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legal conclusion.
A. As I said, I would defer to the Human Rights Bureau for questions about their process.
BY MS. MAHE:
Q. Do you understand the obligations that are imposed on DLI that are statutorily mandated?
MR. DEWHIRST: Objection. Calls for a legal conclusion.
A. Yes.
BY MS. MAHE:
Q. Okay. So do you understand that the department is statutorily mandated that if a complaint is untimely, it shall dismiss the finding on a finding of no reasonable cause?
MR. DEWHIRST: Objection. Same objection.
A. That would be the determination of the Human Rights Bureau.
BY MS. MAHE:
Q. So the Human Rights Bureau can decide not to dismiss a complaint on a finding of no reasonable cause if it is untimely?
MR. DEWHIRST: Same objection.
A. I would defer to them for questions about their process.

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BY MS. MAHE:
Q. The department has authority to apply for a preliminary injunction related to 49-2-312, doesn't it?
A. I would defer to the Human Rights Bureau regarding questions about their process.
Q. Okay. Well, let's turn to the next page in Exhibit 53 which is 49-2-503, which states that "At any time after a complaint is filed under this chapter, a district court may, upon the application of the commissioner, the department, or the charging party, enter a preliminary injunction."
Do you see that?
A. I do.
Q. Okay. So the commissioner, in fact, also has the authority to move for a preliminary injunction. Correct?
MR. DEWHIRST: Objection. Calls for a legal conclusion.
A. I'm not an attorney. I wouldn't be able to answer conclusively about what the statute says.
BY MS. MAHE:
Q. Do you --
A. Or means. I'm sorry.

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Q. The commissioner is obligated to comply with their statutorily mandated duties. Correct?
A. Yes.
Q. And sitting here today as a representative of DLI, you don't know what those statutorily mandated duties are?
MR. DEWHIRST: Objection. Argumentative.
A. This does not appear to be a statutory duty.
BY MS. MAHE:
Q. Okay. But are you aware of the authority that the commissioner has statutorily?
A. You didn't ask about the authority. You asked about the duty.
Q. I'm asking you about it now.
A. So could you --
MR. DEWHIRST: Objection. Yeah, what is the question?
A. What's the question?
BY MS. MAHE:
Q. Yeah. So the question was the commissioner, in fact, herself has the authority to apply for a preliminary injunction.
MR. DEWHIRST: Objection. Form.
A. It appears so, yes.

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BY MS. MAHE:
Q. And the Department of Labor, through the Human Rights Bureau, is mandated to conduct informal investigations of alleged violations of Montana Code Annotated 49-2-312. Right?
MR. DEWHIRST: Objection. Calls for a legal conclusion.
A. That would be under the purview of the Human Rights Bureau. I'd defer to them for answers about their process.
BY MS. MAHE:
Q. Well, let's turn to the next page in Exhibit 53, which is subsection 504. It says [As Read]: "The department shall informally investigate the matters set out in the complaint and promptly and impartially determine whether there is reasonable cause to believe that the allegations are supported by a preponderance of the evidence."
Do you see that?
A. I do.
Q. Are you aware that that's the department's statutorily mandated duty?
MR. DEWHIRST: Objection. Calls for a legal conclusion.
A. Yes.

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BY MS. MAHE:
Q. And so DLI, through the HRB, is charged with making determinations regarding whether there is reasonable cause to believe there's been a violation of 49-2-312?
MR. DEWHIRST: Objection to form and calls for a legal conclusion.
MS. MAHE: What's wrong with the form?
MR. DEWHIRST: It wasn't a question.
BY MS. MAHE:
Q. Correct?
A. Could you reask the question, please?
Q. Sure. So the Department of Labor is charged with making determinations regarding whether there is reasonable cause to believe that there has been a violation of 49-2-312. Correct?
MR. DEWHIRST: Objection. Calls for a legal conclusion.
A. The department's Human Rights Bureau is charged with doing that, correct.
BY MS. MAHE:
Q. And the Human Rights Bureau uses investigators to conduct those investigations. Correct?
A. Correct.

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Q. How are those investigators trained to conduct the investigations?
MR. DEWHIRST: Objection. I'm going to object to the line of questioning. You all noted up depositions for both HRB and DLI. HRB is the agency within the department that can testify about this information.
You can answer.
A. I would defer to HRB to answer those questions.
BY MS. MAHE:
Q. So you don't know?
A. I said I would defer to them to answer the questions.
Q. Well, I'm asking you.
A. I would defer to them to answer the questions.
Q. Well, you have to answer the question with the information you know. That's the way these work.
MR. DEWHIRST: Could you ask the question again? I -- I forgot what it was.
BY MS. MAHE:
Q. Sure. I said how are the HRB investigators trained to conduct investigations

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under that statute?
A. I'm not specifically familiar with the training they receive.
Q. Are you generally familiar with the training?
A. No.
Q. The HRB investigators issue a final investigative report at the end of an investigation. Is that right?
A. I would defer to them to discuss their process.
Q. Do you know?
A. Yes.
Q. Okay. Do they do that?
A. I would defer to them to discuss their -- their processes.
Q. Well, you said you knew, so I get to know what you know while we're sitting here today, and that's what I'm asking.
A. So ask the question again, please?
Q. Sure. The investigators issue a final investigative report as part of the investigation?
A. That is my understanding.
Q. And those final investigation reports are either -- are -- are for cause to believe

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discrimination occurred or no reasonable cause? Is that correct?
A. I believe that there are -- I would defer to them to talk about the specifics of their process.
Q. Do you know?
A. No.
Q. If the HRB determines that there's reasonable cause to believe discrimination has occurred, does it then issue a for-cause finding?
A. I would defer to them to discuss the process.
Q. Do you know?
A. No.
Q. If there is a for-cause finding, does the case then proceed to the office of administrative hearings?
A. I would defer to them to discuss their process.
Q. Do you know?
A. No.
Q. Other than deferring to the HRB, does DLI have any role in training the hearing officers related to investigating 49-2-312?
MR. DEWHIRST: Objection. Vague.

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A. Yeah. I guess I'm not sure what you mean by "any role." They are DLI employees and, you know, they receive DLI IT equipment, you know, they're part of our human resources, so I would say is there a role, yes.
BY MS. MAHE:
Q. Do the -- Does DLI provide specific guidance to them regarding enforcement of 49-2-312?
A. The Human Rights Bureau would be able to better answer that question, but the department as a whole does not, no.
Q. Can you explain to me the role of the Human Rights Commission in relation to the DLI?
A. I would defer to the Human Rights Bureau to talk about the Human Rights Act and its enforcement processes.
Q. Do you know how the Human Rights Commission relates to the Department of Labor?
MR. DEWHIRST: Objection. Vague.
A. Yeah. How do you mean by how it relates to it?
BY MS. MAHE:
Q. So in enforcing the Montana Human Rights Act, how does the Montana -- what is the relationship? You mentioned that the HRB is an arm

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or a department or agency within DLI. What is the Human Rights Commission?
A. The Human --
MR. DEWHIRST: Objection to form.
A. The Human Rights Commission is administratively attached to the department.
BY MS. MAHE:
Q. Does the department exercise authority over the Human Rights Commission?
MR. DEWHIRST: Objection. Calls for a legal conclusion.
A. No.
BY MS. MAHE:
Q. Does the HRB provide guidance to the Human Rights Commission on how to enforce 49-2-312?
MR. DEWHIRST: I'm sorry, could you -- sorry. Could you repeat that for my benefit, please?
BY MS. MAHE:
Q. Sure. Does the HRB provide guidance to the Human Rights Commission regarding the enforcement of 49-2-312?
A. I would defer to the HRB for that question.
Q. Do you know?

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A. No.
Q. Does the DLI, independent of the HRB, provide guidance to the Human Rights Commission regarding the enforcement of 49-2-312?
MR. DEWHIRST: Objection to form.
A. Does it provide guidance or does it provide guidance to the commission?
BY MS. MAHE:
Q. To the commission.
A. No.
Q. Okay. Does the Department of Labor, independent of the Human Rights Bureau, provide guidance related to the enforcement of 49-2-312?
A. Does it provide it or does it provide it to the commission?
Q. Provide it.
A. Yes.
MR. DEWHIRST: And, yeah. Not really sure what the question was there at the end, but you were.
BY MS. MAHE:
Q. After, then, there has been a for-cause finding, can the parties agree to resolve the matter without the approval of the department?
MR. DEWHIRST: Objection. Vague.

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A. I would defer to the HRB to talk about their process.
BY MS. MAHE:
Q. Do you know?
A. No.
Q. The Department of Labor is tasked with ensuring that a resolution provides redress for the claimant. Correct?
MR. DEWHIRST: Objection. Vague; calls for a legal conclusion.
A. I don't know.
BY MS. MAHE:
Q. The Department of Labor & Industry is statutorily mandated to ensure that resolution includes conditions that eliminate the discriminatory practice. Correct?
MR. DEWHIRST: Objection. Calls for a legal conclusion.
A. I don't know.
BY MS. MAHE:
Q. If a hearing officer finds that a respondent engaged in a discriminatory practice, the department must order a party to refrain from engaging in discriminatory conduct. Correct?
MR. DEWHIRST: Objection. Calls for a

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legal conclusion.
A. I don't know.
BY MS. MAHE:
Q. The Department of Labor can prescribe conditions on a respondent's future conduct relevant to discriminatory conduct, can't it?
MR. DEWHIRST: Objection. Vague and calls for a legal conclusion.
A. I would defer to the Human Rights Bureau for that question.
BY MS. MAHE:
Q. Do you know?
A. No.
Q. The Department of Labor can require any reasonable measure to correct a discriminatory practice and rectify any harm. Correct?
MR. DEWHIRST: Same objections.
A. I would defer to the HRB.
BY MS. MAHE:
Q. Do you know?
A. No.
Q. The Department of Labor can require a respondent to report on compliance after a for-cause finding. Correct?
MR. DEWHIRST: Same objections.

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A. I would defer to the Human Rights Bureau.
BY MS. MAHE:
Q. Do you know?
A. No.
Q. If an order from a hearing officer is not obeyed, the department can petition the district court to enforce the order. Correct?
MR. DEWHIRST: Same objections.
A. I would defer to the Human Rights Bureau.
BY MS. MAHE:
Q. Do you know?
A. No.
Q. The commissioner also, if an order is not obeyed, can petition the district court to enforce the order. Correct?
MR. DEWHIRST: Same. Calls -- Objection. Calls for a legal conclusion.
A. I would defer to the Human Rights Bureau on the Human Rights Act -- on the Human Rights Act process.
BY MS. MAHE:
Q. Okay. But this is related to what the commissioner has authority to do.
A. I would defer to the Human Rights Bureau.
Q. Do you know?

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MR. DEWHIRST: Objection. What are we talking about whether he knows.
MS. MAHE: Whether he knows that the commissioner can petition a district court to enforce an order of the office of administrative hearing.
MR. DEWHIRST: So objection. Calls for a legal conclusion.
A. Yeah. That's a legal conclusion, and I don't have the answer.
BY MS. MAHE:
Q. Okay. If you turn to 49-2-508 in Exhibit 53.
MR. DEWHIRST: 508?
MS. MAHE: Yep.
BY MS. MAHE:
Q. [As Read]: "If the order is issued under 49-2-506 is not obeyed, the commissioner, the department, or a party may petition the district court and the county where the discriminatory practice occurred or which in the respondent resides or transacts business to enforce the commission's or the department's order by any appropriate order."
Do you see that?

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A. Yes.
Q. And you were not aware of that requirement before?
A. It does not appear to be a requirement.
Q. Or that authority.
A. I was aware that the commissioner had certain authorities but could not speak conclusively or specifically as to what those would be with regards to the Human Rights Act.
Q. Are you aware that the department can sue a party in district court for breach of a conciliation agreement?
A. Yes.
Q. Are you aware that the commissioner can also do that?
A. Yes.
Q. Does the Department of Labor have to sign off on conciliation agreements?
MR. DEWHIRST: Objection. Calls for a legal conclusion.
A. I would defer to the Human Rights Bureau for the exact -- for that process.
BY MS. MAHE:
Q. Do you know?
A. No.

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Q. Does the Department of Labor require targeted equitable relief in order to resolve a claim after a for-cause finding?
MR. DEWHIRST: Objection. Calls for a legal conclusion.
A. The Human Rights Bureau would be the best place to direct that question.
BY MS. MAHE:
Q. Do you know?
A. No.
Q. Do you know how many conciliation agreements have been entered into related to 49-2-312?
A. No.
Q. Do you know how many voluntary resolution agreements have been entered into related to 49-2-312?
A. No.
Q. Do you know whether there was targeted equitable relief in any of those conciliation agreements?
A. No.
Q. What about voluntary resolution agreements?
MR. DEWHIRST: Objection. Vague.

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BY MS. MAHE:
Q. Do you know whether there was targeted equitable relief in any of the voluntary resolution agreements?
A. No.
MR. DEWHIRST: Objection. Still vague.
BY MS. MAHE:
Q. Do you know how many for-cause findings had occurred related to 49-2-312?
MR. DEWHIRST: Objection.
A. No.
MR. DEWHIRST: Vague.
MS. MAHE: What's vague about that?
MR. DEWHIRST: You're using terms of art from statutes; not really defining them.
MS. MAHE: But define the department's enforcement power?
MR. GRAYBILL: Isn't he the chief of staff in --
MS. MAHE: Yeah.
MR. GRAYBILL: -- his department?
MR. DEWHIRST: Are you taking the deposition?
MR. GRAYBILL: I'm just asking you in regards to your objections. He's the chief of

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staff of his department?
MR. DEWHIRST: Yes, he's --
MR. GRAYBILL: Is that his testimony?
MR. DEWHIRST: We also haven't talked through about what these terms of art that are just being rattled off, what they actually mean.
BY MS. MAHE:
Q. Well, let's --
MR. DEWHIRST: And how they're being used.
BY MS. MAHE:
Q. -- let's talk about your role as chief of staff a little bit. What do you do as chief of---- staff?
A. I'm the principal deputy to the commissioner for a wide -- for a wide portfolio involving communications for the department, and working with the department's other leadership team -- rest of the department's leadership team at her direction and under her management.
Q. What is the Department of Labor's role related to enforcement of the Americans With Disabilities act?
A. The Human Rights Bureau --
MR. DEWHIRST: Objection. Calls for a

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legal conclusion. You can answer.
A. The Human Rights Bureau is contracted by the federal government to -- and there's a term of art, I don't know what it is -- but there's a term of art to basically investigate and adjudicate potential ADA claims or violations.
BY MS. MAHE:
Q. Is that term of art deferral agency?
A. It is.
Q. So I want to make sure I understood what you said. That the HRB contracts with the federal government? Is that what you said?
A. The Human Rights Bureau is the -- is the arm of the department that conducts that activity for -- for the federal government, yes.
Q. So is the contract with the HRB?
A. I believe that they're the body of the department that is tasked with executing the contract.
Q. Is the contract with the Department of Labor?
A. I don't know.
Q. And you -- you spoke your answer so fast, so I think you said that they contract with them related to investigations of alleged violations of

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the Americans with Disabilities Act?
A. Correct. I don't know what the exact terminology for the deferral agreement is, but in general they are responsible for conducting ADA investigations and adjudicating those on behalf of the federal government.
Q. Do they have a role in determining appropriate penalties for violations of the Americans with Disabilities Act?
A. I would defer to the Human Rights Bureau for the exact details of how that works.
Q. Do you know?
A. No.
Q. Does the Department of Labor provide training related to the Americans with Disabilities Act?
A. It does, yes. In a lot of different contexts. So, for instance, ensuring our communications are ADA compliant, for example.
Q. Internal communications?
A. External communications.
Q. Do you also provide trainings for people externally to watch about compliance with the Americans with Disabilities Act?
A. Yes.

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Q. And what other contexts do you provide that training?
A. Our local Job Service offices will speak with different citizen groups, be it chambers of commerce or other groups, and offer guidance and advice on how to ensure their compliance with the ADA. I understand our Human Rights Bureau also conducts training seminars and other informative sessions about the ADA. For the specifics of those, I'd defer you to them, but...
Q. So I'm going to make sure I understood you. The -- The first part of that you were talking about things that were provided to the chamber of commerce?
A. Citizen groups, employers. Just as a general public education and informational service that we provide.
Q. And who with the Department of Labor of Industry does that?
A. Various parts. It depends on the situation. It is in consultation with the Human Rights Bureau to ensure the accuracy of the information being presented, but it could be a local -- we call them Job Service offices, which are local branch offices in many of Montana's

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cities that provide counseling and other services to employers and individuals.
We have business engagement personnel who will speak with employers and other groups to try to educate them. It's part of a broader public education and informational effort the department provides.
Q. How long does the Department of Labor have to conduct an investigation related to a claim of an alleged violation of 49-2-312?
A. I would --
MR. DEWHIRST: Objection. Calls for a legal conclusion.
A. I would defer you to the Human Rights Bureau for those questions.
BY MS. MAHE:
Q. Do you know?
A. No.
Q. Do the Department of Labor investigators make a determination as to whether there's reasonable cause to believe a violation of 49-2-312 has occurred?
A. I would defer you --
MR. DEWHIRST: Objection. Calls for a legal conclusion.

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A. I would defer you to the Human Rights Bureau.
BY MS. MAHE:
Q. Okay. We have to stop talking over each other.
MR. DEWHIRST: Yeah. Legal conclusion. That was mine.
BY MS. MAHE:
Q. And then yours was?
A. Defer to the Human Rights Bureau.
Q. Do you know?
A. No.
Q. Are you doing okay?
A. Mm-hmm. How long have we been -- Maybe take a break in five or ten minutes, if that's okay? Five minutes or so?
Q. We can take a break now, if that makes sense and maybe --
MR. DEWHIRST: Are you at a good --
BY MS. MAHE:
Q. -- I'll just --
MR. DEWHIRST: -- stopping point?
BY MS. MAHE:
Q. -- maybe slow down.
MS. MAHE: Let's go off the record.

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(Recess taken from 1:37 p.m. to 1:48 p.m.)

BY MS. MAHE:

Q. John, you understand that you're still under oath.

A. Yes.

Q. And you still understand that you are testifying on behalf of DLI.

A. Yes.

Q. How does DLI determine whether the exemptions in 49-2-312 are satisfied?

MR. DEWHIRST: Objection. Calls for a legal conclusion.

A. I would defer to the Human Rights Bureau for that question.

BY MS. MAHE:

Q. Do you know?

A. No.

MR. DEWHIRST: What was -- 49-34-12, is that what you said?

MS. MAHE: Yes.

MR. DEWHIRST: So that's Exhibit 52?

MS. MAHE: Yeah.

MR. DEWHIRST: Okay.

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BY MS. MAHE:

Q. Has the Department of Labor determined that any entities were exempt under 49-2-312?

MR. DEWHIRST: Objection. Calls for a legal conclusion.

A. I would defer to the Human Rights Bureau for that question.

BY MS. MAHE:

Q. Do you know?

A. No.

Q. The Department of Labor & Industry operates the Montana Safety and Health Bureau. Correct?

A. Yes.

Q. And the goal of that bureau is to help improve safety and health in the workplace. Is that right?

A. Yes.

Q. And you would agree with me that the health of workers in Montana is important. Correct?

A. Yes.

Q. Keeping workers healthy and safe is in the public's interest. True?

MR. DEWHIRST: Objection. Calls for a legal conclusion.

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A. I'm not sure how you define "the public's interest."

BY MS. MAHE:

Q. Well, it's certainly in the interest of the Department of Labor. Correct?

A. Yes.

Q. Has the Department of Labor made any public statements regarding the state's interest in enacting House Bill 702?

A. No.

Q. Has Commissioner Esau made any public statements regarding the state's interest in enacting House Bill 702?

A. No.

Q. Has the department made any public statements related to the state's interest related to the exemptions in House Bill 702?

A. No.

Q. What about Commissioner Esau?

A. No.

Q. Did the Department of Labor testify in support of the passage of House Bill 702?

A. No.

Q. Did Commissioner Esau?

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A. No.

MR. DEWHIRST: For the record, it's Commissioner Esau.

MS. MAHE: Oh, I'm sorry.

A. It's okay.

MR. DEWHIRST: That's all right.

A. I knew who you were talking about.

MR. DEWHIRST: We don't -- We don't want the boss here in this deposition being upset.

A. I think you spelled it "ES-saw" [phonetic] in some of these documents, too, but it's quite all right, so...

BY MR. DEWHIRST:

Q. Luckily the record won't reflect my mispronunciation.

MR. COLE: Now it will.

MS. MAHE: Excuse me, Counsel. You're not talking.

BY MS. MAHE:

Q. How have claims under 49-2-312 been handled by the Department of Labor against healthcare facilities that are subject to the CMS COVID vaccination requirement?

MR. DEWHIRST: Objection. Calls for a legal conclusion.

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MS. MAHE: I'm not done.
MR. DEWHIRST: You're not?
MS. MAHE: I'm not done.
MR. DEWHIRST: Oh, well, please finish.
MS. MAHE: Yes.
MR. DEWHIRST: Just know there's something for you at the end of this.
MS. MAHE: Now I have to start over.
MR. DEWHIRST: Yeah.
BY MS. MAHE:
Q. How have claims regarding alleged violations of 49-2-312 been handled by DLI when they're brought against healthcare facilities subject to the CMS COVID vaccination requirement -- been handled since the injunction was issued in this case?
MR. DEWHIRST: Objection -- No, I'll withdraw the objection.
A. I would defer to the Human Rights Bureau for that question.
BY MS. MAHE:
Q. Do you know?
A. No.
MR. DEWHIRST: I'll just put on the record that I had a standing objection to all of

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these questions about HRB's administration of the Human Rights Act on the basis that that's the subject of a different deposition. Just a standing objection.
MS. MAHE: Well, I'm a little confused by that. Are you saying you had a standing objection to the questions that I've already asked or are you saying that you have it moving forward?
MR. DEWHIRST: I did. Because it was a standing objection, I didn't bring it up every time, but, yeah, I did, at the beginning of what you said.
MS. MAHE: I don't think you get to make a standing objection after the questions are asked.
MR. GRAYBILL: I -- I don't remember you asserting a standing objection.
MR. DEWHIRST: Well, we can go back and look on the record. It's there, so...
MR. GRAYBILL: Well, we can look it up later.
MR. DEWHIRST: Yeah.
MR. GRAYBILL: Do you -- Do you want to assert one going forward?
MR. DEWHIRST: Yeah. Just refreshing

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since we took a break; making sure you're all aware.
BY MS. MAHE:
Q. Do you have Exhibit 36 in front of you over there? You should.
A. 36.
Q. It's --
A. Would it be in this stack? I don't know what any of this is.
Q. Yeah. And I pulled right to it. That was, like, magic.
A. Great.
Q. I've handed you what has been marked Deposition Exhibit 36.
MR. DEWHIRST: Could I get a copy of that, please?
MS. MAHE: I gave it to Brent. He took it.
MR. DEWHIRST: Okay.
BY MS. MAHE:
Q. These are the FAQs that are from the Department of Labor & Industry's website. Have you seen those FAQs on House Bill 702 before?
A. So the first couple of pages are FAQs. The next set of pages is a different document.

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Q. Right. And that's a document that's referenced in that FAQs, so that's why it's attached.
But my question is, have you seen these FAQs before?
A. Yes.
Q. And who developed these FAQs?
A. The FAQs were developed initially by the Department of Human Rights Bureau to provide educational information to employers and other public accommodations about House Bill 702.
Q. Okay. You said they were initially developed by the HRB.
A. There was an initial set of them that was developed all at once at the beginning. As events transpired that required the addition of information based on litigation, federal mandates and other events, they were added to.
Q. By the HRB?
A. Ultimately it's my staff in the communications office that does the act of actually adding them, but they were developed in consultation with the HRB, yes.
Q. So I want to try and understand which ones were the initial HRB ones and then which ones were

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process.
A. That's correct.
Q. The guidance in Exhibit 36, did the Department of Labor help prepare this guidance with DPHHS?
A. No.
EXHIBIT:
(Deposition Exhibit 54 marked for identification.)
BY MS. MAHE:
Q. So for the record, the court reporter has just handed you what has been marked as Exhibit 54.
MS. MAHE: David, just so that you understand, the way that these were produced in discovery, you couldn't print off on a page, it was a poster-sized document?
MR. DEWHIRST: One at a time they open up.
MS. MAHE: Yes.
MR. DEWHIRST: Yeah.
MS. MAHE: So what we did is we made it an excerpt from Defendant's 293.
MR. DEWHIRST: Okay.
MS. MAHE: So that's the Bates number, but in order --

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MR. DEWHIRST: It's just blown up on 293?
MS. MAHE: So it's an excerpt so that it would fit on one page.
MR. DEWHIRST: Understood.
BY MS. MAHE:
Q. So I'll represent to you, John, that this is part of the documents that we were provided in discovery, one of the many versions of the FAQs we were provided. And this one says "In light of the Biden Administration's vaccine mandate announcement, should all health care facilities begin requiring their employees to be vaccinated against COVID-19?"
Do you see that?
A. Yes.
Q. And it looks like this was last updated on September 24th, '21. Is that correct?
A. It appears to be, from the document, yes.
Q. Okay. Is this one of the ones that your department helped prepare in consultation with HRB?
A. Yes, and I would want to go back and review some of the language from some of the other questions because I believe some of this language comes straight from some of the other questions already in there, but I would need to go back and

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review all the questions and answers individually, but, yes, to answer your question.
Q. So one of the issues we had is the way that these were just produced was all in one bunch so we couldn't tell which were effective when or not so, that's why it's separate from the whole group. Does that make sense?
A. It does.
Q. Okay. Do you know what this FAQ said before it was updated on September 24th of '21?
A. Not to be able to recite it to you, no.
Q. Do you have a general idea of what the changes were?
A. I don't believe there was a vaccine mandate announcement. I believe that was right around the time the announcement was made. I'm not sure that it wasn't added -- I -- I don't know that there was a different version. That was -- The vaccine mandate was announced by the president right around that time, and I -- I don't recall there being a previous version of that.
Q. And why was it updated with this FAQ?
A. I'm sorry. I don't understand your question.
Q. Well, I'm trying to figure out why this

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FAQ was added when it was.
A. Because the president announced an vaccine mandate for healthcare workers.
Q. And when was this FAQ removed from the FAQs?
A. I believe it was when it was no longer operative. I don't recall the exact timeline of court orders and injunctions that rendered different mandates offered at different times, but I believe it was when that mandate ceased to be operative.
Q. So you said when that mandate ceased to be operative?
A. Or when the question itself ceased to be operative.
Q. Okay. And the answer to the question -- I'll read the question again -- "In light of the Biden Administration's vaccine mandate announcement, should all health care facilities begin requiring their employees to be vaccinated against COVID-19?"
And the answer was [As Read]: "No. House Bill 702 prohibits an employer from refusing employment, barring a person from employment or discriminating in any term, condition, or privilege

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of employment based on vaccination status or whether the person has an immunity passport."

Was that the answer that you helped to develop?

A. It was a collaborative process, but, yes.

Q. Remember you're testifying on behalf of DLI.

A. Correct. I'm sorry.

Q. So is that the answer that DLI?

A. Yes.

Q. And so was it DLI's position at this point in time that to comply with the vaccine mandate for healthcare facilities would violate 702?

MR. DEWHIRST: Objection. Calls for a legal conclusion.

A. The department did not have a position. That was the responsibility of the Human Rights Bureau to take an individual look at individual cases as they came before them. This information was provided as an educational and informational resource, but the department itself did not have a position. That would be up to the human resource -- or the Human Rights Bureau to determine.

BY MS. MAHE:

Q. And the position of the department in this

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answer is that, no, they shouldn't begin requiring employees to be vaccinated against COVID. Right?

A. That was provided as an educational informational resource to employers.

Q. By the DLI.

A. By the DLI.

EXHIBIT:

(Deposition Exhibit 55 marked for identification.)

BY MS. MAHE:

Q. The court reporter has handed you what has been marked Deposition Exhibit 55, and this is an excerpt from Defendant's 326. Part of the issue with these is the way they were produced we couldn't tell what the date was for all of these.

So you'll see this second box down at the bottom that says [As Read]: "I'm an employee of the health care facility. How does the United States Supreme Court ruling on CMS's."

Do you see that?

A. Mm-hmm.

Q. Is that a yes?

A. Yes. I'm sorry.

Q. Okay. Do you know what the rest of that sentence is or should be?

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A. Should be CMS's vaccine mandate --

Q. So --

A. -- affect me.

MR. DEWHIRST: Say that again?

A. So the sentence should read "How does the United States Supreme Court ruling on CMS's vaccine mandate affect me?"

BY MS. MAHE:

Q. And then it looks like it's the same answer that we talked about before with the reference to the guidance in Exhibit 36. Correct?

A. Correct.

Q. And then there's another paragraph that says "DPHHS encourages covered health care facilities and providers to review and adopt its religious exemption form which can be found here" with a button.

Do you see that?

A. I do.

Q. Okay. When was that -- Was that paragraph ever removed from this FAQ?

A. I'm sorry, which paragraph are we talking about?

Q. Just that last paragraph I just read.

A. I don't recall.

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Q. Do you know when this FAQ was added?

A. It was added soon after the Supreme Court's ruling on the CMS vaccine mandate.

Q. So when you say you don't recall, is it that you don't recall whether that paragraph was removed?

A. That's correct.

Q. Why was the Department of Labor encouraging people to use DPHHS's form?

MR. DEWHIRST: Objection. That's -- Objection to form.

A. Well, the sentence says the Department of Public Health and Human Services encourages people, not the Department of Labor.

BY MS. MAHE:

Q. This is the Department of Labor's website, though, correct?

A. It was providing information and educational resources, and as the sentence says, DPHHS encouraged covered health care facilities and providers to review that form.

Q. And this is the DLI's website, correct?

A. (Nods head.)

Q. Is that a "Yes"?

A. That's correct.

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BY MS. MAHE:
Q. Right. And my question was as part of your process with Charlie, did you make a determination that requiring proof of a booster vaccination would be a violation of 702?
A. Again, I -- I wouldn't go any further than the text says right here, and I would let that speak for itself.
Q. Right. But that's not what I'm asking about. I'm asking about your discussions with Charlie.
A. I don't recall coming to a conclusion there.
Q. Do you recall discussing it?
A. Discussing the question or discussing the specific question you asked?
Q. Discussing the question I asked.
A. That's -- Not specifically, no. I -- The discussion was about the texts that's before us right here, and, again, after consultation with the Human Rights Bureau, it was reviewed to be appropriate to share in an informational capacity.
Q. So you guys were interpreting how House Bill 702 would apply in this situation.
A. We weren't interpreting --

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MR. DEWHIRST: Objection.
A. Yeah. We weren't --
MR. DEWHIRST: Objection to form.
A. -- interpreting it. We were providing educational guidance and educational information to Montanans that after consultation with the Human Rights Bureau was judged to be appropriate.
BY MS. MAHE:
Q. Well, you say HB 702 applies in this circumstance. Correct?
A. Yeah, I think the -- I think the text here speaks for itself.
Q. So you are interpreting that House Bill 702 applies in this circumstance. Correct?
A. Again, this was an educational informational piece. Now, a specific case would be adjudicated or reviewed by the Human Rights Bureau and they would look at specific facts in each circumstance that, you know, apply those facts to the law. But in an educational, informational capacity, that's correct.
EXHIBIT:
(Deposition Exhibit 57 marked for identification.)

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BY MS. MAHE:
Q. The court reporter has handed you what has been marked Deposition Exhibit 57. Have you seen this document before?
A. Yes.
Q. What is this document?
A. This is a letter that I sent with the commissioner's approval under her name to a Montana employer who we had come to believe may not have been aware of House Bill 702, and it was shared with the employer to ensure, in an educational capacity, that they were aware of the law, and we directed them to the information included for their educational purposes.
Q. And so this particular letter was sent to Montana -- sorry, Mountain-Pacific Quality Health. Correct?
A. Yes.
Q. And you drafted this letter.
A. Yes, with the commissioner's authority and approval.
Q. And how many letters like this were sent?
A. They were produced in discovery. I think it's about nine or so, but they were -- they were all produced in discovery.

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Q. And how did you determine who the letters would be sent to?
A. We became aware of employers that may not have been aware of House Bill 702 and its protections for employers. As we became aware of those, we engaged in a public education and outreach effort to ensure that they were informed of them. And as we became aware of them, we would communicate with them to share with them information, particularly the FAQ documents we had discussed a few moments ago.
Q. Okay. Where -- Where does it reference the FAQs in this document?
A. This particular draft of the letter does not. Others do, but again, the purpose, by and large, was to inform the House Bill 702 in a public education capacity.
Q. And how did you become aware that these individuals might not be aware of 702?
A. Individuals would -- Let me start over. We would become aware of concerns by individuals, typically employees, who would contact us or others. There were a variety of ways. Could have been a news report, could have been a communication with a legislator or the governor's

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office, but as the department and the commissioner's office became aware of them, part of our public information and education effort included reaching out to employers directly to ensure that they were aware of the law.

Q. And -- And this set of letters is dated November 12th, 2021. Is that correct?

A. That's correct.

Q. Were letters similar to this all sent out around that same time?

A. There was a -- Depending on how you say "around the same time," yeah, reasonably, within the -- within a couple of months, yeah.

Q. And in this letter you state "We understand that these conflicting directives from federal and state government are challenging for employers seeking to comply with the law."

Do you see that?

A. I do.

Q. And those conflicting directives would be the federal government mandates versus House Bill 702. Is that what you were talking about?

A. I -- I think the letter speaks for itself. It discusses the executive order issued

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by President Biden and it discusses House Bill 702.

MS. MAHE: Mary, can you read back my question?

THE COURT REPORTER: "And those conflicting directives would be the federal government mandates versus House Bill 702. Is that what you were talking about?"

A. Yes.

BY MS. MAHE:

Q. And later in there in that letter it states "COVID-19 vaccine mandates, including as a condition of employment, are illegal in Montana."

Do you see that?

A. Yes.

Q. Then at the end you direct the employer to respond to the letter in writing affirming that it was received within seven days.

Do you see that?

A. Yes.

Q. Did you get responses from these employers?

A. The responses varied, and whether we got them at all varied. Occasionally nothing would come of them and we would never hear anything

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again. Occasionally they would reach out to receive more information or better understand what House Bill 702 required. It varied situation by situation.

Q. And then it says [As Read]: "Note that continued discrimination against employees based on vaccination status may constitute a willful violation of Montana law subject to criminal penalties under MCA Section 49-2-601."

Do you see that?

A. I do.

Q. And you included that in there to inform them of the potential criminal penalties associated with the law?

A. This was an educational effort.

Q. Is that a yes?

A. It was included as part of the educational effort, yes.

EXHIBIT:

(Deposition Exhibit 58 marked for identification.)

BY MS. MAHE:

Q. The court reporter has handed you what has been marked Exhibit 58. Have you seen this document before?

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A. Yes.

Q. And this looks like a letter that was sent on December 17th of 2021 to Big Sky Resort. Is that correct?

A. That's correct.

Q. So in discovery it looked like there was a set of letters that were like the Exhibit 57 that were sent in November and then kind of a set of letters that were the same as this December letter. Does that sound correct to you?

A. That sounds correct, yes.

Q. And how did you go about determining who this December letter would be sent to?

A. The process was the same. As we became aware of employers or public accommodations that may not be aware of House Bill 702, we would communicate with them in -- among this -- among the different ways.

Q. And did you draft this letter?

A. I did.

Q. You mentioned public accommodations. How did you determine what constituted a public accommodation?

A. In consultation with the Human Rights Bureau.

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Q. Who at the Human Rights Bureau?
A. Marieke Beck.
Q. Okay. And I guess I should have asked that too in relation to the FAQ we were discussing related to the booster vaccines. Remember that testimony?
A. Yes.
Q. Who at the Human Rights Bureau were you speaking with in consultation?
A. Marieke Beck. I do -- Can I add one thing to that, though? I want to be clear about the process about what happened there. I had been in contact with Charlie regarding that -- that particular question, and for miscommunication it got added. I had understood that Marieke had already seen it and reviewed it. I realized within 24 hours that was not the case, so she did not have prior communication about that question, but she did review it following it and agreed that it was appropriate to share in an educational capacity.
Q. And is it still one of the FAQs on the website?
A. Yes.
Q. So Marieke wasn't actually involved in

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developing that answer. Correct?
A. That's correct.
Q. In this Exhibit 58, it looks like you're -- in here you're talking about the executive order requiring vaccination for federal contractors, the OSHA emergency temporary standard, and the CMS vaccine -- CMS vaccine mandate. Is that accurate?
MR. DEWHIRST: I'm gonna object to form on that one.
A. I'm sorry. So you're ask -- Ask me that one more time, please?
BY MS. MAHE:
Q. Sure. In this third paragraph of your letter here it looks like you're talking about the executive order related to federal contractors, the OSHA ETS and the CMS vaccine mandate. Correct?
A. That's correct.
Q. And -- And then you say [As Read]: "As a result House Bill 702 remains the law of the land in Montana and its protections remain in place." Is that accurate?
A. That's correct.
Q. And why did you feel the need to send this letter?
A. We'd become aware that Big Sky Resort may

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not be aware of House Bill 702 and its protections.
Q. And how did you become aware of that?
A. I don't recall this particular instance. I can speak in general that we would become aware from reports from individuals who contacted us, from legislators who contacted us, from the governor's office, if they received a constituent complaint, or if we just became aware of it through seeing it in the news media or some other way, but there was a variety of different ways they came to our attention.
Q. And then you direct Big Sky Resort to confirm receipt of this letter in writing within seven days and detail the steps taken by your organization to ensure compliance with House Bill 702?
A. Correct.
Q. Did they respond to this?
A. I don't recall them responding to this communication directly. I understand there were other conversations that were taking place with them about this issue by the lieutenant governor, and I'm not sure what the outcome was, but I don't recall there being a specific response to this

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letter, but I would -- I don't recall there being a specific response to this letter.
Q. Do you know whether the governor's office was also reaching out to businesses regarding compliance with 702?
A. I think they -- Well, actually I know that they shared the department's interest in ensuring that businesses, employers, and public accommodations were aware of it.
Q. Do you know whether the governor's office was reaching out to businesses regarding compliance with 49-2-312?
MR. DEWHIRST: And, again, you can respond to the extent the department has that knowledge.
A. Right. I could not speak to specific interactions, but I believe that was taking place, yes.
BY MS. MAHE:
Q. Do you know who they reached out to?
A. No.
MR. DEWHIRST: Objection. Vague.
BY MS. MAHE:
Q. And then your letter says that [As Read]: "Note that continued discrimination against

employees based on vaccination status may constitute a willful violation of Montana law subject to criminal penalties under MCA Section 49-2-601." Correct?

A. Correct.

Q. And you included that in there to make sure they were aware that there were potential criminal penalties associated with violations of 49-2-312?

A. As part of the public education and information effort.

Q. I'm sorry. Is that a "Yes"?

A. Yes.

EXHIBIT:

(Deposition Exhibit 59 marked for identification.)

BY MS. MAHE:

Q. The court reporter has handed you what has been marked Exhibit 59. Have you seen this document before?

A. Yes.

Q. Did you draft this document?

A. Yes.

Q. And what is this document?

A. This is a communication with the circuit

executive of the -- I believe it's the Ninth U.S. Circuit Court.

Q. And what is the correspondence regarding?

A. We had become aware that they were -- the -- I'm sorry, the Ninth Circuit Court was planning on holding a -- a legal conference, I guess would be the term. I don't know if there's a term of art you guys use, but legal conference at Big Sky that would require the attendees to be vaccinated for COVID-19. After becoming aware of the conference, we shared the specific statutes in 49-2-312 to educate them and ensure they were aware of House Bill 702 and the provisions of 49-2-312.

Q. When you say the Ninth Circuit, you're talking about the Ninth Circuit Federal Court of Appeals? Is that what you're talking about?

A. I believe so. It's -- Looking at this, it's the Ninth Circuit Judicial Conference, so I believe that's the appellate court. I'm -- I'm not an attorney, so I don't know the exact...

Q. And you said you became aware that they were holding a conference that was requiring vaccination. How did you become aware of that?

A. The lieutenant governor contacted me and

indicated that attorneys who had wished to attend the conference had contacted her with concerns about the requirement.

Q. Did you send any other letters at the direction of the lieutenant governor related to --

MR. GRAYBILL: Could we -- Could we pause one second while we ask these folks to pipe down, or close the door?

(Discussion held off the record.)

MS. MAHE: I don't remember my question.

THE COURT REPORTER: "Did you send any other letters at the direction of the lieutenant governor related to --"

MR. DEWHIRST: Objection. Misstates his testimony.

MS. MAHE: I asked him if he -- if he sent any other letters.

MR. DEWHIRST: At the direction of the lieutenant governor. Misstates his testimony.

A. The lieutenant governor played an active role in the department's outreach and education efforts, and was helpful in identifying employers that may not have been aware with -- of the -- of House Bill 702 and 49-2-312.

///

BY MS. MAHE:

Q. At what point in time?

MR. DEWHIRST: Objection. Vague.

BY MS. MAHE:

Q. So at what point in time did she provide you information regarding individuals that may not know about 702?

A. It's been an ongoing process over the course of the last year and a half or so.

Q. Is it still continuing?

A. I've not received any communications from her regarding that recently. The volume and activity in terms of employer vaccine mandate simply isn't what it was a year ago.

Q. Right. We haven't had flu season though, yet.

Okay. Going back to Exhibit 59. On the second page of there you state [As Read]: "the Ninth Circuit Judicial Conference's requirement that attendees of its July 18 through 21st, 2022 conference in Big Sky, Montana be fully vaccinated against COVID-19 and show proof of vaccination is prohibited by law."

Do you see that?

A. I do.

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Q. How did you come to that conclusion?
A. The House Bill 702 FAQs indicated that discrimination against individuals based on their vaccination status would be a violation, and consistent with those FAQs and that information, we provided this information to this conference in an educational and informational capacity.
Q. Okay. You -- You say educational and informational capacity, but you then say "The conference website, registration form, and all associated materials must be revised immediately to conform to Montana law and remove any references to requirements of vaccination or proof of vaccination as a condition of attendance."
Do you see that?
A. I do.
Q. So you're directing them that they must revise their website registration form and associated materials immediately. Correct?
A. That was our education and information we provided to them. The commissioner, outside of the human rights process, has no enforcement ability. There's no enforcement arm outside of the -- outside of the Human Rights Bureau process.
Q. Okay. But we talked about that earlier

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and you said you didn't know, and we went through all those statutes which say that the commissioner can file an action in district court, the commissioner can file a petition for an injunction; the commissioner can order compliance and discriminatory conduct to stop. So --
MR. DEWHIRST: Objection. Misstates his testimony, and to form.
BY MS. MAHE:
Q. So I'm confused as how you're saying now you know the enforcement authority of the commissioner, but you didn't earlier today.
MR. DEWHIRST: Objection. Misstates his testimony.
A. Was that -- Was that a question?
BY MS. MAHE:
Q. Yeah. So which is it? Do you know what reenforcement authority is or not?
MR. DEWHIRST: I'll object to this one instead.
BY MS. MAHE:
Q. So do you know what the commissioner's enforcement authority is related to 49 --
A. No.
Q. I got to finish the question. -- 49-2-312?

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MR. DEWHIRST: Objection. Calls for a legal conclusion.
BY MS. MAHE:
Q. Do you know?
A. No.
Q. And then you direct them to "Please let my office know once these changes have been made and your organization is complying with Montana law."
Do you see that?
A. Yes.
Q. So you're directing them to respond and let -- let them know once they were in compliance?
A. Yes.
Q. And -- And did they respond?
A. I understand there was a series of additional conversations held with the department's chief legal counsel that led them to adjust their policies following the information about House Bill 702.
Q. Who is "them"?
A. The Ninth Circuit Judicial Conference.
Q. Do you know whether the Ninth Circuit Judicial Conference required vaccination to attend?
A. I don't.
Q. What changes did they make to their

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policies?
A. I'm not certain. Once this letter was sent, my educational and informational role in the process was completed. Our chief legal counsel had additional conversations with them. I don't know what the contents of those are, and I don't know how it -- how the situation concluded.
Q. Do you know whether the Department of Labor has jurisdiction over federal agencies?
MR. DEWHIRST: Objection. Calls for a legal conclusion.
A. No.
MS. MAHE: Do we want to take a break and cool off?
MR. DEWHIRST: Please.
A. That'd be great.
(Recess taken from 2:40 p.m. to 2:53 p.m.)
BY MS. MAHE:
Q. John, you understand that you're still under oath?
A. Yes.
Q. And that you're still testifying on behalf of DLI?
A. Yes.

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immediately I realized what the mistake was. They reviewed it, determined it to be appropriate, and we moved on from there.

Q. Has the Department of Labor put together any presentations related to 49-2-312?

A. The department has not. The Human Rights Bureau specifically I know puts together training materials regularly on the topics that they're responsible for covering, so I would refer you to them specifically for any specific content that they may have developed.

Q. Are you aware of any of the specific content the HRB developed?

A. I understand they did a PowerPoint presentation, and a -- I guess a YouTube video.

Q. Any others?

A. Not that I'm specifically aware of.

Q. And the PowerPoint presentation, was that provided in discovery?

A. I -- I don't know the answer to that. I believe so. I don't know the answer to that.

Q. Will you look at Exhibit 51 which is the notice of deposition? And you look at page 4 of that, you see that topic 8 is all documents produced by defendants in discovery. Do you see

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that there?

A. (Nods head.)

Q. Is that a "Yes"?

A. Yes, sir. I'm sorry.

Q. And you were designated to testify as to that topic?

A. Yes.

Q. And you don't know whether the HRB PowerPoint was produced in discovery?

A. I was -- I believe that it was.

Q. And do you know the title of that document?

A. I don't have it in front of me, no.

Q. But it was in relation to House Bill 702?

A. I believe so. I believe it at least made reference to it.

Q. You also referenced a YouTube video.

A. That's correct.

Q. And is that a YouTube video that the Human Rights Bureau created?

A. Yes.

Q. Did anyone from the department, other than the Human Rights Bureau, have any collaboration in creating that video?

A. No.

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MR. DEWHIRST: Objection. Vague.

BY MS. MAHE:

Q. Is the PowerPoint presentation that you're referencing the same PowerPoint presentation that was presented in that video?

A. There are similarities. I don't know if they're precisely the same.

Q. Do you know who with HRB created that video?

A. I do not.

Q. Do you know who with the HRB created the PowerPoint you were discussing?

A. I do not.

Q. Do you know when the PowerPoint was created?

A. I do not.

Q. Do you know when the YouTube video was created?

A. I do not. For all these questions I would refer you to the Human Rights Bureau.

Q. Do you know who the PowerPoint presentation was given to?

A. I do not know who it was given to or if it was given. I do not.

Q. Do you know whether the YouTube video was

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ever made public?

A. I do not.

Q. Have you watched the YouTube video?

A. Yes.

Q. Have you gone through the PowerPoint that you're discussing?

A. I reviewed it briefly before coming here.

Q. We were -- Other -- I can't remember if I asked this, I apologize, but other than the presentations put on by the HRB, has the DLI put on any other presentations related to 49-2-312?

A. No.

Q. Has Commissioner Esau put on any presentations related to 49-2-312?

A. No.

Q. Has the Department of Labor within the last two years put on any presentations related to vaccines?

A. No.

Q. Has Commissioner Esau put on any presentations related to vaccines?

A. No.

Q. Has the Department of Labor put on any presentations other than the ones we've discussed from the HRB related to vaccination status?

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A. No.
Q. Has Commissioner Esau put on any presentations related to vaccination status?
A. No.
Q. Has the Department of Labor put on, again, in that last two-year period, put on any presentations related to the CMS regulations related to vaccination?
A. No.
Q. Has Commissioner Esau put on any presentations related to the CMS regulations?
A. No.
EXHIBIT:
(Deposition Exhibit 60 marked for identification.)
BY MS. MAHE:
Q. The court reporter has handed you what has been marked Deposition Exhibit 60. Have you seen that document before?
A. I have.
Q. And what is it?
A. This is a communication between Jessica Nelson, the department's public information officer; and Sam Wilson who is a reporter with a local news outlet.

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Q. And what's the date of this communication?
A. December 21st, 2021.
Q. Was this information accurate as of December 21st, 2021?
A. I have no reason to believe it not to be, yes.
Q. She says in here that there have been 163 total filed with 13 of those filed prior to July 21st, 2021. Do you see that section there?
A. I do.
Q. That's referring to the total number of human rights complaints filed with the HRB alleging discrimination on the basis of vaccination status. Right?
A. That's correct.
Q. So how many have been filed now?
A. I'd refer you to the Human Rights Bureau for those statistics.
Q. Do you know?
A. No.
Q. And it references one voluntary resolution agreement. Do you see that?
A. I do.
Q. And how many have there been since this date?

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A. I would refer you to the Human Rights Bureau for the most up-to-date statistics.
Q. Do you know?
A. No.
Q. You said up-to-date statistics. Do you know some earlier statistics that's different than one?
A. More up to date than these.
Q. That's going to read weird on the transcript. So do you know of any?
A. I don't.
Q. The next section says that the bureau has issued five no-cause findings. Do you see that section?
A. Yes. I'm sorry, yeah.
Q. And how many no-cause findings have been issued since this date?
A. I'd refer you to them to their most up-to-date statistics.
Q. Do you know?
A. No.
Q. We can take a really quick break. I'll just go through my notes real fast, and then --
MR. DEWHIRST: Wrapping up? All right.
(Recess taken from 3:07 p.m. to

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3:22 p.m.)
BY MS. MAHE:
Q. So, for the record, we had a discussion off the record about the HRB's deposition and documents that were produced in discovery, and we agreed that the HRB will be allowed to talk about those subject to other objections that may be lodged at that time, but the objection will not be that they're outside the scope of her designation. Correct?
MR. DEWHIRST: That's right. We -- The state won't make an objection that questions about the documents produced in response to the intervenor-plaintiff's discovery requests earlier this week. Those -- You can question the HRB witness about those.
MS. MAHE: And any documents that he deferred to the HRB regarding?
MR. DEWHIRST: Yes. Yes.
BY MS. MAHE:
Q. John, have you answered all of my questions truthfully and accurately?
A. I have.
Q. I have nothing further at this time.
///

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Q. And you just testified that to the collective knowledge of DLI, no commissioner of DLI has ever -- let's start with 503 was the first one -- has ever petitioned a district court for a preliminary injunction. Correct? That was your testimony?

MR. DEWHIRST: Objection. Misstates his testimony.

A. Under the provisions of 49-2-503, that's correct.

BY MS. MAHE:

Q. So it's your testimony that that has never happened.

A. That's correct.

Q. Okay. And it was your -- In the history of DLI, no commissioner has ever done that.

A. In our collective understanding, yes, that's correct, no commissioner's ever done that.

Q. And same thing for 508. If we turn to that in there, it's your testimony that in DLI's collective knowledge over the history of DLI, no commissioner has ever petitioned a district court to enforce the commission's order. Is that correct?

A. That's correct.

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Q. And that, again, is in the history of DLI.

A. Within the department's understanding and awareness, yes.

Q. And it's also your testimony under 508, then, in the collective knowledge and information held by the DLI that the commissioner has never commenced a civil action to enforce a breach of a conciliation agreement. Correct?

A. Correct.

Q. And again, and that's in the history of DLI to DLI's collective knowledge.

A. To our collective knowledge.

Q. And then the last question, which I can't remember exactly how David phrased it, but I believe it was to your knowledge had anybody outside of the HRB taken any enforcement action in relation to the Montana Human Rights Act. Was that --

A. I think close enough, and the answer is no.

Q. And that's in the collective knowledge of the DLI. Correct?

A. Correct.

Q. Over the history of the DLI.

A. Correct.

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Q. Okay.

MS. MAHE: I have nothing further.

EXAMINATION

BY MR. DEWHIRST:

Q. Yeah. I'll just clarify one thing. My last question was whether the department -- mine -- mine was not -- the last question was not historical. Has the department, under Commissioner Esau, has any officer of the department, outside of the HRB, taken any enforcement action under the Human Rights Act?

A. No.

MS. MAHE: I think we're good.

MR. GRAYBILL: Nothing from me.

(Deposition concluded at 3:41 p.m. Deponent excused; signature reserved.)

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DEPONENT'S CERTIFICATE

I, DEPARTMENT OF LABOR AND INDUSTRY 30(b)(6) DESIGNEE JOHN ELIZANDRO, the deponent in the foregoing deposition, DO HEREBY CERTIFY, that I have read the foregoing pages of typewritten material and that the same is, with any changes thereon made in ink on the corrections sheet, and signed by me, a full, true and correct transcript of my oral deposition given at the time and place hereinbefore mentioned.

DEPARTMENT OF LABOR AND INDUSTRY 30(b)(6) DESIGNEE JOHN ELIZANDRO, Deponent.

Subscribed and sworn to before me this day of , 2022.

PRINT NAME:
Notary Public, State of
Residing at:
My commission expires:

MRS - Montana Medical Association, et al. vs. Austin Knudsen, et al.

C E R T I F I C A T E

STATE OF MONTANA)
: ss
COUNTY OF MISSOULA)

I, Mary R. Sullivan, RMR, CRR, and Notary Public for the State of Montana, residing in Missoula, do hereby certify:

That I was duly authorized to and did swear in the witness and report the deposition of DEPARTMENT OF LABOR AND INDUSTRY 30(b)(6) DESIGNEE JOHN ELIZANDRO in the above-entitled cause; that the foregoing pages of this deposition constitute a true and accurate transcription of my stenotype notes of the testimony of said witness, all done to the best of my skill and ability; that the reading and signing of the deposition by the witness have been expressly reserved.

I further certify that I am not an attorney nor counsel of any of the parties, nor a relative or employee of any attorney or counsel connected with the action, nor financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal on August 23, 2022.

Montana Medical Association, et al. v
Austin Knudsen, et al.

Karyn Trainor 30(b)(6)
August 10, 2022

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION

MONTANA MEDICAL ASSOCIATION,
et al.,
Plaintiff, Case No. CV-21-00108-DWM
and
MONTANA NURSES ASSOCIATION,
Plaintiff-Intervenors,
v.
AUSTIN KNUDSEN, et al.,
Defendants.

VIDEOCONFERENCE/VIDEOTAPED DEPOSITION
UPON ORAL EXAMINATION OF
PROVIDENCE HEALTH & SERVICES 30(b)(6) DESIGNEE
KARYN TRAINOR

BE IT REMEMBERED, that the videoconference/videotaped deposition upon oral examination of Providence Health & Services 30(b)(6) Designee Karyn Trainor, appearing at the instance of the Defendants, was taken at 500 West

Broadway, Missoula, Montana, on Monday, August 10, 2022, beginning at the hour of 9:03 a.m., pursuant to the Federal Rules of Civil Procedure, before Mary R. Sullivan, Registered Merit Reporter, Certified Realtime Reporter, and Notary Public.

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ALSO PRESENT: Nicole Tomac, Videographer

I N D E X

S T I P U L A T I O N S

It was stipulated by and between counsel for the respective parties that the deposition be taken by Mary R. Sullivan, Freelance Court Reporter and Notary Public for the State of Montana, residing in Missoula, Montana.

It was further stipulated and agreed by and between counsel for the respective parties that the deposition be taken in accordance with the Federal Rules of Civil Procedure.

It was further stipulated and agreed by and between counsel for the respective parties and the deponent that the reading and signing of the deposition would be expressly reserved.

WEDNESDAY, AUGUST 10, 2022

THE VIDEOGRAPHER: This is the video-recorded and videoconference deposition of Karyn Trainor, 30(b)(6) representative of Providence Health & Services taken in the United States District Court for the District of Montana, Missoula Division. Cause No. CV-21-108-M-DWM, Montana Medical Association, et al., and Montana Nurses Association vs. Austin Knudsen, et al.

Today is August 10th, 2022. The time is 9:04 a.m.

We are present with the witness at St. Patrick's Hospital at 500 West Broadway Street in Missoula, Montana.

The court reporter is Mary Sullivan, and the video operator is Nicole Tomac of Fisher Court Reporting.

The deposition is being taken pursuant to notice.

I would now ask the attorneys to identify themselves, who they represent, and whoever else is present. For those attending remotely, please note from where you are appearing.

MS. MAHE: Katie Mahe appearing on behalf of the plaintiffs. And with me today is Justin

Cole.

MR. MEAD: Brett Mead with the Montana Attorney General's Office appearing remotely from Helena, Montana. Also on the line are David Dewhirst and Christian Corrigan with the Montana Attorney General's Office, all representing the defendants.

MR. GRAYBILL: Raph Graybill on behalf of plaintiff-intervenor, the Montana Nurses Association, appearing remotely from Helena, Montana.

THE VIDEOGRAPHER: The court reporter will now administer the oath.

Thereupon,

PROVIDENCE HEALTH & SERVICES 30(b)(6) DESIGNEE
KARYN TRAINOR,

a witness of lawful age, having been sworn to tell the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MR. MEAD:

Q. Good morning, Ms. Trainor. My name -- As I said, my name's Brent Mead. I'm with the Montana Attorney General's Office. I'm representing the defendants in this case. My goal today is to

a legal conclusion.
You can answer.
A. So C -- So CMS and joint commission have thousands of articles that we have to comply with in order to be able to receive payment from them, and to ensure that we are protecting our patients and our caregivers, and so I -- you know, without looking at that gigantic document, I can't tell you what articles they are, but we are required to under -- under that, prior to House Bill 702, we are required -- we were required to be able to say what somebody had and their status, and to be able to track that on an annual basis and be able to produce that documentation if we were surveyed.
BY MR. MEAD:
Q. Okay. So staying prior to House Bill 702, did Providence require physicians, nurses and other health care professionals to -- to provide proof of vaccination for immunity as a condition of employment?
MS. MAHE: Object to the form.
A. So they would have provided -- either been asked to provide proof that they've had it, or to -- if they didn't have it, we would run a titer to determine their immunization level, and

if they didn't have it and needed an accommodation, then we go through an interactive process to be able to work with them on that.
BY MR. MEAD:
Q. I -- I'll -- I'll return to the question of accommodation in a little bit, but sticking with required vaccinations, prior to House Bill 702, did Providence require its healthcare workers to get periodic boosters for any vaccine?
MS. MAHE: Object to the form.
A. It is always highly encouraged that we provide a safe work environment for our caregivers and be able to protect our patients and the community as best we can, and so a booster is always recommended. But obviously under accommodation we have some people that cannot, and so there's always protocol that we can follow.
BY MR. MEAD:
Q. So Ms. Trainor, prior to House Bill 702, did Providence require, as a condition of employment, that its healthcare workers receive a booster for, say, the Tdap vaccine?
A. It is always encouraged, and so it is -- we pay for it, we provide it for them. Most -- I would tell you most people want it to protect

themselves and to protect the -- especially younger children and more vulnerable populations, immunocompromised, but they have an opportunity to say that they will not take it, and we have accommodated. But again, there's different accommodations that go with that.
Q. Okay. And so prior to House Bill 702, did Providence require its healthcare workers to receive an annual flu shot as a condition of employment?
A. We highly encourage it, and I would tell you our percentages are extremely high for those that take it. Again, for the same reasons in protecting our patients and their coworkers, but they have an ability to decline the flu shot, and they would sign a declination form, and if an outbreak was there, then they would have to follow the accommodations needed.
Q. And so Ms. Trainor, on that note, prior to House Bill 702, what -- what did Providence -- Well, strike that.
Ms. Trainor, prior to House Bill 702, what did Providence's declination process look like?
A. We have a declination form that talks about the information around flu shots, why it's

important. They have an option to decline it and to -- and to share with us why they are declining it, and so they would go through and fill that out. It would be kept with employee health. We keep the employment files and employee health files separate to be able to protect their status.
Q. Ms. Trainor, when -- and prior to House Bill 702, when an employee signed this declination form, did Providence have any ability to reject or deny that declination?
MS. MAHE: Object to the form.
A. I would tell you we have not denied or objected. It -- It's strongly recommended for their safety. People die from the flu every year, and we want to protect our patients and our co-workers, so most people, I would tell you, bang down our door to get the flu shot.
BY MR. MEAD:
Q. Ms. Trainor, prior to House Bill 702, did Providence offer declination forms for all otherwise required vaccines?
A. If somebody would decline it, they would fill out a declination form, correct.
Q. Okay. And Ms. Trainor, prior to House Bill 702, was -- was the declination form, is

to clarify on PL 171, 174, that policy we've been discussing. I just want to clarify that prior to House Bill 702, that was Providence's vaccination policy for healthcare professionals.

A. Prior to House Bill 702, yes, we would have followed these -- these rules.

Q. Okay. Thank you.

So I want to move over into the Americans with Disability Act and Montana Human Rights Act. If I use the acronym ADA, do you understand that to mean the Americans with Disability Act?

A. Yes.

Q. If I use "the Human Rights Act," do you understand that to mean the Montana Human Rights Act?

A. Yes, I can.

Q. Thank you. So prior to House Bill 702, are you aware of any instance where a patient requested that they be treated by Providence employees that were vaccinated for a vaccine-preventable disease?

A. I'm sorry, can you restate that?

Q. Sure. Prior to House Bill 702, are you aware of any instance where a patient requested that they only be treated by Providence employees

that were vaccinated for a vaccine-preventable disease?

A. Prior to House Bill 702 during COVID, the answer would be yes. We have had patients who have asked to only be treated by vaccinated caregivers. Generally they tend to be patients who have immunocompromised situations like chemotherapy, could be a heart condition. People have been very concerned about not being exposed unduly to somebody who could have been vaccinated.

Q. And prior to House Bill 702, what was Providence policy if a patient requested that they only be treated by employees that were vaccinated for a vaccine-preventable disease?

MS. MAHE: Object to the form. And Brent, your beep is still happening.

MR. MEAD: Thank you, Counsel.

BY MR. MEAD:

Q. Did you understand the question, Ms. Trainor, or did I need to repeat it?

A. Sorry. Please repeat.

Q. Okay. Prior to House Bill 702, what was Providence's policy if a patient requested that they only be treated by employees that were vaccinated for a vaccine-preventable disease?

A. Prior to House Bill 702, we would try to accommodate as best we could, and trying to be able to provide appropriate PPE or to be able to do a temporary assignment in order to provide safe -- safe and effective care.

Q. And so Ms. Trainor, you had said that these requests came in after the onset of the COVID-19 pandemic. So for January 2019 to, let's say, March 2020, so the onset of the COVID pandemic, are you aware of any request by patients to only be treated by Providence employees that were vaccinated?

A. Timeframe-wise people were very nervous. And again, part of it is looking at how many people had access to the vaccine during that time. So, again, we have requests for lots of things to ensure that people are going to be safe. I don't -- I -- I don't recall exactly during that time what may have happened, but we have lots of requests that come in from patients to ensure that we can provide them a safe place to get care.

Q. So Ms. Trainor, from the time period when COVID-19 vaccines were made available to healthcare workers until House Bill 702 was enacted, so May 2021, in that timeframe, were these types of

patient requests to only be treated by vaccinated employees, were they limited to COVID-19?

MS. MAHE: Object to the form.

A. At that point I would say most of it would be COVID, yes.

BY MR. MEAD:

Q. Are -- During this time period, are you aware of any request to be treated by patients who were vaccinated for any other specific diseases?

MS. MAHE: Object to the form.

A. I'm sorry. Can you say that again?

BY MR. MEAD:

Q. Sure. So you have -- you said that these requests were largely limited to COVID-19, so I'm wondering during this time period from when COVID-19 vaccines were available until House Bill 702 was enacted, are you aware of any similar requests to be treated by employees who were vaccinated for any other specific disease?

MS. MAHE: Object to the form.

A. So I would tell you the general public assumes that our people are vaccinated and were required to be vaccinated in many cases, so the -- the -- the types of questions we would get would have been very limited because, again, you

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had to have your -- for -- for vaccinations you had to have it in school, you had to have it for day care, you had it have it to go to university. The assumption our patients have is that we are providing a safe place, and so I would tell you until House Bill 702, we had limited requests that would come in around the people who were treating them, but we have had questions about the safety of the people treating them, and -- and so I -- I don't -- I don't know that we -- I mean, I can't tell you specifically 'cause most of those don't come into me, but, again, it would go back to the assumption that we would be making sure that people were safe if they were coming to get care here.

BY MR. MEAD:

Q. Okay. And so Ms. Trainor, if I understood you correctly, you -- you said that the public assumed that Providence's caregivers were vaccinated, and then you referenced schools, day cares, and university vaccination policies. Are you aware of any changes to vaccination policies at schools, day cares, or universities since House Bill 702?

MS. MAHE: Object to the form, and

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exceeds her designation.

A. So I know that there are exemptions for them, but again, it goes back to the general public having knowledge that you can do something different since House Bill 702 than before, so I don't know what their perception is. I'm just sharing that the assumption in many cases is that those were normal vaccines to be expected with somebody in a health care setting.

BY MR. MEAD:

Q. Okay. So prior to House Bill 702, did Providence provide reasonable accommodations under the Human Rights Act to employees due to the vaccination status of Providence patients?

MS. MAHE: Object to the form, and calls for a legal conclusion.

A. I need you to say it again 'cause I'm not exactly sure what you're asking.

BY MR. MEAD:

Q. Sure. So prior to House Bill 702 did Providence provide a -- did Providence fulfill a reasonable accommodation request made by a Providence employee that was based on the vaccination status of Providence patients?

MS. MAHE: Same objections.

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A. So that's a difficult question to answer. And depending on what area the patient would be coming in for, if it comes in through the ED or different things under EMTALA, we have to treat them, and they wouldn't necessarily know. Depending on the emergent nature of the issue, our caregiver wouldn't know their history. So to ask for an accommodation would be difficult if you don't know the status of them at that point.

If they -- If they had -- So if it was not an emergent issue, then potentially they could ask to have a reassignment or something to -- to ensure that they would not harm themselves. You know, we have things like x-ray. If somebody's pregnant, they have an accommodation that we process so that they're not going to get, you know, unduly harmed. So, again, prior to House Bill 702 there was a lot of things that we could do, but it depends on what area they worked whether we would know the vaccination status or not.

BY MR. MEAD:

Q. Okay. And so prior to House Bill 702, did Providence fulfill a reasonable accommodation request under the Montana Human Rights Act to any

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employee due to the vaccination status of other Providence employees?

MS. MAHE: Object to the form, and calls for a legal conclusion.

A. So prior to House Bill 702, we have followed the interactive process under house -- under the Human Rights Bureau, Human Rights Act, and under ADA to go through a process to determine what could happen. You know, the -- in looking at an accommodation, there was a lot more flexibility pre House Bill 702 than there is post House Bill 702.

BY MR. MEAD:

Q. So Ms. Trainor, prior to House Bill 702, in that interactive process you're describing, did Providence take into account the vaccination status of other Providence employees when considering a reasonable accommodation request by an employee?

MS. MAHE: Object to the form.

You can answer.

A. So it's a really broad question. Again, any -- any request for accommodation would be individualized based on what that -- what that person and their provider would be asking, and then we would have to make a determination if it

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could be done or if it could not be done, and whether or not it was a reasonable accommodation for them to be able to do -- you know, to do their job. So without a specific, it makes it very difficult to say how to navigate that. We -- I would say that we probably have had limited requests due to vaccination.

BY MR. MEAD:

Q. So Ms. Trainor, prior to House Bill 702, are you aware of any specific request by a Providence employee for a reasonable accommodation based on the vaccination status of other Providence employees?

MS. MAHE: Object to the form.

A. The only accommodation -- The only accommodations I'm most familiar with that they would have been asking prior to House Bill 702 was mostly around COVID.

BY MR. MEAD:

Q. Okay. So just to clarify, Ms. Trainor, you're not aware of any specific reasonable accommodation request under the Human Rights Act by a Providence employee based on the vaccination status of other Providence employees --

MS. MAHE: Object to the form.

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BY MR. MEAD:

Q. -- prior to House Bill 702?

MS. MAHE: Sorry. Object to the form, and misstates her testimony.

A. So I am -- I have -- I am not aware of requests specific to that. We have requests that come in for a myriad of reasons, and it usually is immunocompromise issues, and so it could pertain to vaccination as part of it, but it could also have other parts of medical concern. It's usually not just one thing.

BY MR. MEAD:

Q. So Ms. Trainor, again, prior to House Bill 702, under the Human Rights Act, did Providence ever adjust the scope of work for a Providence caregiver based on another Providence caregiver's reasonable accommodation request?

MS. MAHE: Object to the form, and calls for a legal conclusion.

A. I'm sorry, you're gonna have to help me out. Give me an example.

BY MR. MEAD:

Q. Sure. So again, I want to be clear that this is all prior to House Bill 702.

So I'm wondering if there is an example

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where in order to accommodate an -- an employee who puts in a reasonable accommodation request, that Providence adjusted the locations of work, shift schedule, for a different Providence employee.

MS. MAHE: Object to the form.

A. So it would depend. It could be that person who's asking for the accommodation, it could be that, you know, it's moving somebody from one desk to a next, that could be the accommodation. Again, without the specifics it's really hard to say. Again, we work with all of our employees, and prior to House Bill 702 had a lot of latitude to be able to do what we needed to do and being able to accommodate these things.

BY MR. MEAD:

Q. So prior to House Bill 702, did Providence ever ask a caregiver to receive a vaccination based on the reasonable accommodation request of a different Providence employee?

MS. MAHE: Object to the form.

A. I'm trying to understand exactly what you're asking. So you're -- you're saying that somebody has said I want this other person to have a vaccine?

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BY MR. MEAD:

Q. Yes.

A. Well, again, it would go back to depending on what the -- the situation was, we would be working through the accommodation of that person and not necessarily impinging on somebody else's right.

Q. Okay. That's helpful. Thank you.

Give me one moment here.

So prior to House Bill 702, if an employee received a medical or religious exemption to a required vaccine, did Providence require that employee to take any precautions such as wearing additional PPE based on that exemption?

MS. MAHE: Object to the form.

A. So prior to House Bill 702 if -- if they had an accommodation, part of that accommodation might be additional PPE, could be a different work assignment on a temporary basis. There's a number of things that we could look at doing, but PPE is the No. 1 thing that the CDC and other health organizations indicate in order to protect them from patients who could potentially have these diseases.

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vaccination required by the Montana Department of Public Health and Human Service -- Services as a condition of participation in Medicaid?

MS. MAHE: Object to the form.

A. I'm sorry. You'll have to say that again.

BY MR. MEAD:

Q. Sure. Are you aware of any vaccination required by the Montana Department of Health and Human Services -- Strike that.

Prior to House Bill 702, are you aware of any vaccination required by the Montana Department of Health and Human Services as a condition of participation in Medicaid?

MS. MAHE: Object to the form, and calls for a legal conclusion.

A. So CMS has required different things. I am not aware that the Department of Health and Human Services in Montana has.

BY MR. MEAD:

Q. Okay. Thank you.

MR. MEAD: If we could just take a couple-minute break, I just need to review my notes, but I think I'm about ready to wrap up.

THE VIDEOGRAPHER: We are going off the

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record. The time is 11:39 a.m.

(Recess taken from 11:39 a.m. to 11:43 a.m.)

THE VIDEOGRAPHER: We are back on the record. The time is 11:43 a.m.

BY MR. MEAD:

Q. Ms. Trainer, thank you for your time this morning, and my last question is just if -- if there's anything that you would like to add to your testimony today or if you would like to clarify anything that you have spoken to today.

A. Thank you. I think I'm fine.

Q. I am done.

MS. MAHE: We'll reserve.

MR. MEAD: No further questions.

MS. MAHE: Sorry. I talked over you. We'll reserve.

MR. GRAYBILL: Likewise.

THE VIDEOGRAPHER: That concludes the deposition. The time is 11:44 a.m.

(Deposition concluded at 11:44 a.m. Deponent excused; signature reserved.)

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DEPONENT'S CERTIFICATE

I, PROVIDENCE HEALTH & SERVICES 30(b)(6) DESIGNEE KARYN TRAINOR, the deponent in the foregoing deposition, DO HEREBY CERTIFY, that I have read the foregoing pages of typewritten material and that the same is, with any changes thereon made in ink on the corrections sheet, and signed by me, a full, true and correct transcript of my oral deposition given at the time and place hereinbefore mentioned.

PROVIDENCE HEALTH & SERVICES 30(b)(6) DESIGNEE KARYN TRAINOR, Deponent.

Subscribed and sworn to before me this day of , 2022.

PRINT NAME:
Notary Public, State of
Residing at:
My commission expires:

MRS - Montana Medical Association, et al. vs. Austin Knudsen, et al.

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C E R T I F I C A T E

STATE OF MONTANA)
: ss
COUNTY OF MISSOULA)

I, Mary R. Sullivan, RMR, CRR, and Notary Public for the State of Montana, residing in Missoula, do hereby certify:

That I was duly authorized to and did swear in the witness and report the deposition of PROVIDENCE HEALTH & SERVICES 30(b)(6) DESIGNEE KARYN TRAINOR in the above-entitled cause; that the foregoing pages of this deposition constitute a true and accurate transcription of my stenotype notes of the testimony of said witness, all done to the best of my skill and ability; that the reading and signing of the deposition by the witness have been expressly reserved.

I further certify that I am not an attorney nor counsel of any of the parties, nor a relative or employee of any attorney or counsel connected with the action, nor financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal on August 23, 2022.

Montana Medical Association, et al. v
Austin Knudsen, et al.

Kirk Bodlovic 30(b)(6)
August 10, 2022

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION

MONTANA MEDICAL ASSOCIATION,
et al.,
Plaintiff, Case No. CV-21-00108-DWM
and
MONTANA NURSES ASSOCIATION,
Plaintiff-Intervenors,
v.
AUSTIN KNUDSEN, et al.,
Defendants.

VIDEOCONFERENCE/VIDEOTAPED DEPOSITION
UPON ORAL EXAMINATION OF
PROVIDENCE HEALTH & SERVICES 30(b)(6) DESIGNEE
KIRK BODLOVIC

BE IT REMEMBERED, that the videoconference/videotaped deposition upon oral examination of Providence Health & Services 30(b)(6) Designee Kirk Bodlovic, appearing at the instance of the Defendants, was taken at 500 West

Broadway, Missoula, Montana, on Wednesday, August 10, 2022, beginning at the hour of 1:01 p.m., pursuant to the Federal Rules of Civil Procedure, before Mary R. Sullivan, Registered Merit Reporter, Certified Realtime Reporter, and Notary Public.

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ALSO PRESENT: Nicole Tomac, Videographer

I N D E X

DEPONENT: PAGE:

PROVIDENCE HEALTH & SERVICES 30(b)(6) DESIGNEE
KIRK BODLOVIC

EXHIBITS:

S T I P U L A T I O N S

It was stipulated by and between counsel for the respective parties that the deposition be taken by Mary R. Sullivan, Freelance Court Reporter and Notary Public for the State of Montana, residing in Missoula, Montana.

It was further stipulated and agreed by and between counsel for the respective parties that the deposition be taken in accordance with the Federal Rules of Civil Procedure.

It was further stipulated and agreed by and between counsel for the respective parties and the deponent that the reading and signing of the deposition would be expressly reserved.

WEDNESDAY, AUGUST 10, 2022

THE VIDEOGRAPHER: This is the video-recorded and videoconference deposition of Kirk Bodlovic, 30(b)(6) representative of Providence Health & Services, taken in the United States District Court for the District of Montana, Missoula Division. Cause No. CV-21-108-M-DWM, Montana Medical Association, et al., and Montana Nurses Association vs. Austin Knudsen, et al.

Today is August 10th, 2022. The time is 1:02 p.m. We are present with the witness at St. Patrick's Hospital at 500 West Broadway Street in Missoula, Montana.

The court reporter is Mary Sullivan, and the video operator is Nicole Tomac of Fisher Court Reporting.

The deposition is being taken pursuant to notice.

I would now ask the attorneys to identify themselves, who they represent, and whoever else is present. For those attending remotely, please note from where you are appearing.

MS. MAHE: My name is Katie Mahe, and I'm representing the plaintiffs, and with me today is Justin Cole.

MR. MEAD: It's Brent Mead representing the defendants appearing remotely from Helena, Montana. Also on the line with me are David Dewhirst and Christian Corrigan with the Montana Attorney General's Office also representing the defendants.

MR. GRAYBILL: Raph Graybill on behalf of plaintiff-intervenor, the Montana Nurses Association, appearing remotely from Helena.

THE VIDEOGRAPHER: The court reporter will now administer the oath.

Thereupon,

PROVIDENCE HEALTH & SERVICES 30(b)(6) DESIGNEE
KIRK BODLOVIC,

a witness of lawful age, having been sworn to tell the truth, the whole truth, and nothing but the truth, testified as follows:

MR. MEAD: Now, before we get into your testimony today, Mr. Bodlovic, the defendants want to state for the record that Providence's earlier 30(b)(6) deponent invoked the Fifth Amendment, and the defendants believe that indication to be improper. We would ask for clarification as to whether the deponent was invoking the amendment on behalf of herself or on behalf of Providence

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702," does it make sense that that time period refers to January 1st, 2019 to May 6, 2021?
A. It does.
Q. Okay. And when I say "since House Bill 702," does it make sense that I am referring to May 7, 2021 to the present?
A. It does.
Q. Okay. And again, to state for the record, the reason for that break in dates is that House Bill 702 was signed on May 7, 2021.
So Mr. Bodlovic, I want to sort of understand the scope of facilities that Providence operates. So can you please describe the types of facilities that Providence operates in Montana?
A. Yes. So in Montana we have two acute care hospitals. One, St. Patrick Hospital here in Missoula, Montana. We have also a critical access facility in Polson, St. Joseph Medical Center. In addition to that, we have 30 to 40 clinics, some freestanding, some embedded within hospital properties and operations.
Additionally up at St. Joe's there's an assisted living facility. I could get in to some of the service lines we provide, but those are the facilities -- basic facilities that we operate,

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so...
Q. Mr. Bodlovic, you mentioned the assisted living facility in Polson. Does Providence operate any skilled nursing facilities in Montana?
A. We don't operate any. We do have a -- we do have an ownership in one of the Goodman Group managed properties in Missoula, Riverside Nursing Home, we're, I would say, a very silent partner in that. We have zero control over any operations of the -- of that facility.
Q. Okay. Does Providence operate any long-term care facilities in Montana?
A. Not in Montana.
Q. Okay. And speaking specifically to the two St. Joseph facilities in Polson, do St. Joseph Medical Center and St. Joseph assisted living center -- do they operate under separate DPHHS licenses?
A. First let me state that the assisted living facility is technically a department of the larger entity. They all fall under the same tax ID number. And I will be honest, I don't know if there's a separate assisted living. There's different requirements. I'm assuming there's separate licensure, but I'm not -- I can't speak

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to the specifics of the licenses -- the licensure for the assisted living facility, but they are all under the same entity.
Q. Okay. And you -- you just got to my next question which is going to be what are the specific requirements placed on the assisted living center that are different than St. Joseph's Medical Center?
A. Sure. From --
MS. MAHE: Object --
A. Oh.
MS. MAHE: -- to the form.
You can answer.
THE DEPONENT: Okay. Okay. Sorry.
A. From a standpoint of the -- how it -- from a policy standpoint on employees, I will say that we have employees that go back and forth. We share staff. So all of the policies -- employment policies apply to -- they're -- the same policies apply to employees at the facility, the hospital, and at the assisted living facility, so...
BY MR. MEAD:
Q. Okay. Does -- Does that apply to things like pre-employment criminal background checks?

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A. Those are all the same, that is correct.
Q. Okay. So now for this next series of questions, I'm -- I'm probably going to say "Providence," but I want to be clear that unless I specifically note otherwise, I'm talking about St. Patrick's Hospital.
A. Okay.
Q. Does St. Patrick's refer patients to other healthcare providers?
A. We don't have referral agreements as a hospital. Those referral discussions are physician to physician.
Q. Okay. Does St. Patrick's have any referral policy that it places on its physicians regarding patient referral?
A. We do not.
Q. Okay. And so prior to House Bill 702, Providence did not have a policy to check the staff vaccination policies at a provider receiving patients from Providence.
MS. MAHE: Object to the form.
A. Yeah. Prior to -- Prior to House Bill 702 and post, we do not have any -- we have not checked in any other facility's vaccination policy.

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BY MR. MEAD:
Q. Okay. And prior to House Bill 702, Providence did not have a policy to check the actual vaccination status of healthcare professionals at a receiving institution?
MS. MAHE: Object to the form.
A. That is correct. We don't check into those vaccination status of -- of the other facilities.
BY MR. MEAD:
Q. So since -- Excuse me here. Since 2019, are you aware of any healthcare provider refusing to transfer a patient to Providence based on the vaccination status of Providence employees?
MS. MAHE: Object to the form.
You can answer.
A. I'm not aware.
BY MR. MEAD:
Q. Okay. So I want to move into some of the patient screening policies, and if I -- let me know if this isn't clear, but when I refer to a wellness check, what I am referring to are the pre-visits questionnaires that a patient does such as "Are you suffering symptoms from a communicable disease?" "Are you running a fever?" "Have you been exposed

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to someone who is affected with a communicable disease?"
Does that make sense?
A. Can I clarify the question?
Q. Sure.
A. You're -- You're asking for any visit to a -- one of our physician clinics or to the hospital if they went through a prescreening checklist?
Q. Yes. And so basically I just want to establish that we can agree what that prescreening checklist is and that we understand what it means.
A. Understood.
Q. Okay. So prior to House Bill 702, did -- did Providence ask patients to disclose their vaccination status prior to a patient visit?
MS. MAHE: Object to the form.
A. We did not.
BY MR. MEAD:
Q. Prior to House Bill 702 -- Strike that.
So prior to House Bill 702, Providence then did not require patients to disclose their vaccination -- vaccination status prior to a patient visit.
MS. MAHE: Object to the form.

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A. That is correct, we did not require any disclosure of vaccination status.
BY MR. MEAD:
Q. Okay. Now, prior to House Bill 702, if Providence learned that a patient was unvaccinated for a vaccine-preventable disease, did Providence require any precautions prior to their patient visit?
MS. MAHE: Object to the form.
A. Can you clarify the question for me?
BY MR. MEAD:
Q. Sure. So if a patient -- Prior to House Bill 702, just to be clear on the timeframe, if a patient let their vaccine status be known to Providence, based on that information, did Providence take any precautions based on that information?
MS. MAHE: Object to the form.
BY MR. MEAD:
Q. As an example, it might be requiring they show up wearing a mask.
MS. MAHE: Object to the form.
A. Okay. Prior to House Bill 702, and I'll say from the start of that pandemic, all visitors and patients to this facility were required to

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mask.
BY MR. MEAD:
Q. Okay.
A. So despite -- Whether or not they disclosed their vaccination status or not, so...
Q. Sure. So a similar question looking for that -- from 2019 to the onset of the COVID-19 pandemic, if Providence learned of a patient's vaccine status, did they require any precaution from that patient?
MS. MAHE: Object to the form.
A. Certain precautions depending on the nature of that, I would say, communicable disease, probably were taken. As an example, I'll just throw this out there, and it's extreme, but we have a critical care unit for our -- in our ICU for Rocky Mountain Laboratory down in Hamilton. So clearly in those instances of a infected patient -- potential patient would be -- precautions would have been taken as an example.
BY MR. MEAD:
Q. Okay. So looking again to that period from January 2019 to the onset of the COVID-19 pandemic, did St. Patrick's Hospital, did they conduct temperature checks of individuals before

you look to any documents filed by Providence Health with the appropriate regulatory entities of Montana?

MS. MAHE: I'm gonna object to the form. Assumes that Providence files documents with regulatory authority.

You can answer.

A. Yeah, and I might need some clarification. I'm not aware of any based on the way the question was asked. I apologize. I'm just not clear.

BY MR. MEAD:

Q. Sure. Mr. Bodlovic, in your -- in the process of complying with Request for Production No. 40, did you search for documents that Providence filed with the Montana Commissioner of Political Practices?

MS. MAHE: Object to the form.

A. I did not do that -- that search, no.

MR. MEAD: Nothing further.

THE VIDEOGRAPHER: We are going off the record. The time is 2:17 p.m.

(Deposition concluded at 2:17 p.m. Deponent excused; signature reserved.)

DEPONENT'S CERTIFICATE

I, PROVIDENCE HEALTH & SERVICES 30(b)(6) DESIGNEE KIRK BODLOVIC, the deponent in the foregoing deposition, DO HEREBY CERTIFY, that I have read the foregoing pages of typewritten material and that the same is, with any changes thereon made in ink on the corrections sheet, and signed by me, a full, true and correct transcript of my oral deposition given at the time and place hereinbefore mentioned.

PROVIDENCE HEALTH & SERVICES 30(b)(6) DESIGNEE KIRK BODLOVIC, Deponent.

Subscribed and sworn to before me this day of , 2022.

PRINT NAME:
Notary Public, State of
Residing at:
My commission expires:

MRS - Montana Medical Association, et al. vs. Austin Knudsen, et al.

C E R T I F I C A T E

STATE OF MONTANA)
: ss
COUNTY OF MISSOULA)

I, Mary R. Sullivan, RMR, CRR, and Notary Public for the State of Montana, residing in Missoula, do hereby certify:

That I was duly authorized to and did swear in the witness and report the deposition of PROVIDENCE HEALTH & SERVICES 30(b)(6) DESIGNEE KIRK BODLOVIC in the above-entitled cause; that the foregoing pages of this deposition constitute a true and accurate transcription of my stenotype notes of the testimony of said witness, all done to the best of my skill and ability; that the reading and signing of the deposition by the witness have been expressly reserved.

I further certify that I am not an attorney nor counsel of any of the parties, nor a relative or employee of any attorney or counsel connected with the action, nor financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal on August 23, 2022.

Montana Medical Association, et al. v
Austin Knudsen, et al.

Meghan Morris 30(b)(6)
August 8, 2022

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION

MONTANA MEDICAL ASSOCIATION,
et al.,
Plaintiff, No. CV-21-108-M-DWM
and
MONTANA NURSES ASSOCIATION,
Plaintiff-Intervenors,
v.
AUSTIN KNUDSEN, et al.,
Defendants.

VIDEOCONFERENCE/VIDEOTAPED DEPOSITION
UPON ORAL EXAMINATION OF
WESTERN MONTANA CLINIC 30(b)(6) DESIGNEE
MEGHAN MORRIS

BE IT REMEMBERED, that the videoconference/videotaped deposition upon oral examination of Western Montana Clinic 30(b)(6) Designee Meghan Morris, appearing at the instance of the Defendants, was taken at 211 North Higgins,

Suite 303, Missoula, Montana, on Monday, August 8, 2022, beginning at the hour of 9:18 a.m., pursuant to the Federal Rules of Civil Procedure, before Mary R. Sullivan, Registered Merit Reporter, Certified Realtime Reporter, and Notary Public.

A P P E A R A N C E S

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A P P E A R A N C E S (Contd.)

ALSO PRESENT: Nicole Tomac, Videographer

I N D E X

S T I P U L A T I O N S

It was stipulated by and between counsel for the respective parties that the deposition be taken by Mary R. Sullivan, Freelance Court Reporter and Notary Public for the State of Montana, residing in Missoula, Montana.

It was further stipulated and agreed by and between counsel for the respective parties that the deposition be taken in accordance with the Federal Rules of Civil Procedure.

It was further stipulated and agreed by and between counsel for the respective parties and the deponent that the reading and signing of the deposition would be expressly reserved.

MONDAY, AUGUST 8, 2022

THE VIDEOGRAPHER: This is the video-recorded and videoconference deposition of Megan Morris, 30(b)(6) representative of Western Montana Clinic, taken in the United States District Court for the District of Montana, Missoula Division. Cause No. CV-21-108-M-DWM. Montana Medical Association, et al., and Montana Nurses Association vs. Austin Knudsen, et al.

Today is August 8th, 2022. The time is 9:18 a.m.

We are present with the witness at the offices of Fisher Court Reporting at 211 North Higgins Avenue, Suite 303 in Missoula, Montana.

The court reporter is Mary Sullivan, and the video operator is Nicole Tomac of Fisher Court Reporting.

The deposition is being taken pursuant to notice.

I would now ask the attorneys to identify themselves, who they represent, and whoever else is present. For those attending remotely, please note from where you are appearing.

MS. MAHE: Katie Mahe representing the plaintiffs. And appearing via Zoom from Missoula

is Justin Cole for the plaintiffs.

MR. CORRIGAN: And this is Christian Corrigan from the office of the Montana Attorney General representing defendants in the case. Also on the line -- excuse me, I'll -- and I'll be appearing via Zoom from Helena, Montana. Also on the line is Brent Mead and David Dewhirst from the Montana Attorney General's Office appearing via Zoom from Helena.

THE VIDEOGRAPHER: The court reporter will now administer the oath.

Thereupon,

WESTERN MONTANA CLINIC 30(b)(6) DESIGNEE
MEGHAN MORRIS,

a witness of lawful age, having been sworn to tell the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MR. CORRIGAN:

Q. All right. Good morning.

A. Morning.

Q. Ms. Morris, thank you for being here today. Before we get started, I just want to go over a few guidelines for the deposition and make sure we're on the same page.

A. We have a few locations in Missoula. One is at 500 West Broadway, one is at 2835 Palmer, one is at the Southgate Mall, and one is on Fort Missoula Road on the Community Medical Center campus.

Q. And so all WMC facilities are located in the Missoula area?

A. Yes, currently.

Q. And how many employees are there across all WMC facilities?

A. We have about 190 employees, and that fluctuates from week to week as we hire and replace people.

Q. Okay. And is there a main WMC facility that's larger than the rest, or what's the breakdown as -- as far as employees between the different facilities?

A. Roughly approximately 50 to 60 percent of our folks are located at the 500 West Broadway location. Then we have another smaller percentage, again, roughly about 20 percent, at the Palmer location that is our business offices location. We don't do patient care there. The Community Medical Center campus location is another 30 or 40 percent. And then we have a very

small percentage at the Southgate Mall location.

Q. And do WMC employees, as part of their -- as part of their employment with WMC, do they provide services at facilities that are not run by WMC?

A. I -- That question I would answer differently. The only people who work under the umbrella are the physicians at Western Montana Clinic. Everyone else is an employee of the corporate entity Tamarack Management.

Q. Okay. Are you familiar with what it means to be a licensed health care facility by the state of Montana?

A. I'm not sure I understand your question.

Q. Sure. Let's go ahead and bring in Exhibit 10, which, Katie, you should have as WMC-1.

THE COURT REPORTER: Christian, I'm not sure which document is which. I just printed, so I will need more of a description to hand to the witness.

MR. CORRIGAN: Sure. It's -- On -- On the first page, it's highlighted "Montana Code Annotated 2021," and in other big print it says "Definitions."

THE COURT REPORTER: Thank you.

EXHIBIT:

(Deposition Exhibit 10 marked for identification.)

BY MR. CORRIGAN:

Q. Let me know when we've got everything set, and I'll proceed.

A. I have the exhibit.

Q. Okay. Could you go to page 3 of that exhibit, and subsection (26)(a) should be there on page 3. And for the -- for the record, this is 50-5-101 of the Montana Code Annotated. And I want to point you to Section (26)(a) there where it defines "Health care facility" or for short "facility."

And my question for you is is Western Montana Clinic -- or does Western Montana Clinic fall under the definition of "health care facility" in (26)(a) there?

MS. MAHE: Objection. Calls for a legal conclusion, and outside of her designation.

You can answer, if you know.

A. As I'm reviewing that Section (26)(a) that you pointed out, I don't see that we squarely fit into any one of those specifically named

entities.

BY MR. CORRIGAN:

Q. Great.

MR. CORRIGAN: Can we bring in now we'll call Exhibit 11? It says license. For Katie, that's going to be WMC-2.

EXHIBIT:

(Deposition Exhibit 11 marked for identification.)

BY MR. CORRIGAN:

Q. So this is Montana 50-5-201, which is the license requirements for health care facilities, and -- and I would note that one of the topics that we noticed was WMC's licensure history.

So looking at Exhibit 11 here, does WMC currently hold a license as defined under this chapter?

MS. MAHE: Objection. Calls for a legal conclusion.

You can answer.

A. For the services we provide, we've been licensed as a business, and that's what we've chosen to be through our operation.

BY MR. CORRIGAN:

Q. So are -- are -- to clarify, are you

Does WMC have a government affair staff or lobbyist?
A. No. Western Montana Clinic does not.
Q. Does any organization that WMC is a member of have a government affair staff or a lobbyist?
MS. MAHE: Object to the form, and outside her designation.
You can answer.
A. I -- I'm not sure if any organization that we're a member of employs those staff or not.
BY MR. CORRIGAN:
Q. Did WMC or any organization that it's a member of take a public position opposing or supporting House Bill 702?
MS. MAHE: Object to the form, and exceeds her designation.
A. Western Montana Clinic as an organization did not.
BY MR. CORRIGAN:
Q. So WMC did not conduct any lobby activities related to House Bill 702. Is that correct?
A. Not as an organization, no.
Q. Did individuals employed by WMC take

public positions on House Bill 702?
MS. MAHE: Object to the form. Calls for speculation and outside of her designation.
You can answer, if you know.
A. I don't know and can't speak to the independent actions of all of Western Montana Clinic's members, and I would refer to the physician members as members, not employees.
BY MR. CORRIGAN:
Q. I'd like to ask that same question but as it applies to high level and executive staff such as yourself or others that I -- that would be high level executives with WMC.
MS. MAHE: Object to the --
BY MR. CORRIGAN:
Q. Did any high level executives with WMC take public positions on House Bill 702?
MS. MAHE: Object to the form. Calls for speculation, vague, and outside her designation.
A. To my knowledge as the representative of Western Montana Clinic, those individuals did not take positions on behalf of Western Montana Clinic.
BY MR. CORRIGAN:
Q. And is WMC a member of the Montana

Medical Association?
A. I understand that to be true, yes. The physicians are members.
Q. When you say "the physicians are members," what do you mean by that?
A. The physicians are individual members of the MMA.
Q. But WMC is not a -- a official member of -- or strike that.
But Western Montana Clinic is not an official member of the Montana Medical Association.
A. As an organization, no. The Western Montana Clinic physicians are individual members.
Q. Okay. Thank you.
And are -- are those physicians nonequity partners of WMC?
MS. MAHE: Object to the form.
You can answer.
A. The structure is that they become nonequity shareholders after a certain period of time practicing with the groups.
BY MR. CORRIGAN:
Q. And how many nonequity shareholders does WMC currently have?

A. We have 31 physicians. I believe that three of them -- and I would double-check this math -- but I believe that three of them are not yet designated shareholders. That means they're in that early stage before they've earned that status.
Q. Okay. Does WMC participate in the federal Medicare and Medicaid programs?
MS. MAHE: Object to the form; outside of her designation. They have not put their Medicare or Medicaid status at issue in this lawsuit.
You can answer.
A. The Western Montana Clinic physicians provide services and they receive payment through the Medicare and Medicaid programs, and that's the level and extent of their participation.
BY MR. CORRIGAN:
Q. And do you have any idea, approximately, how much of WMC's revenue comes from participation in Medicare or Medicaid?
MS. MAHE: Object to the form; outside of her designation. This is beyond the scope of our participation in this litigation.
You can answer.
A. It varies by each specialty department

pretty significantly depending on the patient population that's being treated. For instance, the pediatrics department would have no Medicare participation because of the age of the participants.

BY MR. CORRIGAN:

Q. Does WMC generally refer patients to other healthcare providers?

MS. MAHE: Object to the form. Vague. You can answer.

A. Western Montana Clinic as an organization is not the entity making the referral. Each referral or sending a patient to a different level of care is based on the unique event of that patient, the care that they need, and the provider that's caring for them.

BY MR. CORRIGAN:

Q. So providers under the umbrella of WMC, do they refer patients to other healthcare providers?

A. When necessary for patient care, I'm sure they do.

Q. Do you know how the referral process works for a WMC patient?

MS. MAHE: Object to the form.

You can answer.

A. There is no one way that a referral happens. I think we mentioned the volume of visits that we have and the different kinds of visits that we have are wildly variable, and so each of those referrals is going to be based on the unique circumstances of the care that the patient needs.

BY MR. CORRIGAN:

Q. Do some referrals occur because a patient requires services that WMC cannot provide?

MS. MAHE: Object to the form, and also this is outside of her designation.

You can answer.

A. That would generally be why a referral would occur.

BY MR. CORRIGAN:

Q. So now I'd like to -- to ask you about referrals and how those happen. And -- And the first question is, do -- or does WMC screen providers that they're providing referrals to prior to making the referral?

MS. MAHE: I'm gonna object to the form. That misstates her testimony. WMC does not facilitate the referrals, the individual providers

do.

A. And I would want to understand what you mean by "screen."

BY MR. CORRIGAN:

Q. Sure. Does WMC look to whether the potential provider has the proper licensing and accreditation?

MS. MAHE: Object to the form; outside of her designation.

You can answer.

A. My understanding in the direct patient care is that referrals are made based on what level of care and expertise the patient needs. I would assume and state with fairly decent certainty that the individual providers are not investigating those pieces. They're focusing on a direct need for patient care and the services that those referring or referral-accepting providers provide.

BY MR. CORRIGAN:

Q. And to your knowledge, do the providers under the umbrella of WMC conduct any investigation into the infectious disease control measures of the providers that they refer patients to?

MS. MAHE: Object to the form, and outside of her designation.

You can answer.

A. Generally we will rely on that facility or receiving provider or any other entity to comply with their own needs and standards in that area.

BY MR. CORRIGAN:

Q. And so to be very clear, physicians who practice at WMC are the ones who refer patients to other physicians or to hospitals.

MS. MAHE: I'm gonna object to the form. That misstates her testimony. I think we're getting caught up in semantics a little bit, but I don't think it's limited to physicians, I think it's limited to providers.

You can answer.

A. I'll expand on that clarification that physicians certainly refer patients, but APPs or advanced practice providers such as nurse practitioners and physician assistants also refer and they are not directly employed by Western Montana Clinic, they're employed by TMI, which is owned by Western Montana Clinic.

BY MR. CORRIGAN:

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testified multiple times WMC does not do the referrals, the individual providers do.

You can answer.

A. And, no, the referrals are based on the needs of the patient and what level of care they need.

BY MR. CORRIGAN:

Q. So to your knowledge has WMC or a provider operating under WMC ever refused to refer a patient to a healthcare provider due to concerns about that healthcare provider's health and safety protocols?

MS. MAHE: Object to the form; compound; calls for speculation; outside of her designation.

You can answer.

A. I -- The -- The same answer applies. The referrals and the independent medical judgment of making a referral that each provider uses and each referral circumstances are based on those expertise and the care needed. So "no" is the answer to your question.

BY MR. CORRIGAN:

Q. So I'm gonna switch the question up just a little bit here.

To your knowledge, has another healthcare

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provider ever declined to refer a patient to WMC due to the vaccination status of WMC employees?

MS. MAHE: Object to the form, and outside of her designation.

A. And I'm not sure that I can speak to what's in the minds of other providers outside of our organization, if I understood your question correctly.

BY MR. CORRIGAN:

Q. Mm-hmm. All right. Now I'd like to discuss WMC's patient intake policies and procedures.

From January 1st, 2019 to March 1st, 2020, as part of its intake policies for new patients, did WMC require new patients to disclose their vaccination status for any vaccine-preventable disease?

MS. MAHE: Object to the form.

You can answer.

A. I -- Before I can answer, I need clarification on what you're describing as intake procedures. That's an incredibly broad term when you talk about receiving patients.

BY MR. CORRIGAN:

Q. All right. So let's -- let's -- Yeah, I

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think it's important to get some clarification here on terminology.

So before -- before a patient could be seen by a physician or other employee of WMC for the first time, what types of paperwork and -- what types of paperwork and procedures does that patient have to go through?

MS. MAHE: Object to the form.

A. There are many departments in our multispecialty clinic under the Western Montana Clinic umbrella, and so that intake process, as you've just described it, are different in each department.

BY MR. CORRIGAN:

Q. So understanding that they're different across all the departments, from January 1st, 2019 to March 1st, 2020, did WMC require new patients to disclose their vaccination status for any vaccine-preventable disease prior to coming in for their first visit?

MS. MAHE: Object to the form.

You can answer.

A. It's difficult to answer because I'm thinking through all of the various scenarios in which --

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BY MR. CORRIGAN:

Q. Sure.

A. -- this happens, and generally the answer is no. There may have been discussions at the point of care about vaccination as related to the patient's condition, but not as an access entry point question.

Q. And so with the same caveat that -- that I and you both provided to that answer, from January 1st, 2019 to March 1st, 2020, as a part of those intake procedures that we discussed generally, did WMC require patients to provide proof of vaccination or immunity status for any vaccine-preventable disease?

MS. MAHE: Object to the form.

You can answer.

A. Western Montana Clinic as an organization did not require that.

BY MR. CORRIGAN:

Q. To your knowledge, did any of the physicians operating under the umbrella of WMC require proof of vaccination or immunity status for vaccine-preventable diseases?

MS. MAHE: Object to the form, and outside of her designation.

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There are limited circumstances where telehealth is a reasonable substitute, and the one example I can think of to help you understand is a medication change follow-up. We're having a very quick check-in, voice to voice, face to face on-camera conversation about, "Yes, that's going fine, I changed my medication a month ago, I'm good."

Q. And are there some prescriptions and refills for prescriptions that can be done via telehealth at WMC?

MS. MAHE: Object to the form, and outside of her designation.

A. And I'll just go back to the comment that we are a multispecialty clinic, and so the breadth of what is prescribed by each different specialty treating patients is very, very deep, and I -- there's -- with specificity I can't answer that question about which particular medications would be appropriate to prescribe would also be based on that individual independent medical judgment of that provider in the situation.

BY MR. CORRIGAN:

Q. Switching gears just slightly, from January 1st, 2019 to March 1st, 2020, did WMC

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conduct health status checks of patients prior to in-office visits?

MS. MAHE: Object to the form.

You can answer.

A. And you'll have to clarify what you mean by a "health status check."

BY MR. CORRIGAN:

Q. Sure. Did WMC screen patients for symptoms of vaccine-preventable diseases such as influenza?

MS. MAHE: Object to the form.

You can answer.

A. I'm going to attempt to answer this based on what I think you're asking, and generally I'll say no, but I will provide you one of many, many examples where we would what we call triage a patient, and if their symptoms were specific to something that we could take extra precautions while they were in our offices, we may put that patient in a different exam room, we may put that patient in a negative pressure room that we have at our urgent care location. So that's one very limited example I can give you.

BY MR. CORRIGAN:

Q. Okay. Was there any type of general

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questionnaire asking a patient before they came in whether they had symptoms such as coughing, sneezing, fever, things such as that?

MS. MAHE: Object to the form.

You can answer.

A. I -- I will -- I will say again that each intake prior to any visit in every specialty department is different, and so there very well may have been a question where we inquired whether a patient was sick and their reason for the visit that day prior to the visit. Very standard practice.

BY MR. CORRIGAN:

Q. From January 1st, 2021 until March 1st -- Excuse me. Strike that.

From January 1st, 2019 to March 1st, 2020, were patients ever told not to come in to WMC due to experiencing symptoms of a communicable disease such as influenza?

MS. MAHE: Object to the form, and outside of her designation.

You can answer.

A. I can't speak to every single instance where a patient may have contacted one of our offices and spoken with a nurse or a physician and

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described their symptoms who then directed them to a different level of care based on that conversation, so I don't know how else to answer that question.

BY MR. CORRIGAN:

Q. All right. From January 1st, 2019 to March 1st, 2020, did WMC require patients visiting for in-office visits to social distance from other patients upon arriving at WMC due to experiencing symptoms of communicable diseases such as influenza?

MS. MAHE: Object to the form.

Answer.

A. So again, there's not one instance that can answer that question. I can give you a couple of examples where we do that for basic standard protection of patients and infection control. One example is the pediatrics department where we have a well side of the waiting room and a sick side of the waiting room so that sick children aren't interacting with well children based on the kind of visit that they're there for.

In other instances, if flu had been highly prevalent in the community, we would potentially have that same side of waiting room

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segregation to help protect patients from sick and well in other departments.
BY MR. CORRIGAN:
Q. And would those determinations be made on an as-needed basis?
MS. MAHE: Object to the form.
BY MR. CORRIGAN:
Q. So --
A. And they're generally self-directed.
Q. So, for example, the pediatric unit that you just mentioned that has a sick versus well side, is that a permanent distinction that -- that WMC uses of sick versus well?
A. Our waiting room has a physical designation where sick children can sit versus where well children can sit, but it is self-directed by parents.
Q. Okay. And there -- And according to what you just told me, there may be other areas at WMC that utilize that same designation from time to time but it's on an as-needed basis?
MS. MAHE: Are you still talking about pre March 1st, 2020?
MR. CORRIGAN: Correct.
MS. MAHE: Object to the form.

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A. Yes. We would make those determinations as needed.
BY MR. CORRIGAN:
Q. And from January 1st, 2019 to March 1st, 2020, did WMC require masking for patients that said they were experiencing symptoms of influenza?
MS. MAHE: Object to the form.
You can answer.
A. Masking was offered but not required.
BY MR. CORRIGAN:
Q. Earlier we discussed WMC policy as it related to new patients coming in and their vaccination status. I want to focus on the same series of questions but as it relates to current patients that would be coming in for an in-office visit and make sure we're on the same page.
Were current patients from January 1st, 2019 to March 1st, 2020 required to disclose their vaccination status for influenza prior to coming in for an in-office visit?
MS. MAHE: Object to the form.
A. No.
BY MR. CORRIGAN:
Q. And currently does WMC require patients coming in for an in-office visit to disclose their

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vaccination status for any vaccine-preventable disease?
MS. MAHE: Object to the form. Vague as to time period. Pre -- Pre visit or when they're there?
MR. CORRIGAN: I'll -- I'll -- I'll rephrase to make this more clear.
BY MR. CORRIGAN:
Q. For current patients who are coming in for an in-office visit, does WMC require those patients to disclose their current vaccination status for vaccine-preventable diseases prior to coming in for that visit?
MS. MAHE: Object to the form.
A. You're using the word "require," and the answer is no, but it is very common and standard practice to discuss a patient's immunization status for any immunization that's available as part of the care event.
BY MR. CORRIGAN:
Q. That answered that for me. Thank you.
Currently if a patient discloses that they have not received the most recent dose of the influenza vaccine, does WMC policy require WMC or the patient to take special precautions to prevent

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transmission of influenza?
MS. MAHE: Object to the form.
You can answer.
A. I'll answer that with specificity to influenza or any other diagnosed condition, no. What we do as part of our routine practice day to day is take standard precautions when you are in an exam room with a sick patient of any kind.
BY MR. CORRIGAN:
Q. That makes sense. Do -- And -- And just to clarify, on that same question, if a patient discloses that they have not received the most recent dose of the influenza vaccine, does WMC policy require WMC or the patient to take special precautions while the patient is in a -- while the patient is in a waiting room to prevent transmission of influenza?
MS. MAHE: Object to the form.
You can answer.
A. And -- And generally speaking, the way you phrased the question, that's not the order in which the -- the discussion about vaccination happens. You know, at check-in or registration our registration staff would not be aware or asking a patient about vaccination status, and so

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vaccine-preventable diseases?
MS. MAHE: Object to the form.
A. And I need to you restate the question, please.
BY MR. CORRIGAN:
Q. Sure. Prior to January 1st, 2021, were WMC patients allowed to request that they only be treated by physicians, nurses, and other licensed healthcare professionals that were vaccinated for vaccine-preventable diseases?
MS. MAHE: Object to the form. Calls for a legal conclusion.
A. So your use of the word "allowed" to request makes this question difficult to answer the way you've phrased it. What I would say is that --
BY MR. CORRIGAN:
Q. I can rephrase.
A. I'll just say that patients are always allowed to request various accommodations to their care.
Q. Prior to January 1st are you aware of any requests made by a WMC patient that they only be treated by vaccinated physicians, nurses, or other licensed healthcare professionals?

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MS. MAHE: Object to the form, and exceeds her designation. Western Montana Clinic sees approximately 400 patients per day.
You can answer.
A. Additionally you're asking about all requests made for any vaccination status which, you know, I -- I can't know whether any one of those thousands and tens of thousands of patients made that request in a visit setting.
BY MR. CORRIGAN:
Q. Sure. Prior to January 1st, 2021, was there any written or unwritten WMC policy regarding a patient's request that they only be treated by physicians, nurses, or other licensed healthcare professionals that were vaccinated for vaccine-preventable diseases?
MS. MAHE: Object to the form. If you're gonna ask her about written policies, I would request that she's allowed to look at those.
MR. CORRIGAN: I'm asking about the existence of any such policy.
MS. MAHE: Well, I mean, that's so incredibly broad because technically any ADA policy that they would have would potentially apply. So if you're going to ask her if there is

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any policy, she'd need to look through all of their policies and their compliance plan to determine whether any of those are responsive to your question.
MR. CORRIGAN: We can get into specific ADA matters in a minute. I'm just wondering if any such policy exists.
MS. MAHE: But those would be ADA policies because there's a requirement to provide public accommodation, reasonable accommodations. There are public accommodations. So, I mean, it's -- it's just so broad, I don't know how she's expected to answer it.
A. And at this point I'll ask you to restate the question.
BY MR. CORRIGAN:
Q. Prior to January 1st, 2021 was there a written or unwritten WMC policy regarding a request from patients that they only be treated by physicians, nurses, or other licensed healthcare professionals that were vaccinated for vaccine-preventable diseases?
MS. MAHE: Same objections.
A. And -- And prior to 2021, again, if you're talking about -- we've been in existence

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for a hundred years, I -- I can't respond to anything --
BY MR. CORRIGAN:
Q. Sure.
A. -- prior 2021, but also the way you phrased specifically to a request by a patient, a written policy and how that would be handled, no.
Q. Okay. And is your answer the same for WMC's policy now or that same question now? Is there any written policy within the parameters of the question I just asked you?
MS. MAHE: Same objection. Same objections.
A. And I'll back up and respond that those are the kinds of unique circumstances that we deal with every day. I know you're asking specifically about patients requesting treatment by vaccinated providers, which also can mean many different kinds of vaccinations, but I will say that we would deal with a request by a patient to the best of our ability to accommodate that patient in their desires, their preferences for safety, for peace of mind. We do the same thing. I'll use an example that might -- you could analogize is when a patient requests a female provider versus a male

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provider for a certain kind of procedure, we do our best to accommodate that.
BY MR. CORRIGAN:
Q. So for the next series of questions I want to be clear that I'm not asking about or seeking any personally identifiable information about any particular employee or patient. Your counsel will probably object, but I want to make sure that -- to make clear that I'm not asking for any personally identifiable information, and I'm -- I'm not seeking anything along those lines.
From January 1st, 2019 to January 1st, 2021, did WMC provide reasonable accommodations under the Montana Human Rights Act to prospective employees or contractors due to the vaccination status of that prospective employee or contractor?
MS. MAHE: I'm gonna object to the form. Calls for a legal conclusion.
You can answer.
A. For an employee, for a contractor, I'll separate those two out in the answer. For a contractor I don't believe there were any requests made to respond to or needs for accommodation. We have one employee provider who has a hearing impairment, and so we provided alternate PPE with

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clear facing so that that person could be heard and also understand patients better.
BY MR. CORRIGAN:
Q. From January 1st, 2019 to January 1st, 2021, did WMC provide reasonable accommodations under -- under the Montana Human Rights Act to a prospective employer or contractor due to the vaccination status of an existing WMC employee?
MS. MAHE: Object to the form, and it calls for a legal conclusion.
A. And I -- Again, I'll ask you to restate that very long question.
BY MR. CORRIGAN:
Q. Sure. So the time period I'm asking about is January 1st, 2019 to January 1st, 2021, and my question is did WMC provide reasonable accommodations under the Montana Human Rights Act to a prospective employee or contractor due to the vaccination status of an existing WMC employee?
MS. MAHE: Same objections.
A. Not that I'm aware of.
BY MR. CORRIGAN:
Q. Same question for January 1st, 2019 to January 1st, 2021. Did WMC provide reasonable accommodations under the Montana Human Rights Act

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to prospective employees or contractors due to the vaccination status of WMC patients?
MS. MAHE: Object to the form, and calls for a legal conclusion.
A. And -- And truly I'm not sure I understand your question.
BY MR. CORRIGAN:
Q. So I -- I'm asking if during that time period, WMC, under the Montana Human Rights Act, provided an accommodation to an employee or a contractor due to the vaccination status of a patient. So, for example, was an accommodation -- was there an accommodation to an employee based on a patient being unvaccinated for a particular disease?
MS. MAHE: Object to the form, and calls for a legal conclusion.
A. As I understand that question, that present -- that situation did not present itself. So, no.
BY MR. CORRIGAN:
Q. From January 1st, 2019 to January 1st, 2021, did WMC provide reasonable accommodations under the Montana Human Rights Act to current employees or contractors due to the vaccination

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status of other WMC employees?
MS. MAHE: Object to the form, and calls for a legal conclusion.
A. And as I understand the question actually providing an accommodation, no, that situation did not arise.
BY MR. CORRIGAN:
Q. All right. So I'd like to ask the -- the same set of questions, but start after January 1st, 2021, and I'll -- I'll rephrase or I'll -- I'll restate the question.
Has WMC provided reasonable accommodations under the Montana Human Rights Act to employees or contractors since January 1st, 2021 due to the vaccination status of another WMC employee or employees?
MS. MAHE: I'm gonna object to the form. I'm also gonna object that it calls for a legal conclusion, and to the extent that your answer would implicate you required others to take specific action or treated others differently based upon vaccination status, that implicates the Fifth Amendment because there's potential criminal penalties after the enactment of House Bill 702, so it might make sense for us to take a quick --

THE VIDEOGRAPHER: We are going off the record. The time is 12:00 p.m.

(Recess taken from 12:00 p.m. to 12:12 p.m.)

THE VIDEOGRAPHER: We are back on the record. The time is 12:12 p.m.

BY MR. CORRIGAN:

Q. All right. Well, I just have one more question for you. And before I ask the question, I want to specify that I'm not asking for any type of lawyer/client or privileged information when I ask this. But could you articulate for me why WMC challenged the legality of HP 702?

MS. MAHE: We'll object and instruct you not to answer. The reasoning behind that is work product which is protected under the rules, so we'll instruct her not to answer that question.

BY MR. CORRIGAN:

Q. What interest does WMC have in HP 702?

MS. MAHE: Same objection.

Instruct you not to answer.

MR. CORRIGAN: Can you clarify the deliberative process objection?

MS. MAHE: Excuse me?

MR. CORRIGAN: Can you clarify your

objection?

MS. MAHE: Yeah. It's work product as to why they have an interest in the litigation and why they have an interest in objecting to House Bill 702. It implicates the attorney-client privilege as well as their internal processes in making a determination about litigation.

MR. CORRIGAN: So I think I'd clarify that we're asking the CEO of an organization why that particular organization is a plaintiff in the litigation.

MS. MAHE: Which goes against --

MR. CORRIGAN: I'm not asking for any privileged information.

MS. MAHE: That, in and of itself, is privileged information, it's work product as to anticipation of litigation and decisions that are made in anticipation of litigation. So I will continue to instruct her not to answer.

MR. CORRIGAN: Okay. So is it fair to say that you're limiting WMC's reasoning for being in the litigation to what's in the record?

MS. MAHE: No. What I'm instructing her is not to answer as to work product information about why Western Montana Clinic is a party to

this lawsuit.

BY MR. CORRIGAN:

Q. So I'll ask one follow-up, then.

Is WMC suing on behalf of its physician members?

MS. MAHE: I'm gonna object that that calls for a legal conclusion and also gets potentially into attorney-client privilege or work product information.

BY MR. CORRIGAN:

Q. So no answer on that?

MS. MAHE: WMC is a plaintiff in this litigation.

MR. CORRIGAN: All right. That's all I have.

MS. MAHE: Great. I -- I don't really have any questions for you, Meghan, but I -- to make it easier for the record, Mary, could you mark that as Exhibit 14? It's just the designation that we provided to you, Christian, after receipt of the 30(b)(6) notice. Rather than reading it all into the record, I'm just gonna include it as an exhibit for the record.

EXHIBIT:

(Deposition Exhibit 14 marked for

identification.)

MR. CORRIGAN: Can we clarify what exhibit we're ending on just for tomorrow?

MS. MAHE: Sure. This is -- The one that we just entered is going to be marked as Exhibit 14, so tomorrow we'd start at 15.

MR. CORRIGAN: Well, thanks for being here today, I appreciate it, and I'm ready to end whenever you all are.

THE VIDEOGRAPHER: That concludes the deposition. The time is 12:17 p.m.

(Deposition concluded at 12:17 p.m. Deponent excused; signature reserved.)

DEPONENT'S CERTIFICATE

I, WESTERN MONTANA CLINIC 30(b)(6) DESIGNEE MEGHAN MORRIS, the deponent in the foregoing deposition, DO HEREBY CERTIFY, that I have read the foregoing pages of typewritten material and that the same is, with any changes thereon made in ink on the corrections sheet, and signed by me, a full, true and correct transcript of my oral deposition given at the time and place hereinbefore mentioned.

WESTERN MONTANA CLINIC 30(b)(6) DESIGNEE MEGHAN MORRIS, Deponent.

Subscribed and sworn to before me this day of , 2022.

PRINT NAME:
Notary Public, State of
Residing at:
My commission expires:

MRS - Montana Medical Association, et al. vs. Austin Knudsen, et al.

C E R T I F I C A T E

STATE OF MONTANA)
: ss
COUNTY OF MISSOULA)

I, Mary R. Sullivan, RMR, CRR, and Notary Public for the State of Montana, residing in Missoula, do hereby certify:

That I was duly authorized to and did swear in the witness and report the deposition of WESTERN MONTANA CLINIC 30(b)(6) DESIGNEE MEGHAN MORRIS in the above-entitled cause; that the foregoing pages of this deposition constitute a true and accurate transcription of my stenotype notes of the testimony of said witness, all done to the best of my skill and ability; that the reading and signing of the deposition by the witness have been expressly reserved.

I further certify that I am not an attorney nor counsel of any of the parties, nor a relative or employee of any attorney or counsel connected with the action, nor financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal on August 17, 2022.

Montana Medical Association, et al. v
Austin Knudsen, et al.

Marieke Beck MHRB 30(b)(6)
August 22, 2022

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S T I P U L A T I O N S

It was stipulated by and between counsel for the respective parties that the deposition be taken by Mary R. Sullivan, Freelance Court Reporter and Notary Public for the State of Montana, residing in Missoula, Montana.

It was further stipulated and agreed by and between counsel for the respective parties that the deposition be taken in accordance with the Federal Rules of Civil Procedure.

It was further stipulated and agreed by and between counsel for the respective parties and the deponent that the reading and signing of the deposition would be expressly reserved.

MONDAY, AUGUST 22, 2022

Thereupon,

MONTANA HUMAN RIGHTS BUREAU 30(B)(6) DESIGNEE

MARIEKE BECK,

a witness of lawful age, having been sworn to tell the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MS. MAHE:

Q. Ms. Beck, we met a moment ago. I'm -- I'm Katie Mahe, and I represent the plaintiffs in this action. How do you want me to refer to you today?

A. Marieke, unless you don't know how to pronounce it.

Q. I hope I -- I hope I know how to pronounce it.

Have you ever had your deposition taken before?

A. No.

Q. I'm going to go over just some ground rules for the deposition.

Mary's taking down everything that we're saying, and so in order to get a clean transcript, it's important that you answer verbally rather

than using head nods or gestures. Can you do that for me today?

A. Yes.

Q. It's also important that we're careful not to talk over one another because it makes it really hard for her to take it down. Does that seem fair?

A. Yes.

Q. I'm looking for full and complete answers today. Is there any reason you would be prevented from giving those?

A. No.

Q. And I'm not trying to trick you. I want to make sure you understand my question. If you don't understand my question, will you let me know?

A. Yes.

Q. And is it safe for me to assume that if you answer my question, you understood it?

A. Yes.

Q. If at any point you need a break, just let me know. The only thing that I ask is that if we have a question pending, you answer that before we go on break. Does that seem fair?

A. Yes.

Q. And if during the course of your deposition today you think of additional information or clarification about one of the questions that I've asked, will you provide that to me?

A. Yes.

Q. Okay.

EXHIBIT:

(Deposition Exhibit 70 marked for identification.)

BY MS. MAHE:

Q. The court reporter has handed you what has been marked Deposition Exhibit 70, which is the amended notice of Rule 30(b)(6) of the agency representative of the Montana Human Rights Bureau.

Have you seen that document before?

A. No.

Q. Okay. So you have another document in front of you that you brought. What is that document that you brought there?

A. The -- The notice of 30(b)(6).

Q. Okay. And so I will tell you that the only difference between those two documents is that we had originally set your deposition for another date.

A. Oh.

Q. And the amended notice just amends the date for that. But why don't we go ahead and mark the deposition notice that you brought as Deposition Exhibit 71.

EXHIBIT:

(Deposition Exhibit 71 marked for identification.)

BY MS. MAHE:

Q. So you've been designated by the Montana Human Rights Bureau to testify on its behalf related to the topics in the 30(b)(6) deposition notice. Correct?

A. Yes.

Q. And you were informed you would be testifying on behalf of the HRB today?

A. Correct.

Q. And if I say "HRB," do you understand that I'm referring to the Human Rights Bureau?

A. Correct.

Q. Did the Human Rights Bureau gather all information known or reasonably known to it on the topics for which you have been designated to testify?

A. Yes.

Q. Describe the process that the Human Rights Bureau did to make sure that you have all of the information and knowledge of the HRB on those topics.

A. Reviewed emails, standing files, talked to counsel -- talked to staff. I think that's it.

Q. When you said you "reviewed emails," are those the emails that were provided in discovery?

A. Correct. Everything was provided -- Well, I provided it to Quinlan.

Q. And when you say you provided it to Quinlan, that's counsel for the HRB?

A. Correct.

Q. And they were emails that you provided that were responsive to discovery requests?

A. Correct.

Q. You also mentioned -- mentioned standing files. What are those?

A. For now the bureau exists digitally, and so if there were any documents inside of our standing digital files. So the bureau has a -- a self-contained folder, the K drive, and so I reviewed the K drive, if that's the best way to put it.

Q. And what types of documents are on the K

drive?

A. There's the digital files themselves. So every case pulls a digital file. So Joe Smith vs. Company A, there will be a digital file for that, and then there's the investigator library that contains just general information on how to run an investigation. There's form letters, there's data manager files.

Q. Okay. I want to break that down a little bit. You mentioned sort of the actual case files themselves.

A. Mm-hmm.

Q. Did you review some of those in preparation for today?

A. No.

Q. You mentioned the investigation library. Is that what you called it?

A. The investigator library.

Q. And -- And that includes information on how to conduct an investigation?

A. It's how we train up investigators.

Q. And were those documents provided to Quinlan to produce in discovery too?

A. No, they're general documents. So just in case anything got placed in there. So we have

a library that contains, like, our form letters, stock FIRS, the -- like the best of the best FIRS.

Q. Yeah. For the record, "FIRS" means final investigative reports. Correct?

A. Mm-hmm.

Q. Is that a "Yes"?

A. Yes. Requests for information, case law.

Q. And did you review those documents in preparation for today?

A. I flipped through the investigator library to see if there was anything standing in there.

Q. And maybe I got a little confused by your answer. What kinds of documents are in the investigator library?

A. Stock file investigative reports, different type of analyses, legal memos.

Q. In that investigator library, are there legal memos related to application of 49-2-312?

A. No.

MR. DEWHIRST: Objection to form.

BY MS. MAHE:

Q. Do you know what I mean when I talk about 49-2-312?

A. Yes.

Q. Okay. I'm referring to Montana Code Annotated 49-2-312. And, again, just establish, for the record, are you aware that House Bill 702 was codified as Montana Code Annotated 49-2-312 and 313?

A. Yes.

Q. So if I use those terms, we -- we know what we're talking about.

A. (Nods head.)

Q. You said that there were different types of analysis in there as well in the investigator file. Is that right?

A. Yes.

Q. And are -- do any of those analyses relate to 49-2-312?

A. No.

Q. You mentioned stock F-I-R-S or FIRS. Do any of those relate to the application of 49-2-312?

A. An investigator could use a stock FIR, so depending on what -- So let me just back up. There's different type of analyses used in any sort of discrimination complaint. So disparate treatment, disparate impact. So depending on the nature of the allegation you could use a stock

FIR, but it isn't as if it's, like, specific to a VCN case. And when I say "VCN," I'm referring to a vaccination case.

Q. And so what specific documents within the investigator's library did you look at to prepare for today?

A. Just flipped through the file itself to see if there was anything in there that was specific to VCN. Vaccination cases.

Q. Other than the investigator's library, did you review anything else in the standing files?

A. For -- For today?

Q. (Nods head).

A. No.

Q. You mentioned -- Well, first of all, sorry. Other than the documents that we've talked about, did you review any other documents in preparation for today?

A. Yes. I was given the documents that have been produced.

Q. Were you -- And do you know which documents those were?

A. The documents that were produced for DLI, I believe.

Q. So there was, I think, over a thousand pages of documents. Did you have all of those?

A. Yes.

Q. And which of those -- Did you review all the documents?

A. Yes.

Q. Other than -- And the emails that you reviewed, were they within the documents that were produced as part of discovery?

MR. DEWHIRST: Objection to form.

A. Emails that I reviewed.

BY MS. MAHE:

Q. You mentioned reviewing emails in preparation for today?

A. No, not all of them. Some of them were privileged.

Q. And do you know what the privilege was that was asserted related to those?

MR. DEWHIRST: Objection. Calls for a legal conclusion.

A. No.

BY MS. MAHE:

Q. Did you help prepare a privilege log related to those emails?

A. No, I provided it to counsel. I reviewed

the privilege log to -- Yeah.

Q. Are you -- You're talking about the privilege log that relates to the FIRS?

A. Correct.

Q. Okay. And -- And I'm -- I want to ask you about the emails. Did you create -- help create a privilege log related to the emails?

A. No.

Q. Have you seen one of those?

A. No.

Q. Any other documents that you reviewed in preparation for today?

A. I looked through the EEOC guidance again.

Q. And which EEOC guidance?

A. The EEOC guidance that's been prepared on COVID.

Q. And does that EEOC guidance relate to a specific type of discrimination?

A. So the EEOC prepared guidance for all of the FEPAs. And the FEPAs are the Fair Employment Practice Agencies that have the EEOC contracts on COVID issues that can exist inside of a complaint that may touch on federal laws, and so it -- it's not 49-2-312 specific, it's specific, again, to the different employment discrimination laws that

the EEOC enforces.

Q. And is that guidance public?

A. Oh, yeah.

Q. Is it on the EEOC's website?

A. Correct.

Q. Does that guidance contain anything that applies to 49-2-312?

A. Well, it's --

MR. DEWHIRST: Objection. Calls for a legal conclusion. Sorry.

A. To the extent that federal guidance is looked at by the bureau, to the extent that it doesn't conflict with state law.

BY MS. MAHE:

Q. And what do you mean to the extent it doesn't conflict with state law?

MR. DEWHIRST: Same objection.

A. The bureau's been told by the courts that they can look at federal guidance to the extent that it doesn't conflict with state law.

BY MS. MAHE:

Q. Okay. Can you explain that a little bit more to me on what you mean by they've been told by the courts?

A. You're going to make me remember the case

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name.
Q. I'm not. What I want to understand is are you talking about the case law that says if there's not basically Montana jurisprudence on a -- on a particular area of discrimination law, that the state courts follow federal law?
A. That the -- I'm talking for the bureau only.
Q. Okay.
A. So the -- that the bureau has been directed to look to federal guidance to the extent that it doesn't conflict with state law.
Q. And what has the bureau been directed to do if it does conflict with state law?
A. The state law controls.
Q. And that direction comes from the courts?
A. Correct.
Q. From a court case.
A. Correct.
Q. Is there any other documents that you reviewed in preparation for today?
A. No.
Q. You mentioned speaking with staff. Who did you speak with to prepare for today?
A. For this deposition, Tim Little, case

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manager.
Q. Anyone else?
A. No, I -- I didn't talk to my staff, my investigators or -- or anything. Oh, of course I did dep prep.
Q. So you talked to counsel.
A. Correct.
Q. And did you talk to HRB internal counsel or did you talk to the solicitor general's office?
A. Both.
Q. You mentioned reviewing the documents that were produced in discovery. Did you also review the discovery responses?
A. I would not be able to say that I reviewed all of them, but I did review discovery responses.
Q. Did you review the discovery responses that were -- Say this again. I'm going to start over.
Did you review the defendants' discovery responses?
A. I believe I reviewed those that pertain to HRB.
MS. MAHE: And David, this is an aside, but I wanted to bring this up, so I'm just going

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to do it now before I forget. We never got verification for anybody from the AAG on our discovery responses.
MR. DEWHIRST: Like, nobody signed?
MS. MAHE: Yeah. We don't have any signed.
MR. DEWHIRST: All right. We'll get that to you.
MS. MAHE: Okay. I just -- I thought of it, so I wanted to bring it up.
MR. DEWHIRST: Those on the line will take note it needs to get done.
MS. MAHE: We do -- We do have the one from DLI, so Laurie Esau --
MR. DEWHIRST: Okay.
MS. MAHE: -- did.
MR. DEWHIRST: Yeah. I think Christian -- Christian signed as to objections, right? You just need someone to verify the actual responses.
MS. MAHE: Correct, yeah.
MR. DEWHIRST: Understood.
MS. MAHE: Yeah.
BY MS. MAHE:
Q. Are you confident that you possess all relevant and discoverable information on the

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topics that were included within the deposition notice?
A. Can -- Can you explain your question a bit more?
Q. Yeah. So we're entitled to depose the person that has the most knowledge about what the HRB's knowledge is, and so what I'm trying to make sure is that you're confident that you possess all the necessary knowledge to be able to testify on the topics upon which you have been designated.
A. I -- I can say with some certainty that I probably know more about HRB than anyone.
Q. Okay. You understand today that you are testifying as to the collective knowledge of the HRB?
A. Correct.
Q. And you understand you have an affirmative duty to be prepared to testify fully and knowledgeably on behalf of the HRB today on the topics upon which you have been designated?
A. Correct.
Q. Are you an employee of the HRB?
A. Correct.
Q. And what is your job title?
A. I am the bureau chief.

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Q. How long have you held that position?
A. January 2012.
Q. And what did you do before that?
A. Ten years as counsel for the Human Rights Bureau. 20 years with the state agency as of August 19th.
MR. DEWHIRST: For the record, congratulations.
BY MS. MAHE:
Q. Was that your first job out of law school?
A. No. Clerked for Justice Hunt.
Q. Justice who? Sorry?
A. Justice Hunt. William E. Hunt.
Q. And how long did you clerk for him?
A. A year.
Q. And then went to work at the HRB?
A. No. I'm older than that. Then I worked for a civil rights organization that works for folks with disabilities. It was, at the time, known as the Montana Advocacy Program.
Q. And how long were you there?
A. Five years.
Q. Then did you go to the HRB?
A. Correct. And to be clear, I -- I started

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as counsel for DLI. My primary assignment was working with HRB, but I worked for DLI generally.
Q. Yeah. Explain to me a little bit, what is the relationship between the HRB and DLI?
A. HRB is an agency within ERD, the -- Oh, that just changed. It's the Employment Standards Division, and forgive me if I get that wrong 'cause I think it just changed on Friday. So HRB is an agency within the Employment Standards Division which is inside of the Department of Labor & Industry.
Q. How much time did you spend preparing for your deposition today?
A. Dep prep was probably four, five hours. And then I reviewed the documents this -- this weekend, so that was probably another four hours.
Q. If I say "you" today, do you understand that I'm referring to the HRB?
A. Yes.
Q. What is the HRB's role in enforcement of Montana Code Annotated 49-2-312?
A. We're the agency that conducts the informal investigation into complaints of discrimination under 49-2-504.
Q. And does 49-2-312 apply only to the

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COVID-19 vaccination?
A. No.
MR. DEWHIRST: Objection. Calls for a legal conclusion.
BY MS. MAHE:
Q. Does it apply to all vaccines?
A. Yes.
MR. DEWHIRST: Same objection.
BY MS. MAHE:
Q. Does the HRB have an FAQ that says that the COVID-19 -- that 49-2-312 applies to all vaccines?
A. Yes.
EXHIBIT:
(Deposition Exhibit 72 marked for identification.)
BY MS. MAHE:
Q. The court reporter has just handed you what has been marked Deposition Exhibit 72. Have you seen that document before?
A. Yes.
Q. And is -- on the bottom there that third one down, is that the FAQ that discusses that House Bill 702 applies to all vaccines?
A. Yes.

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Q. So complaints that are brought under 49-2-312 are filed with the HRB. Correct?
A. Yes.
Q. And the HRB determines whether or not those complaints are timely filed. Right?
A. Yes.
Q. And if they're not timely, the HRB must dismiss those claims on a finding of no reasonable cause.
A. Correct. Under 49-2-501.
Q. And the HRB has authority to apply for a preliminary injunction in district court related to 49-2-312. Correct?
A. Arguably, yes.
Q. Well, DLI has that authority. Does DLI defer to the HRB on -- on those filings?
A. Having never used the injunction, I would not know the -- the process. We've -- We've never sought an injunction before.
Q. And the HRB is mandated to conduct informal investigations of alleged violations of 49-2-312. Right?
A. Correct.
Q. And the HRB is tasked with promptly and impartially determining whether there is

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reasonable cause to believe that there has been a violation of 49-2-312. Correct?
A. Correct.
Q. And that determination is based upon the preponderance of the evidence; is that right?
A. Correct.
Q. And I think you testified that the HRB's role is to do the informal investigation for alleged violations of 49-2-312. Is that right?
A. Yes.
Q. And are all of the investigators lawyers?
A. No.
Q. How are the investigators trained to conduct an investigation for an alleged violation of 49-2-312?
A. Goes back to when they're initially hired. So every investigator is brought on and walks through a three-week onboarding period, and we do about four hours in the morning, and they do four hours of different types of non actual training in the afternoon. Then they're given one or two cases until they eventually pull a full load, probably three or four months.
So -- So if you're asking about how they're trained to do the vaccination cases, it's

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-- it starts at the very beginning. And then they sit in on other investigators' interviews, they have staffing every week with the case manager Tim Little. I certainly talk to new investigators a lot as well.
Q. Are they provided scripts of -- of questions to ask in interviews?
A. No. Investigators have to come up with their own questions for -- for cases. Certainly there's a lot of sharing internally about, you know, if you're doing a harassment case and this is the scenario, try and figure out how to get this information.
Q. During the training, are they provided with documents that give them guidance on how to investigate an alleged violation of 49-2-312?
A. 3 -- 312, no. So, again, when you're running an investigation, it depends on what the allegation is. And so perhaps more than you want to know, it's disparate treatment, disparate impact, failure to accommodate both disability and religion, direct evidence, mixed motive, per se type violations. There's miscellaneous as well. So the -- how a complaint gets analyzed, the vaccination or race, will depend on what the

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allegation is.
Q. So are they provided documentation on those types that you mentioned --
A. Correct.
Q. -- for how to do it?
A. Like a direct evidence analysis.
Q. And the investigator conducts the investigation and then they issue an FIR. Is that right?
A. Well, they provide it to management, and then management -- a case manager or myself has -- have to review every FIR before it's issued.
Q. So before the FIR goes out, it is reviewed by either a case manager or yourself?
A. Correct.
Q. And those FIRs, they can either find cause to believe that discrimination occurred or no cause. Correct?
A. Correct. Or untimely. Again, there's a statutory provision that allows us to find no cause based on timeliness.
Q. Yeah. So the finding is still a no-cause finding.
A. Correct, yeah.
Q. Okay. If there is a for-cause finding,

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then -- or I guess that's a bad question. On any FIR, does the bureau chief sign off on the FIR after it has been issued? You mentioned reviewing it before, but is there a -- is a signoff afterwards?
A. No.
Q. If there is a for-cause finding, does the case then proceed to conciliation?
A. Correct.
Q. And conciliation is a 30-day period where the parties can resolve the matter?
A. Correct.
Q. Is that right?
A. Maybe a little bit longer, but hearings gets upset if we hold onto the case more than 30 days.
Q. And after the conciliation period ends, then it goes to a contested case hearing?
A. Correct. The complaint and only the complaint is transmitted over to the office of administrative hearings.
Q. After a for-cause finding, can the parties agree to resolve the matter without involving the HRB?
A. No.

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Q. Does the HRB have to sign off on any conciliation agreement that is reached?
A. Yeah. So let me just sort of explain that. After there is a cause finding, the bureau has an obligation to seek redress for any discrimination. And, again, this is under 49-2-504. So any agreement that's reached between the parties necessarily involves the bureau to the extent that we're going to ask for what we refer to as targeted equitable relief, or TER. So many acronyms. Sorry. It used to be called affirmative relief, but just training policy changes, policy review.
Q. And the HRB requires targeted equitable relief in order to resolve a matter after there's been a for-cause finding. Correct?
A. Correct. There are circumstances, like, somebody goes bankrupt or something like that where we may not pursue the matter.
Q. But if the -- it's still a -- the entity is still an operating business, then you would require targeted equitable relief?
MR. DEWHIRST: Objection to form. You can answer.
A. Our -- Our -- Our charge is to seek

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redress.
BY MS. MAHE:
Q. And HRB has to attempt to resolve the complaint with conditions that eliminate the discriminatory practice found in the investigation. Right?
A. Correct.
Q. What types of targeted equitable relief does the bureau require?
A. Well, I'm super excited about it. We have a targeted equitable relief coordinator, Andrea Hardin, and so we now have a more uniform approach to targeted equitable relief. Typically it involves, as I mentioned, things like training, policy changes, we might have postings. But it is an opportunity to get creative and try and have an employer and, of course, it's not just employers, follow the law in a way that serves their interests and the state's interests at the same time.
EXHIBIT:
(Deposition Exhibit 73 marked for identification.)
BY MS. MAHE:
Q. The court reporter has handed you what

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has been marked Exhibit 73. Have you seen this document before?
A. I don't remember this formatting.
Q. Have you seen a document similar to this, then?
A. Yes.
Q. Okay. Is this a document that the Human Rights Bureau put out to help provide ideas for targeted equitable relief?
A. Yes.
Q. And those ideas for targeted equitable relief can -- can include training for staff. Is that right?
A. Correct.
Q. It can require them to post signage. Is that right?
A. Correct.
Q. It can require them to develop a survey of their employees. Correct?
A. I think you're referring to bullet 1, 2, 3, 4, 5, 6 down?
Q. Right.
A. Are you referring to the climate survey?
Q. Yes.
A. That's, yes, correct. That's one of the

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ideas.
Q. And then that would also involve a plan to remedy any deficiencies identified by the survey. Correct?
A. Correct.
Q. And it can also involve changes to performance evaluations how they are conducted?
A. Oh, definitely. That's a -- I think that's a great idea.
Q. And it can require staff meetings, right? Like, all staff meetings could be targeted equitable relief where you discuss discrimination and -- and things of that nature?
A. Correct. It's one of the ideas for the targeted equitable relief an employer -- for example, an employer can say at the staff meeting we'll have X topic.
Q. How does the HRB make sure that it is providing redress for the claimant?
A. As I mentioned before, we just hired a -- a single individual to sort of run oversight, Andrea Hardin is our targeted equitable relief coordinator.
Q. And HRB is the deferral agency for the EEOC related to the Americans with Disabilities

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Act. Right?
A. For Title 1, correct. Not for Title 2 or Title 3.
Q. And what is Title 2?
A. Public entities. The ADA has five titles. Title 1 is employment, Title 2 is public entities, Title 3 is public accommodations.
Q. If a hearing officer finds that the respondent engaged in a discriminatory practice, the Department of Labor must order that the party refrain from engaging in discriminatory conduct. Correct?
A. Underneath the 49-2-506 provisions, the remedy provisions?
Q. Correct.
A. Correct.
Q. And the department also can prescribe conditions on a respondent's future conduct relevant to the discriminatory conduct. Correct?
A. Correct.
Q. And can require any reasonable measure to correct the discriminatory practice and rectify any harm. Right?
A. Correct.
Q. And the department can require the

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respondent to report on the manner of compliance in the future. Right?
A. Correct.
Q. And if an order is not obeyed, the department can petition the district court to enforce the order. Correct?
A. Yes.
Q. And the department can sue a party in district court for breach of a conciliation agreement?
A. Correct.
Q. How many conciliation agreements have been entered related to 49-2-312?
A. My best recollection is four.
Q. Were any of those conciliation agreements with a hospital?
A. I do not believe.
Q. Were any of those conciliation agreements with a critical access hospital?
A. I don't know what a critical access hospital is.
Q. It's a type of licensure for a hospital. So, for example, it's not an acute -- it's not a tertiary care facility, but that probably doesn't matter much.

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What about an office of private physician?
A. No.
Q. Are any of those conciliation agreements related to any type of healthcare facility?
A. I do not believe.
Q. And what was the TER in those conciliation agreements?
MR. DEWHIRST: Objection to form.
A. Our targeted equitable relief coordinator, Andrea, has been requiring an amount of training and policy change.
BY MS. MAHE:
Q. What was the amount of settlement that was paid for those conciliation agreements?
A. I do not know the amounts off the top of my head. I'd have to get that for you.
Q. Before there's a for-cause finding, so take this back a little bit. After a complaint has been filed --
A. Mm-hmm.
Q. -- but before an investigator has issued a for-cause finding, can the parties resolve the matter?
A. Yes. We have a voluntary resolution

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program.
Q. And is the HRB involved in those voluntary resolution agreements?
MR. DEWHIRST: Objection to form.
A. To the extent that we -- So the parties can agree to settle separately and by themselves or they can use our mediator. We have a designated firewalled mediator Stacey Weldele-Wade.
BY MS. MAHE:
Q. And if they use the mediator, does the -- well, I guess, yeah, does the HRB require targeted equitable relief in voluntary resolution agreements?
MR. DEWHIRST: Objection to form.
A. Prior to a cause finding we do not require TER. Targeted equitable.
BY MS. MAHE:
Q. Do you know how many voluntary resolution agreements have been entered into related to 49-2-312?
A. I thought I wrote it down, but I did not write it down.
Q. And when you say "write it down," you're looking on the back of Exhibit --

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A. Correct. I knew that you were going to want some statistics, so I wrote the numbers down just so I that would have, like, the -- per my notice of 30(b)(6) there were several questions such as the number of claims asserted, number of claims dismissed, so I -- I -- on the form itself I just wrote down the numbers to answer your questions.

Q. And I was just trying to make clear for the record that's Exhibit 71, is it?

A. Correct.

Q. Okay. On the conciliation agreements that we discussed previously with targeted equitable relief, is the HRB monitoring compliance with that targeted equitable relief?

A. We monitor compliance on all of our conciliation agreements.

Q. So on those ones are you continuing to monitor them?

A. Correct.

Q. How many for-cause findings has the HRB issued related to 49-2-312?

A. 25.

Q. Were any of those related to a hospital?

A. I believe so.

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Q. How many?

A. I believe two or three. I did not break the data down to that extent.

Q. Were those FIRs provided in discovery?

A. My understanding is yes.

Q. And were any of those for-cause findings related to an office of private physician?

A. For cause, no.

Q. Were any of those for-cause findings related to other healthcare facilities besides a hospital?

MR. DEWHIRST: Objection to form.

A. So can you say that again?

BY MS. MAHE:

Q. Sure. Were any of the for-cause findings related to a healthcare facility other than a hospital?

A. Yes.

Q. How many?

A. Again, one or two. And when you say "healthcare facility," part of it is is that I don't have that entire definition stuffed in my head, and so there are entities that I believe are medical facilities, and so I simply provided all of those first.

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Q. And if you need to look at that definition, I believe that if you look at Exhibit 10, that definition of healthcare facility should be in that document.

MR. DEWHIRST: Just a real simple ten-line definition.

A. Right. And -- And as much as folks would like everything to -- to get jammed inside of there, you're always going to have something that you're not a hundred percent sure whether it falls within or without. I erred on the side of simply anything that suggested medical I provided.

BY MS. MAHE:

Q. Thank you.

How many no-cause findings have there been related to 49-2-312?

A. 50.

Q. And that's as of today, I'm guessing?

MR. DEWHIRST: Objection to form.

A. 50. Although this morning one was issued.

BY MS. MAHE:

Q. So is that one that was issued this morning included in the 50?

A. No.

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Q. And on the for-cause findings, the 25, is that as of today?

A. Correct.

Q. What are -- What is the HRB's role in enforcement of Title 1 of the ADA? When I say "ADA," do you know what I'm talking about?

A. I do.

Q. So what is HRB's role in enforcement of the ADA?

A. We are the deferral agency for Title 1, meaning that we pull the contract for the EEOC to investigate on their behalf, the Equal Employment Opportunity Commission.

Q. And does the HRB have a role in determining the appropriate penalties for violating the ADA?

A. No.

Q. So the HRB performs the investigation and then issues a for-cause or no-cause finding related to the ADA?

A. Correct.

MR. DEWHIRST: Objection to form.

BY MS. MAHE:

Q. And then does the EEOC sign off on the HRB's findings?

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you require that to be changed?
MR. DEWHIRST: Objection. Calls for a legal conclusion; speculation.
A. I don't -- Again, it would be fact specific to -- So, again, that -- that's the nice part about having a targeted equitable relief coordinator. She is making these recommendations, and hopefully they're consistent.
BY MS. MAHE:
Q. We were talking about the number of for-cause findings. You mentioned there were 25.
A. Mm-hmm.
Q. How many -- You said that you weren't quite sure what all what -- included in healthcare facilities so you pulled any related to medical.
A. Medical.
Q. Right? Is that correct?
A. Correct.
Q. And how many for-cause findings were related to anything medical?
A. My best recollection is one or two.
Q. Are offices of private physicians excluded from the definition of healthcare facility in 49-2-312?
MR. DEWHIRST: Objection. Calls for a

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legal conclusion.
A. My understanding is is that 49-2-312 pulls in the definition. I'm not going to be able to cite that particular, but that that particular definition excludes under sub (b).
BY MS. MAHE:
Q. And when you say "that particular definition," you're talking about the definition of healthcare facility in Exhibit 10?
A. Correct.
Q. And I just want to make sure I understand. And your understanding is that offices of private physicians are excluded from that definition. Correct?
A. My understanding is is that we're required to use that definition.
Q. Okay. And are offices of private physicians included within that definition?
A. No. Under sub (b), the term does not include private physicians.
Q. So for my next questions I want you to assume that an employer is an office of private physician, okay?
Does the HRB consider terminating someone due to vaccination status to be reasonable cause

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to believe discrimination occurred under 49-2-312?
MR. DEWHIRST: Objection. Speculation; calls for a legal conclusion.
A. We would need to know the fact pattern on -- on any case. Like any -- any scenario we would need to know what the facts were.
BY MS. MAHE:
Q. If an employer terminates a nonvaccinated person because they are not vaccinated, would that constitute unlawful discrimination under 49-2-312?
MR. DEWHIRST: Same objections.
A. It could.
BY MS. MAHE:
Q. Does the HRB consider reassigning someone due to not being vaccinated to be discrimination under 49-2-312?
MR. DEWHIRST: Same objections, plus let's add vagueness.
A. Reciting?
BY MS. MAHE:
Q. Reassigning.
A. Oh, reassigning. Could you explain a little bit what, like, "reassigning" is?
Q. Sure. For example, in a physician office if you have a nurse who primarily does direct

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patient care and she is not vaccinated and reassigned so that she no longer does any direct patient care.
MR. DEWHIRST: Same objections.
A. It would be fact specific to the case. Again, whether or not it was a violation we would look at whether or not it was an adverse act. That's part of every analysis.
BY MS. MAHE:
Q. And how do you determine whether something is an adverse act?
A. That's a very, very -- It's part of the investigation. It has to impact somebody adversely.
Q. So would removing their core job duty of having direct patient care, would that be an adverse impact?
A. It could --
MR. DEWHIRST: Same objections plus form.
A. It could be a violation.
BY MS. MAHE:
Q. Does the HRB consider requiring only nonvaccinated employees to wear masks to be a violation of 49-2-312?
MR. DEWHIRST: Same objections minus

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form.
A. Employers can have any policies that they want as long as it's applying to all employees equally, and they're providing for accommodations.
BY MS. MAHE:
Q. Well, let's talk about that for a minute 'cause I'm not talking about healthcare facilities. I'm talking about now as a private physician, which is not a healthcare facility. If they have a policy that requires only nonvaccinated people to wear masks, is that considered a violation of 49-2-312 by the HRB?
MR. DEWHIRST: I'll restate the objections. Calls for a legal conclusion; speculation; and to form.
A. It could be.
BY MS. MAHE:
Q. Are you familiar with the YouTube video that the HRB created related to vaccination status discrimination?
A. Yes.
Q. And I'm going to say the website that it's found at, a long list here. So if you want to look at the computer and see if this is the vaccination status discrimination video that the

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HRB created; rather than listening to the whole thing on the record I thought we could do it this way. Does that appear to be the video that the HRB created?
A. Yes.
Q. Okay. And the website for that is YouTube.com/watch?v=s7ladzl5yz4&t=7s. Is that correct?
A. Correct.
MR. DEWHIRST: Almost as long as the video.
BY MS. MAHE:
Q. Who created this video?
A. Andrea.
Q. Andrea Hardin?
A. Correct.
Q. And when was it created?
A. July 2022.
Q. And why was it created?
A. As mentioned before, part of what we have to do with any cause finding is require training or perhaps policy changes, and we didn't have anything that was specific to vaccination so we needed something that we could offer folks.
Q. And when was this video published on your

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YouTube channel?
A. I don't believe I know the exact date.
Q. Is -- Was it just published on the YouTube channel or did you also send it out to people?
A. If -- If somebody requests, we would send a link.
MR. DEWHIRST: Sorry. Objection. I think that misstates the testimony, but you can answer if you understand.
A. Like, are you asking me did we send the link out to people or --
BY MS. MAHE:
Q. Correct.
A. We would -- If somebody wanted the link, if -- we would send the link out to somebody.
Q. But it wasn't created to specifically -- to provide to a specific set of people, or was it?
A. To all the people who are super interested in what we do. So it -- it was created for people who were interested in the topic.
Q. Right. But you didn't have, like, a massive list serve where you pushed it out to all those people.
MR. DEWHIRST: Objection to form.

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A. No, but it was probably a First Friday. So the bureau does training every month free. It's called First Friday. I believe this was a First Friday training.
BY MS. MAHE:
Q. And is this video still up on your YouTube channel?
A. I've not checked this morning. Yes, I believe.
Q. And the information -- Have you listened to this video?
A. When Andrea first put it together I went through it, yes.
Q. Is the -- Is the information in the video accurate?
MR. DEWHIRST: Objection to form.
A. For what I reviewed and then her -- then she worked with Stacey Weldele-Wade after. So if they changed it after I reviewed it, I do not know. But I trust both Stacey and Andrea to accurately represent.
BY MS. MAHE:
Q. And so remember that when I say "you" I'm really asking about the Human Rights Bureau. So, you know, it -- in the Human Rights Bureau's

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opinion, is this video accurate?
A. Yes.
Q. Under 49-2-312 there's an exception for healthcare facilities. Are you familiar with that?
A. Yes.
Q. How does the bureau determine whether an entity is a healthcare facility under 49-2-312?
A. We look at the definition in the statute.
Q. And what exemption is provided for healthcare facilities in 49-2-312? And if you want to look at the statute, we can pull it.
A. That would be nice.
Q. I believe it's 52.
MR. DEWHIRST: 52 or 51?
MS. MAHE: I think it's that one.
A. Could you restate the question?
BY MS. MAHE:
Q. Maybe. Let me think about it for a second. Oh. What is the exemption -- or exception provided in 49-2-312 for healthcare facilities?
A. Would you like me to read it or?
Q. Just summarize.
MR. DEWHIRST: Objection to form.

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A. So Section 2(b) carves out healthcare facilities from a violation of the statute if it's in compliance with sub i and sub double i.
BY MS. MAHE:
Q. And how does the bureau determine compliance with that exception?
MR. DEWHIRST: Objection. Calls for speculation.
A. We look at the plain language of the statute for now since we do not have any guidance.
BY MS. MAHE:
Q. If a healthcare facility requires vaccination for a particular disease and there are no reasonable accommodation measures that can be given to the nonvaccinated person to protect the safety and health of employees, patients, visitors, and other persons from communicable diseases, would it be unlawful discrimination for that facility to terminate the employee under 49-2-312?
MR. DEWHIRST: Objection. Speculation; calls for a legal conclusion; and form.
A. We run an analysis from the perspective of whomever filed the complaint, and so we would analyze the person who filed and, of course, the

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defense proffered by respondent to answer that.
BY MS. MAHE:
Q. And what if there are no reasonable accommodation measures that can be put in place to protect the health and safety of employees, patients, visitors, and other persons from communicable diseases?
MR. DEWHIRST: Same objections.
A. It could be a violation.
BY MS. MAHE:
Q. Turning to 49-2-313, which is that third page?
MR. DEWHIRST: It's this one right here. Here you go.
BY MS. MAHE:
Q. This contains an exemption from 49-2-312. Correct?
A. Correct.
Q. How does the HRB determine whether this exemption has been met?
MR. DEWHIRST: Objection. Speculation; calls for a legal conclusion.
A. I don't believe we've had to -- to travel all the way down that path in a decision yet, but we would use the plain language of the statute.

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BY MS. MAHE:
Q. How does the HRB determine if an entity is an assisted living facility?
MR. DEWHIRST: Same objections.
A. If not provided by the respondent, we would ask.
BY MS. MAHE:
Q. Has the HRB made any determination that any entities were exempt under 313?
A. Not in a -- I don't believe that we've made the full exemption determination.
Q. What do you mean when you say "the full exemption determination"?
A. We've had complaints that involve licensed nursing homes, but as with every complaint, the facts have been also specific and attaching -- facts attaching to the charging party, facts attaching to the respondent. And so the full application of 49-2-313 we haven't traveled all the way down the path -- that path.
Q. Does that mean that you found no reasonable cause before you had to get to the exemption?
A. Arguably, yes. There were other reasons which is -- which is quite common.

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Q. How many claims for alleged violations of 49-2-312 have been brought in entirety?
A. 220 -- 221 as of this morning.
Q. And how many of those claims were brought against a hospital?
A. Hospital.
Q. Mm-hmm.
A. I did not break down by hospital.
Q. What did you break it down by?
A. Medical services.
Q. So how many were brought related to medical services?
MR. DEWHIRST: Objection. Asked and answered.
A. For decisions issued by the HRB I believe I identified 24 that were medical in nature.
BY MS. MAHE:
Q. And I'm not asking about -- Those are total complaints? I just want to make sure we're talking about the same thing.
MR. DEWHIRST: Objection.
BY MS. MAHE:
Q. Not for-cause findings?
A. Oh, yeah, no.
MR. DEWHIRST: Objection. Form.

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BY MS. MAHE:
Q. You were referring to total complaints?
A. Total complaints with findings issued. So by way of explanation, not all of the investigations are complete, and then we have complaints that are in a holding pattern due to the injunction.
Q. And so what statutory authority has allowed the HRB to put those complaints on hold?
MR. DEWHIRST: Objection. Calls for a legal conclusion.
A. No statutory authority, it was an injunction.
BY MS. MAHE:
Q. So those claims that are subject to the injunction, how many claims are those, do you know?
A. 15 are current -- No, I did not write that down. We have 15 complaints that were filed after the injunction that are in a holding pattern. We have, I believe, 20 to 25 that are in a holding pattern that had been filed prior to the injunction.
Q. Let's talk about the ones that were filed prior to the injunction, okay?

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A. Okay.
Q. How are those claims handled if the 180-day statutory timeframe for the investigation to be concluded has passed?
A. I view it as lifting the needle. So the bureau is afforded 180 days to complete an investigation. When we get hit with the injunction, that stops the clock on the number of days that we have to complete our investigation. When the injunction gets lifted and our obligation is -- resumes, then we'll continue to have whatever time is remaining in the 180 days to complete.
Q. And what do you base that upon?
MR. DEWHIRST: I'm gonna object and instruct you not to answer to the extent the answer implicates communications you've had with counsel about that issue.
BY MS. MAHE:
Q. So what do you base that upon?
MR. DEWHIRST: Same objection; same instruction.
BY MS. MAHE:
Q. You're not going to answer the question?
MS. MAHE: I understand that your

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objection was a partial objection.
MR. DEWHIRST: It's a limited -- Yeah. To be clear, it's a limited instruction. To the extent that answering Katie's question would implicate conversations that you've had with counsel about this issue, I would instruct you not to answer.
A. I've read the injunction, so I don't know if that answers the question.
MR. DEWHIRST: Okay.
BY MS. MAHE:
Q. So it's based on your reading of the injunction?
A. Correct.
Q. And conversations with counsel. Is it based on anything else?
A. No. The bureau's never had an injunction before.
Q. Right. But there has been case law about tolling the 180-day timeframe in Montana, hasn't there?
A. Are you referring to Cringle?
Q. I believe that's the case name where the court basically said that there's no statutory provision that allows the HRB to toll the 180-day

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statute. Are you familiar with that?
A. I -- I argued Cringle, I am familiar with Cringle. That situation was a -- just a little bit different. That had to do with respondent's failure to appeal within 14 days of the issuance of the final investigative report. I'm not familiar with any case law that has to do with the bureau's obligation to issue within 180 days. So just so you're understanding, there are different timelines at play.
Q. So can the bureau toll the 180-day timeframe for any other reason other than the parties are attempting to resolve the matter?
MR. DEWHIRST: Objection. Calls for a legal conclusion; speculation.
A. We've tolled for an injunction.
BY MS. MAHE:
Q. And other than an injunction, any other reasons?
A. Not that I'm aware of.
Q. So those claims that were filed prior to the injunction are just sort of sitting in wait. Is that correct?
MR. DEWHIRST: Objection. Form; vague.
A. We are not investigating; we are not what

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I would consider to be enforcing on those complaints.
BY MS. MAHE:
Q. But if the injunction is lifted, then you would go back to the investigation and enforcement?
MR. DEWHIRST: Objection. Speculation.
A. It would depend on the language of the injunction -- the lifting of the injunction, but if it said -- or tasked the bureau with completing its investigations, yes, we would complete those investigations.
BY MS. MAHE:
Q. Let's talk about the complaints that were filed after the injunction was in place that you mentioned.
A. Mm-hmm.
Q. What is the status of those?
A. They're sitting in a green folder in Kim's office, the data manager's office.
Q. So is the bureau undertaking any investigation or enforcement related to those?
A. No.
Q. And if the injunction is lifted, will the bureau then take investigation and enforcement of

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those claims?
MR. DEWHIRST: Objection. Speculation.
A. Correct.
BY MS. MAHE:
Q. How many of the total claims under 49-2-312 were employment discrimination claims?
A. Gosh. I'd guess 95 percent.
Q. And how many were related to public accommodation discrimination?
A. A handful.
Q. What is the status of Providence's claims before the HRB related to alleged violations of 49-2-312?
A. I did not --
MR. DEWHIRST: Object to form, I think, but also not sure that I heard the entire question. Could I ask you to restate it, please?
MS. MAHE: Mary, can you read it back?
THE COURT REPORTER: "What is the status of Providence's claims before the HRB related to alleged violations of 49-2-312?"
MR. DEWHIRST: Okay. I will object to form, but also object on the basis that this may implicate the confidentiality concerns provided for in statute, regulation, for the HRB.

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MS. MAHE: Which statute and regulation?
MR. DEWHIRST: The ones that we've cited repeatedly to you in discovery papers back and forth.
MS. MAHE: The ones that say that the HRB has to contact both parties and determine whether they object to releasing the information?
MR. DEWHIRST: I'm not under oath, so I'm not going to answer your questions but --
MS. MAHE: Because you don't know? Yeah.
BY MS. MAHE:
Q. You can answer.
MR. DEWHIRST: Because I don't -- I'm sorry, because I don't know?
MS. MAHE: Yeah. Is that right?
MR. DEWHIRST: Sitting here right in front of me whether I know the exact pincites for the regulations we've cited repeatedly in papers? Do you not know? I mean, we have cited them repeatedly.
MS. MAHE: And I'm asking, is it the one that refers to the HRB has to contact the parties to make a determination as to whether they object to releasing of the information?
MR. DEWHIRST: Among others.

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A. I told Quinlan that we had not had the opportunity to take a look at this before it was issued.
BY MS. MAHE:
Q. Did you look at it, then, after it was posted and approve it?
MR. DEWHIRST: Objection. Compound.
A. Did I review it after it was posted? Yes.
BY MS. MAHE:
Q. Did you approve it?
A. I don't think it's incorrect. I don't -- Again, the -- the manner in which HRB approaches information and the providing of information is to state what's said in the law.
Q. If a healthcare facility that's subject to the CMS vaccine mandate requires proof of booster if a person has had one, does that violate 49-2-312?
MR. DEWHIRST: Objection. Calls for a legal conclusion; speculation.
A. We have not had that case.
BY MS. MAHE:
Q. We've been going for about another -- Do you want a break?

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A. I'm fine.
Q. You're okay?
MR. DEWHIRST: I might take one, if you've got one on loan.
MS. MAHE: Sure.
(Recess taken from 10:48 a.m. to 10:55 a.m.)
BY MS. MAHE:
Q. Marieke, you understand you're still under oath?
A. Yes.
Q. And still testifying on behalf of the RHB?
A. Yes.
Q. When you spoke earlier about reviewing the EEOC guidance, I want to make sure I know which guidance you were talking about. And the only way I know how to do that is to show you this website and see if this is it. You said you reviewed it online. Right?
A. Oh, you have it with you. Right.
Q. Oh, perfect. Well, we'll just go ahead and mark that as an exhibit.
A. And to be clear, I was reviewing this for other work-related reasons. I don't normally pick

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up and review EEOC guidance on the weekend, that makes me sound super boring, but we -- there was another -- I was -- I was reviewing this as -- as part of dep prep and also reviewing something for something else I was looking at.
Q. Well, that must mean I'm super boring because I think I do review EEOC guidance on the weekends.
EXHIBIT:
(Deposition Exhibit 74 marked for identification.)
BY MS. MAHE:
Q. For the record, the court reporter has handed you what has been marked Exhibit 74, and is that the EEOC guidance that you indicated you had reviewed in preparation for your deposition?
A. In part, yes.
Q. In part in preparation or --
A. In part in preparation for the deposition; in part for a different question.
Q. Was there other EEOC guidance besides Exhibit 74 that you reviewed in preparation for your deposition?
A. No.
Q. If you'd turn to Deposition Exhibit 57.

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A. I think --
MR. DEWHIRST: There we go.
BY MS. MAHE:
Q. Have you seen that document before?
A. I have.
Q. Did HRB have any role in creating that letter?
A. No.
Q. Did HRB have any role in determining who that letter should be sent to?
A. No.
Q. Did HRB have any role in determining that that letter should be sent?
A. No.
Q. Would you turn to Exhibit 58? Have you seen that document before?
A. I have.
Q. Is it a letter sent by the Commissioner of the Montana Department of Labor & Industry. Correct?
A. Correct.
Q. Did the HRB have any role in drafting that letter?
A. No.
Q. Did the HRB have any role in determining

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who that letter should be sent to?
A. No.
Q. Did the HRB have any role in determining that that letter should be sent?
A. No.
Q. Will you turn to Exhibit 59? Have you seen that document before?
A. Yes.
Q. And what is that document?
A. This is a letter to Renee Lorda.
Q. With the Ninth Circuit Court of Appeals?
A. Correct.
Q. And sent by the Commissioner of the Department of Labor & Industry?
A. Correct.
Q. Did the HRB have any role in drafting that letter?
A. No.
Q. Did the HRB have any role in determining who that letter should be sent to?
A. No.
Q. Did the HRB have any role in determining that that letter should be sent?
A. No.
Q. And the HRB doesn't have jurisdiction

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over federal agencies, does it?
MR. DEWHIRST: Objection. Calls for a legal conclusion.
A. No.
BY MS. MAHE:
Q. And, in fact, you have an FAQ up on the website for 49-2-312 that states that the HRB doesn't have any jurisdiction over federal agencies. Correct?
A. Correct. That's an example of a raft of calls that we were getting.
Q. When HRB investigators are investigating a claim that includes disability discrimination under the ADA, does that also include claims that there has been a failure to accommodate?
MR. DEWHIRST: Objection to form.
A. When a charging party brings a complaint of disability discrimination, they can assert that they were discriminated against on the basis of disability, and part of that could be a failure to accommodate.
BY MS. MAHE:
Q. Could part of that be a failure to engage in the interactive process?
A. Yes, it could be.

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Q. Part of the process when the HRB is investigating a claim of disability discrimination related to a failure to accommodate would be determined whether the employer granted reasonable accommodations. Is that correct?
MR. DEWHIRST: Objection to form.
A. When the bureau's investigating a claim of failure to accommodate, determining whether the employer provided a reasonable accommodation is inherently part of the analysis.
BY MS. MAHE:
Q. Does the employer have to provide the accommodation requested by the employee?
A. No.
Q. And the employer just has to provide an equally effective accommodation. Correct?
MR. DEWHIRST: Objection. Calls for a legal conclusion.
A. Effective accommodation.
BY MS. MAHE:
Q. It's not --
A. It's not necessarily equally 'cause equally is -- So it's effective. They have to provide an effective alternative accommodation.
Q. Even under the ADA.

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A. Correct.
MR. DEWHIRST: Same objection.
BY MS. MAHE:
Q. Part of the HRB's process in investigating ADA claims, does the HRB have to make a determination as to whether the individual is disabled?
A. Correct.
Q. And how -- what is the standard for determining whether someone is disabled?
A. The definition, 49-2-101(19), you have an actual disability, a record of a disability, or you're perceived as disabled, and if you have an actual disability, you have a condition or an impairment that substantially limits a major life activity.
Q. Would cancer be an example of a disability?
MR. DEWHIRST: Objection. Calls for a legal conclusion; and speculation.
A. Yes. Most likely cancer would be considered a disabling condition.
BY MS. MAHE:
Q. What about rheumatoid arthritis?
MR. DEWHIRST: Same objections.

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A. Well, we don't go by diagnosis, per se. Cancer is interesting underneath the guidelines that have been put out underneath the Americans with Disabilities Act. They do talk about cell growth specifically. That's why when you asked about cancer, I mention that 'cause you would find that in the federal guidance. But for conditions -- other conditions, it does depend on whether or not it impacts. Unless, of course, the person is perceiving you as disabled because you have rheumatoid arthritis; then, of course, you would be considered a person with a disability.

BY MS. MAHE:

Q. And what are major life activities?

A. There is an actual list, but I will give you a few. Caring for self, thinking, walking, breathing, eating.

Q. Would someone who has had a kidney transplant be considered disabled?

MR. DEWHIRST: Same objections.

A. They could be.

BY MS. MAHE:

Q. Would it constitute reasonable cause to believe discrimination under the ADA occurred if a person has a physical impairment that

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substantially limits a major life activity and the person's employer refuses to grant any reasonable accommodation?

MR. DEWHIRST: Objection to form; objection, calls for speculation; and calls for a legal conclusion.

A. It could. As I said before, we look at every case as it comes in. What -- What are the facts being presented by the charging party and what are the defenses being raised by the respondent.

BY MS. MAHE:

Q. If the HRB makes a determination that an employer failed to engage in an interactive process, would that result in a for-cause finding?

MR. DEWHIRST: Objection. Speculation.

A. It could.

BY MS. MAHE:

Q. Does the HRB give discretion to an individual's medical provider as to what the individual's functional limitations are?

MR. DEWHIRST: Same objection.

A. I want to make sure I'm understanding the question.

///

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BY MS. MAHE:

Q. Sure.

A. Discretion to the medical care provider to tell the bureau what the charging party's limitations are?

Q. Yes. Or if the provider has provided a note saying this employee has X, Y, and Z functional limitations, does the bureau defer to that provider's determination that they have those functional limitations?

MR. DEWHIRST: Same objection.

A. I'm not trying to quibble here, but, like, deferred to it. I mean, do we take that as evidence in a case? Of course, yes.

BY MS. MAHE:

Q. And do you take that information when you're trying to determine whether the employer made a reasonable accommodation?

MR. DEWHIRST: Same objection and to form.

A. We always look at what the employee's requested accommodation is. So, yes, we look -- look at that as -- as part of the analysis.

BY MS. MAHE:

Q. Did you help prepare all of the FIRs that

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were provided to us in discovery? For discovery. I'm not talking did you write the FIRs, did you help gathering them for discovery?

A. Correct.

Q. And did you review what was provided in preparation for your deposition today?

A. Yes.

MR. DEWHIRST: Objection. Vague.

BY MS. MAHE:

Q. Did the HRB contact the parties within those FIRs to determine whether they objected to the release of the information?

A. No.

EXHIBIT:

(Deposition Exhibit 75 marked for identification.)

BY MS. MAHE:

Q. This is one of the final investigative reports that was provided to us in discovery, and I want to make sure we have the same document there. That's been marked as Exhibit 75, and the Bates-stamp on it is DEFS 1013 through 1015. Is that correct?

A. Correct.

Q. Okay. Have you reviewed this document

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before?
A. I have.
Q. And this looks like a finding of for cause related to 49-2-312. Is that accurate?
A. Correct.
Q. And did this situation involve a flight paramedic? Is that correct?
A. Correct. Under "Charging Party's Position Statement" it says "Flight Paramedic."
Q. Right. And the charging party alleged that he was required to be vaccinated with the influenza vaccine?
A. Correct. That's charging party's position.
Q. If you turn to page 3 of that FIR, the investigator in this case stated "A resulting effect of HB 702 becoming law was that" blank's "longstanding influenza policy was suddenly a violation of Montana law." Blank, "when it conditioned" blank's "continued employment on his compliance with the vaccination policy, engaged in an unlawful discriminatory practice."
Do you see that there?
A. I do.
Q. So in this FIR, the investigator found

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that there was for cause to believe that discrimination occurred based upon a requirement to have a flu vaccine. Is that accurate?
A. Correct.
Q. Was there any adverse action taken against the flight paramedic in this matter?
A. The requirement to vaccinate.
Q. Without any corresponding employment adverse action?
A. Correct.
Q. Do you know who did the redactions on these FIRs?
A. DLI, I believe, did the redactions on this FIR.
Q. What about the FIR -- All of the FIRs that were produced in discovery?
A. My understanding is is that we produced the bulk of the FIRs, and then a second batch was provided last week.
Q. So who -- who did the redactions on the initial batch?
A. Quinlan's crew. Quinlan at DLI.
Q. And then who did the redactions on the second batch?
A. David's crew.

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Q. Did you participate in drafting the privilege log that went along with the FIRs?
A. Quinlan put it together and had me take a look at it. Or I may not be a hundred -- That may not be accurate. I don't actually know who produced the privilege log. Quinlan sent it to me for review.
Q. And just for clarification, the privilege log that you are talking about is the one that just relates to the redactions in the FIRs.
A. To the FIRs.
EXHIBIT:
(Deposition Exhibit 76 marked for identification.)
BY MS. MAHE:
Q. The court reporter has handed you what has been marked Deposition Exhibit 76. Have you seen that document before?
A. Yes.
Q. And for the record, Exhibit 76 is DEFS Bates-stamp 120 through 123.
A. Correct.
MR. DEWHIRST: Counsel, it's 1020.
MS. MAHE: Oh, yes, I'm sorry.
///

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BY MS. MAHE:
Q. 1020 through 1023.
And did this situation involve a charging party who is claiming that she had been denied access to a retreat?
A. Correct.
Q. And I can't tell from this, but do you know what the retreat was regarding?
A. My understanding, it's for cancer survivors.
Q. And what is your understanding of what the retreat was requiring?
A. Attendees to be vaccinated.
Q. Was the retreat providing an opportunity for those who were not vaccinated to appear remotely?
A. Correct. As it states under the respondent's position statement.
Q. And this FIR, the investigator found reasonable cause to believe that a violation of 49-2-312 had occurred. Correct?
A. Correct.
Q. And the investigator mentioned that on page 3, the last full paragraph there, "The bureau acknowledges" blank "was clearly addressing

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difficult and necessary health and safety issues amidst unprecedented circumstances created by the COVID-19 pandemic."
Do you see that?
A. I do.
Q. "Nonetheless, by limiting in-person attendance for the" blank "to include only persons vaccinated against COVID-19 was a clear violation of the Montana Human Rights Act."
Do you see that there?
A. I do.
Q. And then it says "Such a position could have been avoided by choosing to allow only virtual attendance (thereby treating vaccinated and unvaccinated attendees the same)."
Do you see that there?
A. I do.
Q. So requiring a nonvaccinated person in this scenario to appear remotely constituted discrimination. Is that correct?
A. Repeat the question?
Q. Sure. So requiring a nonvaccinated person to participate virtually in this scenario constituted a reasonable cause to believe discrimination occurred?

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A. That's the finding.
Q. This one's a large exhibit, so it's got a clamp on it rather than a staple.
EXHIBIT:
(Deposition Exhibit 77 marked for identification.)
BY MS. MAHE:
Q. The court reporter has handed you what has been marked Exhibit 77, and Exhibit 77 should be Bates-stamped DEFS 1371 through 1466.
These were the documents that were provided to us within the second batch of FIRs that were provided that you talked about earlier.
Have you seen these documents before?
A. Yes.
Q. And I don't want you to tell me who the respondent was, but I need to know a little bit more information about the respondent.
So what type of facility was the respondent?
MR. DEWHIRST: I'm gonna object to the question as phrased to the extent the documents speak for themselves, that's fine, but I'll reassert the objections that we made that led to the redactions in the first place.

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A. An institution.
BY MS. MAHE:
Q. Is it a correctional facility?
MR. DEWHIRST: Same objection.
A. An institution.
BY MS. MAHE:
Q. Is it a prison?
MR. DEWHIRST: Same objection.
MS. MAHE: Well, David, we need to know this information because it goes directly to the equal protection arguments, so I -- and you missed some redactions in there so I know it's the Montana State Prison.
BY MS. MAHE:
Q. Was this a prison?
A. If you know, yes.
Q. And there, I think, are nine FIRs in this package. Does that sound about right to you?
A. Correct.
Q. And judging from a footnote here on Exhibit 77, it sounds like they all used a similar template for submitting their claim to the HRB. Is that accurate?
A. Correct. Quite common with inmates.
Q. And so most of these final investigative

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reports are substantially similar. Correct?
A. No.
Q. I mean in this package. I -- I just don't want to make you -- us have to go through every single one.
A. There are both no -- There are no cause for different reasons. For, like, a failure to participate would look different than a party who chose to participate.
Q. Right. So I saw kind of two different types of FIRs in this package. One is a no reasonable cause for failure to participate. Is that correct?
A. Correct.
Q. And then the other is a no reasonable cause based upon the healthcare facility exemption in 49-2-312. Is that right?
A. Correct.
Q. Are there any other types within this package?
A. I do not believe so, no.
Q. Okay. If you turn to page -- Well, let's talk about it this way. So in these complaints it's my understanding that inmates were arguing that they had been denied services -- governmental

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services based upon their vaccination status. Is that accurate?
A. Correct.
Q. And it looks like the investigation was pretty difficult to complete in this situation. Is that accurate?
A. Correct.
Q. If you turn to page 9, which at the bottom is DEFS 1379. Oh, you were the investigator that did these. Is that correct?
A. Working with Bree Koffman. K-o-f-f-m-a-n.
Q. You authored the final investigative reports.
A. With Bree's assistance, correct.
Q. And on that page 9, you say [As Read]: "To start, this is a new statute. There are no interpreting administrative rules, no hearing officer's decisions, much less any court cases to assist the Bureau in the analysis of these complaints."
Do you see that there?
A. Mm-hmm.
Q. Is that a "Yes"?
A. Yes.

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Q. Is that still accurate?
A. Yes.
Q. Have there been any cases scheduled for a contested case hearing related to violations of 49-2-312?
A. My understanding is that one of these has been scheduled.
Q. Okay. And do you know when that contested case hearing is expected to occur?
A. My understanding is one of them has been scheduled and is on the OAH website for the end of August.
Q. Other than that one, have there been any others that have been scheduled for a contested case hearing?
A. I am unaware of OAH scheduling any hearings other than this is the -- the first VC -- vaccination case.
Q. If you turn to page 12 of Exhibit 77, which is DEFS 1382, at the top of that page you say [As Read]: "All this aside, these complaints have raised a whole different question. As noted, the Bureau is working with a new statute and this new statute contains special provisions for health care facilities. Montana Code Annotated

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Section 49-2-312(3)(b). The new statute treats health care facilities differently from other environments and the language suggests that such a facility may have to take measures to protect the health and safety of employees, patients, visitors, and other persons from communicable diseases."
Do you see that?
A. I do.
Q. And that was related to the exemption for healthcare facilities in 49-2-312; is that correct?
A. Correct.
Q. You ended up finding that the state prison was a healthcare facility under the exemption in that statute. Correct?
A. I did.
Q. And -- And there was an argument made by the inmates that that healthcare facility designation should be restricted just to the infirmary. Correct?
A. Correct.
Q. But you found that the statute was broad enough to expand to the scope of the entire facility. Is that correct?

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A. Correct.
Q. And on that page 12, you say in that final paragraph, [As Read]: "But the definition says a health care facility means 'all or a portion of an institution' used or designed to provide health services, medical treatment, or nursing, rehabilitative or preventative care to any individual. Meaning if" blank "is providing health services, medical treatment, or nursing, rehabilitative or preventative care outside of the infirmary, then seemingly this expands the scope of that 'facility.'"
Is that accurate?
A. Is that what that says? Correct.
Q. And so is my understanding that you went through this sort of two-part analysis after determining that it qualified as a healthcare facility. Is that accurate?
A. When you say "two-part analysis," I don't --
Q. Yeah. That -- That wasn't a good question.
So you determined that it's a healthcare facility, and then you have to go through an additional analysis to determine whether the

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exemption is satisfied. Correct?
A. Right. So sub (b) says if it complies with the following, and then there's sub i and double i.
Q. And on page 13 of Exhibit 77, the third full -- or the second full paragraph, when I was talking about the two-part analysis, "The statute then says a health care facility does not discriminate if it (1) asks about vaccination status; and then (2), implements reasonable accommodation measures." Is that correct?
A. Correct.
Q. And the next paragraph down you state [As Read]: "As a quick aside, the Bureau notes Montana's Human Rights Act has a definition for 'reasonable accommodation.' Montana Code Annotated 492-101 Section 19."
A. Correct.
Q. And then it says "A reasonable accommodation is some form of assistance provided to a person with a disability that allows that person to perform in a position or perhaps enjoy a governmental service." Is that correct?
A. Correct.
Q. "In this new statute, the term

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'reasonable accommodation measures' appears unrelated to this definition." Is that correct?
A. Yes.
Q. "The term reasonable accommodation measures are not intended to attach to a person with a disability." Is that correct?
A. Correct.
Q. "The 'measures' are to be taken to 'protect the safety and health of employees, patients, visitors and other persons from communicable diseases.'"
Is that correct?
A. Correct.
Q. And in this case you determined that the actions that were taken by the prison were reasonable accommodation measures under the exemption. Is that correct?
A. Correct.
Q. And you found no reasonable cause to believe discrimination had occurred. Correct?
A. Yes.
EXHIBIT:
(Deposition Exhibit 78 marked for identification.)
///

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BY MS. MAHE:
Q. The court reporter has handed you what has been marked Exhibit 78. Have you seen this document before?
A. Yes.
Q. Who is Eric Strauss?
A. Eric?
Q. Yes.
A. He's the administrator for ESD. Employment Services Division. Employment Services Division.
Q. Is he with the DLI?
A. Yes.
Q. And who is Kevin Braun?
A. Kevin is counsel for the Montana State Fund.
Q. And what -- Do you know what "BRQ" stands for?
A. That is my own acronym. Business Rights Question.
Q. And this contains an email that -- the first part of it is an email that you sent to Kevin on May 24th, 2022. Is that correct?
A. Correct.
Q. What prompted you to send this email?

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A. John Elizandro and I had a conversation that there were -- at least he was getting calls regarding a conference being held by State Fund, and I had talked to Kevin in July, sometime the year prior, and I can't really recall that conversation, but I knew that we had a conversation. And so I just offered to reach out to Kevin again. I -- Kevin's my old boss.
Q. And so the State Fund convention, were they requiring vaccination? Is that what the calls were about?
A. That's my understanding. I did not get any calls.
Q. And did you call and talk to Kevin?
A. No, we never touched bases, but we did the year prior. So he had called in '21 at some point after the -- the law had passed, and we had a conversation, but I don't really recall. I had a lot of conversations, and so I don't really recall what he and I talked about, and that's why, again, I agreed to reach out and talk to him again.
Q. So -- And you said John Elizandro reached out to you and asked you to reach out to him. Is that right?

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Q. I did that to myself this morning.
Let's take a break for a minute, and then maybe we'll get you wrapped up here.
MR. DEWHIRST: Okay.
(Recess taken from 11:47 a.m. to 11:55 a.m.)
EXHIBIT:
(Deposition Exhibit 80 marked for identification.)
BY MS. MAHE:
Q. Marieke, you understand that you're still under oath?
A. Yes.
Q. And you understand that you're still testifying on behalf of Human Rights Bureau?
A. Yes.
Q. The court reporter has handed you what has been marked Deposition Exhibit 80. This is -- the Bates number is DEFS 983 through 986; is that correct?
A. Correct.
Q. And this is one of the FIRs that was provided to us in discovery.
And it looks like there was a finding of no reasonable cause in this situation. Is that

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correct?
A. Correct.
Q. And if you turn to page 4 of Exhibit 80, the second or third to the last full paragraph says blank "was asked to rebut" blank "assertions that her position in senior services falls within the above-cited exemption and that CDC guidance recommends vaccination against COVID-19 for all healthcare personnel."
Do you see that there?
A. I do.
MR. DEWHIRST: Counsel, where are you? Sorry.
MS. MAHE: Sorry. Third full paragraph from the bottom on 986.
MR. DEWHIRST: Okay.
BY MS. MAHE:
Q. When you're talking about the above-cited exemption, you're talking -- and when I say "you," I'm talking about the HRB -- you're talking about 49-2-313. Is that correct?
A. Correct.
Q. Okay. And so in this situation, the respondent had argued that that exemption applied because CDC guidance recommended vaccination

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against COVID-19 for all health care personnel. Is that correct?
A. Repeat the question?
Q. Sure. In this case, the respondent had argued that it falls under the exemption in 313 because CDC guidance recommends vaccination against COVID-19 for all health care personnel. Is that correct?
A. Yes.
Q. And then it says "The Bureau notes it has concerns about the application of this section, specifically what constitutes 'guidance' issued by centers for Medicare and Medicaid."
What was meant by that sentence?
A. In 49-2-313 it says would result in a violation of regulation or guidance issued by centers -- by CMC or CDC. So regulations is clear on its face. Guidance is as noted on November 22nd, 2021. That was not as clear, and --
Q. Is there a definition of guidance in the statute?
A. No.
Q. And you said on November 22, 2021 it was not as clear. Has it become clear now?

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A. We still do not have a court ruling on what is and what is not guidance.
Q. Have you changed how that is interpreted since November 22nd, 2021?
A. No, we haven't had a case walk through 313 to the point of having to make a determination about what is and what is not guidance.
Q. So I'm trying to understand why you said it was less clear back then.
A. I think I'm just referring to everything being somewhat less clear in November.
Q. Okay. Then it looks like the charging party chose not to participate and didn't respond to the rebuttal -- or didn't respond to the respondent's response. Is that right?
A. Right. That was quite common.
Q. And then the investigator said "As such," blank's "mandatory vaccination policy for senior services employees, including" blank, "did not violate the Montana Human Rights Act as it appears to fall within the exemption."
Is that correct?
A. Correct.
Q. And, again, that exemption is the one at 313.

A. Correct.
Q. Was the respondent in this case a licensed nursing home?
MR. DEWHIRST: Objection. I'm gonna instruct the witness not to answer that. It's covered by the privileges we've indicated on the privilege log.
MS. MAHE: The type of the facility is not covered by the privileges. Who the respondent is.
BY MS. MAHE:
Q. I'm just trying to figure out what type of facility under the exemption it is. Was it nursing home, long-term care facility, or assisted living facility? Which -- Was it one of those three and if so, which one?
MR. DEWHIRST: If you can answer the question in a way that doesn't -- wouldn't reveal who the respondent is, you can answer that question.
A. One moment.
MR. DEWHIRST: And I will object to the question as stated on the basis that it's compound as well.
MS. MAHE: That wasn't my question, that

was my response to you. My question to her was was the respondent a nursing home?
A. No.
BY MS. MAHE:
Q. Was the respondent a long-term care facility?
MR. DEWHIRST: Same limited instruction.
A. My understanding is is they were making the argument.
BY MS. MAHE:
Q. Do you know whether they were a licensed long-term care facility?
A. No, I don't believe we got to that.
Q. When you say it's your understanding they were making that argument -- Well, I won't ask that way. Were they an assisted living facility?
MR. DEWHIRST: Same objection and instruction.
A. My understanding is is respondent was not an assisted living facility.
BY MS. MAHE:
Q. On page 3 of Exhibit 80 under the documents review, looks like the documents that were reviewed were some of the CDC recommendations for COVID-19 vaccines for health care personnel.

Is that accurate?
A. Correct.
MS. MAHE: I don't think I have anything else for you right now. Raph might, and then...
EXAMINATION
BY MR. GRAYBILL:
Q. Was the case you referenced that went to OAH brought by Jude Ellsworth?
MR. DEWHIRST: I'm gonna object. I mean, that's --
MR. GRAYBILL: It's on the OAH website I'll represent to you.
A. That's what I was referring to earlier.
MR. GRAYBILL: I have no other questions.
MR. DEWHIRST: I don't have anything.
(Deposition concluded at 12:03 p.m. Deponent excused; signature reserved.)

DEPONENT'S CERTIFICATE

I, MONTANA HUMAN RIGHTS BUREAU 30(B)(6) DESIGNEE MARIEKE BECK, the deponent in the foregoing deposition, DO HEREBY CERTIFY, that I have read the foregoing pages of typewritten material and that the same is, with any changes thereon made in ink on the corrections sheet, and signed by me, a full, true and correct transcript of my oral deposition given at the time and place hereinbefore mentioned.

MONTANA HUMAN RIGHTS BUREAU 30(B)(6) DESIGNEE MARIEKE BECK, Deponent.

Subscribed and sworn to before me this day of , 2022.

PRINT NAME:
Notary Public, State of
Residing at:
My commission expires:
MRS - Montana Medical Association, et al. vs. Austin Knudsen, et al.

C E R T I F I C A T E

STATE OF MONTANA)
: ss
COUNTY OF MISSOULA)

I, Mary R. Sullivan, RMR, CRR, and Notary Public for the State of Montana, residing in Missoula, do hereby certify:

That I was duly authorized to and did swear in the witness and report the deposition of MONTANA HUMAN RIGHTS BUREAU 30(B)(6) DESIGNEE MARIEKE BECK in the above-entitled cause; that the foregoing pages of this deposition constitute a true and accurate transcription of my stenotype notes of the testimony of said witness, all done to the best of my skill and ability; that the reading and signing of the deposition by the witness have been expressly reserved.

I further certify that I am not an attorney nor counsel of any of the parties, nor a relative or employee of any attorney or counsel connected with the action, nor financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal on August 22, 2022.

Montana Medical Association, et al. v
Austin Knudsen, et al.

Derek Oestreicher 30(b)(6)
August 19, 2022

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION

MONTANA MEDICAL ASSOCIATION, et al.,
Plaintiff,
and
MONTANA NURSES ASSOCIATION,
Plaintiff-Intervenors,
v.
AUSTIN KNUDSEN, et al.,
Defendants.

Case No. CV-21-00108-DWM

VIDEOCONFERENCE/VIDEOTAPED DEPOSITION
UPON ORAL EXAMINATION OF
ATTORNEY GENERAL'S OFFICE 30(b)(6) DESIGNEE
DEREK OESTREICHER

BE IT REMEMBERED, that the videoconference/videotaped deposition upon oral examination of Attorney General's Office 30(b)(6) Designee Derek Oestreicher, appearing at the instance of the Plaintiff Montana Medical Association, was taken at 800 North Last Chance Gulch, #101, Helena, Montana, on Friday, August 19, 2022, beginning at the hour of 9:01 a.m., pursuant to the Federal Rules of Civil Procedure, before Mary R. Sullivan, Registered Merit Reporter, Certified Realtime Reporter, and Notary Public.

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A P P E A R A N C E S

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A P P E A R A N C E S

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ALSO PRESENT: Nicole Tomac, Videographer

I N D E X

STIPULATIONS

It was stipulated by and between counsel for the respective parties that the deposition be taken by Mary R. Sullivan, Freelance Court Reporter and Notary Public for the State of Montana, residing in Missoula, Montana.

It was further stipulated and agreed by and between counsel for the respective parties that the deposition be taken in accordance with the Federal Rules of Civil Procedure.

It was further stipulated and agreed by and between counsel for the respective parties and the deponent that the reading and signing of the deposition would be expressly reserved.

FRIDAY, AUGUST 19, 2022

THE VIDEOGRAPHER: This is the video-recorded and videoconference deposition of Derek Oestreicher, 30(b)(6) representative of the Attorney General's Office taken in the United States District Court for the District of Montana, Missoula Division. Cause No. CV-21-00108-DWM, Montana Medical Association, et al., and Montana Nurses Association vs. Austin Knudsen, et al.

Today is August 19th, 2022. The time is 9:02 a.m.

We are present with the witness at the offices of Fisher Court Reporting at 800 North Last Chance Gulch, No. 101, in Helena, Montana.

The court reporter is Mary Sullivan, and the video operator is Nicole Tomac of Fisher Court Reporting.

The deposition is being taken pursuant to notice.

I would now ask the attorneys to identify themselves, who they represent, and whoever else is present. For those attending remotely, please note from where you are appearing.

MS. MAHE: Katie Mahe, and I represent the plaintiffs, and with me today is Justin Cole.

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MR. GRAYBILL: Raph Graybill on behalf of plaintiff-intervenor the Montana Nurses Association.
MR. DEWHIRST: David Dewhirst from the attorney general's office defending the defendants, and on Zoom is Christian Corrigan and Brent Mead, both from the attorney general's office appearing remotely from Helena.
THE VIDEOGRAPHER: The court reporter will now administer the oath.
Thereupon,
ATTORNEY GENERAL'S OFFICE 30(b)(6) DESIGNEE
DEREK OESTREICHER,
a witness of lawful age, having been sworn to tell the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MS. MAHE:
Q. We met a minute ago. I'm Katie Mahe, and I'm representing the plaintiffs in this matter. How would you like me to refer to you today?
A. Mr. Oestreicher.
Q. Mr. Oestreicher? Okay, great. Mr. Oestreicher, have you ever had your

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deposition taken before?
A. No.
Q. I'm going to go over just a couple of ground rules for the deposition today. The court reporter is taking down everything that we're saying, so it's really important to answer verbally. Can you do that for me today?
A. Okay.
Q. And we also have to be careful not to talk over one another because that messes up our transcript. Can you agree to do that today?
A. Okay.
Q. I'm looking for full and complete answers today, and I'm not trying to trick you. I want you to understand what I'm asking. So if you don't understand my question, will you let me know?
A. Yes.
Q. And if you answer my question, is it safe for me to assume that you understood what I asked you?
A. Unless I clarify later or think of something later, yeah.
Q. And -- And that's a good point. If you, during the course of your deposition, think of some additional information or clarification, will you

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provide that to me?
A. Yes.
Q. If at any point you need a break, just let me know and we can take one. The only thing that I ask is if I have a question pending, that we answer the question before a break. Does that seem fair?
A. Yes.
Q. Is there any reason that you would be prevented from giving truthful and accurate answers today?
A. No.
EXHIBIT:
(Deposition Exhibit 61 marked for identification.)
BY MS. MAHE:
Q. The court reporter has handed you what has been marked Exhibit 61. Have you seen that document before?
A. Yes.
Q. And that is the notice of the Rule 30(b)(6) deposition for the representative of the attorney general's office. Is that correct?
A. Yes.
Q. And you have been designated by the attorney general's office to testify on its behalf

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related to the topics in the 30(b)(6) deposition notice. Is that true?
A. Yes.
Q. And if I refer to the attorney general's office as the AG's office, do you know what I'm talking about?
A. Yes.
Q. You were informed that you would be testifying today on behalf of the AG's office on the topics in that notice. Correct?
A. Yes.
Q. And did the AG's office gather all information known or reasonably known to it on the topics in the 30(b)(6) notice?
A. Yes.
Q. Describe the process that the AG's office did to make sure that you have all of the knowledge and information the AG's office has on these topics.
A. We searched our records, both electronic and physical records, to make sure that we had everything related to these topics, and we produced it to you guys, I believe, in discovery.
Q. Did you review those documents in preparation for today's deposition?

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Q. What did he tell you about those radio interviews?
A. That when he was given questions related to the federal vaccine mandate, that he would provide a status update of the ongoing litigation.
Q. Did he tell you that he spoke about this litigation?
A. Not specifically, no. Most of the questions, Katie, that we got at this time related to the federal vaccine mandate and the status of our ongoing litigation.
Q. Did he convey to you any of the questions that were asked by those radio hosts?
A. Maybe you can rephrase your question.
Q. What I'm wondering is you mentioned that there were questions and they talked about it. Do you -- Did he recall any of the specific questions?
A. No, not specific questions.
Q. Okay. Did he recall his specific responses?
A. No, he did not recall specific verbatim responses. He recalled a general response, which was our response to all of the questions, which was this is the status at this time of our ongoing litigation or this is the status of this

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litigation.
Q. And when you say "radio interviews," do you know how many?
A. It's detailed in our supplemental response, again, and I stand by that supplemental response. I -- There were a handful.
Q. As you sit here today, do you know the number without looking at the response?
A. Not with any degree of certainty. It was more than one and less than 15.
Q. So you mentioned radio interviews, you mentioned the Havre event, we talked about the Sidney event. Were there any other events that he recalled that you discussed with him?
A. There may have been.
Q. Do you recall any as you sit here today?
A. It's detailed in our supplemental response, and that's -- that's the best answer I have.
Q. So do you -- It's important for you to listen to the question that I'm asking because what I asked is do you recall any other as you sit here today.
A. I recall there may be others because I reviewed our supplemental response, and that

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details all of the things that I recall related to this topic.
Q. Do you have a specific recollection of any others as you sit here today?
A. Not as I sit here today.
Q. All right. So we're going to kind of jump back. So I was asking who you spoke with in order to prepare for today, and you mentioned David and then the attorney general, and your wife, I think. Mr. Mead and Mr. Corrigan. Is there anybody else that you spoke with to prepare for your deposition today?
A. No.
Q. Are you confident that you possess all relevant and discoverable information on behalf of the AG's office for the topics upon which you have been designated to testify?
A. Very confident.
Q. And you understand today that you are testifying as to the collective knowledge of the AG's office?
A. That's correct.
Q. You understand you have an affirmative duty to be prepared to testify fully and knowledgeably on behalf of the AG's office today on

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the topics upon which you have been designated?
A. Yes.
Q. You understand that when I say "you" today, I am speaking about the AG's office?
A. I understand that I'm testifying as a 30(b)(6) witness.
Q. And do you understand, can we have that agreement when I say "you" in my questions that I'm speaking about the AG's office?
A. That's my understanding, yes.
Q. Some of the questions might be to you specifically, and if you have a question, let me know, and I can let you know. Like this one. Are you an employee of the AG's office?
A. I am.
Q. And what is your job title?
A. I'm the chief deputy attorney general.
Q. And how long have you had that position?
A. Three months.
Q. So you began in -- would it be May of 2022?
A. In this role I have served for just about three months.
Q. And I'm just trying to figure out where -- where that is in the year. Is that May of 2022?

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A. It's about end of May, start of June.
Q. And you said "in this role." What role did you have prior?
A. I was the general counsel for the Department of Justice.
Q. And how long were you in that role?
A. From January 4th, 2021 until end of May, start of June of this year.
Q. Did you have a role with the attorney general's office before that?
A. No.
Q. What did you do before that?
A. Before that I was with the state auditor's office as a legal counsel there, yes.
Q. And how long were you there?
A. At the state auditor's office, I was there about three, three and a half years.
Q. What did you do prior to that?
A. For work?
Q. Correct.
A. I was at the Secretary of State's office prior to that for about eight months.
Q. And what did you do prior to that?
A. Prior to that I was in general civil practice in Great Falls with a firm called Davis,

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Hatley, Haffeman & Tighe.
Q. And how long were you with that firm?
A. About three and a half years.
Q. Was that your first job out of law school?
A. That's correct.
Q. When did you graduate from law school?
A. 2013.
Q. How much time did you spend preparing for your 30(b)(6) deposition?
A. I'd say about six or seven hours.
Q. And how much of that time was spent reviewing documents?
A. About half.
Q. And what was the other half spent doing?
A. Discussing the documents with counsel.
Q. Have you ever been designated as a 30(b)(6) witness before?
A. I've never been deposed before or designated as a 30(b)(6).
Q. Is it the AG's office position that 49-2-312 -- Do you know what I'm talking about when I say 49-2-312, that statute?
A. Generally, yes.
Q. You understand that House Bill 702 has been codified at 49-2-312 and 313?

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A. Yes.
Q. Okay. So is it the AG's office's position that 49-2-312 only applies to the COVID vaccine?
MR. DEWHIRST: Just caution the witness you're instructed not to respond to the extent that discloses any attorney-client communications, attorney work product.
A. Yeah. I mean, can you restate the question or rephrase?
BY MS. MAHE:
Q. Sure. Is it the attorney general's position that 49-2-312 only applies to the COVID-19 vaccine?
MR. DEWHIRST: Same objection and instruction.
A. I -- Katie, I think the AG's position relative to 49-2-312 is expressed in our legal filings in this case.
BY MS. MAHE:
Q. Right. But you've been designated today to give the position of a named party in this lawsuit, and so we get to depose you on these questions, and I understand that you want to continue to refer to documents that have been filed, but this is our chance to depose and ask the

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question. So you can go ahead and answer my question.
MR. DEWHIRST: If you --
BY MS. MAHE:
Q. Do you recall it?
MR. DEWHIRST: If you remember the question you can answer.
A. Yeah. Could you restate the question?
BY MS. MAHE:
Q. Sure. Is it the AG's position that 49-2-312 only applies to COVID-19 vaccines?
MR. DEWHIRST: And I'll issue the same objection and instruction and the additional objection that this calls for a legal conclusion, and is therefore improper in a 30(b)(6) deposition.
A. Yeah, Katie, it -- it feels like you're asking me what our litigation strategy or litigation position is relative to 49-2-312, so I'm trying to answer your question, but I -- I don't think I'm supposed to talk about legal conclusions. I don't think I -- that's part of this deposition today.
BY MS. MAHE:
Q. So what are you going to testify to, then?

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A. I'm going --
MR. DEWHIRST: Objection. It's harassing, open ended, vague.
A. I'm -- I'm answering your questions --
BY MS. MAHE:
Q. Okay.
A. -- to the best of my ability.
Q. Okay.
MS. MAHE: So are you instructing him not to answer my question?
MR. DEWHIRST: To the extent that it discloses attorney-client privileged information or attorney work product.
MS. MAHE: Great.
BY MS. MAHE:
Q. So are you refusing to answer my question?
A. No, I'm not.
Q. Great. So does -- Is it the AG's position that 49-2-312 only applies to the COVID-19 vaccine?
MR. DEWHIRST: Same objections.
A. The -- The AG's position is that 49-2-312 speaks for itself.
BY MS. MAHE:
Q. And what does it say?
A. It speaks for itself.

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Q. What does it say?
A. It speaks for itself.
Q. What does it say?
A. I --
MR. DEWHIRST: Okay. Objection. Harassing. He's answered the question three times now.
MS. MAHE: All right. We're gonna take a break for a minute, and then we're going to go make a record of this and then we're going to call the judge 'cause this is not happening. If he's not going to answer any of my questions today, like yesterday when you presented me with a potted plant deponent, that is not going to fly. So we're going to take care of this, and you better figure out if he's going to answer questions today or not. And if you're going to instruct this and be this obstructionist, we will go to the court.
MR. DEWHIRST: Well, maybe you should try some questions other than right out of the gate asking for a legal conclusion. We've made our position clear on this, Katie. It's improper in a 30(b)(6) deposition.
MS. MAHE: It is not. The Mitchell case, which you cited, related to a voter ballot

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initiative, and it was to a licensing agency, not the agency that is charged with enforcing the constitutionality of the law. It is not improper for us to ask what the AG's position on this is when the AG is a party.
MR. DEWHIRST: Also I don't think --
MS. MAHE: So let's take a break. Why don't you have a conversation.
MR. DEWHIRST: Also I don't think the attorney general has really hid the ball on this particular question.
MR. GRAYBILL: Then why not --
MR. DEWHIRST: You've been on --
MS. MAHE: Then why not answer it?
MR. GRAYBILL: Why not answer the question?
MR. DEWHIRST: Why are you asking the question?
MS. MAHE: Because --
MR. DEWHIRST: It's an improper topic for a 30(b)(6).
MS. MAHE: You guys won't admit requests for admission, you've been obstructionist every single turn, you won't provide documents, you won't provide the information. We're deposing

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these people when we shouldn't have to because we can't get straight answers from you guys in discovery. So why not answer the question?
MR. DEWHIRST: We -- I -- I object to your characterization of all that, but we can certainly take a break, if you'd like, or you can put the law in front of him and he can tell --
MS. MAHE: He has it in front of him.
MR. DEWHIRST: -- you what he's going to answer.
THE COURT REPORTER: One at a time, please.
MR. DEWHIRST: Yeah.
THE COURT REPORTER: "You can put the law in front of him" and he can what? He can --
MR. DEWHIRST: He's already answered that the law speaks for itself -- for itself.
MS. MAHE: She just wants to know what you said previously, that's all, so she can take it down.
MR. DEWHIRST: That's -- That's what I said.
MS. MAHE: That's not what you said.
MR. DEWHIRST: But if you'd like to put the text of the bill in front of him, he can -- if

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it speaks for himself -- for itself, then he can answer that question.

MS. MAHE: Great.

BY MS. MAHE:

Q. Please look at Exhibit 52. Do you have Exhibit 52 in front of you?

A. I do.

Q. And Exhibit 52 is the statute that we've been talking about, 49-2-312 and 49-2-313.

Do you see that?

A. I do.

Q. Okay. Is it the AG's office position that 49-2-312 only applies to the COVID-19 vaccine?

A. The -- The statute speaks for itself, but it also refers to other vaccination requirements in Title 20, in Title 52, so I'm trying to understand your question.

Q. Sure. So when it talks about not being able to discriminate based upon vaccination status, is that vaccination status solely limited to COVID-19, is it the AG's opinion -- or position? Sorry.

A. I think it speaks for itself, and I don't know that you can read it to be -- Well, I think it speaks for itself.

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MR. DEWHIRST: Also note for the record --

BY MS. MAHE:

Q. I'm just going to keep asking the question over and over again until you answer.

MR. DEWHIRST: Also note for the record, Counsel, that Judge Molloy asked this question at the motion to dismiss hearing, and he was provided an answer by defense counsel.

MS. MAHE: So why not -- why not allow him to answer it? Why are you being this obstructionist?

MR. DEWHIRST: I'm not being obstructionist. I'm giving him a limited instruction, and I've told you it's calling for a legal conclusion.

BY MS. MAHE:

Q. So why not answer the question?

A. I -- I have answered the question.

Q. Does vax -- Is it the AG's opinion that vaccination status, which is prohibited discriminatory practice, right, to discriminate based on vaccination status? Is that correct?

MR. DEWHIRST: Objection to form.

A. I -- The statute speaks for itself.

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BY MS. MAHE:

Q. Is it --

A. That it is an unlawful discriminatory practice for any person or a governmental entity to refuse, withhold from, or deny to a person any local or state services, goods, facilities, advantages, privileges, licensing, educational opportunities, health care access or employment opportunities based on the person's vaccination status or whether the person has an immunity passport.

Q. And that vaccination status, is it the AG's position that vaccination status only relates to the COVID-19 vaccine?

A. No.

Q. What is the AG's role in enforcing the laws in the state of Montana?

A. Can you -- Can you rephrase your question?

Q. Sure. The attorney general is the chief law enforcement officer for the state of Montana. Correct?

A. Yes.

Q. Okay. So what is the AG offices role in enforcing the laws in Montana?

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A. I think there's -- there's multiple roles. We have the department of criminal investigations, we have investigation role, we have our prosecution services bureau, they prosecute. Appellate services bureau. We handle state appeals and habeas relief, office of consumer protection. I mean, there -- there are multiple roles that the attorney general's office has.

Q. Is one of those roles to defend the constitutionality of a law when it is challenged?

A. Yes.

Q. And of those different roles that you talked about, which of those arms or departments is responsible for enforcing 49-2-312?

A. In -- In what way do you mean "enforcing"?

Q. Well, you mentioned that there's a criminal prosecution component. Correct?

A. Our prosecution services bureau handles criminal prosecutions around the state, yes.

Q. Okay. And in those criminal prosecutions, is that for any violation of criminal law in Montana? Is that what you handle?

A. Prosecution services bureau typically

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handles cases in which our county attorneys are conflicted or, you know, let's say a smaller county has a -- it's oftentimes small counties have one county attorney, no deputy, and they may even be part-time. And so if there's a complex case, they might call in for assistance from our prosecution services bureau.

Q. Okay. And so if there was a -- if there was a criminal prosecution related to a violation of 49-2-312, that could be handled by that criminal prosecution services division?

MR. DEWHIRST: Objection. Calls for speculation.

A. Yeah. And I -- I think you're referencing, there's a statute in Title 49 that discusses misdemeanor criminal penalties associated with violations of the Human Rights Act. That statute has never been used by the attorney general's office to investigate or prosecute. Our position has been that those discrimination claims are private rights of action handled by the Human Rights Bureau.

BY MS. MAHE:

Q. So does the attorney general's office intend not to enforce that criminal statute, then?

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MR. DEWHIRST: Objection. Calls for speculation.

A. Intend not to enforce? I'm not sure I understand what you mean.

BY MS. MAHE:

Q. Well, you said you've never utilized it, right, for prosecution. Correct?

A. Or investigation.

Q. Or investigation. Correct?

A. That's what I said, yes.

Q. Okay. And so does the attorney general's office ever intend to use it for prosecution?

MR. DEWHIRST: Same objection.

A. I -- Based on what?

BY MS. MAHE:

Q. Well, you said that you never had, and so I'm asking is there an intent to start enforcing it?

A. Start enforcing what?

Q. The criminal statute that we've just been talking about.

A. I -- I'm -- I'm not sure what you're asking me. If we're intending to --

Q. Well, you brought up ad hoc that it's never been enforced and it's never been investigated, right? You mentioned that.

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A. The -- The criminal prosecution statute under the Human Rights Act has never been utilized by the Department of Justice to investigate or prosecute a crime because it's our position that those discrimination claims under the Human Rights Act, there's a private right of action avenue where you adjudicate those claims with the Human Rights Bureau.

Q. So because that's your position, the AG's office position, does that mean that the AG office is not going to enforce that criminal statute?

A. I don't think that it means we won't ever use that criminal statute. Technically we could, but we never have. It's not the -- the basis for any current or past investigation that we've had, and it's not the basis for any current or past prosecution.

Q. And when you say "past," how far back are you talking?

A. As far as I've been with the Department of Justice, and I have done some research on that statute. It's never been utilized by the Department of Justice.

Q. So I'm gonna make sure I understand this. You've been with the Department of Justice since January of 2021. Is that right?

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A. That's correct.

Q. Okay. And how far back did you go in your research?

A. As far back as I could.

Q. Do you know when the Montana Human Rights Act was enacted?

A. Not off the top of my head, Katie, no.

Q. And when you say you went -- you did research, what did you do?

A. Searched our records to see if we'd utilized this statute for any investigation or prosecution.

Q. What records did you search?

A. The Department of Justice records. Talked to DCI, talked to attorneys that had been in the office for decades.

Q. When you talk about Department of Justice records, what specific records did you look at?

A. I also did some case law research and looked for that as well.

Q. Great.

MS. MAHE: Do you want to read my question back, Mary?

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THE COURT REPORTER: "When you talk about Department of Justice records, what specific records did you look at?"
A. Well, there weren't any records of this statute being utilized, so there -- there's no specific record to refer to.
BY MS. MAHE:
Q. Where did you go to look for records?
A. I -- I told you. DCI and other attorneys that had been in the office for decades.
Q. And who did you talk to?
A. I think our director at DCI, Bryan Lockerby, and I think -- I think I spoke with Pat Risken who's now retired.
Q. Anyone else?
A. Not that I recall.
Q. Okay. Does the AG's office provide training to other state agencies regarding 49-2-312?
A. No.
Q. You have to answer audibly. Sorry.
A. I did. I said no.
Q. And does the AG's office provide training to the public regarding 49-2-312?
A. Training?

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Q. Correct. About how to be in compliance.
A. No, not -- not training.
Q. Can the AG's office provide legal advice to private citizens?
A. We do not.
Q. Does the AG's office have a role in determining appropriate penalties for violations of 49-2-312?
A. No.
MS. MAHE: Are you guys cold?
MR. DEWHIRST: A little chilly, but feels wrong to complain.
MS. MAHE: I know, but I'm shivering. Maybe we can take a break for a minute.
THE VIDEOGRAPHER: We are going off the record. The time is 9:40 a.m.
(Recess taken from 9:40 a.m. to 9:50 a.m.)
THE VIDEOGRAPHER: We are back on the record. The time is 9:50 a.m.
BY MS. MAHE:
Q. Derek, you understand that you're still under oath still?
A. Yes.
Q. And you understand that you're still testifying on behalf of the AG's office?
A. I do.
Q. Before we went on break we were talking about the criminal statute that's related to the Human Rights Act. Do you remember we were talking about that?
A. I recall.
EXHIBIT:
(Deposition Exhibit 62 marked for identification.)
BY MS. MAHE:
Q. The court reporter has handed you what has been marked Deposition Exhibit 62. Have you seen that document before?
A. I have.
Q. And what is that document?
A. It's an email from a constituent Sean Logan to me, and then an email back from me to Sean Logan on October 31st, 2021.
Q. And so Sean Logan, is he with the AG's office?
A. No, he's not. He's a constituent.
Q. When you say "constituent," does that mean he's a member of the public?
A. That's correct.

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Q. And you responded -- This is your email back to him at the top of page 1 of Exhibit 62?
A. Yes.
Q. And do you see where you say "Additionally, employers who willfully violate the provisions of HB 702 may be subject to criminal prosecution under MCA 49-2-601."
A. Yes.
Q. And what would be the agency that would be responsible for that criminal prosecution?
A. I think technically it could be the Department of Justice. I think technically it could be any one of the county attorney's offices.
Q. Turning your attention back to 49-2-312?
MR. DEWHIRST: So Exhibit 52?
MS. MAHE: I think that's right.
A. Okay.
BY MS. MAHE:
Q. What is the AG's position on what the word "discriminate" means in that statute?
A. Our position on the definition of the word?
Q. Correct.
MR. DEWHIRST: I'll object to the extent the question calls for attorney-client privileged

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information or attorney work product information, and instruct you not to answer to the extent you would reveal any of that information.
A. It may or may not be defined in the Human Rights Act, but my understanding is that it would be to treat people differently based on some -- some protected class.
BY MS. MAHE:
Q. And in 49-2-312, that protected class would be either vaccination status or immunity status?
A. That would be either vaccination status or the possession of an immunity passport.
Q. And what is an immunity passport?
A. An "'immunity passport' means a document, digital record, or software application indicating that a person is immune to a disease, either through vaccination or infection and recovery."
Q. You mentioned the Human Rights Bureau process earlier, correct, when you were discussing the enforcement of this statute?
A. I think I mentioned that -- I'd mentioned the Human Rights Bureau. Maybe not the process, but maybe the Human Rights Bureau.
Q. Well, you mentioned that there's this

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avenue for an action -- a private right of action to proceed through the Human Rights Bureau. You -- You testified as to that. Correct?
A. Yes.
Q. Okay. And apart from the HRBs, that process, does the AG's office take any other steps to enforce 49-2-312?
A. No, the AG does not take any other steps to enforce HB 702 or 49-2-312.
Q. So the AG's office is not making determinations as to whether or not a particular entity is complying with 49-2-312. Is that correct?
MR. DEWHIRST: Objection to the extent that would call for any attorney-client privileged communications or attorney work product. Instruct you not to answer to the extent that it would include any of that information.
A. Can you repeat the question?
MS. MAHE: Mary, can you read it back?
(Discussion held off the record.)
MR. DEWHIRST: I'll -- I'll add an objection that that's calling for a legal conclusion.
A. Yeah, and I -- I think the first part of

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the question confused me 'cause it said how the AG's office is --
BY MS. MAHE:
Q. I think I said "now," but that's okay. It doesn't matter. I couldn't remember the whole extent of the question, but now I do.
A. Yeah, me neither.
Q. Right. So is the AG's office making determinations as to whether a particular entity is complying with 49-2-312?
A. No.
Q. Does the AG's office consider requiring a person who has not provided proof of vaccination to wear additional personal protective equipment to be discrimination under 49-2-312?
MR. DEWHIRST: Objection. Calls for a legal conclusion.
A. And I really don't even understand your question. Can you --
BY MS. MAHE:
Q. Sure.
A. -- rephrase or repeat?
Q. Sure. Do you know what "PPE" is if I say PPE?
A. No.

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Q. It's personal protective equipment like additional masking, goggles, glasses, things like that. Do you understand that?
A. Sure.
Q. Okay. So does the AG's office consider requiring somebody who is not vaccinated to wear additional PPE than someone who is vaccinated discrimination under the statute?
MR. DEWHIRST: Same objection.
A. I -- I don't think the AG's office makes that discrimination determination.
BY MS. MAHE:
Q. So is it --
A. So that would be have to be adjudicated through a private right of action, and I suppose it would depend on the circumstances of that private right of action. I -- I --
Q. So is it your testimony that the AG doesn't take a position on that?
A. No, that's not my testimony. My -- My understanding is there are multiple areas in which people could be discriminated against, not just vaccination status, and that would have to be adjudicated in -- in a private right of action, and the -- the AG's office wouldn't be involved in

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the adjudication of that.
Q. Would the AG -- What's the AG -- Sorry, let me start over.
Is it the AG's position that requiring someone who is not vaccinated for COVID-19 to wear a mask and not having the same requirement for vaccinated people to be discrimination [sic] under that statute?
MR. DEWHIRST: Objection. Calls for a legal conclusion and compound.
A. And I -- And I think I've answered it, and I'm trying to answer your questions here, Katie. Because there are other areas and other protected classes, it would depend on the circumstances of any particular claim that a private individual would bring.
BY MS. MAHE:
Q. So the AG's office wouldn't make a statement that requiring nonvaccinated people to wear masks could be discrimination under that statute?
A. Under 49-2-312?
Q. Correct.
A. 49-2-312 doesn't have anything to do with masking. But, for example, if an employer were to

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make all the women employees wear PPE and not the men, that could be discriminatory.
Q. Under 49-2-312?
A. No, but in reference to your other question, I think your questions previously were more broad, and that's why I was having trouble answering your question.
Q. Okay. I -- I think that my question was limited to 49-2-312, and my question is if an employer requires a nonvaccinated individual to wear a mask and doesn't require that of a vaccinated individual, is it the AG's position that that's a violation of 49-2-312?
MR. DEWHIRST: Same objection.
A. And 49-2-312 doesn't have --
MR. DEWHIRST: Sorry. Same objections.
A. Yeah. Apologize.
MR. DEWHIRST: Sorry.
A. 49-2-312 has to do with discrimination based on vaccination status or possession of an immunity passport, and it doesn't have anything to do with masking.
BY MS. MAHE:
Q. Right. So I want to make sure that you're listening to the question that I'm asking because I

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think you're answering questions that I'm not asking.
So what I'm asking is if an employer has a nonvaccinated employee, that would be vaccination status, correct? Is that correct?
A. Yes.
Q. Okay. We have a nonvaccinated employee that they require to wear a mask, but they do not require their vaccinated employees to wear a mask. Is it the AG's position that that's discrimination under 49-2-312?
MR. DEWHIRST: Objection to form and objection that it calls for a legal conclusion.
A. And 49-2-312 doesn't have anything to do with masking, so it wouldn't -- it wouldn't matter with respect to that statute.
EXHIBIT:
(Deposition Exhibit 63 marked for identification.)
BY MS. MAHE:
Q. Mr. Oestreicher, the court reporter has handed you what has been marked Deposition Exhibit 63. You just testified that that statute doesn't have anything to do with masking, and so the AG's office wouldn't have a position. This is

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a letter that you sent to the Montana Head Start program directors and employees on January 14th of 2021. And in that second-to-last paragraph there you say "Some examples of vaccination-based discrimination include, but are not limited to, requiring only staff who have not received the COVID-19 vaccine to wear a mask."
Do you see that?
A. I do.
Q. Okay. You also see where you said "telling staff members they must resign" -- I think that's supposed to be resign -- "or will have their employment terminated if they do not receive the COVID-19 vaccine."
A. I see that.
Q. "And refusing to schedule unvaccinated employees for work shifts."
Do you see that?
A. I do.
Q. And you sent this as general counsel for the AG's office. Correct?
A. I did.
Q. And then you say [As Read]: "Employees who are illegally discriminated against based on their vaccination status are encouraged to seek legal --

legal advice from a private attorney and to contact the Montana Human Rights Bureau and Department of Labor to seek redress."

Do you see that?

A. Yes, I do.

Q. And this was advice that you sent out to Head Start directors and employees?

A. I think it was information and, yeah, I -- I don't know that I would characterize it as advice, but certainly information that I sent out to Head Start program directors and employees.

Q. And was this in response to the federal vaccine mandate for Head Start?

A. No, this was in response to a separate piece of litigation related to Head Start, the office of Head Start.

Q. The -- Was it related to the mandate that they would require them to wear masks?

A. Yes. Masking, and I believe there was a vaccination component, but it may not have included that.

MR. DEWHIRST: Katie, is there -- is there -- Can we go off for a second? Is there a restroom on this floor?

MS. MAHE: Yes.

THE VIDEOGRAPHER: We are going off the record. The time is 10:05 a.m.

(Recess taken from 10:05 a.m. to 10:07 a.m.)

THE VIDEOGRAPHER: We are back on the record. The time is 10:07 a.m.

BY MS. MAHE:

Q. Mr. Oestreicher you understand that you're still under oath?

A. I do.

Q. And you understand that you're still testifying on behalf of the AG's office?

A. I do.

Q. I think it's Exhibit 52. Do you still have that in front of you?

A. I do.

Q. The second page of Exhibit 52 is 49-2-312. Do you see that? Or it might be the third page. Sorry.

A. Yes.

Q. And that statute deals with an exemption from 49-2-312. Correct?

A. Yes.

Q. Has the AG's office ever determined that an entity was exempt under that statute?

A. No.

Q. Is the AG's office the entity that would be making those determinations?

A. No.

Q. What is the entity that would be making those determinations?

MR. DEWHIRST: Objection. Outside the scope.

You can answer, if you know.

A. Could be the Department of Public Health and Human Services or the Department of Labor & Industry, potentially the Centers for Medicare and Medicaid Services or the Centers for Disease Control.

BY MS. MAHE:

Q. So the Centers for Disease Control, that's a federal agency. Correct?

A. Correct.

Q. And the Centers for Medicaid and Medicare Services, that's a federal agency. Correct?

A. Correct.

Q. So the two state agencies that you mentioned are DPHHS and the Department of Labor?

A. Correct.

///

EXHIBIT:

(Deposition Exhibit 64 marked for identification.)

BY MS. MAHE:

Q. The court reporter has handed you what has been marked Deposition Exhibit 64. Have you seen this document before?

A. I have.

Q. And what is this document?

A. It is a series of email -- emails between a member of the public and our contact DOJ email address as well as an email from me to -- well, two emails from me to Ms. Aarestad.

Q. And was Ms. Aarestad asking you about whether assisted living facilities were exempt from House Bill 702?

A. Ms. Aarestad, on page 2 of the exhibit, wrote to contact DOJ and stated "I was just told by a Montana state employee that assisted living facilities in Montana are exempt from HB702 at the present time. Is this correct?"

Q. And then in your email response did you answer her question?

A. I attempted to provide resources to Ms. Aarestad related to her question about the

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Exhibit 36?
MR. DEWHIRST: Objection. Vague, and objection that it calls for attorney-client privilege information, so I'm going to instruct the witness not to answer.
A. I don't understand your question. What guidance was provided?
BY MS. MAHE:
Q. You said what -- what consultation, I guess, would have been the -- I'm just trying to use your words -- what consultation would have been provided was my question.
A. Attorney-client consultation.
MR. DEWHIRST: And to be clear, Katie, you're talking about the guidance at the end of Exhibit 36.
MS. MAHE: Correct.
MR. DEWHIRST: Okay.
BY MS. MAHE:
Q. Has the AG received any guidance on how to apply 49-2-312?
A. No. We have -- We have obviously seen the guidance like the guidance in Exhibit 36, but we're not -- we have not been provided guidance on how to apply it, no.

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Q. Okay. Is it the AG office's -- I'm going to start over. Is it the AG's office position that violators of House Bill 702 can and should be held accountable?
A. Yes.
Q. Okay.
EXHIBIT:
(Deposition Exhibit 66 marked for identification.)
BY MS. MAHE:
Q. The court reporter has handed you what has been marked as Deposition Exhibit 66. Do you see -- Have you seen that document before?
A. Yes.
Q. And what is that document?
A. It is a letter from Governor Gianforte and Governor and -- on page 1, and then continuing on pages 2, 3, 4 of the exhibit it is Governor Gianforte's guidance on federal contracts mandate.
Q. Did the AG's office prepare the guidance that you just described that starts on page 2?
A. No.
Q. Did the AG's office prepare the letter that's on page 1?

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A. No.
Q. In page 1 Governor Gianforte says [As Read]: "As outlined in the attached guidance from my administration, President Biden's executive order violates Montana law. COVID-19 vaccine mandates, including as a condition of employment, are illegal in Montana, and state law makes clear that contract terms that violate Montana public policy are enforceable."
Do you see that?
A. I see it.
Q. Does the AG's office share that opinion?
MR. DEWHIRST: Objection. Calls for a legal conclusion.
A. And I have a difficult time answering that question without knowing which particular executive order Governor Gianforte is referring to.
BY MS. MAHE:
Q. If you look up at the second paragraph, it talks about -- take your time to read the letter if you need to. And you can certainly read the whole document, but my question was related to the opinion that's expressed in that page 1.
MR. DEWHIRST: And the question again?

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BY MS. MAHE:
Q. Sure. The question is this states [As Read]: "As outlined in the attached guidance from my administration, President Biden's executive order violates Montana law. COVID-19 vaccine mandates, including as a condition of employment, are illegal in Montana, and state law makes clear that contract terms that violate Montana public policy are enforceable."
Does the AG's office share that opinion?
MR. DEWHIRST: Same objection. Calls for a legal conclusion. Also vague as to time.
A. Yeah. As of October 27, 2021 I -- I believe Department of Justice shares or shared the -- the opinion expressed in this letter.
BY MS. MAHE:
Q. What about as of today?
MR. DEWHIRST: Objection. Calls for a legal conclusion.
A. Yeah, and I -- I would like to read the actual guidance.
BY MS. MAHE:
Q. Sure.
A. Yes, as of today.
Q. I'm gonna jump backwards a little bit to

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general recall any specific comments he made at those events?
A. No.
Q. Did he recall whether any of those events were recorded?
A. He recalled that none of the events were recorded by our office.
Q. Is it the attorney general's opinion that masks do not work to prevent COVID?
MR. DEWHIRST: Objection. Speculation.
A. Are you asking his personal opinion?
BY MS. MAHE:
Q. Well, I'm asking his opinion as the attorney general.
MR. DEWHIRST: This is outside the scope of the deposition.
You can answer, if you know.
A. I -- I don't know the attorney general's opinion with respect to masks.
BY MS. MAHE:
Q. Do you know whether he's ever said that publicly?
A. No.
Q. Do you know whether he's ever said that on a radio program publicly?

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A. No.
MR. DEWHIRST: Are you good?
MS. MAHE: I'm good. Sorry. I have to leave it on with kids at home.
MR. DEWHIRST: I get it. I get it.
BY MS. MAHE:
Q. Is it the attorney -- Has the attorney general ever opined that employers are caught between a rock and a hard place in complying with House Bill 702 and the federal vaccine mandates?
MR. DEWHIRST: Objection. Calls for speculation.
A. The attorney general did not recall any specific statement like that during my discussion with him.
BY MS. MAHE:
Q. Has the attorney general ever indicated that employees are put in a difficult position because of House Bill 702 and the federal vaccine mandates?
A. The attorney general --
MR. DEWHIRST: Same objection, by the way.
THE DEPONENT: Sorry.
A. The attorney general did not recall any

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specific statement like that when I spoke with him.
BY MS. MAHE:
Q. Did the attorney general recall saying that employers are in a difficult position because of the civil penalties associated with House Bill 702?
A. The --
MR. DEWHIRST: Objection. Speculation.
A. The attorney general did not recall any specific statement like that when I spoke with him.
BY MS. MAHE:
Q. Did you listen to the radio interviews where the attorney general spoke that were provided in discovery?
A. We did not record the radio interviews.
Q. Are you aware that there are recordings of them?
A. There may be.
Q. Did you listen to those in preparation for your deposition today?
A. No. I have listened live to the attorney general on the radio, but, no, I did not listen to any recordings 'cause we did not maintain

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recordings.
Q. Turning back to 49-2-312, which is Exhibit 52? Does that sound right? Do you see Section 49-2-312(3)(b)? Do you see that section there?
A. I see that.
Q. And this relates to an exemption -- or exception, I'm sorry -- for healthcare facilities as defined in 50-5-101. Do you see that?
A. I see that.
Q. Okay. What is the basis for providing an exception to licensed healthcare facilities under this section?
MR. DEWHIRST: Objection. Calls for a legal conclusion.
A. I think the legislature would be the best ones to address that question to.
BY MS. MAHE:
Q. Well, I'm addressing it to you today. So what is the basis for providing licensed healthcare facilities an exemption under that section?
MR. DEWHIRST: Same objection.
A. The basis is outlined in 49-2-312 subsection (3)(b) one little i and two little i, and those two subparts, if you'd like me to read

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them --
BY MS. MAHE:
Q. The basis --
A. -- are the bases for the exemption, as I understand it.
Q. So you're saying that the basis for the exemption is within the exemption?
A. I'm saying, yes, essentially that the statute speaks for itself, and that's the basis for -- The statute says "A healthcare facility as defined in 50-5-101 does not unlawfully discriminate under this section if it complies with both of the following," and those are the bases for --
Q. Right. And my --
A. -- the exemption.
Q. Sorry. And my question is why does that only apply to healthcare facilities?
MR. DEWHIRST: Objection. Calls for a legal conclusion.
A. I don't know.
BY MS. MAHE:
Q. If you turn to 49-2-313, which is page 3 of Exhibit 52, 49-2-313 provides an exemption for a licensed nursing home, long-term care facility or

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assisted living facility from compliance with 49-2-312. Do you see that there?
A. I see that.
Q. What is the basis for providing an exemption for a licensed nursing home, long-term care facility, and assisted living facilities under this section?
MR. DEWHIRST: Objection. Calls for a legal conclusion.
A. And I think the basis is set by the legislature, and it's -- it's contained within the four corners of the statute itself. The statute speaks for itself.
BY MS. MAHE:
Q. So why were licensed nursing homes, long-term care facilities, and assisted living facilities given an exemption apart from other facilities?
MR. DEWHIRST: Same objection.
A. Yeah, I -- I think that's a -- a question for the legislature.
MS. MAHE: Can you read my question back, Mary?
THE COURT REPORTER: "So why were licensed nursing homes, long-term care facilities,

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and assisted living facilities given an exemption apart from other facilities?"
MR. DEWHIRST: Same objection if there's a question.
MS. MAHE: That is the question.
MR. DEWHIRST: Yeah. Same objection.
A. I don't know.
BY MS. MAHE:
Q. I'm going to switch gears really fast here.
Were you involved in compiling the documents that have been produced in discovery in this case?
A. What do you mean involved? I've reviewed them --
Q. Okay.
A. -- and I was involved in preparing the supplemental response.
Q. Okay. So we received documents from the HRB related to final investigative reports, defendants' 977 through 1037, I believe. Did the AG's office redact those documents?
MR. DEWHIRST: Objection. This is outside the scope.
To the extent you know, you can answer.

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A. It was an attorney for either Department of Labor & Industry or HRB or the attorney general's office if those documents have been redacted, yes, to -- to protect personally identifying information or confidential information.
BY MS. MAHE:
Q. Do you know which of those -- you mentioned three different agencies. Do you know which of those agencies performed the redactions?
A. One of them.
Q. Do you know which one?
A. No.
Q. Did the AG's office contact the parties in those final investigative reports to determine whether they objected to their production?
MR. DEWHIRST: Same objection. Outside the scope.
A. No.
MS. MAHE: Let's take a quick break, and then hopefully we'll be able to finish up.
MR. DEWHIRST: Okay.
THE VIDEOGRAPHER: We are back on the record. The time is 11:12 a.m.
(Recess taken from 11:12 a.m. to

11:23 a.m.)
THE VIDEOGRAPHER: We are back on the record. The time is 11:23 a.m.
BY MS. MAHE:
Q. Mr. Oestreicher, you understand you're still under oath?
A. I do.
Q. You understand you're still testifying on behalf of the AG's office.
A. I do.
EXHIBIT:
(Deposition Exhibit 69 marked for identification.)
BY MS. MAHE:
Q. The court reporter has handed you what has been marked Exhibit 69, and I apologize that it's not stapled but I did paperclip it. Should be, I think, nine pages or something along those lines. Maybe more.
Have you seen that document before?
A. I recall seeing the document on page -- beginning on page 4 of the exhibit.
Q. That would be the letter from Montana Health Network?
A. That's correct.

Q. So the first few pages of this exhibit are a declaration that was filed by Mary Stukaloff in this matter. Do you know who Mary is?
A. Yes, I do.
Q. And who is she?
A. She's a -- a -- administrative assistant front desk employee.
Q. With the attorney general's office?
A. With the attorney general's office.
Q. And you had not seen her declaration before this?
A. I don't specifically recall seeing her declaration, but it may have been in the documents that I reviewed, but I do recall seeing the Montana Health Network letter.
Q. Do you have any reason to dispute Ms. Stukaloff that this letter was received by the attorney general's office on February 10th, 2022?
A. No, I don't.
Q. And you've seen it before, so did you see it when it came into the attorney general's office?
A. I've seen it before, but I don't recall the date on which I have seen it.
Q. The third paragraph on page 1 of that letter starts with "On average, most small

healthcare facilities in our remote, isolated Montana communities receive 60% or more of their gross billing from CMS."
Do you see that?
A. I see that.
Q. Does the AG's office disagree with that statement?
MR. DEWHIRST: Objection. Calls for speculation.
A. The AG's office doesn't take a position on that statement.
BY MS. MAHE:
Q. Does the AG's office disagree with that statement?
A. The AG's office doesn't take a position on the statement at all.
Q. Does the AG's office believe that small healthcare facilities in Montana receive 60 percent or more of their gross billing from CMS?
MR. DEWHIRST: Same objection.
A. I -- The -- The Department of Justice, the AG's office, we don't take a position on that statement.
BY MS. MAHE:
Q. Does the AG's office have any reason to

believe that statement is inaccurate?
MR. DEWHIRST: Same objection.
A. The AG's office didn't test the -- the veracity of that statement to have any reason to dispute it, no.
BY MS. MAHE:
Q. Okay. The next sentence says "Without that revenue, we would not be able to pay our bills."
Does the AG's office agree with that statement?
MR. DEWHIRST: Same objection.
A. The AG's office doesn't take a position on that statement.
BY MS. MAHE:
Q. Does the AG's office have any basis to claim that that statement is incorrect?
MR. DEWHIRST: Same objection.
A. Yeah, and the AG's office didn't test the -- the veracity of that statement to have any reason to dispute it.
BY MS. MAHE:
Q. The next statement is "We would not be able to provide long-term care for our long-term care residents, many of whom rely on Medicaid to

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pay for services."
Do you see that?
A. I see -- I see the sentence, yes.
Q. Does the AG's office have any reason to dispute that statement?
MR. DEWHIRST: Same objection.
A. The AG's office doesn't take a position on the statement and did not investigate the truthfulness or veracity of the statement.
BY MS. MAHE:
Q. The next sentence, "We would go insolvent quickly, as our meager financial reserves become depleted if we have any reserves at all."
Does the AG's office disagree with that statement?
MR. DEWHIRST: Same objection.
A. The attorney general's office does not take a position on that statement and did not conduct any investigation into the truthfulness or veracity of that statement.
BY MS. MAHE:
Q. Does the AG's office have any basis to dispute that statement?
MR. DEWHIRST: Same objection.
A. The AG's office doesn't take a position

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on the statement at all, but didn't investigate whether or not they would go insolvent quickly or whether or not they had meager financial reserves. We didn't investigate the truthfulness of the -- of the statements to -- to take a position on it.
BY MS. MAHE:
Q. So you have no evidence to dispute the statement, then?
MR. DEWHIRST: Same objection.
A. And -- And I think I've -- I've answered that. We don't take a position on it, and we didn't investigate it in order to take a position or dispute it.
BY MS. MAHE:
Q. Okay. The last sentence, "In any instance, we could not rely on commercial insurance or private payers to keep us afloat."
Do you see that statement?
A. I see the statement.
Q. Did the AG's office disagree with that statement?
MR. DEWHIRST: Same objection.
A. The AG's office didn't take a position on that statement, doesn't take a position on that statement, and did not investigate the

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truthfulness or veracity of the statement in order to dispute it.
BY MS. MAHE:
Q. Mr. Oestreicher, have you answered all my questions truthfully and accurately today?
A. Yes, I have.
MS. MAHE: I don't have any more right now.
MR. DEWHIRST: Okay.
MR. GRAYBILL: None.
MR. DEWHIRST: None from Raph?
MR. GRAYBILL: Not today.
MR. DEWHIRST: Okay.
EXAMINATION
BY MR. DEWHIRST:
Q. Mr. Oestreicher, did you talk to the attorney in preparation for this deposition?
A. Yes, I did.
MS. MAHE: Object to the form. Sorry, we have to have a little bit of a break so that we can lodge our objections.
MR. DEWHIRST: There's just so much chemistry, you know, so much chemistry.
MR. GRAYBILL: And we join.
A. Yes.

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BY MR. DEWHIRST:
Q. Okay. And you've reviewed the defendants' responses to plaintiffs' second set of discovery requests?
MS. MAHE: Object to the form.
MR. GRAYBILL: Join.
A. Yes.
BY MR. DEWHIRST:
Q. And in those responses, the defendants have set forth that they provided the evidence of any talks or presentations the attorney general may have had where he may have talked about vaccine mandates. Is that correct?
MS. MAHE: Objection. Leading.
MR. GRAYBILL: Join.
A. That is correct.
BY MR. DEWHIRST:
Q. Okay. Outside of the documents that were produced in response to those discovery requests, did the attorney general recall any specific event where he talked about vaccine mandates?
MS. MAHE: Objection. Asked and answered.
MR. GRAYBILL: Join.
A. Yes, he did. There's another event --

A. The attorney general.
Q. Anyone else from the attorney's general's office besides those two?
A. No.
Q. Was this present litigation discussed at that event?
A. The attorney general did not specifically recall if this present litigation was discussed at the event, but he did recall the large attendance, he recalled many of those in attendance being railroad workers, he recalled that it was a pachyderms event at the Duck Inn in Havre, it was a lunchtime event, and he recalled generally discussing the status of the federal vaccine mandate litigation that our office was involved in.
Q. When you say "a large event," how many people was there?
A. I believe that is outlined in our supplemental response, but I -- I -- it was more than 25, less than a hundred.
Q. Less than 50?
A. Again, it's -- it's outlined in our supplemental response, and I -- I don't recall if it was less or more than 50, but it was between 25

and a hundred.
MS. MAHE: I don't have anything further right now.
MR. GRAYBILL: Reserve.
MR. DEWHIRST: Thank you.
THE VIDEOGRAPHER: That concludes the deposition. The time is 11:36 a.m.
(Deposition concluded at 11:36 a.m. Deponent excused; signature reserved.)

DEPONENT'S CERTIFICATE

I, ATTORNEY GENERAL'S OFFICE 30(b)(6) DESIGNEE DEREK OESTREICHER, the deponent in the foregoing deposition, DO HEREBY CERTIFY, that I have read the foregoing pages of typewritten material and that the same is, with any changes thereon made in ink on the corrections sheet, and signed by me, a full, true and correct transcript of my oral deposition given at the time and place hereinbefore mentioned.

ATTORNEY GENERAL'S OFFICE 30(b)(6) DESIGNEE DEREK OESTREICHER, Deponent.

Subscribed and sworn to before me this day of , 2022.

PRINT NAME:
Notary Public, State of
Residing at:
My commission expires:
MRS - Montana Medical Association, et al. vs. Austin Knudsen, et al.

C E R T I F I C A T E

STATE OF MONTANA)
: ss
COUNTY OF MISSOULA)

I, Mary R. Sullivan, RMR, CRR, and Notary Public for the State of Montana, residing in Missoula, do hereby certify:

That I was duly authorized to and did swear in the witness and report the deposition of ATTORNEY GENERAL'S OFFICE 30(b)(6) DESIGNEE DEREK OESTREICHER in the above-entitled cause; that the foregoing pages of this deposition constitute a true and accurate transcription of my stenotype notes of the testimony of said witness, all done to the best of my skill and ability; that the reading and signing of the deposition by the witness have been expressly reserved.

I further certify that I am not an attorney nor counsel of any of the parties, nor a relative or employee of any attorney or counsel connected with the action, nor financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal on August 21, 2022.

Montana Medical Association, et al. v
Austin Knudsen, et al.

John O'Connor
August 9, 2022

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UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION

MONTANA MEDICAL ASSOCIATION, ET AL.,

Plaintiffs,

and Cause No. DV-21-108-M-DWM

MONTANA NURSES ASSOCIATION,

Plaintiff-Intervenor,

vs.

AUSTIN KNUDSEN, ET AL.,

Defendants.

VIDEO DEPOSITION UPON ORAL EXAMINATION OF
JOHN O'CONNOR

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BE IT REMEMBERED, that the video-taped deposition upon oral examination of JOHN O'CONNOR, appearing at the instance of the Defendants, was taken at the offices of Fisher Court Reporting, 211 N. Higgins Avenue, Suite 303, Missoula, Montana, on August 9, 2022, beginning at 9:00 a.m., pursuant to Montana Rules of Civil Procedure, before Robyn Ori English, Court Reporter - Notary Public.

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I N D E X

E X H I B I T S

DEPOSITION EXHIBITS:		PAGE:
Exhibit 15	30(b)(6) Notice of Deposition	10
Exhibit 16	Plaintiffs' 30(b)(6) Deposition Designations for Five Valleys Urology	11

VIDEO OPERATOR: This is the video-recorded and video conference deposition of John O'Connor 30(b)(6) Representative of Five Valleys Urology, taken in the United States District Court for the District of Montana, Missoula Division, Cause No. CV-21-108-M-DWM, Montana Medical Association, et al, and Montana Nurses Association, versus Austin Knudsen, et al.

Today is August 9th, 2022. The time is 9:00 a.m. We are present with the witness at the offices of Fisher Court Reporting, at 211 North Higgins Avenue, Suite 303, in Missoula, Montana. The Court Reporter is Robyn Ori English and the video operator is Nicole Tomac of Fisher Court Reporting. The deposition is being taken pursuant to Notice.

I would now ask the attorneys to identify themselves, who they represent and whoever else is present. For those attending remotely, please note from where you are appearing.

MS. MAHE: I'm Katie Mahe, and I represent the Plaintiffs in this lawsuit. With me today is Britton Fraser who is just observing this deposition from our office.

MR. CORRIGAN: This is Christian Corrigan representing Defendants in the matter of the Office of the Montana Attorney General. I'm appearing remotely via Zoom from Helena, Montana. Also on the line with me are David Dewhirst and Brent Mead from the Office of the Attorney General, appearing remotely from Helena, Montana, and they won't be speaking.

MR. GRAYBILL: This is Raph Graybill on behalf of Plaintiff-Intervenor, the Montana Nurses Association, and I'm appearing remotely from Helena, Montana.

VIDEO OPERATOR: The Court Reporter will now administer the oath.

WHEREUPON, the following proceedings were had and testimony taken, to wit.

.....

JOHN O'CONNOR,

called as a witness herein, having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. CORRIGAN:

Q. All right. Good morning, Mr. O'Connor.

A. Good morning.

Q. Before we get started, I just want to go over a few general guidelines for a deposition, some things to help us make sure that we can communicate

efficiently since we're over Zoom. My goal today is to ask you questions and learn about Five Valleys.

As I do that, because we are on Zoom, I'm going to do my best to take a pause and give you as much time as possible to answer a question. I'll do my best not to talk over you so we don't end up in a situation where we're talking back and forth. Sometimes that's accidentally going to happen due to the nature of the online format, but we'll try to stop if that happens and let you finish and even clear up and re-ask the question if we need to to make sure we're on the same page.

Please feel free to ask me to repeat the question if you don't understand. Ask me to clarify something if you need to. Take your time answering and think about it. Sometimes my questions may seem overly simple, and we're not trying to trick, we're trying to establish basic things before we move on and discuss more specific items.

And sometimes my questions are going to be a little bit longer because we'll need to discuss about a time frame or make sure we include specific language that particularizes the question. So please, again, feel free to ask me to repeat the question if it's -- if you need it repeated because

that's absolutely -- that's absolutely okay.
The second thing is, if you need a break, please let me know. The answer is always going to be yes. I'll just ask that if we're in the middle of a question, you finish the question before we take a break. We are going to try to take a break about every hour; either five or ten, fifteen-minute breaks. We're going to definitely take a break before 11 o'clock because I know we've got a court hearing that your counsel has to attend quickly. So we'll do that. That will play on a longer break around that time, but again, if you need a break, please let us know.
Also, if you need to take a drink of water, get coffee or anything like that, it's not rude. We totally understand. I'm going to be drinking coffee as well. So not a problem.
Does that all sound good to you?
A. Yes, thank you.
Q. Great. So we'll start with a really easy question. Could you please state and spell your name, please?
A. My name is John Terry O'Connor. It's J-O-H-N, T-E-R-R-Y, O apostrophe, C-O-N-N-O-R.
Q. And what is your address?

A. Would you like my home address or my work address?
Q. Residential address.
A. My residential address is 610 West Crestline Drive, Missoula, Montana, 59803.
Q. And have you ever been deposed before?
A. Yes.
Q. What type of deposition was it?
A. I was the plaintiff in a wrongful discharge suit.
Q. And other than speaking with counsel, what did you do to prepare for today's deposition?
A. I reviewed the materials that were submitted and I reviewed the Complaint.
Q. Do the materials submitted include the 30(b)(6) Notice for Five Valleys Urology?
A. Yes.
Q. Great. Can we introduce Exhibit 15 which is the 30(b)(6) Notice?

(Deposition Exhibit No. 15 was marked for identification)

Q. (By Mr. Corrigan) He's got it, right? And then can we also introduce Exhibit 16 which is his designation and Plaintiff's objections?

(Deposition Exhibit No. 16 was marked for identification)

MS. MAHE: He has that as well.
MR. CORRIGAN: Great.
Q. (By Mr. Corrigan) So you have read through the topics as well as the designations and are prepared to testify about the topics for which you've been designated?
A. I have and I am.
Q. Great. What is your position at Five Valleys Urology?
A. I am the practice administrator.
Q. And what does the role of practice administrator entail?
A. In essence, I run the operations. I'm responsible for all governance activities, human resources, operations, marketing, and accounting.
Q. And how long have you been in that role?
A. Twenty years.
Q. And one thing I forgot to mention, if I use the term Five Valleys or the acronym FVU, can we agree that I'm referring to Five Valleys Urology?

A. We can.
Q. Great. And so what is Five Valleys Urology? What type of practice is it?
A. Five Valleys Urology is an independent urology practice, single specialty.
Q. And so the specialty is urology?
A. That is correct.
Q. And where are Five Valleys facilities located?
A. We have one location at 2875 Tina Avenue, Suite 101, in Missoula. The zip code is 59808.
Q. And how many employees approximately --
A. Approximately --
Q. -- does Five Valleys have?
A. Pardon me. Approximately 40.
Q. And is it correct that FVU has five physician providers and two mid-level providers?
A. We now have five physician providers and three midlevels, also called APPs.
Q. And what is a midlevel provider or APP?
A. In this case, we employ two certified physician assistants and one certified nurse practitioner.
Q. And what is the ownership structure of FVU?

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MS. MAHE: The same objection. Five Valleys Urology sees approximately 1,400 patients per month and does not track this information, and also this is outside the scope of his designation.

THE WITNESS: That information would be extremely difficult for me to even gather because patient's health status changes on a regular basis. And while we track diagnosis codes, those diagnoses can also change. And so I can't -- I can't even begin to answer that question because of the sheer volume of patients that we have. And it would require going back through every -- every single medical record of somebody that we've seen through a period of time.

Q. (By Mr. Corrigan) Okay, thank you.

MR. CORRIGAN: I'm at a good stopping point right now. Why don't we take -- why don't we come back at 10:05, and then that puts us at another -- another point to stop before the break that we need to take later. So if it works for everybody, let's come back in 13 minutes, at 10:05.

VIDEO OPERATOR: We are going off the record. The time is 9:52 a.m.

(Whereupon a recess was taken)

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VIDEO OPERATOR: We are back on the record. The time is 10:04 a.m.

Q. (By Mr. Corrigan) All right.

Mr. O'Connor, I'm going to ask you now about FVU's employment practices and policies, and I'm going to work in the time period from January 1st, 2019 to May 6, 2021, understanding that that's the period before HB 702 became law. And so I'm not going to ask you to -- unless in the context of a very specific question, I'm not asking you about the time period after HB 702 became law. So I just want to clarify that for you.

From January 1st, 2019 to May 6, 2021, did FVU require physicians, nurses, or other licensed health care professionals, as that's defined by Montana Code 50-5-101 subpart 36, to disclose their vaccination status for any vaccine preventable disease as a condition of employment?

MS. MAHE: Object to the form.

MR. GRAYBILL: Object to the form.

MS. MAHE: Calls for a legal conclusion. He doesn't have that statute in front of him, so I don't know that he knows that.

MR. CORRIGAN: Yeah, so let's go ahead and reintroduce, I believe it's Exhibit 10 from yesterday.

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It's helpful for clarification.

MR. GRAYBILL: And I would like to join the Plaintiffs' objection.

MS. MAHE: And they don't have the exhibits here from yesterday, so I don't know what you want to do.

Q. (By Mr. Corrigan) So I think we can limit it to -- from January 1st, 2019 to May 6, 2021, did FVU require physicians or nurses to disclose their vaccination status for any vaccine preventable disease as a condition of employment?

A. As a condition of employment, no.

Q. From January 1st, 2019 to May 6, 2021, did FVU require any employee to disclose their vaccination status for any vaccine preventable disease as a condition of employment?

A. The answer to that is -- I think I need to clarify my original answer, because while FVU itself doesn't require disclosure of vaccination status as a condition of employment, for our providers who are going to have privileges at a hospital that requires vaccination disclosure and proof of immunizations in order to get those privileges, it's a conflict because while we don't necessarily require it, they can't be employed with us unless they can have the privileges at the

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hospitals.

Q. So as I understand it, if those employees needed to have privileges at hospitals that had a vaccination requirement, you would need to verify that they met the requirements of the hospital?

MS. MAHE: Object to the form.

Q. (By Mr. Corrigan) Strike that. Let me ask this. So as I understand what you're saying is, it was not FVU policy to have a vaccination requirement, but if another facility where an FVU employee needed to have admittance privileges required vaccination, that would be a scenario where those employees would need to disclose their vaccination status or provide proof of vaccination?

MS. MAHE: Object to the form.

MR. GRAYBILL: Object to the form.

THE WITNESS: That's correct.

Q. (By Mr. Corrigan) And for those employees that we were just mentioning, who is responsible for verifying that information?

MS. MAHE: Object to the form. We're still talking pre-May?

MR. CORRIGAN: Correct.

Q. (By Mr. Corrigan) So for this time, prior to the enactment of House Bill 702 in the

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scenario we just discussed, was Five Valleys responsible for verifying that information, or was the facility that had the requirement responsible for verifying that information?

MS. MAHE: Object to the form.

THE WITNESS: There is a process for a provider, physician, NP, PA, a process for them to get credentialed and to get -- obtain privileges at a facility. As part of that process, there is an application. The application requires documentation be submitted with it. The documentation will be the proof of immunization or vaccination depending upon the hospital's requirement. In almost all cases, I assist the providers in gathering that information to submit to the facilities.

Q. (By Mr. Corrigan) For that time period from January 1st of 2019 to May 6, 2021, did FVU ask any other facility to require vaccination as a condition of admittance privileges to that facility?

MS. MAHE: Object to the form.

THE WITNESS: I'm sorry, I do not understand that question. Could you --

Q. (By Mr. Corrigan) My question is, for that time period, January 1st, 2019 to May 6, 2021, did FVU request that another facility require vaccination as a condition of admittance privileges

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for a physician?

MS. MAHE: Object to the --

Q. (By Mr. Corrigan) What I'm trying to figure out is, we're discussing requirements that other facilities might have for FVU physicians when they're in that facility, and I'm trying to figure out if FVU had any role in setting those vaccination requirements at that other facility, if they were requested. So I can rephrase the question.

So I guess my question is, with that being said, did FVU, from the period of January 1st, 2019 to May 6, 2021, ever ask a facility to require vaccination for any vaccine preventable disease as a condition of admittance privileges?

MS. MAHE: Object to the form.

THE WITNESS: The answer to that would be no, because those requirements are already in place and that's part of the hospital's guidelines. And as far as I know, that may be part of hospital requirements for the conditions of participation with the Medicare and Medicaid programs. So we would have no role in that.

Q. (By Mr. Corrigan) So in that scenario, a hospital sets the requirements; is that correct?

MS. MAHE: Object to the form.

Q. (By Mr. Corrigan) Or the hospital sets

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the requirements through the federal government or whatever entity; it's not FVU?

MS. MAHE: Object to the form.

THE WITNESS: FVU does not set the policies for any other facilities.

Q. (By Mr. Corrigan) For that time period from January 1st, 2019 to May 6, 2021, did FVU take measures to ensure FVU employees' compliance with other facilities' vaccine reporting requirements?

MS. MAHE: Object to the form.

THE WITNESS: Just to clarify, would you please clarify that question again?

Q. (By Mr. Corrigan) Sure. So from the period of January 1st, 2019 to May 6, 2021, did FVU take any measures to ensure FVU employees' compliance with those other facilities' vaccine requirements?

MS. MAHE: Object to the form.

THE WITNESS: Yes.

Q. (By Mr. Corrigan) And I think you touched on this a few minutes ago, but can you explain what those types of measures were?

MS. MAHE: Object to the form.

THE WITNESS: If a physician/employee was requesting privileges at one of the facilities that we operate

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within, and that facility, as part of their process to grant those privileges -- it's called the credentialing process -- required proof of vaccination or immunization records, then I would gather those records to submit them with the packet requesting those privileges.

Q. (By Mr. Corrigan) Thank you.

A. I'll also add to that answer if you don't mind. In an instance where -- if, for example, an employee/physician wasn't up-to-date on hepatitis B or some other requirement, then we would facilitate getting an appointment set up for them to make that happen.

Q. So from the period of January 1st, 2019 to May 6, 2021, if FVU learned that an employee was unvaccinated or not immune to any vaccine preventable disease, did FVU take any special precautions relating to that employee?

MS. MAHE: Object to the form.

THE WITNESS: I'm trying to think of any scenario where that might have been the case, and I can't think of any scenario where that was the case.

Q. (By Mr. Corrigan) From the period of January 1st, to May 6, 2021, are you aware of any instance where a patient requested that they only being treated by FVU employees that were vaccinated

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for a vaccine preventable disease?
A. Can you give me the time frame again, please?
Q. January 1st of 2019 to May 6, 2021.
A. I cannot give you specific examples, but I know that it happened.
Q. And I should clarify that when we're asking these questions, I'm not asking for any type of personally identifiable information or any confidential medical records. We're speaking generally about cases; not about any -- we're not looking for information on any individual. So I just want to make sure.
In your recollection in that instance or instances, did that happen prior to COVID, the COVID-19 pandemic?
MS. MAHE: Object to the form.
THE WITNESS: I can't -- I can't tell you because I wasn't part of every single conversation or every scheduling phone call whether a patient called in and said, hey, I want to make sure when I come in that everybody's had the flu vaccine. I just can't -- I can't tell you the answer for that.
Q. (By Mr. Corrigan) That's okay. From January 1st, 2019 to May 6, 2021, did FVU have a

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policy in place if a patient requested that they only be treated by employees that were vaccinated for a vaccine preventable disease?
MS. MAHE: Object to the form.
THE WITNESS: You know, during that time frame, I believe our only policies relevant to this scenario were policies that we made in regards to scheduling. But I don't recall any instance where a patient and where we had a policy about that.
Q. (By Mr. Corrigan) Thank you. I want to clarify for the next set of questions that, again, I'm not asking about personally identifiable information.
From January 1st, 2019 to May 6, 2021, did FVU provide accommodations under the Montana Human Rights Act to employers or contractors due to the vaccination status of FVU patients?
MS. MAHE: Object to the form, it calls for a legal conclusion.
THE WITNESS: Can you repeat that question, please?
Q. (By Mr. Corrigan) Sure. From January 1st, 2019 to May 6, 2021, did FVU provide accommodations under the Montana Human Rights Act to employees or contractors due to the vaccination status of FVU patients?

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MS. MAHE: Object to the form and calls for a legal conclusion.
THE WITNESS: I do not recall any instance where there was a accommodation request due to vaccination status.
Q. (By Mr. Corrigan) So I'm asking you the same question now but as it applies to FVU, the vaccination status of FVU employees just for the record.
So from January 1st, 2019 to May 6, 2021, did FVU provide accommodations under the Montana Human Rights Act to employees or contractors due to the vaccination status of other FVU employees?
MS. MAHE: Object to the form and calls for a legal conclusion.
THE WITNESS: Five Valleys Urology did provide accommodations to employees based upon the general public health crisis. I'm not specifically -- let me rephrase that. FVU did provide accommodations at least once to an employee who was concerned about the vaccination status of other of employees. On other occasions, Five Valleys Urology provided accommodations to employees surrounding the general climate of the pandemic.
Q. (By Mr. Corrigan) So starting first with the last thing you said about general accommodations

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along the lines -- along the general lines of the pandemic, can you describe for me the types of accommodations that were in response to the pandemic?
MS. MAHE: Objection, calls for a legal conclusion.
Q. (By Mr. Corrigan) And to be clear, I'm just asking you about the facts about what FVU would have done to accommodate those requests in the past.
A. To accommodate those requests in the past, or during that time frame that you're --
Q. And thank you for asking. During that time frame that we've been speaking about.
A. In general, we try to accommodate all employees' requests related to the Human Rights Act, the ADA where possible. We've had accommodations where we've allowed certain employees whose position afforded them the ability to work from home, so to work remote.
We've had accommodations where certain employees requested leave and there was a paid leave provision at the beginning of the pandemic that allowed us to grant -- grant those requests.
There have been accommodations made for employees who felt it necessary to isolate themselves while at work.

strike that. So these would be -- these would be contractors that are not direct employees of FVU.
MS. MAHE: Object to the form.
Q. (By Mr. Corrigan) They would be employed by outside entities.
MS. MAHE: Object to the form.
THE WITNESS: Yes.
Q. (By Mr. Corrigan) What types of services would these contractors perform, generally, if you can give examples?
A. We only have one, and the services that that individual performs are that of a laboratory director.
Q. And does FVU -- so let me clarify. Prior to May 6, 2021, did FVU ever ascertain the vaccination status of that contractor?
A. I believe the answer to that is yes. He voluntarily provided that information.
MR. CORRIGAN: I think I'm about done. I know we have -- I know we're supposed to stop in 10 minutes. I'd like to take a short break and finish up with a few extra questions after that. Why don't we go off the record and then we can figure out something.
VIDEO OPERATOR: We are going off the record. The time is 10:45 a.m.

(Whereupon a recess was taken)

VIDEO OPERATOR: We are back on the record. The time is 11:12 a.m.
Q. (By Mr. Corrigan) All right, Mr. O'Connor, welcome back. I just have a few more questions, and then I'll wrap up.
Earlier, we spoke about the existence of ambulatory surgery center that is part-owned by FVU. Could you explain what that center is?
A. Yes, that's the Big Sky Surgery Center located on the Community Medical Center campus here in Missoula.
Q. And is that facility a licensed health care facility under Montana law?
MS. MAHE: Object to the form, calls for a legal conclusion.
THE WITNESS: As far as I know, yes.
Q. (By Mr. Corrigan) And just to clarify, when you were designated as FVU's 30(b)(6) witness, did you understand yourself to be designated to discuss this particular ambulatory surgery center?
MS. MAHE: Objection to form and calls for a legal conclusion.
THE WITNESS: I didn't think about it.

Q. (By Mr. Corrigan) Are you familiar with the employment policies of -- strike that. What is the name of the surgery center again?
A. Big Sky Surgery Center.
Q. Got it. I won't forget it again. Are you familiar with the employment policies of the Big Sky Surgery Center beginning January 1st of 2019?
MS. MAHE: Object to the form. It exceeds his designation.
THE WITNESS: I am only familiar with the policies with regards to our physicians' privileges and practice at that location.
Q. (By Mr. Corrigan) To your knowledge, from January 1st, 2019 to May 6, 2021, did Big Sky Surgery Center require any employees to be vaccinated for any vaccine preventable diseases as a term or condition of employment?
MS. MAHE: Object to the form, exceeds his designation, and foundation.
THE WITNESS: I am not aware of their policies with regards to vaccinations or vaccination status.
Q. (By Mr. Corrigan) All right. I just have a couple wrap-up questions.
Is there anything you'd like to add to the discussion we've had over these various

questions or anything you'd like me to clarify regarding what we've discussed here today? Anything clarification I can offer?
MS. MAHE: Object to the form.
THE WITNESS: No.
Q. (By Mr. Corrigan) And is there anything you would like to add to your testimony here today in response to any of my previous questions?
A. No.
MR. CORRIGAN: That's it for me.
THE WITNESS: Thank you.
MS. MAHE: We'll reserve.
MR. GRAYBILL: Nothing from us.
VIDEO OPERATOR: That concludes the deposition. The time is 11:15 a.m.

(Whereupon, the deposition concluded at 11:15 a.m. for the day)

(Signature reserved)

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DEPONENT'S CERTIFICATE

I, John O'Connor, Deponent in the foregoing deposition, DO HEREBY CERTIFY, that I have read the foregoing pages of typewritten material and that the same is, with any changes thereon made in ink on the correction sheet and signed by me, a full, true and correct transcript of my oral deposition given at the time and place hereinbefore mentioned.

John O'Connor, Witness

SUBSCRIBED AND SWORN to before me this day of , 20___.

NOTARY PUBLIC
Residing at
My Commission Expires

ROE - MMA v. Austin Knudsen

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C E R T I F I C A T E

STATE OF MONTANA)
:ss
COUNTY OF BEAVERHEAD)

I, Robyn Ori English, Freelance Court Reporter and Notary Public for the State of Montana, residing in Dillon, do hereby certify:

That I was duly authorized to and did swear in the witness and report the deposition of John O'Connor, in the above-entitled cause; that the foregoing pages of this deposition constitute a true and accurate transcription of my stenotype notes of the testimony of said witness, all done to the best of my skill and ability; that the reading and signing of the deposition by the witness has been expressly reserved.

I further certify that I am not an attorney nor counsel of any of the parties, nor a relative or employee of any attorney or counsel connected with the action, nor financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed by notarial seal on this, the 11th day of August, 2022.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-22-09-ALL
Revised 4/05/22

DATE: **January 14, 2022**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: *Revised* Guidance for the Interim Final Rule - Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination

Memorandum Summary

- CMS is committed to ensuring America's healthcare facilities respond effectively in an evidence-based way to the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE).
- On November 05, 2021, CMS published an interim final rule with comment period (IFC). This rule establishes requirements regarding COVID-19 vaccine immunization of staff among Medicare- and Medicaid-certified providers and suppliers.
- CMS is providing guidance and survey procedures for assessing and maintaining compliance with these regulatory requirements.
- The guidance in this memorandum specifically applies to the following states: Alabama, Alaska, Arizona, Arkansas, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, Utah, West Virginia and Wyoming.
- The guidance in this memorandum does not apply to the following state at this time: Texas.

  Surveyors in Texas should not undertake any efforts to implement or enforce the IFC.
- States that are not identified above are expected to continue under the timeframes and parameters identified in the December 28, 2021 memorandum (QSO-22-07-ALL-*Revised*)

Background

Since the beginning of the Public Health Emergency, CMS and the Centers for Disease Control and Prevention (CDC) data show as of mid-October, over 44 million COVID-19 cases, 3 million COVID-19 related hospitalization, and 720,000 COVID-19 deaths have been reported. The CDC has reported that COVID-19 vaccines are safe and effective at preventing severe illness from COVID-19 and limiting the spread of the virus that causes it. On December 11, 2020, the Advisory Committee in Immunization Practices (ACIP) recommended, as interim guidance, that both 1) health care personnel, and 2) residents of long-term care (LTC) facilities be offered

COVID-19 vaccine in the initial phase of the vaccination program. To support this recommendation, on May 13, 2021, CMS published an interim final rule with comment period (IFC), entitled "Medicare and Medicaid Programs; COVID-19 Vaccine Requirements for Long-Term Care (LTC) Facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs-IID) Residents, Clients, and Staff" (86 FR 26306). Also, CMS released guidance for surveyors and LTC facilities in the CMS memo, QSO-21-19-NH, Interim Final Rule - COVID-19 Vaccine Immunization Requirements for Residents and Staff. This rule required all certified LTC facilities (i.e., nursing homes) to educate all residents and staff on the benefits and potential side effects associated with the COVID-19 vaccine, and offer the vaccine.

The regulation was intended to help increase vaccination rates among nursing home residents and staff to reduce the risk of infection and disease associated with COVID-19. Approximately two months after the publication of the rule, about 80 percent of nursing home residents were vaccinated. However, during that same time, roughly 60% of nursing home staff were vaccinated.[1] Therefore, more actions are warranted to increase vaccination rates among staff.

On August 18, 2021, CMS announced that it would be issuing a regulation that all nursing home staff would have to be vaccinated against COVID-19 as a requirement for LTC facilities participating with the Medicare and Medicaid programs. Subsequently, on September 9, 2021, CMS announced that this requirement would be extended to nearly all Medicare and Medicaid-certified providers and suppliers. These actions aim to support increasing vaccination rates among staff working in all facilities, providers, and certified suppliers that participate in Medicare and Medicaid.

Discussion

On November 5, 2021, CMS published an IFC with comment period (86 FR 61555), entitled "Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination," revising the infection control requirements that most Medicare- and Medicaid-certified providers and suppliers must meet to participate in the Medicare and Medicaid programs. These changes are necessary to protect the health and safety of patients and staff during the COVID-19 public health emergency. The COVID-19 vaccination requirements and policies and procedures required by this IFC must comply with applicable federal non-discrimination and civil rights laws and protections, including providing reasonable accommodations to individuals who are legally entitled to them because they have a disability or sincerely held religious beliefs, practices, or observations that conflict with the vaccination requirement. More information on federal non-discrimination and civil rights laws is available here: https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws.

Vaccination Enforcement– Surveying for Compliance

Medicare and Medicaid-certified facilities are expected to comply with all regulatory requirements, and CMS has a variety of established enforcement remedies. For nursing homes, home health agencies, and hospice (beginning in 2022), this includes civil monetary penalties, denial of payments, and—as a final measure—termination of participation from the Medicare and Medicaid programs. The sole enforcement remedy for non-compliance for hospitals and certain other acute and continuing care providers is termination; however, CMS's primary goal is

[1] COVID-19 Nursing Home Data - Centers for Medicare & Medicaid Services Data (cms.gov)

to bring health care facilities into compliance. Termination would generally occur only after providing a facility with an opportunity to make corrections and come into compliance.

CMS expects all providers' and suppliers' staff to have received the appropriate number of doses by the timeframes specified in the QSO-22-07 unless exempted as required by law, or delayed as recommended by CDC. **Facility staff vaccination rates under 100% constitute non-compliance under the rule.** Non-compliance does not necessarily lead to termination, and facilities will generally be given opportunities to return to compliance. Consistent with CMS's existing enforcement processes, this guidance will help surveyors determine the severity of a noncompliance deficiency finding at a facility when assigning a citation level. These enforcement action thresholds are as follows:

Within 30 days after issuance of this memorandum[2], if a facility demonstrates that:

- Policies and procedures are developed and implemented for ensuring all facility staff, regardless of clinical responsibility or patient or resident contact are vaccinated for COVID-19; **and**
- 100% of staff have received at least one dose of COVID-19 vaccine, or have a pending request for, or have been granted qualifying exemption, or identified as having a temporary delay as recommended by the CDC, the **facility is compliant under the rule; or**
- Less than 100% of all staff have received at least one dose of COVID-19 vaccine, or have a pending request for, or have been granted a qualifying exemption, or identified as having a temporary delay as recommended by the CDC, the **facility is non-compliant under the rule.** The facility will receive notice[3] of their non-compliance with the 100% standard. A facility that is above 80% **and** has a plan to achieve a 100% staff vaccination rate within 60 days would not be subject to additional enforcement action. States should work with their CMS location for cases that exceed these thresholds, yet pose a threat to patient health and safety. Facilities that do not meet these parameters could be subject to additional enforcement actions depending on the severity of the deficiency and the type of facility (e.g., plans of correction, civil monetary penalties, denial of payment, termination, etc.).

Within 60 days after the issuance of this memorandum[4], if the facility demonstrates that:

- Policies and procedures are developed and implemented for ensuring all facility staff, regardless of clinical responsibility or patient or resident contact are vaccinated for COVID-19; **and**
- 100% of staff have received the necessary doses to complete the vaccine series (i.e., one dose of a single-dose vaccine or all doses of a multiple-dose vaccine series), or have been granted a qualifying exemption, or identified as having a temporary delay as recommended by the CDC, the **facility is compliant under the rule; or**

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[2] If 30 days falls on a weekend or designated federal holiday, CMS will use enforcement discretion to initiate compliance assessments the next business day.
[3] This information will be communicated through the CMS Form-2567, using the applicable Automated Survey Process Environment (ASPEN) federal tag.
[4] If 60 days falls on a weekend or designated federal holiday, CMS will use enforcement discretion to initiate compliance assessments the next business day.

- Less than 100% of all staff have received at least one dose of a single-dose vaccine, or all doses of a multiple-dose vaccine series, or have been granted a qualifying exemption, or identified as having a temporary delay as recommended by the CDC, the **facility is non-compliant under the rule.** The facility will receive notice[5] of their non-compliance with the 100% standard. A facility that is above 90% **and** has a plan to achieve a 100% staff vaccination rate within 30 days would not be subject to additional enforcement action. States should work with their CMS location for cases that exceed these thresholds, yet pose a threat to patient health and safety. Facilities that do not meet these parameters could be subject to additional enforcement actions depending on the severity of the deficiency and the type of facility (e.g., plans of correction, civil monetary penalties, denial of payment, termination, etc.).

Within 90 days and thereafter following issuance of this memorandum, facilities failing to maintain compliance with the 100% standard may be subject to enforcement action.

Federal, state, Accreditation Organization, and CMS-contracted surveyors will begin surveying for compliance with these requirements as part of initial certification, standard recertification or reaccreditation, and complaint surveys 30 days following the issuance of this memorandum. *Surveying for staff vaccination requirements is not required on Life Safety Code (LSC)-only complaints, or LSC-only follow-up surveys. Surveyors may modify the staff vaccination compliance review if the provider/supplier was determined to be in substantial compliance with this requirement within the previous six weeks.* Additional information and expectations for compliance can be found at the provider-specific guidance attached to this memorandum.

Provider-Specific Guidance:

Guidance specific to provider types and certified suppliers is provided in the following attachments. The provider-specific guidance should be used in conjunction with the information in this memo.

- Attachment A: LTC Facilities (nursing homes)
- Attachment B: ASC
- Attachment C: Hospice
- Attachment D: Hospitals
- Attachment E: PRTF
- Attachment F: ICF/IID
- Attachment G: Home Health Agencies
- Attachment H: CORF
- Attachment I: CAH
- Attachment J: OPT
- Attachment K: CMHC
- Attachment L: HIT
- Attachment M: RHC/FQHC
- Attachment N: ESRD Facilities

Enforcement Actions

[5] This information will be communicated through the CMS Form-2567, using the applicable Automated Survey Process Environment (ASPEN) tag.

CMS will follow current enforcement procedures based on the level of deficiency cited during a survey.

Contact:
DNH_TriageTeam@cms.hhs.gov for questions related to nursing homes;
QSOG_Emergencyprep@cms.hhs.gov for question related to acute and continuing care providers.

Effective Date: This policy should be communicated with all survey and certification staff, their managers, and the State/CMS Location training coordinators immediately. The effective dates of the specific actions are specified above.

/s/

Karen L. Tritz
Director, Survey & Operations Group

David R. Wright
Director, Quality, Safety & Oversight Group

cc: Survey and Operations Group Management
Attachments: A through N

Hospital Attachment
Revised

This attachment is a supplement to and should be used in conjunction with the following memoranda: *QSO-22-07-ALL-Revised*, *QSO-22-09-ALL-Revised*, and *QSO 22-11-ALL-Revised* memorandum: Guidance for the Interim Final Rule – Medicare and Medicaid Programs; OmnibusCOVID-19 Health Care Staff Vaccination.

While the memoranda noted above apply to specific states, the regulations and guidance described in this attachment applies to all states. *Implementation of this guidance will occur according* to *the* timeframes and parameters identified in either *QSO-22-07-ALL-*Revised effective December 28, 2021, *QSO-22-09-ALL- Revised* effective January 14, 2022, or *QSO-22-11-ALL-Revised* effective January 20, 2022.

A-0792
§ 482.42 Condition of participation: Infection prevention and control and antibiotic stewardship programs.

(g) ***Standard: COVID-19 Vaccination of hospital staff.*** **The hospital must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.**

(1) **Regardless of clinical responsibility or patient contact, the policies and procedures must apply to the following hospital staff, who provide any care, treatment, or other services for the hospital and/or its patients:**

(i) Hospital employees;

(ii) Licensed practitioners;

(iii) Students, trainees, and volunteers; and

(iv) Individuals who provide care, treatment, or other services for the hospital and/or its patients, under contract or by other arrangement.

(2) **The policies and procedures of this section do not apply to the following hospital staff:**

(i) Staff who exclusively provide telehealth or telemedicine services outside of the hospital setting and who do not have any direct contact with patients and other staff specified in paragraph (g)(1) of this section; and

EXHIBIT 39
30(b)(6) Designee
Thu, Aug 18, 2022
Reported by:
Mary Sullivan, RMR, CRR

(ii) Staff who provide support services for the hospital that are performed exclusively outside of the hospital setting and who do not have any direct contact with patients and other staff specified in paragraph (g)(1) of this section.

(3) The policies and procedures must include, at a minimum, the following components:

(i) A process for ensuring all staff specified in paragraph (g)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the hospital and/or its patients;

(ii) A process for ensuring that all staff specified in paragraph (g)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by CDC, due to clinical precautions and considerations;

(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;

(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (g)(1) of this section;

(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by CDC;

(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;

(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the hospital has granted, an exemption from the staff COVID-19 vaccination requirements;

(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of

practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:

(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and

(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the hospital's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;

(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and

(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

GUIDANCE

DEFINITIONS

"Booster," per CDC, refers to a dose of vaccine administered when the initial sufficient immune response to the primary vaccination series is likely to have waned over time.

"Clinical contraindication" refers to conditions or risks that precludes the administration of a treatment or intervention. With regard to recognized clinical contraindications to receiving a COVID-19 vaccine, facilities should refer to the CDC informational document, *Summary Document for Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the United States*, accessed at https://www.cdc.gov/vaccines/covid-19/downloads/summary-interim-clinical-considerations.pdf. For COVID-19 vaccines, according to the CDC, a vaccine is clinically contraindicated if an individual has a severe allergic reaction (e.g., anaphylaxis) after a previous dose or to component of the COVID-19 vaccine or an immediate (within 4 hours of exposure) allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine.

"Fully vaccinated" refers to staff who are two weeks or more from completion of their primary vaccination series for COVID-19.

"**Good Faith Effort**" refers to a provider that has taken aggressive steps toward achieving compliance with staff vaccination requirement **and/or** the provider has no or has limited access to vaccine, and has documented attempts to access to the vaccine.

"Primary Vaccination Series" refers to staff who have received a single-dose vaccine or all required doses of a multi-dose vaccine for COVID-19.

"Staff" refers to individuals who provide any care, treatment, or other services for the hospital and/or its patients, including employees; licensed practitioners; adult students, trainees, and volunteers; and individuals who provide care, treatment, or other services for the hospital and/or its patients, under contract or by other arrangement. This also includes individuals under contract or arrangement with the hospital, including hospice and dialysis staff, physical therapists, occupational therapists, mental health professionals, licensed practitioners, or adult students, trainees or volunteers. **Staff would not include anyone who provides only telemedicine services or support services outside of the hospital and who does not have any direct contact with patients and other staff specified in paragraph (g)(1).**

"Temporarily delayed vaccination" refers to vaccination that must be temporarily *deferred*, as recommended by CDC, due to clinical considerations, including *known COVID-19 infection until recovery from the acute illness (if symptoms were present) and criteria to discontinue isolation have been met* (https://www.cdc.gov/vaccines/covid-19/downloads/summary-interim-clinical-considerations.pdf)

Background

All hospitals are required to achieve a 100% vaccination rate for their staff through the development of a policy to address vaccination applicable to all staff who provide any care, treatment, or other services for the hospital and/or its patients.

There may be many infrequent services and tasks performed in or for a hospital that is conducted by "one-off" vendors, volunteers, and professionals. Hospitals are not required to ensure the vaccination of individuals who very infrequently provide ad hoc non-healthcare services (such as annual elevator inspection), or services that are performed exclusively off-site, not at or adjacent to any site of patient care (such as accounting services), but they may choose to extend COVID-19 vaccination requirements to them if feasible. Hospitals should consider the frequency of presence, services provided, and proximity to patients and staff.

Surveying for Compliance

Surveyors will begin surveying facilities from states identified in each memorandum for compliance 30 days after the issuance of the *applicable* memorandum.. Surveyors should focus on the staff that regularly work in the hospital (e.g., weekly), using a phased-in approach as described below.

NOTE: *Facility staff who have been suspended or are on extended leave e.g., Family and Medical Leave Act (FMLA) leave, or Worker's Compensation Leave, would not count as unvaccinated staff for determining compliance with this requirement.*

Surveying for staff vaccination requirements is not required on Life Safety Code (LSC)-only complaints, or LSC-only follow-up surveys. Surveyors may modify the staff vaccination compliance review if the facility was determined to be in substantial compliance with this requirement within the previous six weeks.

Hospitals will be expected to meet the following:

Vaccination Enforcement:
CMS expects all facilities' staff to have received the appropriate number of doses by the timeframes specified in the memorandum unless exempted as required by law. **Facility staff vaccination rates under 100% constitute non-compliance under the rule.** Non-compliance does not necessarily lead to termination, and facilities will generally be given opportunities to return to compliance.

Within 30 days following the issuance of the *applicable* memorandum[1], if a facility demonstrates:

- Policies and procedures are developed and implemented for ensuring all facility staff, regardless of clinical responsibility or patient contact are vaccinated for COVID-19, including all required components of the policies and procedures specified below (e.g., related to tracking staff vaccinations, documenting medical and religious exemptions, etc.); **and**
- 100% of staff have received at least one dose of COVID-19 vaccine or have a pending request for, or have been granted a qualifying exemption, or are identified as having a temporary delay as recommended by the CDC, the **facility is compliant under the rule.**
- Less than 100% of all staff have received at least one dose of COVID-19 vaccine, or have a pending request for, or have been granted a qualifying exemption, or are identified as having a temporary delay as recommended by the CDC, the **facility is non-compliant under the rule.** The facility will receive notice[2] of their non-compliance with the 100% standard. A facility that is above 80% **and** has a plan to achieve a 100% staff vaccination rate within 60 days would not be subject to an enforcement action. States should work with their CMS location for cases that exceed these thresholds, yet pose a threat to patient health and safety. Facilities that do not meet these parameters could be subject to additional enforcement actions depending on the severity of the deficiency and the type of facility (e.g., plans of correction and/or termination).

Within 60 days following the issuance of the *applicable* memorandum[3], if the facility demonstrates--

- 100% of staff have received the necessary doses to complete the vaccine series (i.e., one dose of a single-dose vaccine or all doses of a multiple vaccine series) or have been granted a qualifying exemption, or are identified as having a temporary delay as recommended by the CDC, the **facility is compliant under the rule.**
- Less than 100% of all staff have received at least one dose of a single-dose vaccine, or all doses of a multiple vaccine series, or have been granted a qualifying exemption, or are identified as having a temporary delay as recommended by the CDC, the **facility is non-compliant under the rule.** The facility will receive notice[4] of their non-compliance with

[1] If 30 days falls on a weekend or designated federal holiday, CMS will use enforcement discretion to initiate compliance assessments the next business day.
[2] This information will be communicated through the CMS Form-2567, using the appropriate Automated Survey Process Environment (ASPEN).
[3] If 60 days falls on a weekend or designated federal holiday, CMS will use enforcement discretion to initiate compliance assessments the next business day.
[4] This information will be communicated through the CMS Form-2567, using the appropriate Automated Survey Process Environment (ASPEN).

the 100% standard. A facility that is above 90% **and** has a plan to achieve a 100% staff vaccination rate within 30 days would not be subject to an enforcement action. States should work with their CMS location for cases that exceed these thresholds, yet pose a threat to patient health and safety. Facilities that do not meet these parameters could be subject to additional enforcement actions depending on the severity of the deficiency and the type of facility (e.g., plans of correction and/or termination).

Within 90 days and thereafter following issuance of the *applicable* memorandum, facilities failing to maintain compliance with the 100% standard may be subject to enforcement action.

Note: The requirements described above do not include the 14-day waiting period as identified by CDC for full vaccination. Rather these requirements are considered met with the completed vaccine series (i.e., one dose of a single dose vaccine, or final dose of a multi-dose vaccine series).

Policies and Procedures
The hospital policies and procedures must be implemented within **30 days**[5] after the issuance of the *applicable* memorandum and address each of the following components:

Hospitals must have a process for ensuring all staff (as defined above) have received at least a single-dose, or the first dose of a multi-dose COVID-19 vaccine series prior to providing any care, treatment, or other services for the facility and/or its patients.

The policy must also ensure those staff who are not yet fully vaccinated, or who have been granted an exemption or accommodation as authorized by law, or who have a temporary delay, adhere to additional precautions that are intended to mitigate the spread of COVID-19. This requirement is not explicit and does not specify actions that must be taken; there are a variety of actions or job modifications a facility can implement to potentially reduce the risk of COVID-19 transmission examples, including, but not limited to:

- Reassigning staff who have not completed their primary vaccination series to non-patient care areas, to duties that can be performed remotely (i.e., telework), or to duties which limit exposure to those most at risk (e.g., assign to patients who are not immunocompromised, unvaccinated);
- Requiring staff who have not completed their primary vaccination series to follow additional, CDC-recommended precautions, such as adhering to universal source control and physical distancing measures in areas that are restricted from patient access (e.g., staff meeting rooms, kitchen), even if the facility or service site is located in a county with low to moderate community transmission.
- Requiring at least weekly testing for exempted staff and staff who have not completed their primary vaccination series, until the regulatory requirement is met, regardless of

[5] If 30 days falls on a weekend or designated federal holiday, CMS will use enforcement discretion to initiate compliance assessments the next business day

whether the facility or service site is located in a county with low to moderate community transmission, in addition to following CDC recommendations for testing unvaccinated in facilities located in counties with substantial to high community transmission.
- Requiring staff who have not completed their primary vaccination series to use a NIOSH-approved N95 or equivalent or higher-level respirator for source control, regardless of whether they are providing direct care to or otherwise interacting with patients

NOTE: *This requirement is not explicit and does not specify which actions must be taken. The examples above are not all inclusive, and represent actions that can be implemented. However, facilities can choose other precautions that align with the intent of the regulation which is intended to "mitigate the transmission and spread of COVID-19 for all staff who are not fully vaccinated."*

Facilities may also consult with their local health departments to identify other actions that can potentially reduce the risk of COVID-19 transmission from unvaccinated staff.

The hospital must track and securely document:
- Each staff member's vaccination status (this should include the specific vaccine received, and the dates of each dose received, or the date of the next scheduled dose for a multi-dose vaccine);
- Any staff member who has obtained any booster doses (this should include the specific vaccine booster received and the date of the administration of the booster);
- Staff who have been granted an exemption from vaccination (this should include the type of exemption and supporting documentation) requirements by the hospital; and
- Staff for whom COVID-19 vaccination must be temporarily delayed, should track when the identified staff can safely resume their vaccination.

Facilities that employ or contract staff who telework full-time (e.g., 100 percent of their time is remote from sites of patient care and staff who do work at sites of care) should identify these individuals as a part of implementing the facility's policies and procedures, but those individuals are not subject to the vaccination requirements. Note, however, that these individuals may be subject to other federal requirements for COVID-19 vaccination. Facilities have the flexibility to use the tracking tools of their choice; however, they must provide evidence of this tracking for surveyor review. Additionally, facilities' tracking mechanism should clearly identify each staff's role, assigned work area, and how they interact with patients. This includes staff who are contracted, volunteers, or students.

Vaccination Exemptions:
Facilities must have a process by which staff may request an exemption from COVID-19 vaccination based on an applicable Federal law. This process should clearly identify how an exemption is requested, and to whom the request must be made. Additionally, facilities must have a process for collecting and evaluating such requests, including the tracking and secure documentation of information provided by those staff who have requested exemption, the facility's determination of the request, and any accommodations that are granted.

Note: Staff who are unable to furnish proper exemption documentation must be vaccinated or the

facility must follow the actions for unvaccinated staff.

Medical Exemptions:
Certain allergies, or recognized medical conditions may provide grounds for exemption. With regard to recognized clinical contraindications to receiving a COVID-19 vaccine, Hospitals should refer to the CDC informational document, *Summary Document for Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the United States*, accessed at https://www.cdc.gov/vaccines/covid-19/downloads/summary-interim-clinical-considerations.pdf. In general, CDC considers a history of a severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine, or an immediate allergic reaction of any severity to a previous dose, or known (diagnosed) allergy to a component of the COVID-19 vaccine, to be a contraindication to vaccination with COVID-19 vaccines.

Medical exemption documentation must specify which authorized or licensed COVID-19 vaccine is clinically contraindicated for the staff member and the recognized clinical reasons for the contraindication. The documentation must also include a statement recommending that the staff member be exempted from the hospital's COVID-19 vaccination requirements based on the medical contraindications.

A staff member who requests a medical exemption from vaccination must provide documentation signed and dated by a licensed practitioner acting within their respective scope of practice and in accordance with all applicable State and local laws. The individual who signs the exemption documentation cannot be the same individual requesting the exemption.

Hospitals must have a process to track and secure documentation of the vaccine status of staff whose vaccine is temporarily delayed. CDC recommends a temporary delay in administering the COVID-19 vaccination *due to clinical considerations, including known COVID-19 infection until recovery from the acute illness (if symptoms were present) and criteria to discontinue isolation have been met.*

Non-Medical Exemptions, Including (Religious) Exemptions:
Requests for non-medical exemptions, such as a religious exemption in accordance with Title VII, must be documented and evaluated in accordance with each hospital's policies and procedures. We direct hospitals to the Equal Employment Opportunity Commission (EEOC) Compliance Manual on Religious Discrimination (https://www.eeoc.gov/laws/guidance/section-12-religious-discrimination) for information on evaluating and responding to such requests.

Note: Surveyors will **not** evaluate the details of the request for a religious exemption, **nor** the rationale for the hospital's acceptance or denial of the request. Rather, surveyors will review to ensure the hospital has an effective process for staff to request a religious exemption for a sincerely held religious belief.

Accommodations of Unvaccinated Staff with a Qualifying Exemption:
While accommodations could be appropriate under certain limited circumstances, no accommodation should be provided to staff that is not legally required. For individual staff members that have valid reasons for exemption facility can address those individually. An example of an accommodation for an unvaccinated employee with a qualifying exemption could

include mandatory routine COVID-19 testing in accordance with OSHA and CDC guidelines, physical distancing from co-workers and patients, re-assignment or modification of duties, teleworking, or a combination of these actions. Accommodations can be addressed in the hospital's policies and procedures.

Staff who have been granted an exemption to COVID-19 vaccination requirements should adhere to national infection prevention and control standards for unvaccinated health care personnel. For additional information see CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic webpage.

Regulatory Provisions implemented **60 days after issuance of the applicable memorandum:** Facilities must have a process for ensuring that all staff are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by CDC, due to clinical precautions and considerations.

Contingency Plan

For staff that are not fully vaccinated, the hospital must develop contingency plans for staff who have not completed the primary vaccination series for COVID-19.

Contingency plans should include actions that the hospital would take when staff have indicated that they will not get vaccinated and do not qualify for an exemption, but contingency plans should also address staff who are not fully vaccinated due to an exemption or temporary delay in vaccination, such as through the additional precautions. Facilities should prioritize contingency plans for those staff that have obtained no doses of any vaccine over staff that have received a single dose of a multi-dose vaccine. For example, contingency plans could include a deadline for staff to have obtained their first dose of a multiple-dose vaccine. The plans should also indicate the actions the hospital will take if the deadline is not met, such as actively seeking replacement staff through advertising or obtaining temporary vaccinated staff until permanent vaccinated replacements can be found.

Survey Process

Compliance will be assessed through observation, interview, and record review as part of the survey process.

1. Entrance Conference
    - Surveyors will ask hospitals to provide vaccination policies and procedures. At a minimum, the policy and procedures must provide:
        - A process for ensuring all required staff have received, at a minimum, the first dose of a multi-dose COVID-19 vaccine, or a one-dose COVID-19 vaccine, before staff provide any care, treatment, or other services for the hospital and/or its patients;
        - A process for ensuring that all required staff are fully vaccinated;
        - A process for ensuring that the hospital continues to follow all standards of infection prevention and control practice, for reducing the transmission

and spread of COVID-19 in the hospital, especially by those staff who are unvaccinated or who are not yet fully vaccinated;

- A process for tracking and securely documenting the COVID-19 vaccination status for all required staff;
- A process for ensuring all staff obtain any recommended booster doses, and any recommended additional doses for individuals who are immunocompromised, in accordance with the recommended timing of such doses;
- A process by which staff may request a vaccine exemption from the COVID-19 vaccination requirements based on recognized clinical contraindications or applicable Federal laws, such as religious beliefs or other accommodations;
- A process for tracking and securely documenting information confirming recognized clinical contraindications to COVID-19 vaccines provided by those staff who have requested and have been granted a medical exemption to vaccination;
- A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
  - all information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
  - a statement by the authenticating practitioner recommending that the staff member be exempted from the hospital's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
- A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, or individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and
- Contingency plans for staff that are not yet vaccinated for COVID-19 (and without an exemption for medical contraindications or without a temporary delay in vaccination due to clinical considerations as recommended by the CDC and as specified in paragraph (g)(3)(x)), including deadlines for staff to be vaccinated.

- The hospital will provide a list of all staff and their vaccine status:

- Including the percentage of unvaccinated staff, excluding those staff that have approved exemptions
- If any concerns are identified with the staff vaccine status list, surveyors should verify the percentage of vaccinated staff.
- The provider or supplier must identify any staff member remaining unvaccinated because it's medically contraindicated or has a religious exemption.
- The hospital must also identify newly hired staff (hired in the last 60 days).
- The hospital must indicate the position or role of each staff member

- *The hospital will provide their process for how the hospital ensures that their contracted staff are compliant with the vaccination requirement.*

2. Record Review, interview, and observations:
   - Surveyors will review the policy and procedure to ensure all components are present.
   - Surveyors will review any contingency plan developed to mitigate the spread of COVID-19 infections by the hospital that may include:
     - Requiring unvaccinated staff to follow additional, CDC-recommended precautions, such as adhering to universal source control and physical distancing measures in areas that are restricted from patient access (e.g., staff meeting rooms, kitchen), even if the facility or service site is located in a county with low to moderate community transmission.
     - Reassigning unvaccinated staff to non-patient care areas, to duties that can be performed remotely (i.e., telework), or to duties which limit exposure to those most at risk (e.g., assign to patients who are not immunocompromised, unvaccinated);
     - Requiring at least weekly testing for unvaccinated staff, regardless of whether the facility or service site is located in a county with low to moderate community transmission
     - Requiring unvaccinated staff to use a NIOSH-approved N95 or equivalent or higher-level respirator for source control, regardless of whether they are providing direct care to or otherwise interacting with patients.

   - Surveyors will select a sample of staff based on current staff sample selection guidelines. Surveyors should also examine the documentation of each staff identified as unvaccinated due to medical contraindications. The sample should include (as applicable):
     - Direct care staff, *including those contracted staff meeting the definition of staff*(vaccinated and unvaccinated)
     - Contracted staff
     - Direct care staff with an exemption

   - *There should be a minimum of 6 direct care/patient engagement staff. This includes direct care contracted staff that are onsite at time of the survey. Of this*

6- person sample, 4 should include vaccinated staff/contractors and 2 unvaccinated staff/contractors (1 that is not fully vaccinated and 1 with a medical exemption or temporary delay). Two of the direct care staff sampled should be contractors.

The list of vaccinated staff maintained by the facility are used for sampling staff. Please refer to survey process for instructions for sampling contracted staff.

- *Surveyors should choose a sample of at least of 2 contracted staff (1 vaccinated and 1 unvaccinated or exempt) who are not included in those direct care contracted staff outlined above.*

- For each individual identified by the hospital as vaccinated, surveyors will:
  - Review hospital records to verify vaccination status. Examples of acceptable forms of proof of vaccination include:
    - CDC COVID-19 vaccination record card (or a legible photo of the card),
    - Documentation of vaccination from a health care provider or electronic health record, or
    - State immunization information system record.
  - Conduct follow-up interviews with staff and administration if any discrepancies are identified. If applicable, determine if any additional doses were provided.

NOTE: *Failure of contract staff to provide evidence of vaccination status reflects noncompliance and should be cited under the requirement to have policies and procedures for ensuring that all staff are fully vaccinated, except for those staff who have been granted exemptions or a temporary delay.*

- For each individual identified by the hospital as unvaccinated, surveyors will
  - Review hospital records.
  - Determine, if they have been educated and offered vaccination.
  - Interview staff and ask if they plan to get vaccinated if they have declined to get vaccinated and if they have a medical contraindication or religious exemption.
    - Request and review documentation of the medical contraindication.
    - Request to see employee record of the staff education on the hospital policy and procedure regarding unvaccinated individuals.
  - Observe staff providing care to determine compliance with current standards of practice with infection control and prevention.

- For each individual identified by the hospital as unvaccinated due to a medical contraindication:

- Review and verify that all required documentation is:
  - Signed and dated by physician or advanced practice provider.
  - States the specific vaccine that is contraindicated and the recognized clinical reason for the contraindication with a statement recommending exemption.

General Information: https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fvaccines%2Fcovid-19%2Finfo-by-product%2Fclinical-considerations.html

Level of Deficiency

For instances of non-compliance identified through the survey process, the level of deficiency will be determined based on the following criteria: From 30-60 days following issuance of this memorandum, the expected minimum threshold for use in these determinations will be 80%. From 60-90 days following issuance of this memorandum, the expected minimum threshold will be 90%. From 90 days on, the expected minimum threshold will be 100%. States should work with their CMS location for cases that exceed these thresholds, yet pose a threat to patient health and safety not otherwise addressed by the criteria below:

- **Immediate Jeopardy**:
  - 40% or more of staff remain unvaccinated creating a likelihood of serious harm **OR**
  - Did not meet the 100% staff vaccination rate standard ; observations of noncompliant infection control practices by staff (e.g., staff failed to properly don PPE) **and** 1 or more components of the policies and procedures were not developed or implemented.

- **Condition Level**:
  - Did not meet the 100% staff vaccination rate standard; **and**
    - 1 or more components of the policies and procedures were not developed and implemented.

    OR,
    - 21-39% of staff remain unvaccinated creating a likelihood of serious harm.

- **Standard Level**:
  - 100% of staff are vaccinated and all new staff have received at least one dose; **and**
    - 1 or more components of the policies and procedures were not developed and implemented.

    OR,
    - Did not meet the 100% staff vaccination rate standard, but are making good faith efforts toward vaccine compliance.

Plan of Correction

To Qualify for Substantial Compliance and Clear the Citation:

- The hospital has met the requirement of staff fully vaccinated (either by staff obtaining additional doses, or replacing unvaccinated staff with vaccinated staff).
  OR
- The combined number of staff that are vaccinated (have received a single dose of a vaccine or all of the doses in the multiple dose vaccine series or have received at least one dose of a multiple vaccine series) meet the requirement.
  - Staff that has received at least one dose must also have their second dose scheduled.

To Qualify for Substantial Compliance, but the Citation Remains at Standard Level:

- The hospital has not met the requirement, but has provided evidence of the unvaccinated staff that have obtained their first dose, AND the remainder of the unvaccinated staff are scheduled for their first dose.

Components of a Plan of Correction AND/OR Actions Required **for IJ Removal**
Plans of correction or Immediate Jeopardy removal plans for noncompliance should be reviewed to ensure they include the following:

- Correcting any gaps in the facility's policies and procedures.
- Implementation of the facility's contingency plan, that should include a deadline for each unvaccinated staff to have received their first dose of a vaccine.
- Implementation of additional precautions to mitigate the spread of COVID-19 by unvaccinated staff.

Good-Faith Effort:
Surveyors and CMS may lower the citation level and/or enforcement action if they identify that any of the following have occurred **prior to the survey** (note: noncompliance is still cited, only the citation level and enforcement is adjusted).

a. If the hospital has no or has limited access to vaccine, and the hospital has documented attempts to obtain vaccine access (e.g., contact with health department and pharmacies).

b. If the hospital provides evidence that they have taken aggressive steps to have all staff vaccinated, such as advertising for new staff, hosting vaccine clinics, etc.

Enforcement Actions
CMS will follow current enforcement procedures based on the level of deficiency cited during the survey.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
CMS Denver-Survey & Operations Group
1961 Stout Street, Room 08-148
Denver, CO 80294

CENTERS FOR MEDICARE & MEDICAID SERVICES

E-Mailed: kfouts@mt.gov
CMS Certification No.: 274086

April 08, 2022

Kyle Fouts, Administrator
Montana State Hospital
100 Grant Way
Warm Springs, Montana 59756

IMPORTANT NOTICE - PLEASE READ CAREFULLY

RE: Involuntary Termination of Medicare Provider Agreement Effective April 12, 2022
Appeal Rights
Reinstatement Process

Dear Administrator:

In accordance with 42 CFR §489.53(a)(1),(3), CMS is terminating Montana State Hospital's provider agreement based on the hospital's failure to comply with Title XVIII of the Social Security Act (the Medicare statute) and to maintain compliance with the Conditions of Participation (CoP). **This involuntary termination is effective: April 12, 2022.**

CMS surveyors conducted a complaint survey at Montana State Hospital on February 8-10, 2022. Based on the survey findings, CMS determined that Montana State Hospital was not in compliance with the Medicare Conditions of Participation for Hospitals. Specifically, CMS found that Montana State Hospital's noncompliance with the CoPs governing Patients Rights and Infection Control placed patients at risk of serious injury, harm, impairment, or death.

On February 18, 2022, CMS issued the Statement of Deficiencies relating to the findings of noncompliance identified during the survey conducted from February 8-10, 2022. Additionally, CMS notified Montana State Hospital that its Medicare provider agreement would terminate on March 13, 2022, based upon its failure to comply with the Conditions of Participation and because the deficiencies placed patients in immediate jeopardy. CMS indicated that the termination would be averted only if Montana State Hospital corrected the Condition-level deficiencies. CMS provided information regarding the procedures that Montana State Hospital could take to appeal CMS's findings of noncompliance.

On February 23-24, 2022, CMS conducted a revisit survey. This survey found that the two previously cited IJs were not corrected and one additional IJ was identified related to the use of psychotropic medications. A second revisit survey conducted on March 9, 2022, found that all three IJs remained. A complaint survey was conducted on March 24-25, 2022, due to an allegation of patient-to-patient assault. The assault allegation was based upon a report that a male patient violently assaulted a female patient while they were not being supervised, resulting in the female patient suffering significant injuries that will require, among other things, reconstructive surgery. Based on the complaint survey's findings, an additional IJ was cited under Patients being free from Abuse. Moreover, the complaint investigation found that the three other previously cited IJ-level deficiencies remained. Overall, Montana State Hospital remained out of compliance with Medicare Conditions of Participation for Hospitals. As such, termination of the provider agreement is authorized under 42 C.F.R. §489.53(a)(1),(3).

The Medicare program will not make payment for covered services furnished to patients whose plan of treatment was established on or after **April 12, 2022.** For Medicare patients whose plans of treatment were established prior to April 12, 2022**,** payment is available for inpatient hospital services (including inpatient psychiatric hospital services) and post hospital extended care services furnished up to 30 days after the effective date of termination as set forth in 42 C.F.R. § 489.55.

Termination of your participation in the Medicare program will also result in termination of your Medicaid agreement. Therefore, CMS is forwarding a copy of this letter to the Montana Department of Public Health and Health Service, Medicaid Division. CMS is also sending a copy of this letter to your Medicare Administrative Contractor (MAC), Noridian Healthcare Solutions, LLC. Please contact your MAC to make arrangements for filing a final cost report.

Notice of Termination

CMS gives the provider notice of termination at least 2 days before the effective date of termination of the provider agreement (42 CFR §489.53(d)(1)).

Public Notice

CMS gives at least 2 days' notice to the public of the termination of its provider agreement (42 CFR §489.53 (d)(5)). CMS will post the legal notice of termination **and** will remain on the following website for six months: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Termination-Notices.html

Appeal Rights

CMS has previously provided you with your appeal rights relating to the February 8-10, 2022 survey. If you are dissatisfied with the findings of noncompliance identified during the February 24, March 8, and March 24 surveys and the decision to terminate your Medicare provider agreement, you may request a hearing before an administrative law judge (ALJ) of the Departmental Appeals Board in accordance with 42 C.F.R. § 498.40 et. seq. A request for hearing must be filed electronically **no later than sixty (60) calendar days after the date this letter is received**. You should file your request for an appeal (accompanied by a copy of this letter) to the Department Appeals Board Electronic Filing System website (DAB E-file) at https://dab.efile.hhs.gov.

Please note: all documents must be submitted in Portable Document Format ("pdf :"). You are required to e-file your appeal request unless you do not have access to a computer or internet service. In such circumstances, you may file in writing, but must provide an explanation as to why you cannot file submissions electronically and request a waiver from e-filing in the mailed copy of your request for a hearing. Written request for appeals must be submitted to the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
330 Independence Ave, SW
Cohen Building, Room G-644
Washington, D.C. 20201

Reinstatement after Termination

In accordance with the Medicare regulation at 42 CFR 489.57, a new Medicare provider agreement will not be accepted unless CMS finds that the reason for termination of the previous agreement has been removed and there

is reasonable assurance that it will not recur; and that the provider has fulfilled, or has made satisfactory arrangements to fulfill, all of the statutory and regulatory responsibilities of its previous agreement.

If you have question regarding reimbursement, please contact your Medicare Administrative Contractor (MAC). If you have questions regarding this letter, please contact Benton Williams via e-mail at Benton.Williams@cms.hhs.gov.

Sincerely,

Benton Williams
Acting Division Director
CMS Kansas City & Denver, Survey & Operations Group

Enclosures: CMS Form 2567-February 10, 2022
CMS Form 2567-February 24, 2022
CMS Form 2567-March 9, 2022
CMS Form 2567-March 25, 2022

Copies via e-mail to:
Montana Department of Public Health and Health Services, Quality Assurance Division, Certification Bureau
Montana Department of Public Health and Health Services, Medicaid Division
Charlie Brereton, Chief of Staff, MT DPHHS, and Health Care Policy Advisor to Governor Gianforte
Adam Meier, Director, MT DPHHS
Carter Anderson, Inspector General, MT DPHHS
Noridian Healthcare Solutions, LLC
CMS Denver Regional Office, Office of the Regional Administrator
CMS Denver Regional Office, Medicaid
CMS Denver Regional Office, OPOLE
Office of the General Counsel, Denver Office

PROVIDER QUESTIONS

CRITICAL ACCESS HOSPITAL

Q1: CAH vs LTC vs ALF Surveys (continued)

A1b: Assisted Living Facilities (ALF) Surveys are conducted by the Licensure Bureau of OIG. These are not certified providers (facilities types) so they are not reviewed under CMS Certification regulations or the Montana OIG Certification Bureau.

ALF questions contact Tara Wooten, Health Care License Program Manager, at 406-444-1575 or Tara.Wooten@mt.gov

Survey Activity Report: Survey History

Provider or Supplier Name: LOGAN HEALTH MEDICAL CENTER
CMS Certification Number: 270051
Provider or Supplier Type: Hospital
Address: 310 SUNNYVIEW LANE
KALISPELL, MT 59901
Phone Number: 406 752-5111
Participation Date: 07/01/1973
Region: (VIII) Denver
Accreditation Type: Non-Accredited
Number of Certified Beds: 160
Ownership Type: Non-Profit
Subtype: Short-Term

Surveys for FY 2022

03/08/2022 COMPLAINT SURVEY HEALTH SURVEY

Deficiencies:

Level	Tag #	Deficiency Description	Date Cited (2567 Date)
Standard	A0792	COVID-19 Vaccination of Facility Staff	03/08/2022

No Followup Visits.

EXHIBIT 49
30(b)(6) Designee
Thu, Aug 18, 2022
Reported by:
Mary Sullivan, RMR, CRR

Survey Activity Report: Survey History

Provider or Supplier Name: BITTERROOT HEALTH - DALY HOSPITAL
CMS Certification Number: 271340
Provider or Supplier Type: Hospital
Address: 1200 WESTWOOD DR
HAMILTON, MT 59840
Phone Number: 406 375-4408
Participation Date: 12/01/2004
Region: (VIII) Denver
Accreditation Type: Non-Accredited
Number of Certified Beds: 25
Ownership Type: Non-Profit
Subtype: Critical Access Hospitals

Surveys for FY 2022

03/01/2022 COMPLAINT SURVEY HEALTH SURVEY

Deficiencies:

Level	Tag #	Deficiency Description	Date Cited (2567 Date)
Standard	C1260	COVID-19 Vaccination of Facility Staff	03/01/2022

No Followup Visits.

EXHIBIT 50
30(b)(6) Designee
Thu, Aug 18, 2022
Reported by:
Mary Sullivan, RMR, CRR

In light of the Biden Administration's vaccine mandate announcement, should all health...

Excerpt from Production: DEF's 293

In light of the Biden Administration's vaccine mandate announcement, should all health care...

In light of the Biden Administration's vaccine mandate announcement, should all health care facilities begin requiring their employees to be vaccinated against COVID-19?

No. House Bill 702 prohibits an employer from refusing employment, barring a person from employment, or discriminating in any term, condition, or privilege of employment based on vaccination status or whether the person has an immunity passport.

However, HB 702 does not prohibit a health care facility asking employees about vaccination status. If an employee chooses not to provide their vaccination status, the health care facility may assume the employee is not vaccinated. If a health care facility determines or assumes that an employee is not vaccinated, then the law permits the health care facility to implement "reasonable accommodation measures for employees, patients, visitors, and other persons who are not vaccinated or not immune to protect the safety and health of employees, patients, visitors, and other persons from communicable diseases.

The reasonable accommodation measures imposed by a health care facility may include a face mask requirement for all employees, patients, visitors, and other persons who are not vaccinated or non-immune or who are assumed to be not vaccinated or non-immune.

Last Updated 9.24.21

EXHIBIT 54
30(b)(6) Designee
Thu, Aug 18, 2022
Reported by:
Mary Sullivan, RMR, CRR

Montana Department of
LABOR & INDUSTRY

November 12, 2021

Ms. Barbara Flynn
Director of Human Resources
Mountain-Pacific Quality Health
PO Box 5119
Helena, MT 59604

Dear Ms. Flynn:

On May 7, 2021, Montana Governor Greg Gianforte signed into law House Bill 702, which prohibits discrimination based on an individual's vaccination status. Codified under the Montana Human Rights Act as MCA § 49-2-312, the law prohibits an employer from refusing employment, barring a person from employment, or discriminating in any term, condition, or privilege of employment based on vaccination status or whether the person has an immunity passport.

An Executive Order issued by President Biden in September titled "Executive Order on Ensuring Adequate COVID Safety Protocols for Federal Contractors" has led to much confusion for Montana employers who do business with or receive funding from the federal government. We understand that these conflicting directives from federal and state government are challenging for employers seeking to comply with the law.

Attached to this letter is guidance issued by the Governor's Office to help employers navigate this situation. I want to call your attention to three specific points:

- The Executive Order applies only to new or renewed contracts, not existing contracts.
- Not every recipient of federal dollars is considered a contractor for the purposes of this order, and the order specifically excludes federal grants. Employers should seek legal advice to properly determine whether their contracts are covered by the Executive Order to avoid liability under Montana's vaccine discrimination ban.
- COVID-19 vaccine mandates, including as a condition of employment, are illegal in Montana, and state law makes clear that contract terms that violate Montana public policy are unenforceable. As such, President Biden's order is unenforceable.

Please respond to this letter in writing affirming you received it within seven (7) days. Note that continued discrimination against employees based on vaccination status may constitute a willful violation of Montana law subject to criminal penalties under MCA § 49-2-601. Please contact John Elizandro at John.Elizandro@mt.gov with any questions you may have. Thank you for your attention to this matter.

Sincerely,

Commissioner Laurie Esau
Montana Department of Labor & Industry

EXHIBIT 57
30(b)(6) Designee
Thu, Aug 18, 2022
Reported by:
Mary Sullivan, RMR, CRR

Montana Department of
LABOR & INDUSTRY

December 17, 2021

Mr. Troy Nedved
General Manager, Operations
Big Sky Resort
PO Box 160001
Big Sky, MT 59716

Dear Mr. Nedved,

The Montana Department of Labor & Industry has become aware of internal communications from Big Sky Resort that may constitute a violation of Montana law prohibiting discrimination based on vaccination status.

On May 7, 2021, Montana Governor Greg Gianforte signed into law House Bill 702, which prohibits discrimination based on an individual's vaccination status. Codified under the Montana Human Rights Act as MCA § 49-2-312, the law prohibits an employer from refusing employment, barring a person from employment, or discriminating in any term, condition, or privilege of employment based on vaccination status or whether the person has an immunity passport.

Additionally, in recent weeks three separate federal vaccine mandates – an Executive Order requiring vaccination for federal contractors, an Occupational Safety and Health Administration Emergency Temporary Standard requiring vaccinations for employees of large employers, and a Centers for Medicare and Medicaid Services rule requiring vaccination for health care workers – were halted by federal court orders pending the outcome of ongoing litigation.

As a result, House Bill 702 remains the law of the land in Montana and its protections remain in place.

Please confirm receipt of this letter in writing within seven (7) days and detail steps taken by your organization to ensure compliance with HB 702. Note that continued discrimination against employees based on vaccination status may constitute a willful violation of Montana law subject to criminal penalties under MCA § 49-2-601. Please contact John Elizandro, Director of Strategic Communications & Data, at John.Elizandro@mt.gov with any questions you may have. Thank you for your attention to this matter.

Sincerely,

L. Esau

Commissioner Laurie Esau
Montana Department of Labor & Industry

EXHIBIT 58
30(b)(6) Designee
Thu, Aug 18, 2022
Reported by:
Mary Sullivan, RMR, CRR

Montana Department of
LABOR & INDUSTRY

June 20, 2022

Ms. Renee Lorda
Assistant Circuit Executive
Office of the Circuit Executive
PO Box 193939
San Francisco, A 94119-3939

Dear Ms. Lorda:

Montana's House Bill 702, codified as MCA 49-2-312, prohibits discrimination based on vaccination status or possession of an immunity passport.

Specifically:

49-2-312. Discrimination based on vaccination status or possession of immunity passport prohibited – definitions. *(1) Except as provided in subsection (2), it is an unlawful discriminatory practice for:*

(a) a person or a governmental entity to refuse, withhold from, or deny to a person any local or state services, goods, facilities, advantages, privileges, licensing, educational opportunities, health care access, or employment opportunities based on the person's vaccination status or whether the person has an immunity passport;

(b) an employer to refuse employment to a person, to bar a person from employment, or to discriminate against a person in compensation or in a term, condition, or privilege of employment based on the person's vaccination status or whether the person has an immunity passport; or

(c) a public accommodation to exclude, limit, segregate, refuse to serve, or otherwise discriminate against a person based on the person's vaccination status or whether the person has an immunity passport.

Under MCA 49-2-101, a "person" is defined as:

(18) "Person" means one or more individuals, labor unions, partnerships, associations, corporations, legal representatives, mutual companies, joint-stock companies, trusts, unincorporated employees' associations, employers, employment agencies, organizations, or labor organizations.

While the law provides special exceptions for health care facilities in certain circumstances, the law states that a person or public accommodation, as those terms are defined by statute, cannot discriminate against individuals based on their vaccination status.

Montana Department of
LABOR & INDUSTRY

Therefore, the Ninth Circuit Judicial Conference's requirement that attendees of its July 18-21, 2022 conference in Big Sky, Montana be fully vaccinated against COVID-19 and show proof of vaccination is prohibited by law.

The conference website, registration form, and all associated materials must be revised immediately to conform to Montana law and remove any references to requirements of vaccination or proof of vaccination as a condition of attendance.

Please let my office know once these changes have been made and your organization is complying with Montana law. I look forward to your response.

Sincerely,

Laurie Esau
Commissioner
Montana Department of Labor & Industry

From: Oestreicher, Derek
To: SEAN LOGAN
Subject: RE: Employer mandated COVID vaccination
Date: Wednesday, October 13, 2021 3:59:00 PM
Attachments: image001.jpg

Good afternoon Sean,

Yes, HB 702 is the law in Montana. The Montana Human Rights Act provides for a private right of action for individuals who are victims of human rights discrimination (such as discrimination based on vaccination status). Additionally, employers who willfully violate the provisions of HB 702 may be subject to criminal prosecution under MCA 49-2-601.

I hope this general explanation is helpful. There is some useful information on the Department of Labor's website.

Feel free to give me a call should you like to discuss this further.

Thank you,

Derek J. Oestreicher
General Counsel
Attorney General Austin Knudsen, Montana Department of Justice
Work Cell: (406) 603-0748
derek.oestreicher@mt.gov

From: SEAN LOGAN <PIOBAIR64@msn.com>
Sent: Wednesday, October 13, 2021 9:32 AM
To: Oestreicher, Derek <Derek.Oestreicher@mt.gov>
Subject: [EXTERNAL] Employer mandated COVID vaccination

Hi Mr. Ostreicher,

A constituent asked me about a situation he's facing. His employer (private sector) is requiring their staff to get a COVID vaccine by Dec. 8 or face termination. Given HB702, it seems like his employer is in violation of that law. What can he do?

Thanks,

EXHIBIT 62
30(b)(6) Designee
Fri, Aug 19, 2022
Reported by:
Mary Sullivan, RMR, CRR

Sean Logan
Helena City Commissioner

Get Outlook for Android [aka.ms]

AUSTIN KNUDSEN

STATE OF MONTANA

January 14, 2021

To all Montana Head Start Program Directors and Employees:

It is our understanding that your Head Start program received a "Litigation Update" from the federal Office of Head Start ("OHS") regarding its COVID-19 vaccine and mask mandates earlier this week. While this update correctly notes that a court has enjoined the federal government from implementing and enforcing these requirements in Montana, OHS incorrectly implies that your program is permitted to develop and implement your own policy to require masks and vaccines. Understandably, this implication has caused confusion. This letter serves to caution that any such masking or vaccination policy developed by your Head Start program must comply with Montana law.

Under Montana law, an employer is prohibited from refusing employment, barring a person from employment, or discriminating against an individual in any term, condition, or privilege of employment based on vaccination status. While you may ask employees their vaccination status, you cannot treat them differently for their answer or non-answer.

Some examples of vaccination-based discrimination include, but *are not limited to*, requiring only staff who have not received the COVID-19 vaccine to wear a mask; telling staff members they must resign or will have their employment terminated if they do not receive the COVID-19 vaccine; and refusing to schedule unvaccinated employees for work shifts. Employees who are illegally discriminated against based on their vaccination status are encouraged to seek legal advice from a private attorney and to contact the Montana Human Rights Bureau at the Department of Labor to seek redress.

If you have any questions regarding this letter please contact our office.

Derek J. Oestreicher
General Counsel

DEPARTMENT OF JUSTICE

215 North Sanders
PO Box 201401
Helena, MT 59620-1401

(406) 444-2026
Contactdoj@mt.gov
mtdoj.gov

EXHIBIT 63
30(b)(6) Designee
Fri, Aug 19, 2022
Reported by:
Mary Sullivan, RMR, CRR

OFFICE OF THE GOVERNOR
STATE OF MONTANA

GREG GIANFORTE
GOVERNOR

KRISTEN JURAS
LT. GOVERNOR

October 27, 2021

Dear Fellow Montanans,

While I encourage Montanans to consult with their health care provider and get vaccinated, doing so is voluntary and no individual should face discrimination based on their vaccination status. Vaccine passports, or any documentation related to an individual's vaccination status, are unwarranted infringements on our liberties and illegal in Montana.

In September, President Biden issued an executive order, entitled "Executive Order on Ensuring Adequate COVID Safety Protocols for Federal Contractors." This order, which directs *new or renewed federal contracts* to require COVID-19 vaccination for contractor and subcontractor employees, has raised concerns and created confusion for Montana employees and employers, who are already struggling with a workforce shortage.

As outlined in attached guidance from my administration, President Biden's executive order violates Montana law. COVID-19 vaccine mandates, including as a condition of employment, are illegal in Montana, and state law makes clear that contract terms that violate Montana public policy are unenforceable. As such, President Biden's order is unenforceable.

If you are a Montana employer or employee contracted with the federal government with questions about President Biden's executive order, please refer to the attached guidance for additional information.

Sincerely,

Greg Gianforte
Governor

EXHIBIT 66
30(b)(6) Designee
Fri, Aug 19, 2022
Reported by:
Mary Sullivan, RMR, CRR

STATE CAPITOL • P.O. BOX 200801 • HELENA, MONTANA 59620-0801
TELEPHONE: 406-444-3111 • FAX: 406-444-5529 • WEBSITE: WWW.MT.GOV

Governor Gianforte's Guidance on Federal Contracts Mandate
Issued October 27, 2021

President Biden's Executive Order, entitled "Executive Order on Ensuring Adequate COVID Safety Protocols for Federal Contractors," has both raised concerns and created confusion for Montana's employers regarding vaccine mandates. To assist Montana employers with navigating this issue, the following guidance is provided.[1]

Who The Executive Order Applies To.

Receipt of federal funds does not mean the Executive Order applies. For example, contractors working on a federal highway project under a contract administered by the State of Montana are not subject to the Executive Order merely because the project receives federal funding. As discussed in more detail below, the Executive Order specifically excludes recipients of federal grants from the vaccine mandate.

Rather, the Executive Order applies only to those who enter certain types of new contracts with the federal government or renew those contracts, and most subcontracts to those contracts.

For existing contracts, the Executive Order acknowledges that employers are subject to state law: "For all existing contracts, … agencies are encouraged, *to the extent permitted by law*, to ensure that the safety protocols required under those contracts … are consistent with the requirements … of this order." This means nothing has changed: Montana's vaccine discrimination ban applies to these existing contracts.

To determine whether an existing contract is subject to renewal, employers are encouraged to consult the contracts themselves, as they often include language addressing under what circumstances they can be renewed. The Executive Order does not create an obligation to renew existing contracts.

Exclusions for Grants and Other Specified Contracts.

The Executive Order specifically excludes federal grants. A grant is the transfer of anything of value from the federal government to a non-federal entity "to carry out a public purpose of support or stimulation authorized by a law of the United States" and where "substantial involvement is not expected" between the recipient and administering federal agency. 32 U.S.C. § 6304. This important exclusion exempts from the vaccine mandate the numerous Montana entities that deliver a wide variety of services funded with federal grants, including health care, social services, crime prevention, job training, treatment programs, and housing services. For more information on grants, go to https://www.grants.gov/web/grants/learn-grants/grants-101.html.

Other types of contracts excluded from the application of the Executive Order include agreements with Tribal Nations under the Indian Self-Determination and Education Assistance

[1] This document is not and should not be construed as legal advice.

Act, contracts valued at $250,000 or less (other values in certain circumstances), and subcontracts solely for the provision of products.

Employers should seek legal advice to properly determine whether their contracts are covered by the Executive Order to avoid liability under Montana's vaccine discrimination ban.

Effect of the Executive Order on New/Renewed Contracts.

Where new or renewed contracts are at issue, the Executive Order requires those contracts to contain a clause obligating the contractor or subcontractor entering the contract to comply with "all guidance for contractor or subcontract workplace locations published by the Safer Federal Workforce Task Force." In response, this Task Force issued guidance that includes mandatory vaccination of contractor employees – that is, employees who are actually performing work relating to these new or renewed contracts, or who are working at locations where such contracts are being performed. An exception is provided "where an employee is legally entitled to an accommodation." This exception—which includes religious and medical exemptions—is required by federal law.

But Montana law requires more. MCA § 28-2-701 makes clear that a contract, in whole or in part, is unlawful where it is either "contrary to an express provision of law" or where it is "contrary to the policy of express law." *See MPH v. Imagineering*, 243 Mont. 342, 349 (1990) (refusing to enforce an entire agreement because the subject of the agreement was prohibited by Montana law and stating that "[a] party to an illegal contract may not use the courts of this state to enforce the agreement."); *Belgrade Educ. Ass'n v. Belgrade Sch. Dist. No 44,* 2204 MT 318, 17 (refusing to enforce a clause in a collective bargaining agreement because it did not comply with Montana law and declaring the provision "unlawful and void."). Parties to a contract cannot avoid the requirements of state law through contract. MCA § 1-3-204 ("A law established for a public reason cannot be contravened by a private agreement."); *see, e.g., Rothwell v. Allstate Ins. Co.,* 1999 MT 50, ¶ 6 ("individuals may waive any of their statutory rights *unless waiver of those rights violates public policy*.") (emphasis in original).

Here, the guidance unlawfully mandates employee vaccination in direct contravention to Montana's vaccine discrimination ban enacted by the 2021 legislature as HB 702 and codified at MCA § 49-2-312. The guidance also illegally discriminates against unvaccinated employees by imposing masking and social distancing requirements that do not apply to vaccinated employees. The guidance violates both Montana law and public policy. As a result, any language in a new or renewed contract entered into by a Montana employer that has the effect of requiring compliance with this guidance is unenforceable. This does not render the whole contract void, but rather means that the offending language is void and unenforceable. *See* MCA § 28-2-604 ("Where a contract has several distinct objects of which one at least is lawful and one is at least unlawful, in who or in part, the contract is void as to the latter and valid as to the rest.").

For more information on Montana's vaccine discrimination ban, see "House Bill 702: Frequently Asked Questions" published by the Montana Department of Labor & Industry at https://erd.dli.mt.gov/human-rights/human-rights-laws/employment-discrimination/hb-702.

Reasonable Accommodations for Health Care Facilities

Under MCA § 49-2-312, no employer may refuse employment or discriminate against an employee based on a person's vaccination status. However, a health care facility is allowed under MCA § 49-2-312(3)(b) to implement reasonable accommodation measures for employees known or considered to be unvaccinated to protect others from communicable diseases. Such measures may, for example, include masking and social distancing requirements. Employers other than health care facilities are not allowed to implement reasonable accommodation measures for employees known or considered to be unvaccinated.

"Health care facility" is defined at MCA § 50-5-101 and does not include offices of private physicians, dentists, or other physical or mental health care workers.

Special Rules for Licensed Nursing Homes and Long-term Care and Assisted Living Facilities

MCA § 49-2-313 temporarily suspends the obligation of a licensed nursing home, long-term care facility or assisted living facility to comply with the anti-discrimination rules of MCA § 49-2-312 during any period of time that compliance would result in a violation of regulations or guidance issued by the Centers for Medicare & Medicaid Services (CMS) or the Centers for Disease Control and Prevention (CDC). There are currently no Montana licensed nursing homes, long-term care facilities or assisted living facilities for which the anti-discrimination rules of MCA § 49-2-312 have been suspended.

In the event CMS or CDC were to issue regulations or guidance that would result in a suspension of the obligation of a nursing home or long-term care or assisted living facility's to comply with the non-discrimination rules of MCA § 49-2-312, such facilities must nonetheless consider appropriate medical and religious exemptions for employees during the temporary suspension period. An overwhelming body of case law clearly holds that the First Amendment right to the free exercise of religion protects all sincerely held religious beliefs, and not just those "held because of membership in an established or recognized religion." Mt. Att'y Gen. Op. 44-7 (1991) (ruling that a "school district should refrain from challenging an affidavit claiming a religious exemption from mandatory immunization"). "The free exercise of religion means, first and foremost, the right to believe and profess whatever religious doctrine one desires." *Emp. Div., Dep't of Hum. Res. Of Or. v. Smith,* 494 U.S. 872, 877 (1990). The resolution of what constitutes a "sincerely held religious belief" is not to turn upon an employer's perception of the particular belief or practice in question. "[R]eligious beliefs need not be acceptable, logical, consistent, or comprehensible to others in order to merit First Amendment protection." *Thomas v. Review Bd. of Ind. Employment Sec. Div.*, 450 U.S. 707, 714 (1981). Title VII of the Civil Rights Act explicitly requires employers to reasonably accommodate an employee's religious beliefs absent evidence that doing so would pose an undue hardship, broadly defining religion to include "all aspects of religious observance and practice, as well as belief[.]" 42 U.S.C. § 2000e(j).

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Montana Attorney General
KRISTIN HANSEN
Lieutenant General
DAVID M.S. DEWHIRST
Solicitor General
CHRISTIAN CORRIGAN
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Attorneys for Defendants

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION

MONTANA MEDICAL ASSOCIATION, et. al., Plaintiffs, and MONTANA NURSES ASSOCIATION, Plaintiff-Intervenors, v. AUSTIN KNUDSEN, et al., Defendants.	CV-21-108-M-DWM **DECLARATION OF MARY STUKALOFF**

I, Mary Stukaloff, declare:

1. I am employed as an administrative assistant at the Montana Attorney General's Office and am competent to testify to the matters set forth.
2. As part of my job duties, I receive, open, and file mail received by the Attorney General's Office.
3. On February 10, 2022, the Attorney General's Office received a letter from Montana Health Network.
4. I stamped and scanned said letter into the Attorney General's Office's mail logging system on February 10, 2022.

5. Attached here as Exhibit A is a true and correct copy of Montana Health Network's letter dated January 14, 2022, and received by the Attorney General's Office on February 10, 2022.

I hereby declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

DATED this 2nd day of March, 2022.

Mary Stukaloff
MARY STUKALOFF

MONTANA HEALTH NETWORK

MONTANA HEALTH NETWORK, INC. – FRONTIER FACILITIES WORKGROUP
RURAL HEALTH DEVELOPMENT, INC.
519 PLEASANT STREET
MILES CITY, MONTANA 59301
(406) 234-1420
FAX: (406) 234-1423

January 14, 2022

Honorable Elected Official:

We, the undersigned, wish to collectively share information about the impact to our facilities and communities due to President Biden's September 2021 proclamation mandating covid-19 vaccination for all healthcare workers and the subsequent Interim Final Rule ("IFR") requiring all CMS providers to fully vaccinate staff and other covered individuals. We have grave concerns about the survivability of rural healthcare as a result of this mandate. The CMS rules will create havoc for all small rural hospitals and nursing homes nationwide over the coming weeks. We ask that your office consider these implications and support an injunction or legislation that would make this situation and any others like it illegal.

The crux of the problem is that they have made the mandate a "condition of participation" in the Medicare and Medicaid programs. CMS providers have a contract which lists the conditions under which the contract is valid. If a facility violates one or more of those conditions, they risk being decertified from the program. If they ignore the vaccine mandate and continue billing Medicare and Medicaid, they are committing fraud against the program, which could result in steep fines and jail terms for some of its employees.

On average, most small healthcare facilities in our remote, isolated Montana communities receive 60% or more of their gross billing from CMS. Without that revenue, we would not be able to pay our bills. We would not be able to provide long-term care for our long-term care residents, many of whom rely on Medicaid to pay for services. We would go insolvent quickly, as our meager financial reserves become depleted if we have any reserves at all. In any instance, we could not rely on commercial insurance or private payers to keep us afloat.

Further, by making it a "condition of participation", it makes it difficult if not impossible for Montana facilities to obtain or retain healthcare licenses even if they chose to decertify their CMS status. Currently, Montana's licensure and certification bureaus follow Federal standards closely when reviewing operations and care to either license or certify healthcare facilities. It is unclear despite inquiries to the state Licensure Bureau what regulations or "conditions of participation" healthcare facilities would follow if they don't receive Medicare or Medicaid.

With varying reasons, several healthcare workers refuse to receive the vaccine, indicating that they intend to terminate their employment if forced to do so. According to the mandate, all facilities had to produce a policy that requires all employees to be fully vaccinated in two stages

ending January 4, 2022 (new deadline of February 14, 2022), unless they have a medical exemption or religious exemption. Those employees who are not vaccinated by that date are violating the policy, which means that they are no longer employable by any facility that receives Medicare or Medicaid funding.

This puts our local healthcare facilities in difficult positions. On the one hand, we cannot defy the mandate by continuing to employ those workers without punitive action being taken by CMS. On the other hand, if those workers persist in refusing to receive the vaccine, we may need to close some of our departments due to severe staffing shortages. Either way, we, and the community, lose out. In some instances, a staffing shortage will be the lesser of the two evils by creating a hardship, but not causing us to close the doors. In other instances, the staffing shortage may cause the doors to close. Either scenario could cause a high percentage of long term care residents to be displaced or Medicare and Medicaid beneficiaries to lose local services. Whether our facilities lose significant percentages of staff or significant portions of funding, this would mean the end to significant local healthcare services to those who have paid into these benefits throughout their entire lifetimes.

Permanent and temporary staff have been difficult to find, and we can expect to pay the following agency rates for the following positions: at least $150/hour for nurses and $55/hour for CNAs. Some of our communities have to advertise $140/hour for radiology techs, all with minimal response. Current staff are working overtime shifts at levels that could exacerbate workforce burnout in a profession that had significant shortages prior to the pandemic. The impact of this mandate on all of our healthcare organizations will be to decrease or stop local access to healthcare for thousands of Montana's residents and millions of Americans.

The impact will hit especially hard in rural and frontier communities where distances to a healthcare facility could exceed 100 miles one way. People who choose the rural and frontier lifestyles won't have the option of going to another facility down the block or a mile or two away. Because of this, many will forego care because of the inconvenience or impossibility of travel and added costs associated with it. The loss of access to critical and life-saving hospital and clinic services as well as long term care will cost lives and diminish the overall health of our communities. Dozens of long term care residents could be displaced from their homes, and thousands of Medicare and Medicaid beneficiaries could lose access to healthcare completely. These individuals cannot even expect to get access in other locations because even the larger healthcare facilities in larger communities are struggling to staff their facilities and serve their communities much less the displaced patients from our communities.

Small healthcare organizations are the top one or two employers in rural communities across America that offer higher paying jobs and usually higher-than-minimum wage jobs for unlicensed employees. Closure of hospitals and clinics will have a high, undetermined negative economic impact on communities of any size. It will also make it difficult for other community businesses to recruit employees to a community without access to basic healthcare. Our communities function with all employers, businesses, and organizations being interdependent upon each other for long term survival and the survivability of the community as a whole. There is a far-reaching negative impact that could create "ghost towns" throughout rural America due to people leaving for lack of jobs, lack of healthcare, lack of education, and lack of a livelihood.

There is no doubt that we need to be prudent and protect our communities and patients much the way we have since the start of the pandemic. However, this mandate will rob healthcare workers who exercise their right to choose to not be vaccinated of their livelihood, will cause economic strife in community businesses where healthcare workers do business, and sharply decrease access to healthcare through decreased services and closures. It will potentially decimate our frontier communities and displace thousands of patients in rural America.

Our facilities follow the CDC healthcare worker recommendations to the tee, which so far have greatly limited nosocomial infections for both staff and patients and have resulted in minimal infections within our facilities despite potential for community spread. We feel that we can manage the risk, but if we lose any of our workers, we aren't as certain that we will be able to continue to operate and retain the safety and health in our facilities and communities. Current mitigating actions have been successful, and additional mandates most likely won't improve infection rates or negative patient outcomes. As representatives of constituents in Montana who will be drastically affected by this mandate, it is imperative that you take the steps necessary to implement an injunction on this mandate or require CMS to rescind it. It is time to reign in and tighten congressional oversight on CMS's power and rulemaking authority.

SIGNATURE	NAME	TITLE	FACILITY	CITY
David Espeland	David Espeland	CEO	Fallon Medical Complex	Baker, MT
Audrey Stromberg	Audrey Stromberg	Administrator	Roosevelt Medical Center	Culbertson MT
N. Rosaaen	Nancy Rosaaen	CEO	McCone County Health Cente	Circle
B K Keltner	Burt J Keltner	CEO	Prairie Community Hospital	Terry, MT
	Sean hill	Ceo	Powder river manor	Broadus, mt
Mindy Price	Mindy Price	CEO	Rosebud Health Care Center	Forsyth
Earline Lawrence	Earline Lawrence	COO	Garfield County Health Cent	Jordan
Ryan Tooke	Ryan Tooke	CEO	Dahl Memorial	Ekalaka
Andrew Riggin	Andrew Riggin	CEO	Phillips County Hospital	Malta
	Kody Brinton	CEO	Daniels Memorial Healthcar	Scobey

citrix | RightSignature

SIGNATURE CERTIFICATE

REFERENCE NUMBER
5739AAB6-1FFE-4E17-BA73-049E0BA2FA51

TRANSACTION DETAILS

Reference Number
5739AAB6-1FFE-4E17-BA73-049E0BA2FA51

Transaction Type
Signature Request

Sent At
01/26/2022 13:49 MST

Executed At
02/01/2022 16:43 MST

Identity Method
email

Distribution Method
email

Signed Checksum
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Signer Sequencing
Disabled

Document Passcode
Disabled

DOCUMENT DETAILS

Document Name
Legislative Letter On Mandates Final

Filename
legislative_letter_on_mandates_final.docx

Pages
3 pages

Content Type
application/vnd.openxmlformats-officedocument.wordprocessingml.document

File Size
43.2 KB

Original Checksum
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SIGNERS

SIGNER

Name
Earline Lawrence

Email
elawrence@gchealth.net

Components
5

E-SIGNATURE

Status
signed

Multi-factor Digital Fingerprint Checksum
d0dd79acfec25ca560be04aa50ea1d9fda5752be3a3ea63209b2711ce3290829

IP Address
216.228.61.22

Device
Chrome via Windows

Drawn Signature

Signature Reference ID
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Signature Biometric Count
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EVENTS

Viewed At
02/01/2022 16:40 MST

Identity Authenticated At
02/01/2022 16:43 MST

Signed At
02/01/2022 16:43 MST

Name
Ryan Tooke

Email
rtooke@dmhainc.com

Components
5

Status
signed

Multi-factor Digital Fingerprint Checksum
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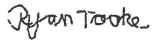
IP Address
72.250.130.36

Device
Chrome via Windows

Drawn Signature



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3528D294

Signature Biometric Count
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Viewed At
01/31/2022 09:05 MST

Identity Authenticated At
01/31/2022 09:06 MST

Signed At
01/31/2022 09:06 MST

Name
Mindy Price
Email
mprice@rosebudhealthcare.com
Components
5

Status
signed
Multi-factor Digital Fingerprint Checksum
19b805e98c503cb24eec131b90ece47e6856acecac1bcfb3d3607842903e050c
IP Address
72.36.14.12
Device
Chrome via Windows
Typed Signature

Mindy Price

Signature Reference ID
D2121859

Viewed At
01/26/2022 13:58 MST
Identity Authenticated At
01/26/2022 13:58 MST
Signed At
01/26/2022 13:58 MST

Name
Burt Keltner
Email
bkeltner@pchc-mt.com
Components
5

Status
signed
Multi-factor Digital Fingerprint Checksum
6851fcffcf56a79ad84efdfcdfd83f38eee4d60942b40dcda094e632b4a40be6
IP Address
108.59.121.114
Device
Chrome via Windows
Drawn Signature

Signature Reference ID
37997C79
Signature Biometric Count
328

Viewed At
01/26/2022 13:55 MST
Identity Authenticated At
01/26/2022 13:56 MST
Signed At
01/26/2022 13:56 MST

Name
Audrey Stromberg
Email
astromberg@roosmem.org
Components
5

Status
signed
Multi-factor Digital Fingerprint Checksum
c4f8f88607f1ba5fbda4cbdbbf267fec8d6425f36b9c07adfcbe7593a3a4dba9
IP Address
199.190.61.87
Device
Chrome via Windows
Typed Signature

Audrey Stromberg

Signature Reference ID
22DC2D83

Viewed At
01/26/2022 13:51 MST
Identity Authenticated At
01/26/2022 13:52 MST
Signed At
01/26/2022 13:52 MST

Name
Nancy Rosaaen
Email
nrosaaen@mcconehealth.org
Components
5

Status
signed
Multi-factor Digital Fingerprint Checksum
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Device
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N. Rosaaen

Signature Reference ID
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01/26/2022 13:51 MST
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01/26/2022 13:51 MST

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Components
5

Status
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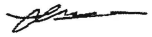

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01/28/2022 10:13 MST

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Status
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Multi-factor Digital Fingerprint Checksum
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Device
Chrome via Windows
Typed Signature

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Signature Reference ID
96AD472A

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Status
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David Espeland

Signature Reference ID
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01/26/2022 16:10 MST

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Signature Biometric Count

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– Does this law apply to my employer?

Yes. The law prohibits an employer from refusing employment, barring a person from employment, or discriminating in any term, condition, or privilege of employment based on vaccination status or whether the person has an immunity passport.

The law provides special provisions for health care facilities. See below for more information about employees, patients, visitors, or other persons of health care facilities.

Last Updated 7/26/21

– I am an employee of a health care facility. How does the United States Supreme Court...

I am an employee of a health care facility. How does the United States Supreme Court ruling on CMS's vaccine rule impact me?

The Department of Public Health and Human Services has issued guidance for health care facilities and providers regarding the CMS vaccine mandate. View Guidance

Last Updated 1/27/22

– Does this legislation only apply to vaccination status or an immunity passport...

Does this legislation only apply to vaccination status or an immunity passport regarding the vaccines for COVID-19?

No. HB 702 applies to all vaccines and is not limited to COVID-19 vaccines.

Last Updated 7/26/21

EXHIBIT 72
30(b)(6) Designee
Mon, Aug 22, 2022
Reported by:
Mary Sullivan, RMR, CRR

DEFS 000254

Exhibit 31 - 1

U.S. Equal Employment Opportunity Commission

What You Should Know About COVID-19 and the ADA, the Rehabilitation Act, and Other EEO Laws

INTRODUCTION

Technical Assistance Questions and Answers - Updated on July 12, 2022.

- *All EEOC materials related to COVID-19 are collected at* ***www.eeoc.gov/coronavirus (https://www.eeoc.gov/coronavirus)*** .
- The EEOC enforces workplace anti-discrimination laws, including the Americans with Disabilities Act (ADA) and the Rehabilitation Act (which include the requirement for reasonable accommodation and non-discrimination based on disability, and rules about employer medical examinations and inquiries), Title VII of the Civil Rights Act (which prohibits discrimination based on race, color, national origin, religion, and sex, including pregnancy), the Age Discrimination in Employment Act (which prohibits discrimination based on age, 40 or older), and the Genetic Information Nondiscrimination Act. Note: Other federal laws, as well as state or local laws, may provide employees with additional protections.
- Title I of the ADA applies to private employers with 15 or more employees. It also applies to state and local government employers, employment agencies, and labor unions. All nondiscrimination standards under Title I of the ADA also apply to federal agencies under Section 501 of the Rehabilitation Act. Basic background information about the ADA and the Rehabilitation Act is available on EEOC's **disability page (https://www.eeoc.gov/eeoc-disability-related-resources)** .

- The EEO laws, including Title I of the ADA and the Rehabilitation Act, continue to apply during the time of the COVID-19 pandemic, but they do not interfere with or prevent employers from following current guidance and suggestions made by CDC or state/local public health authorities about steps employers should take regarding COVID-19.

- The EEOC has provided guidance (a publication entitled **Pandemic Preparedness in the Workplace and the Americans With Disabilities Act (https://www.eeoc.gov/laws/guidance/pandemic-preparedness-workplace-and-americans-disabilities-act) [PDF version (https://www.eeoc.gov/sites/default/files/2020-04/pandemic_flu.pdf)]**) ("Pandemic Preparedness"), consistent with these workplace protections and rules, that can help employers implement strategies to navigate the impact of COVID-19 in the workplace. This pandemic publication, which was written during the prior H1N1 outbreak, is still relevant today and identifies established ADA and Rehabilitation Act principles to answer questions frequently asked about the workplace during a pandemic. It has been updated as of March 19, 2020 to address examples and information regarding COVID-19; **the new 2020 information appears in bold and is marked with an asterisk**.

- On March 27, 2020 the EEOC provided a webinar ("3/27/20 Webinar") which was recorded and transcribed and is available at **www.eeoc.gov/coronavirus (https://www.eeoc.gov/coronavirus)**. The World Health Organization (WHO) has declared COVID-19 to be an international pandemic. The EEOC pandemic publication includes a **separate section (https://www.eeoc.gov/laws/guidance/pandemic-preparedness-workplace-and-americans-disabilities-act#secB)** that answers common employer questions about what to do after a pandemic has been declared.

- **Find COVID-19 Guidance for Your Community (https://www.covid.gov)**: This website provides information on a wide range of COVID-related topics, including treatments, testing, specific considerations for those who are immunocompromised, and a variety of information concerning long COVID (including the possibility of joining a research study). This information is also available by telephone (1-800-232-0233) or TTY (1-888-720-7489).

A. Disability-Related Inquiries and Medical Exams

The ADA has restrictions on when and how much medical information an employer may obtain from any applicant or employee.

Prior to making a conditional job offer to an applicant, disability-related inquiries and medical exams are generally prohibited. They are permitted between the time of the offer and when the applicant begins work, provided they are required for everyone in the same job category. For more information on the timing of disability-related inquiries and medical examinations for applicants, see ***Section C.***

Under the ADA (which is applicable to the Federal sector through the Rehabilitation Act of 1973), once an employee begins work, any disability-related inquiries or medical exams must be "job-related and consistent with business necessity." One way inquiries and medical examinations meet this "business necessity" standard is if they are necessary to determine whether a specific employee has a medical condition that would pose a "direct threat" to health or safety (a significant risk of substantial harm to self or others that cannot be addressed with reasonable accommodation). For more information on reasonable accommodation, see ***Section D****. Where met, the "business necessity" standard allows for consideration of whether a person may have COVID-19, and thus might pose a "direct threat." For information on disability-related questions and COVID-19 vaccinations, see* ***K.7.*** *-* ***K.9.***

CDC has updated its guidance (https://www.cdc.gov/coronavirus/2019-ncov/communication/guidance.html) *over the course of the pandemic and may continue to do so as the pandemic evolves and as CDC acquires more information about the virus and different variants. The ADA "business necessity" standard requires that employers utilize the most current medical and public health information to determine what inquiries/medical examinations are appropriate.*

A.1. How much information may an employer request from an employee who calls in sick, in order to protect the rest of its workforce during the COVID-19 pandemic? *(3/17/20)*

During a pandemic, ADA-covered employers may ask such employees if they are experiencing symptoms of the pandemic virus. For COVID-19, these include symptoms such as fever, chills, cough, shortness of breath, or sore throat.

Employers must maintain all information about employee illness as a confidential medical record in compliance with the ADA.

A.2. When screening employees entering the workplace during this time, may an employer only ask employees about the COVID-19 symptoms EEOC has identified as examples (https://www.eeoc.gov/transcript-march-27-2020-outreach-webinar#q1) , or may it ask about any symptoms identified by public health authorities as associated with COVID-19? *(4/9/20)*

As public health authorities and doctors learn more about COVID-19, they may expand the list of associated symptoms. Employers should rely on the CDC, other public health authorities, and reputable medical sources for guidance on emerging symptoms associated with the disease. These sources may guide employers when choosing questions to ask employees to determine whether they would pose a direct threat to health in the workplace. For example, additional symptoms beyond fever or cough may include new loss of smell or taste as well as gastrointestinal problems, such as nausea, diarrhea, and vomiting.

A.3. When may an ADA-covered employer take the body temperature of employees during the COVID-19 pandemic? *(3/17/20)*

Generally, measuring an employee's body temperature is a medical examination. Because the CDC and state/local health authorities have acknowledged community spread of COVID-19 and issued attendant precautions, employers may measure employees' body temperature. However, employers should be aware that some people with COVID-19 do not have a fever.

A.4. Does the ADA allow employers to require employees to stay home if they have symptoms of the COVID-19? *(3/17/20)*

Yes. The CDC states that employees who become ill with symptoms of COVID-19 should leave the workplace. The ADA does not interfere with employers following this advice.

A.5. When an employee returns to the workplace after being out with COVID-19, does the ADA allow employers to require a note from a qualified medical professional explaining that it is safe for the employee to return (i.e., no risk of transmission) and that the employee is able to perform the job duties? *(Updated 7/12/22)*

Yes. Alternatively, employers may follow **CDC guidance (https://www.cdc.gov/coronavirus/2019-ncov/your-health/quarantine-isolation.html)** to determine whether it is safe to allow an employee to return to the workplace without confirmation from a medical professional.

When an employee returns to the workplace after being out with COVID-19, the ADA allows an employer to require confirmation from a qualified medical professional explaining that the individual is able to safely return. Such a request is permitted under the ADA. First, because COVID-19 is not always a disability, a request for confirmation may not be a disability-related inquiry. Alternatively, if the request is considered a **disability-related inquiry**, it would be justified under the ADA standard requiring that such employee inquiries be job-related and consistent with business necessity. Here, the request meets the "business necessity" standard because it is related to the possibility of transmission and/or related to an employer's objective concern about the employee's ability to resume working. For example, an employer may require confirmation from a medical professional addressing whether an employee may resume specific job duties requiring physical exertion.

As a practical matter, employers may wish to consider other ways to determine the safety of allowing an employee to return to work if doctors and other healthcare professionals are unable to provide such documentation either in a timely manner or at all. This might include reliance on local clinics to provide a form, a stamp, or an e-mail to confirm that an individual is no longer infectious and is able to resume working.

A.6. Under the ADA, may an employer, as a mandatory screening measure, administer a COVID-19 viral test (a test to detect the presence of the COVID-19 virus) when evaluating an employee's initial or continued presence in the workplace? *(Updated 7/12/22)*

Yes, if the employer can show it is job-related and consistent with business necessity.

A COVID-19 **viral test (https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/testing.html)** is a medical examination within the meaning of the ADA. Therefore, if an employer implements screening protocols that include COVID-19 viral testing, the ADA requires that any mandatory medical test of employees be "job-related and consistent with business necessity." Employer use of a COVID-19

viral test to screen employees who are or will be in the workplace will meet the "business necessity" standard when it is consistent with guidance from Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA), and/or state/local public health authorities that is current at the time of testing. Be aware that CDC and other public health authorities periodically update and revise their recommendations about COVID-19 testing, and FDA may revise its guidance or emergency use authorizations, based on new information and changing conditions.

A **positive** viral test result means that the test detected SARS-CoV-2, the virus that causes COVID-19, at the time of testing, and that the individual most likely has a current infection and may be able to transmit the virus to others. A **negative** test result means the test did not detect SARS-CoV-2 at the time of testing. However, a negative test does not mean the employee does not have any virus, or will not later get the virus. It means only that the virus causing SARS-CoV-2 was not detected by the test.

If an employer seeks to implement screening testing for employees such testing must meet the "business necessity" standard based on relevant facts. Possible considerations in making the "business necessity" assessment may include the **level of community transmission (https://www.cdc.gov/coronavirus/2019-ncov/science/community-levels.html)**, the **vaccination status of employees (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html)**, the accuracy and speed of processing for different types of COVID-19 viral tests, the **degree to which breakthrough (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html) infections are possible for employees who are "up to date" on vaccinations (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html)**, t**he ease of transmissibility of the current variant(s), the possible severity of illness from the current variant (https://www.cdc.gov/coronavirus/2019-ncov/variants/about-variants.html)**, what types of contacts employees may have with others in the workplace or elsewhere that they are required to work (e.g., working with medically vulnerable individuals), and the potential impact on operations if an employee enters the workplace with COVID-19. In making these assessments, employers should check the latest **CDC guidance (https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-overview.html)** (and any other relevant sources) to determine whether **screening testing is appropriate (https://www.cdc.gov/coronavirus/2019-**

ncov/community/organizations/testing-non-healthcare-workplaces.html) for these employees.

Note: Question A.6. and A.8. address screening of employees generally. See Question A.9. regarding decisions to test only individual employees.

A.7. Under the ADA, may an employer require antibody testing before permitting employees to re-enter the workplace? *(Updated 7/12/22)*

No. An antibody test, as a medical examination under the ADA, must be job-related and consistent with business necessity. As of July 2022, CDC **guidance (https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/antibody-tests.html)** explains that antibody testing may not show whether an employee has a current infection, nor establish that an employee is immune to infection; as a result, it should not be used to determine whether an employee may enter the workplace. Based on this CDC guidance, at this time such testing does not meet the ADA's "business necessity" standard for medical examinations or inquiries for employees. Therefore, requiring antibody testing before allowing employees to re-enter the workplace is not allowed under the ADA. An **antibody test (https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/antibody-tests.html)** is different from a **test to determine if someone has evidence of infection with SARS-CoV-2 or has COVID-19 (i.e., a viral test) (https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/testing.html)**. The EEOC addresses COVID-19 viral screening tests in **A.6.**

A.8. May employers ask all employees physically entering the workplace if they have been diagnosed with or tested for COVID-19? *(9/8/20; adapted from 3/27/20 Webinar Question 1)*

Yes. Employers may ask all employees who will be physically entering the workplace if they have COVID-19 or symptoms associated with COVID-19, and ask if they have been tested for COVID-19. Symptoms associated with COVID-19 include, for example, fever, chills, cough, and shortness of breath. The CDC has identified a **current list of symptoms (https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html)**.

An employer may exclude those with COVID-19, or symptoms associated with COVID-19, from the workplace because, as EEOC has stated, their presence would pose a direct threat to the health or safety of others. However, for those employees

who are teleworking and are not physically interacting with coworkers or others (for example, customers), the employer would generally not be permitted to ask these questions.

A.9. May a manager ask only one employee—as opposed to asking all employees—questions designed to determine if the employee has COVID-19, or require that this employee alone have a temperature reading or undergo other screening or testing? *(9/8/20; adapted from 3/27/20 Webinar Question 3)*

If an employer wishes to ask only a particular employee to answer such questions, or to have a temperature reading or undergo other screening or testing, the ADA requires the employer to have a reasonable belief based on objective evidence that this person might have the disease. So, it is important for the employer to consider why it wishes to take these actions regarding this particular employee, such as a display of COVID-19 symptoms. In addition, the ADA does not interfere with employers following **recommendations by the CDC (https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/testing-non-healthcare-workplaces.html)** or other public health authorities regarding whether, when, and for whom testing or other screening is appropriate.

A.10. May an employer ask an employee who is physically coming into the workplace whether they have family members who have COVID-19 or symptoms associated with COVID-19? *(9/8/20; adapted from 3/27/20 Webinar Question 4)*

No. The Genetic Information Nondiscrimination Act (GINA) prohibits employers from asking employees medical questions about family members. GINA, however, does not prohibit an employer from asking employees whether they have had contact with anyone diagnosed with COVID-19 or who may have symptoms associated with the disease. Moreover, from a public health perspective, only asking about an employee's contact with family members would unnecessarily limit the information obtained about an employee's potential exposure to COVID-19.

A.11. What may an employer do under the ADA if an employee refuses to permit the employer to take the employee's temperature or refuses to answer questions about whether the employee has COVID-19, has symptoms associated with COVID-19, or has been tested for COVID-19? *(9/8/20; adapted from 3/27/20 Webinar Question 2)*

Under the circumstances existing currently, the ADA allows an employer to bar an employee from physical presence in the workplace if the employee refuses to have a temperature reading taken or refuses to answer questions about whether the employee has COVID-19, has symptoms associated with COVID-19, or has been tested for COVID-19. To gain the cooperation of employees, however, employers may wish to ask the reasons for the employee's refusal. The employer may be able to provide information or reassurance that they are taking these steps to ensure the safety of everyone in the workplace, and that these steps are consistent with health screening recommendations from CDC. Sometimes, employees are reluctant to provide medical information because they fear an employer may widely spread such personal medical information throughout the workplace. The ADA prohibits such broad disclosures. Alternatively, if an employee requests reasonable accommodation with respect to screening, the usual accommodation process should be followed; this is discussed in Question G.7.

A.12. During the COVID-19 pandemic, may an employer request information from employees who work on-site, whether regularly or occasionally, who report feeling ill or who call in sick? *(9/8/20; adapted from Pandemic Preparedness Question 6)*

Due to the COVID-19 pandemic, at this time employers may ask employees who work on-site, whether regularly or occasionally, and report feeling ill or who call in sick, questions about their symptoms as part of workplace screening for COVID-19.

A.13. May an employer ask an employee why the employee has been absent from work? *(9/8/20; adapted from Pandemic Preparedness Question 15)*

Yes. Asking why an individual did not report to work is not a disability-related inquiry. An employer is always entitled to know why an employee has not reported for work.

A.14. When an employee returns from travel during a pandemic, must an employer wait until the employee develops COVID-19 symptoms to ask questions about where the person has traveled? *(9/8/20; adapted from Pandemic Preparedness Question 8)*

No. Questions about where a person traveled would not be disability-related inquiries. If the CDC or state or local public health officials recommend that people who visit specified locations remain at home for a certain period of time, an

employer may ask whether employees are returning from these locations, even if the travel was personal.

B. Confidentiality of Medical Information

With limited exceptions, the ADA requires employers to keep confidential any medical information they learn about any applicant or employee. Medical information includes not only a diagnosis or treatments, but also the fact that an individual has requested or is receiving a reasonable accommodation.

B.1. May an employer store in existing medical files information it obtains related to COVID-19, including the results of taking an employee's temperature or the employee's self-identification as having this disease, or must the employer create a new medical file system solely for this information? *(4/9/20)*

The ADA requires that all medical information about a particular employee be stored separately from the employee's personnel file, thus limiting access to this **confidential information (https://www.eeoc.gov/transcript-march-27-2020-outreach-webinar#q9)** . An employer may store all medical information related to COVID-19 in existing medical files. This includes an employee's statement that the employee has the disease or suspects so, or the employer's notes or other documentation from questioning an employee about symptoms. For information on confidentiality and COVID-19 vaccinations, see **K.4.**

B.2. If an employer requires all employees to have a daily temperature check before entering the workplace, may the employer maintain a log of the results? *(4/9/20)*

Yes. The employer needs to maintain the confidentiality of this information.

B.3. May an employer disclose the name of an employee to a public health agency when it learns that the employee has COVID-19? *(4/9/20)*

Yes (https://www.cdc.gov/coronavirus/2019-ncov/community/contact-tracing-nonhealthcare-workplaces.html) .

B.4. May a temporary staffing agency or a contractor that places an employee in an employer's workplace notify the employer if it learns the employee has COVID-19? *(4/9/20)*

disclosure

Yes. The staffing agency or contractor may notify the employer and disclose the name of the employee, because the employer may need to determine if this employee had contact with anyone in the workplace.

B.5. Suppose a manager learns that an employee has COVID-19, or has symptoms associated with the disease. The manager knows it must be reported but is worried about violating ADA confidentiality. What should the manager do? *(9/8/20; adapted from 3/27/20 Webinar Question 5)*

The ADA requires that an employer keep all medical information about employees confidential, even if that information is not about a disability. Clearly, the information that an employee has symptoms of, or a diagnosis of, COVID-19, is medical information. But the fact that this is medical information does not prevent the manager from reporting to appropriate employer officials so that they can take actions consistent with guidance from the CDC and other public health authorities.

The question is really what information to report: is it the fact that an employee—unnamed—has symptoms of COVID-19 or a diagnosis, or is it the identity of that employee? Who in the organization needs to know the identity of the employee will depend on each workplace and why a specific official needs this information. Employers should make every effort to limit the number of people who get to know the name of the employee.

limit release of info.

The ADA does not interfere with a designated representative of the employer interviewing the employee to get a list of people with whom the employee possibly had contact through the workplace, so that the employer can then take action to notify those who may have come into contact with the employee, without revealing the employee's identity. For example, using a generic descriptor, such as telling employees that "someone at this location" or "someone on the fourth floor" has COVID-19, provides notice and does not violate the ADA's prohibition of disclosure of confidential medical information. For small employers, coworkers might be able to figure out who the employee is, but employers in that situation are still prohibited from confirming or revealing the employee's identity. Also, all employer officials who are designated as needing to know the identity of an employee should be specifically instructed that they must maintain the confidentiality of this

information. Employers may want to plan in advance what supervisors and managers should do if this situation arises and determine who will be responsible for receiving information and taking next steps.

B.6. An employee who must report to the workplace knows that a coworker who reports to the same workplace has symptoms associated with COVID-19. Does ADA confidentiality prevent the first employee from disclosing the coworker's symptoms to a supervisor? *(9/8/20; adapted from 3/27/20 Webinar Question 6)*

No. ADA confidentiality does not prevent this employee from communicating to the employee's supervisor about a coworker's symptoms. In other words, it is not an ADA confidentiality violation for this employee to inform the supervisor about a coworker's symptoms. After learning about this situation, the supervisor should contact appropriate management officials to report this information and discuss next steps.

B.7. An employer knows that an employee is teleworking because the person has COVID-19 or symptoms associated with the disease, and is in self-quarantine. May the employer tell staff that this particular employee is teleworking without saying why? *(9/8/20; adapted from 3/27/20 Webinar Question 7)*

Yes. If staff need to know how to contact the employee, and that the employee is working even if not present in the workplace, then disclosure that the employee is teleworking without saying why is permissible. Also, if the employee was on leave rather than teleworking because the employee has COVID-19 or symptoms associated with the disease, or any other medical condition, then an employer cannot disclose the reason for the leave, just the fact that the fact that the individual is on leave.

B.8. Many employees, including managers and supervisors, are now teleworking as a result of COVID-19. How are they supposed to keep medical information of employees confidential while working remotely? *(9/8/20; adapted from 3/27/20 Webinar Question 9)*

The ADA requirement that medical information be kept confidential includes a requirement that it be stored separately from regular personnel files. If a manager or supervisor receives medical information involving COVID-19, or any other medical

information, while teleworking, and is able to follow an employer's existing confidentiality protocols while working remotely, the supervisor has to do so. But to the extent that is not feasible, the supervisor still must safeguard this information to the greatest extent possible until the supervisor can properly store it. This means that paper notepads, laptops, or other devices should not be left where others can access the protected information.

Similarly, documentation must not be stored electronically where others would have access. A manager may even wish to use initials or another code to further ensure confidentiality of the name of an employee.

C. Hiring and Onboarding

Under the ADA, prior to making a conditional job offer to an applicant, disability-related inquiries and medical exams are generally prohibited. They are permitted between the time of the offer and when the applicant begins work, provided they are required for everyone in the same job category.

C.1. If an employer is hiring, may it screen applicants for symptoms of COVID-19? *(Updated 7/12/22)*

Yes. An employer may screen job applicants for symptoms of COVID-19 after making a conditional job offer, as long as it does so for all entering employees in the same type of job. This ADA rule applies whether or not the applicant has a disability.

In addition, if an employer screens **everyone** (i.e., applicants, employees, contractors, visitors) for COVID-19 before permitting entry to the worksite, then an applicant in the pre-offer stage who needs to be in the workplace as part of the application process (e.g., for a job interview) may likewise be screened for COVID-19. The screening is limited to the same screening that everyone else undergoes; an employer that goes beyond that screening will have engaged in an illegal pre-offer disability-related inquiry and/or medical examination. For information on the ADA rules governing such inquiries and examination, see **Section A**.

C.2. May an employer take an applicant's temperature as part of a post-offer, pre-employment medical exam? *(3/18/20)*

Yes. Any medical exams are permitted after an employer has made a conditional offer of employment. However, employers should be aware that some people with COVID-19 do not have a fever.

C.3. May an employer delay the start date of an applicant who has COVID-19 or symptoms associated with it? *(3/18/20)*

Yes. According to CDC guidance, an individual who has COVID-19 or symptoms associated with it should not be in the workplace.

C.4. May an employer withdraw a job offer when it needs an applicant to start working immediately, whether at the worksite or in the physical presence of others outside of the worksite, because the individual has tested positive for the virus that causes COVID-19, has symptoms of COVID-19, or has been exposed recently to someone with COVID-19? *(Updated 7/12/22)*

An employer should consult and follow current **CDC guidance (https://www.cdc.gov/coronavirus/2019-ncov/your-health/quarantine-isolation.html)** that explains when and how it would be safe for an individual who currently has COVID-19, symptoms of COVID-19, or has been exposed recently to someone with COVID-19, to end **isolation or quarantine (https://www.cdc.gov/coronavirus/2019-ncov/your-health/quarantine-isolation.html)** and thus safely enter a workplace or otherwise work in the physical presence of others. An employer who follows current CDC guidance addressing the individual's situation may withdraw the job offer if (1) the job requires an immediate start date, (2) CDC guidance recommends the person not be in proximity to others, **and** (3) the job requires such proximity to others, whether at the workplace or elsewhere. Given that for some individuals there may only be a short period of time required for isolation or quarantine, employers may be able to adjust a start date or permit telework (if job duties can be performed remotely).

RISK FACTORS for COVID for PROTECTED CLASSES

C.5. May an employer postpone the start date or withdraw a job offer because of the employer's concern that the individual is older, pregnant, or has an underlying medical condition that puts the individual at increased risk from COVID-19? *(Updated 7/12/22)*

No. An employer's concern for an applicant's well-being -- an intent to protect them from what it perceives as a risk of illness from COVID-19 -- does not excuse an action that is otherwise unlawful discrimination. The fact that **CDC**

(https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html) has noted that older adults, people with certain medical conditions, or pregnant and recently pregnant people may be at greater risk of severe illness from COVID-19 does not justify unilaterally postponing the start date or withdrawing a job offer. Therefore, an employer may not discriminate based on age (40 or older) or pregnancy and related conditions. If an underlying medical condition is a disability, an employer must determine whether the individual's disability poses a "direct threat" by starting work immediately and, if so, whether reasonable accommodation can be provided to sufficiently lessen or eliminate any risks without causing an undue hardship. For more information on assessing direct threat and reasonable accommodation in this situation, see **G.4.** and **G.5.** For more information on potential issues regarding discrimination based on age or pregnancy, see Sections **H** and **J.**

D. Disability and Reasonable Accommodation

Under the ADA, reasonable accommodations are adjustments or modifications provided by an employer to enable people with disabilities to enjoy equal employment opportunities. If a reasonable accommodation is needed and requested by an individual with a disability to apply for a job, perform a job, or enjoy benefits and privileges of employment, the employer must provide it unless it would pose an undue hardship, meaning significant difficulty or expense. An employer has the discretion to choose among effective accommodations. Where a requested accommodation would result in undue hardship, the employer must offer an alternative accommodation if one is available absent undue hardship. In discussing accommodation requests, employers and employees may find it helpful to consult the Job Accommodation Network (JAN) website for types of accommodations, ***www.askjan.org (http://www.askjan.org/)****. JAN's materials specific to COVID-19 are at* ***https://askjan.org/topics/COVID-19.cfm (https://askjan.org/topics/COVID-19.cfm)****.*

For more information on reasonable accommodation issues that may arise when employees return to the workplace, see ***Section G****. For more information on reasonable accommodation and pregnancy-related disabilities, see* ***Section J****. For*

more information on reasonable accommodation and COVID-19 vaccinations, see ***K.1.***, ***K.2.***, ***K.5.***, ***K.6.***, *and* ***K.11.***

D.1. If a job may only be performed at the workplace, are there reasonable accommodations (https://www.eeoc.gov/laws/guidance/enforcement-guidance-reasonable-accommodation-and-undue-hardship-under-ada#general) for individuals with disabilities, absent undue hardship (https://www.eeoc.gov/laws/guidance/enforcement-guidance-reasonable-accommodation-and-undue-hardship-under-ada#undue) , that could offer protection to an employee who, due to a preexisting disability, is at higher risk from COVID-19? *(4/9/20)*

There may be reasonable accommodations that **could offer protection to an individual whose disability puts that person at greater risk from COVID-19 (https://www.eeoc.gov/transcript-march-27-2020-outreach-webinar#q17)** and who therefore requests such actions to eliminate possible exposure. Even with the constraints imposed by a pandemic, some accommodations may meet an employee's needs on a temporary basis without causing undue hardship on the employer.

Low-cost solutions achieved with materials already on hand or easily obtained may be effective. If not already implemented for all employees, accommodations for those who request reduced contact with others due to a disability may include changes to the work environment such as designating one-way aisles; using plexiglass, tables, or other barriers to ensure minimum distances between customers and coworkers whenever feasible per **CDC guidance (https://www.cdc.gov/coronavirus/2019-ncov/community/index.html)** or other accommodations that reduce chances of exposure.

Flexibility by employers and employees is important in determining if some accommodation is possible in the circumstances. Temporary job restructuring of marginal job duties, temporary transfers to a different position, or modifying a work schedule or shift assignment may also permit an individual with a disability to perform safely the essential functions of the job while reducing exposure to others in the workplace or while commuting.

D.2. If an employee has a preexisting mental illness or disorder that has been exacerbated by the COVID-19 pandemic, may the employee now be entitled to a reasonable accommodation (absent undue hardship)? *(4/9/20)*

Although many people feel significant stress due to the COVID-19 pandemic, employees with certain preexisting mental health conditions, for example, anxiety disorder, obsessive-compulsive disorder, or post-traumatic stress disorder, may have more difficulty handling the disruption to daily life that has accompanied the COVID-19 pandemic.

As with any accommodation request, employers may: ask questions to determine whether the condition is a disability; discuss with the employee how the requested accommodation would assist the employee and enable the employee to keep working; explore alternative accommodations that may effectively meet the employee's needs; and request medical documentation if needed.

D.3. In a workplace where all employees are required to telework during this time, should an employer postpone discussing a request from an employee with a disability for an accommodation that will not be needed until the employee returns to the workplace when mandatory telework ends? *(4/9/20)*

Not necessarily. An employer may give higher priority to discussing requests for reasonable accommodations that are needed while teleworking, but the employer may begin discussing this request now. The employer may be able to acquire all the information it needs to make a decision. If a reasonable accommodation is granted, the employer also may be able to make some arrangements for the accommodation in advance.

D.4. What if an employee was already receiving a reasonable accommodation prior to the COVID-19 pandemic and now requests an additional or altered accommodation? *(4/9/20)*

An employee who was already receiving a reasonable accommodation prior to the COVID-19 pandemic may be entitled to an additional or altered accommodation, absent undue hardship. For example, an employee who is teleworking because of the pandemic may need a different type of accommodation than what the employee **uses in the workplace (https://www.eeoc.gov/transcript-march-27-2020-outreach-webinar#q20)** . The employer **may discuss (https://www.eeoc.gov/laws/guidance/enforcement-guidance-reasonable-accommodation-and-undue-hardship-under-ada#requesting)** with the employee whether the same or a different disability is the basis for this new request and why an additional or altered accommodation is needed.

D.5. During the pandemic, if an employee requests an accommodation for a medical condition either at home or in the workplace, may an employer still request information to determine if the condition is a disability? *(4/17/20)*

Yes, if it is not obvious or already known, an employer may ask questions or request medical documentation to determine whether the employee has a "disability" as defined by the ADA (a physical or mental impairment that substantially limits a major life activity, or a history of a substantially limiting impairment).

D.6. During the pandemic, may an employer still engage in the interactive process and request information from an employee about why an accommodation is needed? *(4/17/20)*

Yes, if it is not obvious or already known, an employer may ask questions or request **medical documentation (https://www.eeoc.gov/transcript-march-27-2020-outreach-webinar#q17)** to determine whether the employee's disability necessitates an accommodation, either the one the employee requested or any other. **Possible questions (https://www.eeoc.gov/laws/guidance/enforcement-guidance-reasonable-accommodation-and-undue-hardship-under-ada#requesting)** for the employee may include: (1) how the disability creates a limitation, (2) how the requested accommodation will effectively address the limitation, (3) whether another form of accommodation could effectively address the issue, and (4) how a proposed accommodation will enable the employee to continue performing the "essential functions" of the employee's position (that is, the fundamental job duties).

D.7. If there is some urgency to providing an accommodation, or the employer has limited time available to discuss the request during the pandemic, may an employer provide a temporary accommodation? *(4/17/20)*

Yes. Given the pandemic, some employers may choose to forgo or shorten the exchange of information between an employer and employee known as the "interactive process" (discussed in D.5 and D.6., above) and grant the request. In addition, when government restrictions change, or are partially or fully lifted, the need for accommodations may also change. This may result in more requests for short-term accommodations. Employers may wish to adapt the interactive process —and devise end dates for the accommodation—to suit changing circumstances based on public health directives.

Whatever the reason for shortening or adapting the interactive process, an employer may also choose to place an end date on the accommodation (for example, either a specific date such as May 30, or when the employee returns to the workplace part- or full-time due to changes in government restrictions limiting the number of people who may congregate). Employers may also opt to provide a requested accommodation on an interim or trial basis, with an end date, while awaiting receipt of medical documentation. Choosing one of these alternatives may be particularly helpful where the requested accommodation would provide protection that an employee may need because of a pre-existing disability that puts the employee at greater risk during this pandemic. This **could also apply (https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws#D.2)** to employees who have disabilities exacerbated by the pandemic.

Employees may request an extension that an employer must consider, particularly if current government restrictions are extended or new ones adopted.

D.8. May an employer invite employees now to ask for reasonable accommodations they may need in the future when they are permitted to return to the workplace? *(4/17/20; updated 9/8/20 to address stakeholder questions)*

Yes. Employers may inform the workforce that employees with disabilities may request accommodations in advance that they believe they may need when the workplace re-opens. This is discussed in greater detail in Question G.6. If advance requests are received, employers may begin the "interactive process" – the discussion between the employer and employee focused on whether the impairment is a disability and the reasons that an accommodation is needed. If an employee chooses not to request accommodation in advance, and instead requests it at a later time, the employer must still consider the request at that time.

D.9. Are the circumstances of the pandemic relevant to whether a requested accommodation can be denied because it poses an undue hardship? *(4/17/20)*

Yes. An employer does not have to provide a particular reasonable accommodation if it poses an "**undue hardship (https://www.eeoc.gov/laws/guidance/enforcement-guidance-reasonable-accommodation-and-undue-hardship-under-ada#undue)**," which means "significant difficulty or expense." As described in the two questions that follow, in

some instances, an accommodation that would not have posed an undue hardship prior to the pandemic may pose one now.

D.10. What types of undue hardship considerations may be relevant to determine if a requested accommodation poses "significant difficulty" during the COVID-19 pandemic? *(4/17/20)*

An employer may consider whether current circumstances create "significant difficulty" in acquiring or providing certain accommodations, considering the facts of the particular job and workplace. For example, it may be significantly more difficult in this pandemic to conduct a needs assessment or to acquire certain items, and delivery may be impacted, particularly for employees who may be teleworking. Or, it may be significantly more difficult to provide employees with temporary assignments, to remove marginal functions, or to readily hire temporary workers for specialized positions. If a particular accommodation poses an undue hardship, employers and employees should work together to determine if there may be an alternative that could be provided that does not pose such problems.

D.11. What types of undue hardship considerations may be relevant to determine if a requested accommodation poses "significant expense" during the COVID-19 pandemic? *(4/17/20)*

Prior to the COVID-19 pandemic, most accommodations did not pose a significant expense when considered against an employer's overall budget and resources (always considering the budget/resources of the entire entity and not just its components). But, the sudden loss of some or all of an employer's income stream because of this pandemic is a relevant consideration. Also relevant is the amount of discretionary funds available at this time—when considering other expenses—and whether there is an expected date that current restrictions on an employer's operations will be lifted (or new restrictions will be added or substituted). These considerations do not mean that an employer can reject any accommodation that costs money; an employer must weigh the cost of an accommodation against its current budget while taking into account constraints created by this pandemic. For example, even under current circumstances, there may be many no-cost or very low-cost accommodations.

D.12. Do the ADA and the Rehabilitation Act apply to applicants or employees who are classified as "critical infrastructure workers (https://www.cdc.gov/coronavirus/2019-ncov/downloads/Essential-Critical-

Workers_Dos-and-Donts.pdf)" or "essential critical workers (https://www.cdc.gov/coronavirus/2019-ncov/community/critical-workers/implementing-safety-practices.html)" by the CDC? *(4/23/20)*

Yes. These CDC designations, or any other designations of certain employees, do not eliminate coverage under the ADA or the Rehabilitation Act, or any other equal employment opportunity law. Therefore, employers receiving requests for reasonable accommodation under the ADA or the Rehabilitation Act from employees falling in these categories of jobs must accept and process the requests as they would for any other employee. Whether the request is granted will depend on whether the worker is an individual with a disability, and whether there is a reasonable accommodation that can be provided absent undue hardship.

D.13. Is an employee entitled to an accommodation under the ADA in order to avoid exposing a family member who is at higher risk of severe illness from COVID-19 due to an underlying medical condition? *(6/11/20)*

No. Although the ADA prohibits discrimination based on association with an individual with a disability, that protection is limited to disparate treatment or harassment. The ADA does not require that an employer accommodate an employee without a disability based on the disability-related needs of a family member or other person with whom the employee is associated.

D.14. When an employer requires some or all of its employees to telework because of COVID-19 or government officials require employers to shut down their facilities and have workers telework, is the employer required to provide a teleworking employee with the same reasonable accommodations for disability under the ADA or the Rehabilitation Act that it provides to this individual in the workplace? *(9/8/20; adapted from 3/27/20 Webinar Question 20)*

If such a request is made, the employer and employee should discuss what the employee needs and why, and whether the same or a different accommodation could suffice in the home setting. For example, an employee may already have certain things in their home to enable them to do their job so that they do not need to have all of the accommodations that are provided in the workplace.

Also, the undue hardship considerations might be different when evaluating a request for accommodation when teleworking rather than working in the workplace. A reasonable accommodation that is feasible and does not pose an

undue hardship in the workplace might pose one when considering circumstances, such as the place where it is needed and the reason for telework. For example, the fact that the period of telework may be of a temporary or unknown duration may render certain accommodations either not feasible or an undue hardship. There may also be constraints on the normal availability of items or on the ability of an employer to conduct a necessary assessment.

As a practical matter, and in light of the circumstances that led to the need for telework, employers and employees should both be creative and flexible about what can be done when an employee needs a reasonable accommodation for telework at home. If possible, providing interim accommodations might be appropriate while an employer discusses a request with the employee or is waiting for additional information.

D.15. Assume that an employer grants telework to employees for the purpose of slowing or stopping the spread of COVID-19. When an employer reopens the workplace and recalls employees to the worksite, does the employer automatically have to grant telework as a reasonable accommodation to every employee with a disability who requests to continue this arrangement as an ADA/Rehabilitation Act accommodation? *(9/8/20; adapted from 3/27/20 Webinar Question 21)*

No. Any time an employee requests a reasonable accommodation, the employer is entitled to understand the disability-related limitation that necessitates an accommodation. If there is no disability-related limitation that requires teleworking, then the employer does not have to provide telework as an accommodation. Or, if there is a disability-related limitation but the employer can effectively address the need with another form of reasonable accommodation at the workplace, then the employer can choose that alternative to telework.

To the extent that an employer is permitting telework to employees because of COVID-19 and is choosing to excuse an employee from performing one or more essential functions, then a request—after the workplace reopens—to continue telework as a reasonable accommodation does not have to be granted if it requires continuing to excuse the employee from performing an essential function. The ADA never requires an employer to eliminate an essential function as an accommodation for an individual with a disability.

The fact that an employer temporarily excused performance of one or more essential functions when it closed the workplace and enabled employees to telework for the purpose of protecting their safety from COVID-19, or otherwise chose to permit telework, does not mean that the employer permanently changed a job's essential functions, that telework is always a feasible accommodation, or that it does not pose an undue hardship. These are fact-specific determinations. The employer has no obligation under the ADA to refrain from restoring all of an employee's essential duties at such time as it chooses to restore the prior work arrangement, and then evaluating any requests for continued or new accommodations under the usual ADA rules.

D.16. Assume that prior to the emergence of the COVID-19 pandemic, an employee with a disability had requested telework as a reasonable accommodation. The employee had shown a disability-related need for this accommodation, but the employer denied it because of concerns that the employee would not be able to perform the essential functions remotely. In the past, the employee therefore continued to come to the workplace. However, after the COVID-19 crisis has subsided and temporary telework ends, the employee renews the request for telework as a reasonable accommodation. Can the employer again refuse the request? *(9/8/20; adapted from 3/27/20 Webinar Question 22)*

Assuming all the requirements for such a reasonable accommodation are satisfied, the temporary telework experience could be relevant to considering the renewed request. In this situation, for example, the period of providing telework because of the COVID-19 pandemic could serve as a trial period that showed whether or not this employee with a disability could satisfactorily perform all essential functions while working remotely, and the employer should consider any new requests in light of this information. As with all accommodation requests, the employee and the employer should engage in a flexible, cooperative interactive process going forward if this issue does arise.

D.17. Might the pandemic result in excusable delays during the interactive process? *(Updated 7/12/22)*

Yes. Some of the issues initially created by the pandemic that delayed engaging in an interactive process and/or providing reasonable accommodation may no longer exist. But, as the pandemic continues to evolve and new issues arise, it is possible that an employer may face new challenges that interfere with responding

expeditiously to a request for accommodation. Similarly, reopening a workplace may bring a higher number of requests for reasonable accommodation. In all these situations, an employer must show specific pandemic-related circumstances justified the delay in providing a reasonable accommodation to which the employee was legally entitled. To the extent that evolving circumstances created by the pandemic cause a justifiable delay in the interactive process–thereby delaying a decision on a request–employers and employees are encouraged to use interim solutions to enable employees to keep working as much as possible.

D.18. Federal agencies are required to have timelines in their written reasonable accommodation procedures governing how quickly they will process requests and provide reasonable accommodations. What happens if circumstances created by the pandemic prevent an agency from meeting this timeline? *(Updated 7/12/22)*

Situations created by the current COVID-19 pandemic may constitute an "extenuating circumstance"—something beyond a federal agency's control—that may justify exceeding the normal timeline that an agency has adopted in its internal reasonable accommodation procedures.

Some of the issues initially created by the pandemic that delayed engaging in an interactive process and/or providing reasonable accommodation may no longer exist. But, as the pandemic continues to evolve and new issues arise, it is possible that an agency may face new challenges that interfere with responding to a request for accommodation within an agency's timeline. Similarly, reopening a workplace may bring a higher number of requests for reasonable accommodation. In all these situations, an agency must show specific pandemic-related circumstances that constitute an "extenuating circumstance." To the extent that there is an extenuating circumstance, agencies and employees are encouraged to use interim solutions to enable employees to keep working as much as possible.

E. Pandemic-Related Harassment Due to National Origin, Race, or Other Protected Characteristics

E.1. What practical tools are available to employers to reduce and address workplace harassment that may arise as a result of the COVID-19 pandemic? *(4/9/20)*

Employers can help reduce the chance of harassment by explicitly communicating to the workforce that fear of the COVID-19 pandemic should not be misdirected against individuals because of a protected characteristic, including their **national origin, race (https://www.eeoc.gov/wysk/message-eeoc-chair-janet-dhillon-national-origin-and-race-discrimination-during-covid-19)**, or other prohibited bases.

Practical anti-harassment tools provided by the EEOC for small businesses can be found here:

- Anti-harassment **policy tips (https://www.eeoc.gov/employers/small-business/harassment-policy-tips)** for small businesses
- Select Task Force on the Study of Harassment in the Workplace (includes detailed recommendations and tools to aid in designing effective anti-harassment policies; developing training curricula; implementing complaint, reporting, and investigation procedures; creating an organizational culture in which harassment is not tolerated):
    - **report (https://www.eeoc.gov/select-task-force-study-harassment-workplace#_Toc453686319)**;
    - **checklists (https://www.eeoc.gov/select-task-force-study-harassment-workplace#_Toc453686319)** for employers who want to reduce and address harassment in the workplace; and
    - **chart (https://www.eeoc.gov/chart-risk-factors-harassment-and-responsive-strategies)** of risk factors that lead to harassment and appropriate responses.

E.2. Are there steps an employer should take to address possible harassment and discrimination against coworkers when it re-opens the workplace? *(4/17/20)*

Yes. An employer may remind all employees that it is against the federal EEO laws to harass or otherwise discriminate against coworkers based on race, national origin, color, sex, religion, age (40 or over), disability, or genetic information. It may be particularly helpful for employers to advise supervisors and managers of their roles

in watching for, stopping, and reporting any harassment or other discrimination. An employer may also make clear that it will immediately review any allegations of harassment or discrimination and take appropriate action.

E.3. How may employers respond to pandemic-related harassment, in particular against employees who are or are perceived to be Asian? *(6/11/20)*

Managers should be alert to demeaning, derogatory, or hostile remarks directed to employees who are or are perceived to be of Chinese or other Asian national origin, including about the coronavirus or its origins.

All employers covered by Title VII should ensure that management understands in advance how to recognize such harassment. Harassment may occur using electronic communication tools—regardless of whether employees are in the workplace, teleworking, or on leave—and also in person between employees at the worksite. Harassment of employees at the worksite may also originate with contractors, customers or clients, or, for example, with patients or their family members at health care facilities, assisted living facilities, and nursing homes. Managers should know their legal obligations and be **instructed (https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws#E.2)** to quickly identify and resolve potential problems, before they rise to the level of unlawful discrimination.

Employers may choose to send a reminder to the entire workforce noting Title VII's prohibitions on harassment, reminding employees that harassment will not be tolerated, and inviting anyone who experiences or witnesses workplace harassment to report it to management. Employers may remind employees that harassment can result in disciplinary action up to and including termination.

E.4. An employer learns that an employee who is teleworking due to the pandemic is sending harassing emails to another worker. What actions should the employer take? *(6/11/20)*

The employer should take the same actions it would take if the employee was in the workplace. Employees may not harass other employees through, for example, emails, calls, or platforms for video or chat communication and collaboration.

F. Furloughs and Layoffs

F.1. Under the EEOC's laws, what waiver responsibilities apply when an employer is conducting layoffs? *(4/9/20)*

Special rules apply when an employer is offering employees severance packages in exchange for a general release of all discrimination claims against the employer. More information is available in EEOC's **technical assistance document on severance agreements (https://www.eeoc.gov/laws/guidance/qa-understanding-waivers-discrimination-claims-employee-severance-agreements)**.

F.2. What are additional EEO considerations in planning furloughs or layoffs? *(9/8/20; adapted from 3/27/20 Webinar Question 13)*

The laws enforced by the EEOC prohibit covered employers from selecting people for furlough or layoff because of that individual's race, color, religion, national origin, sex, age, disability, protected genetic information, or in retaliation for protected EEO activity.

G. Return to the Workplace

G.1. As government restrictions are lifted or modified , how will employers know what steps they can take consistent with the ADA to screen employees for the virus that causes COVID-19 when entering the workplace? *(Updated 7/12/22)*

The ADA permits employers to make disability-related inquiries and conduct medical exams to screen employees for COVID-19 when entering the workplace if such screening is "job-related and consistent with business necessity." For more information on disability-related inquiries and medical examinations, see **Section A**. For information on reasonable accommodation requests related to screening protocols, see **G.7**.

Employers should make sure not to engage in unlawful disparate treatment based on protected characteristics in decisions related to screening and exclusion.

G.2. An employer requires workers to wear personal protective equipment and engage in other infection control practices. Some employees ask for accommodations due to a disability or a sincerely held religious belief, practice, or observance that affects the ability to wear personal protective equipment

and/or engage in other infection control practices. How should an employer respond? *(Updated 7/12/22)*

In most instances, federal EEO laws permit an employer to require employees to wear personal protective equipment (PPE) (for example, **masks (https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/about-face-coverings.html)** and/or gloves) and observe other infection control practices (for example, regular hand washing or physical distancing protocols). Some employers may need to comply with regulations issued by the Occupational Safety and Health Administration (OSHA) that require the use of PPE. OSHA regulations do not prohibit the use of reasonable accommodations under the EEO laws as long as those accommodations do not violate OSHA requirements. Employers also may follow current CDC guidance about who should wear **masks (https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/about-face-coverings.html)**.

Regardless of the reason an employer requires PPE (or other infection control measures), when an employee with a disability needs a reasonable accommodation under the ADA to comply with an employer's requirement to wear PPE (e.g., non-latex gloves, modified face masks for interpreters or others who communicate with an employee who uses lip reading, or gowns designed for individuals who use wheelchairs), or when an employee requires a religious accommodation under Title VII (such as modified or alternative equipment due to religious attire or grooming practices), the employer should discuss the request and provide accommodation (either what is requested by the employee or an alternative that is effective in meeting the employee's needs) if it does not cause an undue hardship on the operation of the employer's business under the ADA or Title VII. For general information on reasonable accommodation under the ADA, see **Section D**.

G.3. What does an employee need to do in order to request reasonable accommodation from an employer because the employee has one of the medical conditions (https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html) that CDC says may put a person at higher risk for severe illness from COVID-19? *(Updated 7/12/22)*

An employee—or a third party, such as an employee's doctor—must **let the employer know (https://www.eeoc.gov/laws/guidance/enforcement-guidance-reasonable-accommodation-and-undue-hardship-under-ada#requesting)** that

the employee needs a change for a reason related to a medical condition . Individuals may request accommodation orally or in writing. While the employee (or third party) does not need to use the term "reasonable accommodation" or reference the ADA, the employee may do so.

The employee or the employee's representative should communicate that the employee has a medical condition necessitating a change to meet a medical need. After receiving a request, the employer may **ask questions or seek medical documentation (https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws#D.6)** to help decide if the individual has a disability—not all medical conditions meet the ADA's definition of "disability"—and if there is a reasonable accommodation, barring **undue hardship (https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws#D)** , that can be provided. For additional information on reasonable accommodation under the ADA, see **Section D**. For information on pregnancy-related disabilities covered under the ADA, see **J.2**. For general information on reasonable accommodation requests related to a sincerely held religious belief, practice, or observance, see **K.12**.

G.4. CDC identifies a number of medical conditions (https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html) that are more likely to cause people to get severely ill if they get COVID-19. An employer knows that an employee has one of these conditions and is concerned that the employee's health will be jeopardized upon returning to the workplace, but the employee has not requested accommodation. How does the ADA apply to this situation? *(Updated 7/12/22)*

The ADA does not mandate that the employer take action in this situation if the employee has not requested reasonable accommodation. Also, an employer's duty to provide reasonable accommodation applies only if an employee has an actual disability or a record of a disability, as defined in the ADA; this means not every individual with one of the medical conditions that might place them at higher risk of COVID-19 complications will automatically satisfy these ADA definitions of **disability**.

Assuming the employee has a "disability" as discussed above, if the employer is concerned that the health of an employee with a disability may be jeopardized upon returning to the workplace, the ADA generally does not allow the employer to

exclude the employee—or take any other adverse action—because the employee has a disability that CDC identifies as potentially placing the employee at higher risk for severe illness if the employee gets COVID-19. Under the ADA, such an adverse action is not allowed unless the employee's disability poses a "direct threat" to the employee's health or safety that cannot be eliminated or reduced by reasonable accommodation.

The ADA direct threat requirement is a high standard. As an affirmative defense for the employer, direct threat requires an employer to show that the individual has a disability that poses a "significant risk of substantial harm" to the employee's own health or safety, or that of others in the workplace under 29 C.F.R. section 1630.2(r) (regulation addressing direct threat to health or safety of self or others). A direct threat assessment cannot be based solely on the disability being identified in CDC's guidance; the determination must be an individualized assessment based on a reasonable medical judgment about this employee's disability—not the disability in general—using the most current medical knowledge and/or on the best available objective evidence. Thus, an employer analyzing a potential direct threat must consider the duration of the risk, the nature and severity of the potential harm, the likelihood that the potential harm will occur, and the imminence of the potential harm. Analysis of these factors will likely include considerations based on the severity of the pandemic in a particular area and the employee's own health (for example, is the employee's disability well-controlled), and the employee's particular job duties. A determination of direct threat also would include whether the employee is **up to date on vaccinations (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html)** and the likelihood that an individual may be exposed to the virus at the worksite. Measures that an employer may be taking in general to protect all workers, such as mandatory physical distancing, also would be relevant.

Even if an employer determines that an employee's disability poses a "significant risk of substantial harm" to the employee's own health or safety, the employer still cannot exclude the employee from the workplace—or take any other adverse action—unless there is no way to provide a reasonable accommodation (absent undue hardship). The ADA regulations require an employer to consider whether there are reasonable accommodations that would eliminate or sufficiently reduce the risk so that it would be safe for the employee to return to the workplace, while still permitting the employee to perform the essential functions of the job.

An employer's consideration of a possible reasonable accommodation should involve an interactive process with the employee. If there are no accommodations in an employee's current position that sufficiently reduce or eliminate direct threat in the workplace, then an employer must consider accommodations such as telework, leave, or—as a last resort—reassignment (perhaps to a different job in a place where it may be safer for the employee to work or that permits telework).

An employer may only bar an employee from working based on the direct threat analysis if, after going through all these steps, the facts support the conclusion that the employee poses a significant risk of substantial harm to the employee's own health or safety that cannot be reduced or eliminated by reasonable accommodation. For general information on reasonable accommodation under the ADA (i.e., where an individual's request for reasonable accommodation has nothing to do with potential direct threat concerns), see **Section D**.

G.5. What are examples of reasonable accommodation that, absent undue hardship, may eliminate (or reduce to an acceptable level) a direct threat to self or others? *(Updated 7/12/22)*

Reasonable accommodations that may eliminate (or reduce to an acceptable level) a direct threat to self or others may include additional or enhanced protective gowns, masks, gloves, or other gear beyond what the employer may generally provide to, or require from, employees returning to its workplace. Reasonable accommodations also may include additional or enhanced protective measures, such as High Efficiency Particulate Air (HEPA) filtration systems/units or other enhanced air filtration measures, erecting a barrier that provides separation between an employee with a disability and coworkers/the public, or increasing the space between an employee with a disability and others. Another possible reasonable accommodation may be elimination or substitution of particular "marginal" functions (less critical or incidental job duties as distinguished from the "essential" functions of a particular position). In addition, accommodations may include telework, modification of work schedules (if that decreases contact with coworkers and/or the public when on duty or commuting), or moving the location of where one performs work (for example, moving a person to the end of a production line rather than in the middle of it if that provides more physical distancing).

These are only a few ideas. Identifying an effective accommodation depends, among other things, on an employee's job duties and the design of the workspace. An employer and employee should discuss possible ideas; the Job Accommodation

Network (**www.askjan.org (http://www.askjan.org/)**) also may be able to assist in helping identify possible accommodations. As with all discussions of reasonable accommodation during this pandemic, employers and employees are encouraged to be creative and flexible. For general information on reasonable accommodation under the ADA, see **Section D**.

G.6. As a best practice, and in advance of having some or all employees return to the workplace, are there ways for an employer to invite employees to request flexibility in work arrangements? *(Updated 7/12/22)*

Yes. The ADA, the Rehabilitation Act, and Title VII of the Civil Rights Act do not prohibit employers from making information available in advance to **all** employees about whom to contact—if they wish—to request reasonable accommodation that they may need for a disability or a sincerely held religious belief, practice or observance upon return to the workplace. Once requests are received, the employer may begin the interactive process. An employer may choose to include in such a notice all medical conditions identified in **CDC guidance (https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html)** that may place people at higher risk of serious illness if they contract COVID-19, provide instructions about whom to contact, and explain that the employer is willing to consider on a case-by-case basis any requests from employees who have these or other medical conditions which may qualify as disabilities.

Alternatively, an employer may send a general notice explaining that the employer is willing to consider employee requests for reasonable accommodation for employees with a disability or a sincerely held religious belief, practice, or observance, or to consider flexibility on an individualized basis for employees not eligible for reasonable accommodation (e.g., employees who request flexibility due to age). The employer should specify if the point of contact is different depending on whether the request is based on disability, sincerely held religious beliefs, pregnancy, age, or child-care responsibilities.

Either approach is consistent with the Age Discrimination in Employment Act (ADEA), the ADA, the Rehabilitation Act, and Title VII.

Regardless of the approach, employers should ensure that those employees who receive, review, or process these requests are sufficiently trained in how to handle them in accordance with the federal employment nondiscrimination laws that may

apply, for instance, with respect to accommodations due to a disability or a sincerely held religious belief, observance, or practice; or a request related to pregnancy. For additional information on reasonable accommodation under the ADA/Rehabilitation Act, see **Section D**.

G.7. What should an employer do if an employee entering the worksite requests an alternative method of screening due to a medical condition? *(6/11/20)*

This is a request for reasonable accommodation, and an employer should proceed as it would for any other request for accommodation under the ADA or the Rehabilitation Act. If the requested change is easy to provide and inexpensive, the employer might voluntarily choose to make it available to anyone who asks, without going through an interactive process. Alternatively, if a disability is not obvious or already known, an employer may ask the employee for information to establish that the condition is a **disability (https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws#D.5)** and what specific limitations require an accommodation. If necessary, an employer also may request medical documentation to support the employee's request, and then determine if that accommodation or an alternative effective accommodation can be provided, absent undue hardship.

Similarly, if an employee requested an alternative method of screening as a religious accommodation, the employer should determine if accommodation is **available under Title VII (https://www.eeoc.gov/laws/guidance/questions-and-answers-religious-discrimination-workplace)**.

H. Age

H.1. CDC has explained (https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html) that the risk for severe illness with COVID-19 increases with age, with older adults at the highest risk. Do older adults have protections under the federal employment discrimination laws? *(Updated 7/12/22)*

Yes. The Age Discrimination in Employment Act (ADEA) prohibits employment discrimination against individuals age 40 and older. The ADEA would prohibit a covered employer from excluding an individual involuntarily from the workplace based on being older, even if the employer acted for benevolent reasons such as

protecting the employee due to higher risk of severe illness from COVID-19. For more information on postponing a start date or withdrawing a job offer due to older age, see **C.5**.

Unlike the ADA, the ADEA does not include a right to reasonable accommodation for workers due to age. However, employers are free to provide flexibility to older workers; the ADEA does not prohibit this, even if it results in younger workers being treated less favorably based on age in comparison.

Older workers also may have medical conditions that bring them under the protection of the ADA as individuals with disabilities. As such, they may request reasonable **accommodation for their disability (https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws#D.1)** .

H.2. If an employer is choosing to offer flexibilities to other workers, may older comparable workers be treated less favorably based on age? *(9/8/20; adapted from 3/27/20 Webinar Question 12)*

No. If an employer is allowing other comparable workers to telework, it should make sure it is not treating older workers less favorably based on their age.

I. Caregivers/Family Responsibilities

For additional information about pandemic-related caregiver discrimination under the laws enforced by the EEOC, see the EEOC's technical assistance document, **The COVID-19 Pandemic and Caregiver Discrimination Under Federal Employment Discrimination Laws. (https://www.eeoc.gov/laws/guidance/covid-19-pandemic-and-caregiver-discrimination-under-federal-employment)**

I.1. If an employer provides telework, modified schedules, or other benefits to employees with school-age children due to school closures or distance learning during the pandemic, are there sex discrimination considerations? *(3/14/22)*

Employers may provide any flexibilities as long as they are not treating employees differently based on sex or other EEO-protected characteristics. For example, under Title VII, female employees cannot be given more favorable treatment than male employees because of a gender-based assumption about who may have **caregiving**

responsibilities (https://www.eeoc.gov/laws/guidance/enforcement-guidance-unlawful-disparate-treatment-workers-caregiving-responsibilities) for children.

I.2. How might unlawful caregiver discrimination related to the COVID-19 pandemic arise under the laws enforced by the EEOC? *(3/14/22)*

Caregiver discrimination violates the laws enforced by the EEOC if it is based on an applicant's or employee's sex (including pregnancy, sexual orientation, or gender identity), race, national origin, disability, age (40 or older), or another **characteristic covered by federal employment discrimination laws (https://www.eeoc.gov/discrimination-type)**. Caregiver discrimination also is unlawful if it is based on the caregiver's association with an individual with a disability, or on the race, ethnicity, or other protected characteristic of the individual receiving care.

Caregiver discrimination related to the pandemic may arise in a variety of ways. For instance, under Title VII, employers may not discriminate against employees with pandemic-related caregiving responsibilities based on their sex, including gender stereotypes associated with caregiving responsibilities or roles. For example, employers may not decline to assign female employees with caregiving responsibilities demanding or high-profile projects that increase employees' advancement potential but require significant overtime or travel. Likewise, employers may not reassign such projects to other employees based on assumptions that female caregivers cannot, should not, or would not want to work extra hours or be away from their families if a family member is infected with or exposed to COVID-19. Employers also may not deny male employees permission to telework or to adjust their schedules to enable them to perform pandemic-related caregiving obligations, such as caring for young children or parents, while granting such requests when made by similarly situated female employees.

Title VII also prohibits employers from discriminating against employees with pandemic-related caregiving duties based on their race or national origin. For example, employers may not require more burdensome processes for employees of a certain race or national origin who are requesting schedule changes or leave related to COVID-19 caregiving. Employers also may not deny such requests more frequently, or penalize employees for requesting or receiving schedule changes or leave for caregiving purposes, based on employees' race or national origin. Discrimination based on citizenship or immigration status against workers with caregiving responsibilities also can be unlawful under a law enforced by the

Department of Justice (https://www.justice.gov/crt/immigrant-and-employee-rights-section) .

Under the ADA, employers may not discriminate against workers based on stereotypes or assumptions about workers' caregiving responsibilities for an individual with a disability, such as a child, spouse, or parent with a disability. For example, if an applicant is the primary caregiver of an individual with a disability who is at higher risk of complications from COVID-19, an employer may not refuse to hire the applicant out of fear that the care recipient will increase the employer's healthcare costs. If the applicant is hired, the employer may not refuse to allow the care recipient to be added as a dependent on the employer's health insurance because of that individual's disability. An employer also may not refuse to promote employees with caregiving responsibilities for an individual with a disability based on the assumption that they will take a significant amount of leave for caregiving purposes.

I.3. Are these legal protections available only to workers caring for children, or are they also available to workers with other caregiving obligations? *(3/14/22)*

This response includes hyperlinks to non-governmental sources. The EEOC includes these resources solely for informational purposes. The EEOC does not endorse these resources or the entities responsible for them, and it does not vouch for the accuracy of the information provided by referencing the non-governmental sources in this response.

Employers may not discriminate against applicants or employees with caregiving responsibilities based on characteristics protected by the laws enforced by the EEOC, including caregivers' sex (including pregnancy, sexual orientation, or gender identity), race, color, religion, national origin, age (40 or older), disability, association with an individual with a disability, or genetic information (including family medical history). These protections are available to workers with any type of caregiving responsibilities, including care for children, spouses, partners, relatives, individuals with disabilities, or others.

State or local laws may provide additional protections for workers with caregiving responsibilities. Employees with caregiving responsibilities also may have rights under other laws, including the **Family and Medical Leave Act (https://www.dol.gov/agencies/whd/fmla)** or similar **state**

(https://www.ncsl.org/research/labor-and-employment/state-family-and-medical-leave-laws.aspx) or local laws.

I.4. Should employers and employees be aware of any other pandemic-related caregiver discrimination issues? *(3/14/22)*

Yes. In this What You Should Know document, the EEOC addresses several different types of potential pandemic-related caregiver discrimination. For example:

- **A.10** addresses employer inquiries about family members with COVID-19 or related symptoms.
- **C.5** addresses employer-imposed start date postponements or offer withdrawals for pregnant applicants.
- **D.13** addresses whether employees are entitled to accommodations to avoid exposing family members at high risk of complications from COVID-19.
- **J.1** and **J.2** address excluding employees from the workplace based on pregnancy and accommodating pregnancy.
- **K.2** addresses pregnancy accommodation requests related to vaccination.
- **K.3** addresses employer encouragement of vaccination of family members.
- **K.13** addresses decisions not to be vaccinated due to pregnancy.
- **K.18** addresses GINA and incentives for non-employer-provided family member vaccinations or employer requests for documentation of family member vaccinations.
- **K.20** addresses GINA and incentives for employer-provided family member vaccinations.
- **K.21** addresses GINA and family member vaccinations without incentives.

For general information about caregiver discrimination and federal employment discrimination laws, see the EEOC's **policy guidance (https://www.eeoc.gov/laws/guidance/enforcement-guidance-unlawful-disparate-treatment-workers-caregiving-responsibilities)**, associated **fact sheet (https://www.eeoc.gov/questions-and-answers-about-eeocs-enforcement-guidance-unlawful-disparate-treatment-workers)**, and **best practices**

(https://www.eeoc.gov/laws/guidance/employer-best-practices-workers-caregiving-responsibilities) document.

J. Pregnancy

J.1. Due to the pandemic, may an employer exclude an employee from the workplace involuntarily due to pregnancy (https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/pregnancy-breastfeeding.html) ? *(6/11/20)*

No. Sex discrimination under Title VII of the Civil Rights Act includes discrimination based on pregnancy. Even if motivated by benevolent concern, an employer is not permitted to single out workers on the basis of pregnancy for adverse employment actions, including involuntary leave, layoff, or furlough. For more information on postponing a start date or withdrawing a job offer due to pregnancy, see **C.5**.

J.2. Is there a right to accommodation based on pregnancy during the pandemic? *(6/11/20)*

There are two federal employment discrimination laws that may trigger accommodation for employees based on pregnancy (https://www.eeoc.gov/laws/guidance/legal-rights-pregnant-workers-under-federal-law) .

First, pregnancy-related medical conditions may themselves be disabilities under the ADA, even though pregnancy itself is not an ADA disability. If an employee makes a request for reasonable accommodation due to a pregnancy-related medical condition, the employer must consider it under the usual ADA rules.

Second, Title VII as amended by the Pregnancy Discrimination Act specifically requires that women affected by pregnancy, childbirth, and related medical conditions be treated the same as others who are similar in their ability or inability to work. This means that a pregnant employee may be entitled to job modifications, including telework, changes to work schedules or assignments, and leave to the extent provided for other employees who are similar in their ability or inability to work. Employers should ensure that supervisors, managers, and human resources personnel know how to handle such requests to avoid disparate treatment in

violation of Title VII. For information on pregnancy and COVID-19 vaccination, see **K.13**.

K. Vaccinations – Overview, ADA, Title VII, and GINA

Note: Court decisions upholding or rejecting federal vaccination requirements do not affect any statements made in this publication regarding employer and employee rights and responsibilities under the equal employment opportunity laws with respect to employers that require COVID-19 vaccinations.

The availability of COVID-19 vaccinations raises questions under the federal equal employment opportunity (EEO) laws, including the Americans with Disabilities Act (ADA), the Rehabilitation Act, the Genetic Information Nondiscrimination Act (GINA), and Title VII of the Civil Rights Act, as amended, inter alia, by the Pregnancy Discrimination Act (Title VII) (see also ***Section J, EEO rights relating to pregnancy*** and **Section L, Vaccinations – Title VII Religious Objections to COVID-19 Vaccine Requirements**.*)*

This section was originally issued on December 16, 2020, and was updated on October 25, 2021. Note that the Centers for Disease Control and Prevention (CDC) has ***issued guidance (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated.html)*** *for fully vaccinated individuals that addresses, among other things, when they need to wear a mask indoors.*

The EEOC has received many inquiries from employers and employees about the type of authorization granted by the U.S. Department of Health and Human Services (HHS) Food and Drug Administration (FDA) for the administration of COVID-19 vaccines. On August 23, 2021, the FDA approved the Biologics License Application for the Pfizer-BioNTech COVID-19 vaccine for use in individuals 16 years of age and older. Previously, the FDA granted Emergency Use Authorizations (EUAs) for the two other vaccines—one made by Moderna and the other by Janssen/Johnson & Johnson—authorizing them for use in the United States for individuals 18 years of age and older. The Pfizer-BioNTech vaccine is authorized under an EUA for individuals 12 years of age and older and for the administration of a ***third dose (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/booster-shot.html)*** *in certain immunocompromised individuals.* For the current status of vaccines

authorized or approved by the FDA, please visit: **https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html (https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html)**

Also of note, on July 6, 2021, the U.S. Department of Justice's Office of Legal Counsel issued a Memorandum Opinion concluding that section 564 of the Federal Food, Drug, and Cosmetic Act does not prohibit public or private entities from imposing vaccination requirements for a vaccine that is subject to an EUA.

Other federal, state, and local laws and regulations govern COVID-19 vaccination of employees, including requirements for the federal government as an employer. The federal government as an employer is subject to the EEO laws. Federal departments and agencies should consult the website of the ***Safer Federal Workforce Task Force*** **(https://www.saferfederalworkforce.gov/)** *for the latest guidance on federal agency operations during the COVID-19 pandemic.*

This technical assistance on vaccinations was written to help employees and employers better understand how federal laws related to workplace discrimination apply during the COVID-19 pandemic. The EEOC questions and answers provided here set forth applicable EEO legal standards consistent with the federal civil rights laws enforced by the EEOC and with EEOC regulations, guidance, and technical assistance, unless another source is expressly cited. In addition, whether an employer meets the EEO standards will depend on the application of these standards to particular factual situations.

COVID-19 Vaccinations: EEO Overview

K.1. Under the ADA, Title VII, and other federal employment nondiscrimination laws, may an employer require all employees to be vaccinated against COVID-19? *(Updated 7/12/22)*

The federal EEO laws do not prevent an employer from requiring all employees to be vaccinated against COVID-19, subject to the **reasonable accommodation provisions of Title VII and the ADA and other EEO considerations discussed below (https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws#K.5)**. (See also **Section L, Vaccinations – Title VII Religious Objections to COVID-19 Vaccine Requirements (https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-**

rehabilitation-act-and-other-eeo-laws#L)). If there is such an employer requirement, the EEO laws do not prevent employers from requiring documentation or other confirmation that employees are **up to date (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html)** on their vaccinations (**see K.9**.), but the EEO laws may require employers to make exceptions to a vaccination requirement for some employees.

The ADA and Title VII require an employer to provide reasonable accommodations for employees who, because of a disability or a sincerely held religious belief, practice, or observance, do not get vaccinated against COVID-19, unless providing an accommodation would pose an undue hardship on the operation of the employer's business. The analysis for undue hardship depends on whether the accommodation is for a disability (including pregnancy-related conditions that constitute a disability) (**see K.6**.) or for religion (**see K.12**.).

As with any employment policy, employers that have a vaccination requirement may need to respond to allegations that the requirement has a disparate impact on —or disproportionately excludes—employees based on their race, color, religion, sex, or national origin under Title VII (or age under the Age Discrimination in Employment Act [40+]). Employers should keep in mind that because some individuals or demographic groups may face barriers to receiving a COVID-19 vaccination, some employees may be more likely to be negatively impacted by a vaccination requirement.

It would also be unlawful to apply a vaccination requirement to employees in a way that treats employees differently based on disability, race, color, religion, sex (including pregnancy, sexual orientation, and gender identity), national origin, age, or genetic information, unless there is a legitimate non-discriminatory reason.

K.2. What are some examples of reasonable accommodations or modifications that employers may have to provide to employees who do not get vaccinated due to disability; religious beliefs, practices, or observance; or pregnancy? *(5/28/21)*

An employee who does not get vaccinated due to a disability (covered by the ADA) or a sincerely held religious belief, practice, or observance (covered by Title VII) may be entitled to a reasonable accommodation that does not pose an undue hardship on the operation of the employer's business. For example, as a reasonable accommodation, an unvaccinated employee entering the workplace might wear a

face mask, work at a social distance from coworkers or non-employees, work a modified shift, get periodic tests for COVID-19, be given the opportunity to telework, or finally, accept a reassignment.

Employees who are not vaccinated because of pregnancy may be entitled (under Title VII) to adjustments to keep working, if the employer makes modifications or exceptions for other employees. These modifications may be the same as the accommodations made for an employee based on disability or religion.

K.3. How can employers encourage employees and their family members to be vaccinated against COVID-19 without violating the EEO laws, especially the ADA and GINA? *(Updated 10/13/21)*

Employers may provide employees and their family members with information to educate them about COVID-19 vaccines, raise awareness about the benefits of vaccination, and address common questions and concerns. Employers also may work with local public health authorities, medical providers, or pharmacies to make vaccinations available for unvaccinated workers in the workplace. Also, under certain circumstances employers may offer incentives to employees who receive COVID-19 vaccinations, as discussed in K.16 - K.21. The federal government is providing COVID-19 vaccines at no cost to everyone 5 years of age and older.

There are many resources available to employees seeking more information about how to get vaccinated against COVID-19:

- The federal government's online **vaccines.gov (https://www.vaccines.gov/)** site can identify vaccination sites anywhere in the country (or **https://www.vacunas.gov (https://www.vacunas.gov)** for Spanish). Individuals also can text their ZIP code to "GETVAX" (438829)–or "VACUNA" (822862) for Spanish–to find three vaccination locations near them.
- Employees with disabilities (or employees' family members with disabilities) may need extra support to obtain a vaccination, such as transportation or in-home vaccinations. The HHS/Administration for Community Living has launched the Disability Information and Assistance Line (DIAL) to assist individuals with disabilities in obtaining such help. DIAL can be reached at: 888-677-1199 from 9 am to 8 pm (Eastern Standard Time) Mondays through Fridays or by emailing **DIAL@n4a.org**.

- CDC's website offers a link to a listing of **local health departments (https://www.cdc.gov/publichealthgateway/healthdirectories/index.html)**, which can provide more information about local vaccination efforts.

- In addition, CDC provides a complete communication "tool kit" for employers to use with their workforce to educate people about getting a COVID-19 vaccine. Although originally written for essential workers and employers, it is useful for all workers and employers. *See* **Workplace Vaccination Program | CDC (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/essentialworker/workplace-vaccination-program.html)**.

- Some employees may not have reliable access to the internet to identify nearby vaccination locations or may speak no English or have limited English proficiency and find it difficult to make an appointment for a vaccination over the phone. CDC operates a toll-free telephone line that can provide assistance in many languages for individuals seeking more information about vaccinations: 800-232-4636; TTY 888-232-6348.

- Some employees also may require assistance with transportation to vaccination sites. Employers may gather and disseminate information to their employees on low-cost and no-cost transportation resources serving vaccination sites available in their community and offer paid time-off for vaccination, particularly if transportation is not readily available outside regular work hours.

- Employers should provide the contact information of a management representative for employees who need to request a reasonable accommodation for a disability or religious belief, practice, or observance, or to ensure nondiscrimination for an employee who is pregnant.

The ADA and COVID-19 Vaccinations

K.4. Is information about an employee's COVID-19 vaccination confidential medical information under the ADA? *(Updated 7/12/22)*

Yes. The ADA requires an employer to maintain the confidentiality of employee medical information. Although the EEO laws do not prevent employers from requiring employees to provide documentation or other confirmation of

vaccination, this information, like all medical information, must be kept confidential and stored separately from the employee's personnel files under the ADA.

An employer may share confidential medical information, such as confirmation of employee vaccinations (or COVID-19 test results), with employees who need it to perform their job duties. However, such employees also must keep the information confidential. Some possible scenarios include:

- An administrative employee assigned to perform recordkeeping of employees' documentation of vaccination may receive needed access to the information for this purpose but must keep this information confidential.
- An employee assigned to permit building entry only by employees who are in compliance with a work restriction, such as COVID-19 vaccinations, testing, and/or masking, should only receive a list of the individuals who may (or may not) enter, but not any confidential medical information about why they are on (or not on) the list.
- An employee tasked to ensure compliance with a testing requirement for employees would need to review testing documentation submitted by those employees but must keep that testing information confidential.

Mandatory Employer Vaccination Programs

K.5. May an employer require an employee to comply with a COVID-19 vaccination requirement applicable to all employees entering the workplace if that employee has sought an exemption based on disability? *(Updated 7/12/22)*

Under the ADA, an employer may require an individual with a disability to meet a qualification standard applied to all employees, such as a safety-related standard requiring COVID-19 vaccination, if the standard is job-related and consistent with business necessity as applied to that employee. An employer does not have to show that a qualification standard in general (i.e., as applied to all employees) meets the "business necessity" standard. Under the ADA it must satisfy this standard only as applied to an employee who informs the employer that a disability prevents compliance. If a particular employee cannot meet such a safety-related qualification standard because of a disability, the employer may not require compliance for that employee unless it can demonstrate that the individual would pose a "direct threat" to the health or safety of the employee or others while performing their job. A "direct threat" is a "significant risk of substantial harm" that

cannot be eliminated or reduced by reasonable accommodation. **29 C.F.R. 1630.2(r) (https://www.govinfo.gov/content/pkg/CFR-2012-title29-vol4/xml/CFR-2012-title29-vol4-sec1630-2.xml)**. This determination can be broken down into two steps: determining if there is a "significant risk of substantial harm" and, if there is, assessing whether a reasonable accommodation would reduce or eliminate the threat.

To determine if an employee who is not vaccinated due to a disability poses a "direct threat" in the workplace, an employer first must make an individualized assessment of the employee's present ability to safely perform the essential functions of the job. The factors that make up this assessment are: (1) the duration of the risk; (2) the nature and severity of the potential harm; (3) the likelihood that the potential harm will occur; and (4) the imminence of the potential harm. The determination that a particular employee poses a direct threat should be based on a reasonable medical judgment that relies on the most current medical knowledge about COVID-19. Such medical knowledge may include, for example, the level of community spread at the time of the assessment. Statements from the CDC provide an important source of current medical knowledge about COVID-19, and the employee's health care provider, with the employee's consent, also may provide useful information about the employee. Additionally, the assessment of direct threat should take account of the type of work environment, such as: whether the employee works alone or with others or works inside or outside; the available ventilation; the frequency and duration of direct interaction the employee typically will have with other employees and/or non-employees; the number of partially or fully vaccinated individuals already in the workplace; whether other employees are wearing masks or undergoing routine screening testing; and the space available for social distancing.

If the assessment demonstrates that an employee with a disability who is not vaccinated would pose a direct threat to self or others, the employer must consider whether providing a reasonable accommodation, absent undue hardship, would reduce or eliminate that threat. Potential reasonable accommodations could include requiring the employee to wear a mask, work a staggered shift, making changes in the work environment (such as improving ventilation systems or limiting contact with other employees and non-employees), permitting telework if feasible, or reassigning the employee to a vacant position in a different workspace.

As a best practice, an employer introducing a COVID-19 vaccination policy and requiring documentation or other confirmation of vaccination should notify all employees that the employer will consider requests for reasonable accommodation based on disability on an individualized basis. (See also **K.12** recommending the same best practice for religious accommodations.)

K.6. Under the ADA, if an employer requires COVID-19 vaccinations for employees physically entering the workplace, how should an employee who does not get a COVID-19 vaccination because of a disability inform the employer, and what should the employer do? *(Updated 5/28/21)*

An employee with a disability who does not get vaccinated for COVID-19 because of a disability must let the employer know that the employee needs an exemption from the requirement or a change at work, known as a reasonable accommodation. To request an accommodation, an individual does not need to mention the ADA or use the phrase "reasonable accommodation."

Managers and supervisors responsible for communicating with employees about compliance with the employer's vaccination requirement should know **how to recognize an accommodation request from an employee with a disability (https://www.eeoc.gov/laws/guidance/enforcement-guidance-reasonable-accommodation-and-undue-hardship-under-ada#requesting)** and know to whom to refer the request for full consideration. As a best practice, before instituting a mandatory vaccination policy, employers should provide managers, supervisors, and those responsible for implementing the policy with clear information about how to handle accommodation requests related to the policy.

Employers and employees typically engage in a flexible, interactive process to identify **workplace accommodation options** that do not impose an undue hardship (significant difficulty or expense) on the employer. This process may include determining whether it is necessary to obtain supporting medical documentation about the employee's disability.

In discussing accommodation requests, employers and employees may find it helpful to consult the **Job Accommodation Network (JAN) website (https://www.askjan.org)** as a resource for different types of accommodations. JAN's materials about COVID-19 are available at **https://askjan.org/topics/COVID-19.cfm (https://askjan.org/topics/COVID-19.cfm)**.

Employers also may consult applicable **Occupational Safety and Health Administration (OSHA) COVID-specific resources (https://www.osha.gov/SLTC/covid-19/)**. Even if there is no reasonable accommodation that will allow the unvaccinated employee to be physically present to perform the employee's current job without posing a direct threat, the employer must consider if telework is an option for that particular job as an accommodation and, as a last resort, whether reassignment to another position is possible.

The ADA requires that employers offer an available accommodation if one exists that does not pose an undue hardship, meaning a significant difficulty or expense. See 29 C.F.R. 1630.2(p). Employers are advised to consider all the options before denying an accommodation request. The proportion of employees in the workplace who already are partially or fully vaccinated against COVID-19 and the extent of employee contact with non-employees, who may be ineligible for a vaccination or whose vaccination status may be unknown, can impact the ADA undue hardship consideration. Employers may rely on **CDC recommendations (https://www.cdc.gov/coronavirus/2019-ncov/)** when deciding whether an effective accommodation is available that would not pose an undue hardship.

Under the ADA, it is unlawful for an employer **to disclose that an employee is receiving a reasonable accommodation (https://www.eeoc.gov/laws/guidance/enforcement-guidance-reasonable-accommodation-and-undue-hardship-under-ada#li42)** or **to retaliate against an employee for requesting an accommodation (https://www.eeoc.gov/laws/guidance/enforcement-guidance-reasonable-accommodation-and-undue-hardship-under-ada#li19)**.

K.7. If an employer requires employees to get a COVID-19 vaccination from the employer or its agent, do the ADA's restrictions on an employer making disability-related inquiries or medical examinations of its employees apply to any part of the vaccination process? *(Updated 5/28/21)*

Yes. The ADA's restrictions apply to the screening questions that must be asked immediately prior to administering the vaccine if the vaccine is administered by the employer or its agent. An **employer's agent (https://www.eeoc.gov/laws/guidance/section-2-threshold-issues#2-III-B-2)** is an individual or entity having the authority to act on behalf of, or at the direction of, the employer.

The ADA generally restricts when employers may require medical examinations (procedures or tests that seek information about an individual's physical or mental impairments or health) or make disability-related inquiries (questions that are likely to elicit information about an individual's disability). The act of administering the vaccine is not a "medical examination" under the ADA because it does not seek information about the employee's physical or mental health.

However, because the pre-vaccination screening questions are likely to elicit information about a disability, the ADA requires that they must be "job related and consistent with business necessity" when an employer or its agent administers the COVID-19 vaccine. To meet this standard, an employer would need to have a reasonable belief, based on objective evidence, that an employee who does not answer the questions and, therefore, cannot be vaccinated, will pose a direct threat to the employee's own health or safety or to the health and safety of others in the workplace. (See general discussion in **Question K.5**.) Therefore, when an employer requires that employees be vaccinated by the employer or its agent, the employer should be aware that an employee may challenge the mandatory pre-vaccination inquiries, and an employer would have to justify them under the ADA.

The ADA also requires employers to keep any employee medical information obtained in the course of an employer vaccination program confidential.

Voluntary Employer Vaccination Programs

K.8. Under the ADA, are there circumstances in which an employer or its agent may ask disability-related screening questions before administering a COVID-19 vaccine *without* needing to satisfy the "job-related and consistent with business necessity" standard? *(Updated 5/28/21)*

Yes. If the employer offers to vaccinate its employees on a voluntary basis, meaning that employees can choose whether or not to get the COVID-19 vaccine from the employer or its agent, the employer does not have to show that the pre-vaccination screening questions are job-related and consistent with business necessity. However, the employee's decision to answer the questions must be voluntary. (See also Questions **K.16 – 17**.) The ADA prohibits taking an adverse action against an employee, including harassing the employee, for refusing to participate in a voluntary employer-administered vaccination program. An employer also must keep any medical information it obtains from any voluntary vaccination program confidential.

K.9. Does the ADA prevent an employer from inquiring about or requesting documentation or other confirmation that an employee obtained a COVID-19 vaccination? *(Updated 10/13/21)*

No. When an employer asks employees whether they obtained a COVID-19 vaccination, the employer is not asking the employee a question that is likely to disclose the existence of a disability; there are many reasons an employee may not show documentation or other confirmation of vaccination besides having a disability. Therefore, requesting documentation or other confirmation of vaccination is not a disability-related inquiry under the ADA, and the ADA's rules about making such inquiries do not apply.

However, documentation or other confirmation of vaccination provided by the employee to the employer is medical information about the employee and must be kept confidential, as discussed in K.4.

K.10. May an employer offer voluntary vaccinations only to certain groups of employees? *(5/28/21)*

If an employer or its agent offers voluntary vaccinations to employees, the employer must comply with federal employment nondiscrimination laws. For example, not offering voluntary vaccinations to certain employees based on national origin or another protected basis under the EEO laws would not be permissible.

K.11. What should an employer do if an employee who is fully vaccinated for COVID-19 requests accommodation for an underlying disability because of a continuing concern that the employee faces a heightened risk of severe illness from a COVID-19 infection, despite being vaccinated? *(5/28/21)*

Employers who receive a reasonable accommodation request from an employee should process the request in accordance with applicable ADA standards.

When an employee asks for a reasonable accommodation, whether the employee is fully vaccinated or not, the employer should engage in an interactive process to determine if there is a disability-related need for reasonable accommodation. This process typically includes seeking information from the employee's health care provider with the employee's consent explaining why an accommodation is needed.

For example, some individuals who are immunocompromised might still need reasonable accommodations because their conditions may mean that the vaccines may not offer them the same measure of protection as other vaccinated individuals. If there is a disability-related need for accommodation, an employer must explore potential reasonable accommodations that may be provided absent undue hardship.

Title VII and COVID-19 Vaccinations

K.12. Under Title VII, how should an employer respond to employees who communicate that they are unable to be vaccinated for COVID-19 (or provide documentation or other confirmation of vaccination) because of a sincerely held religious belief, practice, or observance? (*Updated 5/28/21*)

Once an employer is on notice that an employee's sincerely held religious belief, practice, or observance prevents the employee from getting a COVID-19 vaccine, the employer must provide a reasonable accommodation unless it would pose an undue hardship. Employers also may receive religious accommodation requests from individuals who wish to wait until an alternative version or specific brand of COVID-19 vaccine is available to the employee. Such requests should be processed according to the same standards that apply to other accommodation requests. For more information on requests for religious accommodations related to COVID-19 vaccination requirements, see **Section L, Vaccinations – Title VII Religious Objections to COVID-19 Vaccine Requirements**.

EEOC guidance explains that the definition of religion is broad and protects beliefs, practices, and observances with which the employer may be unfamiliar. Therefore, the employer should ordinarily assume that an employee's request for religious accommodation is based on a sincerely held religious belief, practice, or observance. However, if an employee requests a religious accommodation, and an employer is aware of facts that provide an objective basis for questioning either the religious nature or the sincerity of a particular belief, practice, or observance, the employer would be justified in requesting additional supporting information. See also 29 CFR 1605.

Under Title VII, an employer should thoroughly consider all possible reasonable accommodations, including telework and reassignment. For suggestions about types of reasonable accommodation for unvaccinated employees, see **question and**

answer K.6., above. In many circumstances, it may be possible to accommodate those seeking reasonable accommodations for their religious beliefs, practices, or observances.

Under Title VII, courts define "undue hardship" as having more than minimal cost or burden on the employer. This is an easier standard for employers to meet than the ADA's undue hardship standard, which applies to requests for accommodations due to a disability. Considerations relevant to undue hardship can include, among other things, the proportion of employees in the workplace who already are partially or fully vaccinated against COVID-19 and the extent of employee contact with non-employees, whose vaccination status could be unknown or who may be ineligible for the vaccine. Ultimately, if an employee cannot be accommodated, employers should determine if any other rights apply under the EEO laws or other federal, state, and local authorities before taking adverse employment action against an unvaccinated employee

K.13. Under Title VII, what should an employer do if an employee chooses not to receive a COVID-19 vaccination due to pregnancy? *(Updated 10/13/21)*

CDC recommends (https://emergency.cdc.gov/han/2021/han00453.asp) COVID-19 vaccinations for everyone aged 12 years and older, including people who are pregnant, breastfeeding, trying to get pregnant now, or planning to become pregnant in the future. Despite these recommendations, some pregnant employees may seek job adjustments or may request exemption from a COVID-19 vaccination requirement.

If an employee seeks an exemption from a vaccination requirement due to pregnancy, the employer must ensure that the employee is not being discriminated against compared to other employees similar in their ability or inability to work. This means that a pregnant employee may be entitled to job modifications, including telework, changes to work schedules or assignments, and leave to the extent such modifications are provided for other employees who are similar in their ability or inability to work. Employers should ensure that supervisors, managers, and human resources personnel know how to handle such requests to avoid **disparate treatment in violation of Title VII**.

GINA And COVID-19 Vaccinations

Title II of GINA prohibits covered employers from using the genetic information of employees to make employment decisions. It also restricts employers from requesting, requiring, purchasing, or disclosing genetic information of employees. Under Title II of GINA, genetic information includes information about the manifestation of disease or disorder in a family member (which is referred to as "family medical history") and information from genetic tests of the individual employee or a family member, among other things.

K.14. Is Title II of GINA implicated if an employer requires an employee to receive a COVID-19 vaccine administered by the employer or its agent? *(Updated 5/28/21)*

No. Requiring an employee to receive a COVID-19 vaccination administered by the employer or its agent would not implicate Title II of GINA unless the pre-vaccination medical screening questions include questions about the employee's genetic information, such as asking about the employee's family medical history. As of May 27, 2021, the pre-vaccination medical screening questions for the first three COVID-19 vaccines to receive Emergency Use Authorization (EUA) from the FDA do not seek family medical history or any other type of genetic information. See **CDC's Pre-vaccination Checklist (https://www.cdc.gov/vaccines/covid-19/downloads/pre-vaccination-screening-form.pdf)** (last visited May 27, 2021). Therefore, an employer or its agent may ask these questions without violating Title II of GINA.

The act of administering a COVID-19 vaccine does not involve the use of the employee's genetic information to make employment decisions or the acquisition or disclosure of genetic information and, therefore, does not implicate Title II of GINA.

K.15. Is Title II of GINA implicated when an employer requires employees to provide documentation or other confirmation that they received a vaccination from a health care provider *that is not affiliated with their employer* (such as from the employee's personal physician or other health care provider, a pharmacy, or a public health department)? *(Updated 10/13/21)*

No. An employer requiring an employee to show documentation or other confirmation of vaccination from a health care provider unaffiliated with the employer, such as the employee's personal physician or other health care provider, a pharmacy, or a public health department, is not using, acquiring, or disclosing genetic information and, therefore, is not implicating Title II of GINA. This is the

case even if the medical screening questions that must be asked before vaccination include questions about genetic information, because documentation or other confirmation of vaccination would not reveal genetic information. Title II of GINA does not prohibit an employee's *own* health care provider from asking questions about genetic information. This GINA Title II prohibition only applies to the employer or its agent.

Employer Incentives For COVID-19 Voluntary Vaccinations Under ADA and GINA

ADA: Employer Incentives for Voluntary COVID-19 Vaccinations

K.16. Does the ADA limit the value of the incentive employers may offer to employees for voluntarily receiving a COVID-19 vaccination from a health care provider *that is not affiliated with their employer* (such as the employee's personal physician or other health care provider, a pharmacy, or a public health department)? *(Updated 7/12/22)*

No. The ADA does not limit the incentives (which includes both rewards and penalties) an employer may offer to encourage employees to voluntarily receive a COVID-19 vaccination, or to provide confirmation of vaccination, if the health care provider administering a COVID-19 vaccine *is not the employer or its agent*. By contrast, if an employer offers an incentive to employees to voluntarily receive a vaccination *administered by the employer or its agent*, the ADA's rules on disability-related inquiries apply and the value of the incentive may not be so substantial as to be coercive. See K.17.

As noted in K 4., the employer is required to keep vaccination information confidential under the ADA.

K.17. Under the ADA, are there limits on the value of the incentive employers may offer to employees for voluntarily receiving a COVID-19 vaccination *administered by the employer or its agent*? *(Updated 10/13/21)*

Yes. When the employer or its agent administers a COVID-19 vaccine, the value of the incentive (which includes both rewards and penalties) may not be so substantial as to be coercive. Because vaccinations require employees to answer pre-vaccination disability-related screening questions, a very large incentive could make employees feel pressured to disclose protected medical information to their

employers or their agents. As explained in K.16., however, this incentive limit does not apply if an employer offers an incentive to encourage employees to be voluntarily vaccinated by a health care provider that is not their employer or an agent of their employer.

GINA: Employer Incentives for Voluntary COVID-19 Vaccinations

K.18. Does GINA limit the value of the incentive employers may offer employees if employees or their family members get a COVID-19 vaccination from a health care provider *that is not affiliated with the employer* (such as the employee's personal physician or other health care provider, a pharmacy, or a public health department)? (*Updated 10/13/21*)

No. GINA does not limit the incentives an employer may offer to employees to encourage them or their family members to get a COVID-19 vaccine or provide confirmation of vaccination if the health care provider administering the vaccine is not the employer or its agent. If an employer asks an employee to show documentation or other confirmation that the employee or a family member has been vaccinated, it is not an unlawful request for genetic information under GINA because the fact that someone received a vaccination is not information about the manifestation of a disease or disorder in a family member (known as "family medical history" under GINA), nor is it any other form of genetic information. GINA's restrictions on employers acquiring genetic information (including those prohibiting incentives in exchange for genetic information), therefore, do not apply.

K.19. Under GINA, may an employer offer an incentive to employees in exchange for the employee getting vaccinated by the employer or its agent? *(5/28/21)*

Yes. Under GINA, as long as an employer does not acquire genetic information while administering the vaccines, employers may offer incentives to employees for getting vaccinated. Because the pre-vaccination medical screening questions for the three COVID-19 vaccines now available do not inquire about genetic information, employers may offer incentives to their employees for getting vaccinated. See **K.14** for more about GINA and pre-vaccination medical screening questions.

K.20. Under GINA, may an employer offer an incentive to an employee in return for an employee's *family member* getting vaccinated by the employer or its agent? *(5/28/21)*

No. Under GINA's Title II health and genetic services provision, an employer may not offer any incentives to an employee in exchange for a family member's receipt of a vaccination from an employer or its agent. Providing such an incentive to an employee because a family member was vaccinated by the employer or its agent would require the vaccinator to ask the family member the pre-vaccination medical screening questions, which include medical questions about the family member. Asking these medical questions would lead to the employer's receipt of genetic information in the form of family medical history *of the employee*. The regulations implementing Title II of GINA prohibit employers from providing incentives in exchange for genetic information. Therefore, the employer may not offer incentives in exchange for the family member getting vaccinated. However, employers may still offer an employee's family member the opportunity to be vaccinated by the employer or its agent, if they take certain steps to ensure GINA compliance.

K.21. Under GINA, may an employer offer an employee's family member an opportunity to be vaccinated *without* offering the employee an incentive? *(5/28/21)*

Yes. GINA permits an employer to offer vaccinations to an employee's family members if it takes certain steps to comply with GINA. Employers must not require employees to have their family members get vaccinated and must not penalize employees if their family members decide not to get vaccinated. Employers must also ensure that all medical information obtained from family members during the screening process is only used for the purpose of providing the vaccination, is kept confidential, and is not provided to any managers, supervisors, or others who make employment decisions for the employees. In addition, employers need to ensure that they obtain prior, knowing, voluntary, and written authorization from the family member before the family member is asked any questions about the family member's medical conditions. If these requirements are met, GINA permits the collection of genetic information.

L. Vaccinations – Title VII Religious Objections to COVID-19 Vaccine Requirements

The EEOC enforces Title VII of the Civil Rights Act of 1964 (Title VII), which prohibits employment discrimination based on religion. This includes a right for job applicants and employees to request an exception, called a religious or reasonable accommodation, from an employer requirement that conflicts with their sincerely held religious beliefs, practices, or observances. If an employer shows that it cannot reasonably accommodate an employee's religious beliefs, practices, or observances without undue hardship on its operations, the employer is not required to grant the accommodation. *See generally* **Section 12: Religious Discrimination (https://www.eeoc.gov/laws/guidance/section-12-religious-discrimination#h_71848579934051610749830452)** ; EEOC **Guidelines on Discrimination Because of Religion (https://www.govinfo.gov/content/pkg/CFR-2016-title29-vol4/xml/CFR-2016-title29-vol4-part1605.xml)** . Although other laws, such as the Religious Freedom Restoration Act, also may protect religious freedom in some circumstances, this technical assistance only describes employment rights and obligations under Title VII.

L.1. Do employees who have a religious objection to receiving a COVID-19 vaccination need to tell their employer? If so, is there specific language that must be used under Title VII? *(3/1/22)*

Employees must tell their employer if they are requesting an exception to a COVID-19 vaccination requirement because of a conflict between that requirement and their sincerely held religious beliefs, practices, or observances. Under Title VII, this is called a request for a "religious accommodation" or a "reasonable accommodation."

When making the request, employees do not need to use any "magic words," such as "religious accommodation" or "Title VII." However, they need to explain the conflict and the religious basis for it.

The same principles apply if employees have a religious conflict with getting a particular vaccine and wish to wait until an alternative version or specific brand of COVID-19 vaccine is available to them. *See* Introduction to Section K, above.

As a best practice, an employer should provide employees and applicants with information about whom to contact and the proper procedures for requesting a religious accommodation.

As an example, here is how ***EEOC designed its own form for its own workplace (https://www.eeoc.gov/sites/default/files/2021-10/EEOC%20Religious%20Accommodation%20Request%20Form%20-%20for%20web.pdf)****. Although the EEOC's internal forms typically are not made public, it is included here given the extraordinary circumstances facing employers and employees due to the COVID-19 pandemic. (Note: Individuals not employed by the EEOC should not submit this form to the EEOC to request a religious accommodation.)*

L.2. Does an employer have to accept an employee's assertion of a religious objection to a COVID-19 vaccination at face value? May the employer ask for additional information? *(3/1/22)*

Generally, under Title VII, an employer should proceed on the assumption that a request for religious accommodation is based on sincerely held religious beliefs, practices, or observances. However, if an employer has an objective basis for questioning either the religious nature or the sincerity of a particular belief, the employer would be justified in making a limited factual inquiry and seeking additional supporting information. An employee who fails to cooperate with an employer's reasonable requests for verification of the sincerity or religious nature of a professed belief, practice, or observance risks losing any subsequent claim that the employer improperly denied an accommodation. *See generally* **Section 12-IV.A.2: Religious Discrimination (https://www.eeoc.gov/laws/guidance/section-12-religious-discrimination#h_790763467358216107498601 35)**.

The **definition of "religion" (https://www.eeoc.gov/laws/guidance/section-12-religious-discrimination#h_95936825968216107486470 76)** under Title VII protects both traditional and nontraditional religious beliefs, practices, or observances, including those that may be unfamiliar to employers. While the employer should not assume that a request is invalid simply because it is based on unfamiliar religious beliefs, practices, or observances, employees may be asked to explain the religious nature of their belief, practice, or observance and should not assume that the employer already knows or understands it.

Title VII does not protect social, political, or economic views or personal preferences. Thus, objections to a COVID-19 vaccination requirement that are purely based on social, political, or economic views or personal preferences, or any other nonreligious concerns (including about the possible effects of the vaccine), do not qualify as religious beliefs, practices, or observances under Title VII. However, overlap between a religious and political view does not place it outside the scope of

Title VII's religious protections, as long as the view is part of a comprehensive religious belief system and is not simply an isolated teaching. *See generally* **Section 12-I.A.1: Religious Discrimination (definition of religion) (https://www.eeoc.gov/laws/guidance/section-12-religious-discrimination#_ftnref18)**; *see also* discussion of "sincerity" below.

The **sincerity (https://www.eeoc.gov/laws/guidance/section-12-religious-discrimination#h_954654327776161074865518 6)** of an employee's stated religious beliefs, practices, or observances is usually not in dispute. The employee's sincerity in holding a religious belief is "largely a matter of individual credibility." **Section 12-I.A.2: Religious Discrimination (credibility and sincerity) (https://www.eeoc.gov/laws/guidance/section-12-religious-discrimination#_ftnref42)**. Factors that—either alone or in combination—might undermine an employee's credibility include: whether the employee has acted in a manner inconsistent with the professed belief (although employees need not be scrupulous in their observance); whether the accommodation sought is a particularly desirable benefit that is likely to be sought for nonreligious reasons; whether the timing of the request renders it suspect (for example, it follows an earlier request by the employee for the same benefit for secular reasons); and whether the employer otherwise has reason to believe the accommodation is not sought for religious reasons.

The employer **may ask for an explanation (https://www.eeoc.gov/laws/guidance/section-12-religious-discrimination#h_790763467358216107498601 35)** of how the employee's religious beliefs, practices, or observances conflict with the employer's COVID-19 vaccination requirement. Although prior inconsistent conduct is relevant to the question of sincerity, an individual's beliefs—or degree of adherence—may change over time and, therefore, an employee's newly adopted or inconsistently observed practices may nevertheless be sincerely held. An employer should not assume that an employee is insincere simply because some of the employee's practices deviate from the commonly followed tenets of the employee's religion, or because the employee adheres to some common practices but not others. No one factor or consideration is determinative, and employers should evaluate religious objections on an individual basis.

If an employee's objection to a COVID-19 vaccination requirement is not religious in nature, or is not sincerely held, Title VII does not require the employer to provide an

exception to the vaccination requirement as a religious accommodation.

L.3. How does an employer show that it would be an "undue hardship" to accommodate an employee's request for religious accommodation? *(3/1/22)*

Under Title VII, an employer should thoroughly consider all possible reasonable accommodations, including telework and reassignment. For suggestions about types of reasonable accommodations for unvaccinated employees, *see* K.2, K.6, and K.12, above. In many circumstances, it may be possible to accommodate those seeking reasonable accommodations for their religious beliefs, practices, or observances without imposing an undue hardship.

If an employer demonstrates that it is unable to reasonably accommodate an employee's religious belief, practice, or observance without an "undue hardship" on its operations, then Title VII does not require the employer to provide the accommodation. 42 U.S.C. § 2000e(j). The Supreme Court has held that requiring an employer to bear more than a "de minimis," or a minimal, cost to accommodate an employee's religious belief is an undue hardship. Costs to be considered include not only direct monetary costs but also the burden on the conduct of the employer's business—including, in this instance, the risk of the spread of COVID-19 to other employees or to the public.

Courts have found Title VII undue hardship where, for example, the religious accommodation would violate federal law, impair workplace safety, diminish efficiency in other jobs, or cause coworkers to carry the accommodated employee's share of potentially hazardous or burdensome work. For a more detailed discussion, *see* **Section 12-IV.B: Religious Discrimination (discussing undue hardship) (https://www.eeoc.gov/laws/guidance/section-12-religious-discrimination#h_1292940343695161074987855 6)**..

An employer will need to assess undue hardship by considering the particular facts of each situation and will need to demonstrate how much cost or disruption the employee's proposed accommodation would involve. An employer cannot rely on speculative or hypothetical hardship when faced with an employee's religious objection but, rather, should rely on objective information. Certain common and relevant considerations during the COVID-19 pandemic include, for example, whether the employee requesting a religious accommodation to a COVID-19 vaccination requirement works outdoors or indoors, works in a solitary or group work setting, or has close contact with other employees or members of the public

(especially medically vulnerable individuals). Another relevant consideration is the number of employees who are seeking a similar accommodation, i.e., the cumulative cost or burden on the employer. *See* K.12 for additional considerations relevant to the undue hardship analysis.

L.4. If an employer grants some employees a religious accommodation from a COVID-19 vaccination requirement because of sincerely held religious beliefs, practices, or observances, does it have to grant all such requests? *(3/1/22)*

No. The determination of whether a particular proposed accommodation imposes an undue hardship on the conduct of the employer's business depends on its specific factual context. When an employer is assessing whether exempting employees from getting a vaccination would impair workplace safety, it may consider, for example, the type of workplace, the nature of the employees' duties, the location in which the employees must or can perform their duties, the number of employees who are fully vaccinated, how many employees and nonemployees physically enter the workplace, and the number of employees who will in fact need a particular accommodation. A mere assumption that many more employees might seek a religious accommodation—or the same accommodation—to the vaccination requirement in the future is not evidence of undue hardship, but the employer may consider the cumulative cost or burden of granting accommodations to other employees.

L.5. Must an employer provide the religious accommodation preferred by an employee if there are other possible accommodations that also are effective in eliminating the religious conflict and do not cause an undue hardship under Title VII? *(3/1/22)*

If there is more than one reasonable accommodation that would resolve the conflict between the vaccination requirement and the sincerely held religious belief, practice, or observance without causing an undue hardship under Title VII, the employer may choose which accommodation to offer. If more than one accommodation would be effective in eliminating the religious conflict, the employer should consider the employee's preference but is not obligated to provide the reasonable accommodation preferred by the employee. However, an employer's proposed accommodation will not be "reasonable" if the accommodation requires the employee to accept a reduction in pay or some other loss of a benefit or privilege of employment (for example, if unpaid leave is the employer's proposed accommodation) and there is a reasonable alternative accommodation that does

not require that and would not impose undue hardship on the employer's business. *See* **Section 12-IV.A.3: Religious Discrimination (reasonable accommodation) (https://www.eeoc.gov/laws/guidance/section-12-religious-discrimination#h_255006745363916107498678 44)**. If the employer denies the employee's proposed accommodation, the employer should explain to the employee why the preferred accommodation is not being granted.

An employer should consider all possible alternatives to determine whether exempting an employee from a vaccination requirement would impose an undue hardship. *See, e.g.*, K.2. Employers may rely on **CDC recommendations (https://www.cdc.gov/coronavirus/2019-ncov/)** when deciding whether an effective accommodation is available that would not pose an undue hardship.

L.6. If an employer grants a religious accommodation to an employee, can the employer later reconsider it? *(3/1/22)*

The obligation to provide religious accommodations absent undue hardship is a continuing obligation that allows for changing circumstances. Employees' sincerely held religious beliefs, practices, or observances may evolve or change over time and may result in requests for additional or different religious accommodations. Similarly, an employer has the right to discontinue a previously granted accommodation if it is no longer utilized for religious purposes, or if a provided accommodation subsequently poses an undue hardship on the employer's operations due to changed circumstances. Employers must consider whether there are alternative accommodations that would not impose an undue hardship. As a best practice, an employer should discuss with the employee any concerns it has about continuing a religious accommodation before revoking it.

M. Retaliation and Interference

*The **anti-retaliation protections (https://www.eeoc.gov/laws/guidance/questions-and-answers-enforcement-guidance-retaliation-and-related-issues)** discussed here only apply to the exercise of rights under the federal equal employment opportunity (EEO) laws. Information about similar protections under other federal workplace laws, such as the **Family and Medical Leave Act (https://www.dol.gov/agencies/whd/fmla)** or the **Occupational Safety and Health Act (https://www.osha.gov/workers)**, is available from the U.S. Department of*

Labor. Information about similar protections under the Immigration and Nationality Act's anti-discrimination provision, which prohibits some types of workplace discrimination based on citizenship status, immigration status, or national origin, and ***protects against retaliation for asserting those rights (http://www.justice.gov/crt/types-discrimination)****, is available from the Civil Rights Division of the U.S. Department of Justice.*

M.1. Do job applicants and employees (including former employees) have protections from retaliation for exercising equal employment opportunity (EEO) rights in connection with COVID-19? *(11/17/21)*

Yes. Job applicants and current and former employees are protected from retaliation by employers for asserting their rights under any of the federal **EEO laws (https://www.eeoc.gov/statutes/laws-enforced-eeoc)**. The EEO laws prohibit workplace discrimination based on race, color, sex (including pregnancy, sexual orientation, and gender identity), national origin, religion, age (40 or over), disability, or genetic information. Speaking out about or exercising rights related to workplace discrimination is called "protected activity."

Protected activity can take many forms. For example, an employee complaining to a supervisor about coworker harassment based on race or national origin is protected activity. Witnesses to discrimination who seek to assist individuals affected by discrimination are also protected. Engaging in protected activity, however, does not shield an employee from discipline, discharge, or other employer actions taken for reasons unrelated to the protected activity.

M.2. What are some examples of employee activities that are protected from employer retaliation? *(11/17/21)*

- **Filing a charge, complaint, or lawsuit, regardless of whether the underlying discrimination allegation is successful or timely**. For example, employers may not retaliate against employees who file charges with the EEOC alleging that their supervisor unlawfully disclosed confidential medical information (such as a COVID-19 diagnosis), even if the EEOC later decides there is no merit to the underlying charges. Moreover, a supervisor may not give a false negative job reference to punish a former employee for making an EEO complaint, or refuse to hire an applicant because of the applicant's EEO complaint against a prior employer.

- **Reporting alleged EEO violations to a supervisor or answering questions during an employer investigation of the alleged harassment**. For example, an Asian American employee who tells a manager or human resources official that a coworker made abusive comments accusing Asian people of spreading COVID-19 is protected from retaliation for reporting the harassment. Workplace discrimination laws also prohibit retaliation against employees for reporting harassing workplace comments about their religious reasons for not being vaccinated. Similarly, workplace discrimination laws prohibit retaliation against an employee for reporting sexually harassing comments made during a work video conference meeting.

- **Resisting harassment, intervening to protect coworkers from harassment, or refusing to follow orders that would result in discrimination**. For example, workplace discrimination laws protect a supervisor who refuses to carry out management's instruction not to hire certain applicants based on the sex-based presumption that they might use parental leave or have childcare needs, or to steer them to particular types of jobs.

- **Requesting accommodation of a disability (potentially including a pregnancy-related medical condition) or a religious belief, practice, or observance regardless of whether the request is granted or denied**. For example, the EEO laws prohibit an employer from retaliating against an employee for requesting continued telework as a disability accommodation after a workplace reopens. Similarly, requesting religious accommodation, such as modified protective gear that can be worn with religious garb, is protected activity. Requests for accommodation are protected activity even if the individual is not legally entitled to accommodation, such as where the employee's medical condition is not ultimately deemed a disability under the ADA, or where accommodation would pose an undue hardship.

M.3. Who is protected from retaliation? *(11/17/21)*

Retaliation protections apply to current employees, whether they are full-time, part-time, probationary, seasonal, or temporary. Retaliation protections also apply to job applicants and to former employees (such as when an employer provides a job reference). In addition, these protections apply regardless of an applicant's or employee's citizenship or work authorization status.

M.4. When do retaliation protections apply? *(11/17/21)*

Participating in an EEO complaint process is protected from retaliation under all circumstances.

Other acts by a current, prospective, or former employee to oppose discrimination are protected as long as the employee is acting on a reasonable good faith belief that something in the workplace may violate **EEO laws (https://www.eeoc.gov/statutes/laws-enforced-eeoc)**, and expresses those beliefs in a reasonable manner. An employee is still protected from retaliation for making a complaint about workplace discrimination even if the employee does not use legal terminology to describe the situation.

M.5. When is an employer action based on an employee's EEO activity serious enough to be unlawful retaliation? *(11/17/21)*

Retaliation includes any employer action in response to EEO activity that could deter a reasonable person from engaging in protected EEO activity. Depending on the facts, this might include actions such as denial of promotion or job benefits, non-hire, suspension, discharge, work-related threats, warnings, negative or lowered evaluations, or transfers to less desirable work or work locations. Retaliation could also include an action that has no tangible effect on employment, or even an action that takes place only outside of work, if it might deter a reasonable person from exercising EEO rights. The fact that an individual is not actually deterred from opposing discrimination or participating in an EEO complaint-related process or activity does not preclude an employer's action from being considered retaliatory.

However, depending on the specific situation, retaliation likely would not include a petty slight, minor annoyance, or a trivial punishment.

M.6. Does this mean that an employer can never take action against someone who has engaged in EEO activity? *(11/17/21)*

No. Engaging in protected EEO activity does not prevent discipline of an employee for legitimate reasons. Employers are permitted to act based on *non-retaliatory and non-discriminatory* reasons that would otherwise result in discipline. For example, if an employee performs poorly, has low productivity, or engages in misconduct, an employer may respond as it normally would, even if the employee has engaged in protected activity. Similarly, an employer may take non-retaliatory, non-

discriminatory action to enforce COVID-19 health and safety protocols, even if such actions follow EEO activity (e.g., an accommodation request).

M.7. Does the law provide any additional protections to safeguard ADA rights? *(11/17/21)*

Yes. The ADA prohibits not only retaliation for protected EEO activity, but also "interference" with an individual's exercise of ADA rights. Under the ADA, employers may not coerce, intimidate, threaten, or otherwise interfere with the exercise of ADA rights by job applicants or current or former employees. For instance, it is unlawful for an employer to use threats to discourage someone from asking for a reasonable accommodation. It is also unlawful for an employer to pressure an employee not to file a disability discrimination complaint. The ADA also prohibits employers from interfering with employees helping others to exercise their ADA rights.

The employer's actions may still violate the ADA's interference provision even if an employer does not actually carry out a threat, and even if the employee is not deterred from exercising ADA rights.

N. COVID-19 and the Definition of "Disability" Under the ADA/Rehabilitation Act

Employees and employers alike have asked when COVID-19 is a "disability" under Title I of the ADA, which includes reasonable accommodation and nondiscrimination requirements in the employment context. These questions and answers clarify circumstances in which COVID-19 may or may not cause effects sufficient to meet the definition of "actual" or "record of" a disability for various purposes under Title I, as well as section 501 of the Rehabilitation Act, both of which are enforced by the EEOC. Other topics covered in this section include disabilities arising from conditions that were caused or worsened by COVID-19. This section also addresses the ADA's "regarded as" definition of disability with respect to COVID-19.

On July 26, 2021, the Department of Justice (DOJ) and the Department of Health and Human Services (HHS) issued ***"Guidance on 'Long COVID' as a Disability Under the ADA, Section 504, and Section 1557" (https://www.ada.gov/long_covid_joint_guidance.pdf)*** *(DOJ/HHS Guidance).* ***The***

CDC uses the terms "long COVID (https://www.cdc.gov/coronavirus/2019-ncov/long-term-effects/)," "post-COVID," "long-haul COVID," "post-acute COVID-19," "long-term effects of COVID," or "chronic COVID" to describe various post-COVID conditions, where individuals experience new, returning, or ongoing health problems four or more weeks after being infected with the virus that causes COVID-19. The DOJ/HHS Guidance focuses solely on long COVID in the context of Titles II and III of the ADA, Section 504 of the Rehabilitation Act of 1973, and Section 1557 of the Patient Protection and Affordable Care Act. These EEOC questions and answers focus more broadly on COVID-19 and do so in the context of Title I of the ADA and section 501 of the Rehabilitation Act, which cover employment. This discussion does not pertain to other contexts, such as eligibility determinations for federal benefit programs.

N.1. How does the ADA define disability, and how does the definition apply to COVID-19? *(12/14/21)*

The ADA's three-part definition of disability applies to COVID-19 in the same way it applies to any other medical condition. A person can be an individual with a "disability" for purposes of the ADA in one of three ways:

- "Actual" Disability: The person has a physical or mental impairment that substantially limits a major life activity (such as walking, talking, seeing, hearing, or learning, or operation of a major bodily function);
- "Record of" a Disability: The person has a history or "record of" an actual disability (such as cancer that is in remission); or
- "Regarded as" an Individual with a Disability: The person is subject to an adverse action because of an individual's impairment or an impairment the employer believes the individual has, whether or not the impairment limits or is perceived to limit a major life activity, unless the impairment is objectively both transitory (lasting or expected to last six months or less) and minor.

The definition of disability is construed broadly in favor of expansive coverage, to the maximum extent permitted by the law. Nonetheless, not every impairment will constitute a disability under the ADA. The ADA uses a case-by-case approach to determine if an applicant or employee meets any one of the three above definitions of "disability."

COVID-19 and the ADA

"Actual" Disability

N.2. When is COVID-19 an actual disability under the ADA? *(12/14/21)*

Applying the ADA rules stated in **N.1.** and depending on the specific facts involved in an individual employee's condition, a person with COVID-19 has an actual disability if the person's medical condition or any of its symptoms is a "physical or mental" impairment that "substantially limits one or more major life activities." An individualized assessment is necessary to determine whether the effects of a person's COVID-19 substantially limit a major life activity. This will always be a case-by-case determination that applies existing legal standards to the facts of a particular individual's circumstances. A person infected with the virus causing COVID-19 who is asymptomatic or a person whose COVID-19 results in mild symptoms similar to those of the common cold or flu that resolve in a matter of weeks—with no other consequences—will not have an actual disability within the meaning of the ADA. However, depending on the specific facts involved in a particular employee's medical condition, an individual with COVID-19 might have an actual disability, as illustrated below.

Physical or Mental Impairment: Under the ADA, a physical impairment includes any physiological disorder or condition affecting one or more body systems. A mental impairment includes any mental or psychological disorder. COVID-19 is a physiological condition affecting one or more body systems. As a result, it is a "physical or mental impairment" under the ADA.

Major Life Activities: "Major life activities" include both major bodily functions, such as respiratory, lung, or heart function, and major activities in which someone engages, such as walking or concentrating. COVID-19 may affect major bodily functions, such as functions of the immune system, special sense organs (such as for smell and taste), digestive, neurological, brain, respiratory, circulatory, or cardiovascular functions, or the operation of an individual organ. In some instances, COVID-19 also may affect other major life activities, such as caring for oneself, eating, walking, breathing, concentrating, thinking, or interacting with others. An impairment need only substantially limit one major bodily function or other major life activity to be substantially limiting. However, limitations in more than one major life activity may combine to meet the standard.

Substantially Limiting: "Substantially limits" is construed broadly and should not demand extensive analysis. COVID-19 need not prevent, or significantly or severely

restrict, a person from performing a major life activity to be considered substantially limiting under Title I of the ADA.

The limitations from COVID-19 do not necessarily have to last any particular length of time to be substantially limiting. They also need not be long-term. For example, in discussing a hypothetical physical impairment resulting in a 20-pound lifting restriction that lasts or is expected to last several months, the EEOC has said that such an impairment is substantially limiting. App. to 29 C.F.R. § 1630.2(j)(1)(ix). By contrast, "[i]mpairments that last only for a short period of time are typically not covered, although they may be covered if sufficiently severe." Id.

Mitigating Measures: Whether COVID-19 substantially limits a major life activity is determined based on how limited the individual would have been without the benefit of any mitigating measures–i.e., any medical treatment received or other step used to lessen or prevent symptoms or other negative effects of an impairment. At the same time, in determining whether COVID-19 substantially limits a major life activity, any negative side effects of a mitigating measure are taken into account.

Some examples of mitigating measures for COVID-19 include medication or medical devices or treatments, such as antiviral drugs, supplemental oxygen, inhaled steroids and other asthma-related medicines, breathing exercises and respiratory therapy, physical or occupational therapy, or other steps to address complications of COVID-19.

Episodic Conditions: Even if the symptoms related to COVID-19 come and go, COVID-19 is an actual disability if it substantially limits a major life activity when active.

N.3. Is COVID-19 always an actual disability under the ADA? *(12/14/21)*

No. Determining whether a specific employee's COVID-19 is an actual disability always requires an individualized assessment, and such assessments cannot be made categorically. See **29 C.F.R. § 1630.2 (https://www.law.cornell.edu/cfr/text/29/1630.2)** for further information on the ADA's requirements relating to individualized assessment.

N.4. What are some examples of ways in which an individual with COVID-19 might or might not be substantially limited in a major life activity? *(12/14/21)*

As noted above, while COVID-19 may substantially limit a major life activity in some circumstances, someone infected with the virus causing COVID-19 who is

asymptomatic or a person whose COVID-19 results in mild symptoms similar to the common cold or flu that resolve in a matter of weeks—with no other consequences—will not be substantially limited in a major life activity for purposes of the ADA. Based on an individualized assessment in each instance, examples of fact patterns include:

Examples of Individuals with an Impairment that Substantially Limits a Major Life Activity:

- An individual diagnosed with COVID-19 who experiences ongoing but intermittent multiple-day headaches, dizziness, brain fog, and difficulty remembering or concentrating, which the employee's doctor attributes to the virus, is substantially limited in neurological and brain function, concentrating, and/or thinking, among other major life activities.
- An individual diagnosed with COVID-19 who initially receives supplemental oxygen for breathing difficulties and has shortness of breath, associated fatigue, and other virus-related effects that last, or are expected to last, for several months, is substantially limited in respiratory function, and possibly major life activities involving exertion, such as walking.
- An individual who has been diagnosed with COVID-19 experiences heart palpitations, chest pain, shortness of breath, and related effects due to the virus that last, or are expected to last, for several months. The individual is substantially limited in cardiovascular function and circulatory function, among others.
- An individual diagnosed with "**long COVID (https://www.cdc.gov/coronavirus/2019-ncov/long-term-effects/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Flong-term-effects.html)**," who experiences COVID-19-related intestinal pain, vomiting, and nausea that linger for many months, even if intermittently, is substantially limited in gastrointestinal function, among other major life activities, and therefore has an actual disability under the ADA.

Examples of Individuals with an Impairment that Does Not Substantially Limit a Major Life Activity:

- An individual who is diagnosed with COVID-19 who experiences congestion, sore throat, fever, headaches, and/or gastrointestinal discomfort, which resolve within several weeks, but experiences no further symptoms or effects, is not substantially limited in a major bodily function or other major life activity, and therefore does not have an actual disability under the ADA. This is so even though this person is subject to CDC guidance for isolation during the period of infectiousness.
- An individual who is infected with the virus causing COVID-19 but is asymptomatic—that is, does not experience any symptoms or effects—is not substantially limited in a major bodily function or other major life activity, and therefore does not have an actual disability under the ADA. This is the case even though this person is still subject to CDC guidance for isolation during the period of infectiousness.

As noted above, even if the symptoms of COVID-19 occur intermittently, they will be deemed to substantially limit a major life activity if they are substantially limiting when active, based on an individualized assessment.

For information on possible services and supports for individuals with Long COVID, see the **report (https://www.covid.gov/assets/files/Services-and-Supports-for-Longer-Term-Impacts-of-COVID-19-08012022.pdf)** issued by the U.S. Dept. of Health and Human Services.

"Record of" Disability

N.5. Can a person who has or had COVID-19 be an individual with a "record of" a disability? *(12/14/21)*

Yes, depending on the facts. A person who has or had COVID-19 can be an individual with a "record of" a disability if the person has "a history of, or has been misclassified as having," **29 C.F.R. § 1630.2(k)(2) (https://www.law.cornell.edu/cfr/text/29/1630.2)**, an impairment that substantially limits one or more major life activities, based on an individualized assessment.

"Regarded As" Disability

N.6. Can a person be "regarded as" an individual with a disability if the person has COVID-19 or the person's employer mistakenly believes the person has

COVID-19? *(12/14/21)*

Yes, depending on the facts. A person is "regarded as" an individual with a disability if the person is subjected to an adverse action (e.g., being fired, not hired, or harassed) because the person has an impairment, such as COVID-19, or the employer mistakenly believes the person has such an impairment, unless the actual or perceived impairment is objectively both transitory (lasting or expected to last six months or less) and minor. For this definition of disability, whether the actual or perceived impairment substantially limits or is perceived to substantially limit a major life activity is irrelevant.

N.7. What are some examples of an employer regarding a person with COVID-19 as an individual with a disability? *(12/14/21)*

The situations in which an employer might "regard" an applicant or employee with COVID-19 as an individual with a disability are varied. Some examples include:

- An employer would regard an employee as having a disability if the employer fires the individual because the employee had symptoms of COVID-19, which, although minor, lasted or were expected to last more than six months. The employer could not show that the impairment was both transitory and minor.
- An employer would regard an employee as having a disability if the employer fires the individual for having COVID-19, and the COVID-19, although lasting or expected to last less than six months, caused non-minor symptoms. In these circumstances, the employer could not show that the impairment was both transitory and minor.

N.8. If an employer regards a person as having a disability, for example by taking an adverse action because the person has COVID-19 that is not both transitory and minor, does that automatically mean the employer has discriminated for purposes of the ADA? *(12/14/21)*

No. It is possible that an employer may not have engaged in unlawful discrimination under the ADA even if the employer took an adverse action based on an impairment. For example, an individual still needs to be qualified for the job held or desired. Additionally, in some instances, an employer may have a defense to an action taken on the basis of the impairment. For example, the ADA's "direct threat" defense could permit an employer to require an employee with COVID-19 or its symptoms to refrain from physically entering the workplace during the CDC-

recommended period of isolation, due to the significant risk of substantial harm to the health of others. See **WYSK Question A.8**. Of course, an employer risks violating the ADA if it relies on myths, fears, or stereotypes about a condition to disallow the employee's return to work once the employee is no longer infectious and, therefore, medically able to return without posing a direct threat to others.

Other Conditions Caused or Worsened by COVID-19 and the ADA

N.9. Can a condition caused or worsened by COVID-19 be a disability under the ADA? *(12/14/21)*

Yes. In some cases, regardless of whether an individual's initial case of COVID-19 itself constitutes an actual disability, an individual's COVID-19 may end up causing impairments that are themselves disabilities under the ADA. For example:

- An individual who had COVID-19 develops heart inflammation. This inflammation itself may be an impairment that substantially limits a major bodily function, such as the circulatory function, or other major life activity, such as lifting.
- During the course of COVID-19, an individual suffers an acute ischemic stroke. Due to the stroke, the individual may be substantially limited in neurological and brain (or cerebrovascular) function.
- After an individual's COVID-19 resolves, the individual develops diabetes attributed to the COVID-19. This individual should easily be found to be substantially limited in the major life activity of endocrine function. See **Diabetes in the Workplace and the ADA (https://www.eeoc.gov/laws/guidance/diabetes-workplace-and-ada)** for more information.

In some cases, an individual's COVID-19 may also worsen the individual's pre-existing condition that was not previously substantially limiting, making that impairment now substantially limiting. For example:

- An individual initially has a heart condition that is not substantially limiting. The individual is infected with COVID-19. The COVID-19 worsens the person's heart condition so that the condition now substantially limits the person's circulatory function.

Definition of Disability and Requests for Reasonable Accommodation

N.10. Does an individual have to establish coverage under a particular definition of disability to be eligible for a reasonable accommodation? *(12/14/21)*

Yes. Individuals must meet either the "actual" or "record of" definitions of disability to be eligible for a reasonable accommodation. Individuals who only meet the "regarded as" definition are not entitled to receive reasonable accommodation.

Of course, coverage under the "actual" or "record of" definitions does not, alone, entitle a person to a reasonable accommodation. Individuals are not entitled to an accommodation unless their disability requires it, and an employer is not obligated to provide an accommodation that would pose an undue hardship. See **WYSK Section D**, and **Enforcement Guidance on Reasonable Accommodation and Undue Hardship under the ADA (https://www.eeoc.gov/laws/guidance/enforcement-guidance-reasonable-accommodation-and-undue-hardship-under-ada)** for more information.

N.11. When an employee requests a reasonable accommodation related to COVID-19 under the ADA, may the employer request supporting medical documentation before granting the request? *(12/14/21)*

Yes. As with employment accommodation requests under the ADA for any other potential disability, when the disability or need for accommodation is not obvious or already known, an employer may ask the employee to provide reasonable documentation about disability and/or need for reasonable accommodation. Often, the only information needed will be the individual's diagnosis and any restrictions or limitations. The employer also may ask about whether alternative accommodations would be effective in meeting the disability-related needs of the individual. See WYSK Questions D.5. and D.6. for more information.

The employer may either ask the employee to obtain the requested information or request that the employee sign a limited release allowing the employer to contact the employee's health care provider directly. If the employee does not cooperate in providing the requested reasonable supporting medical information, the employer can lawfully deny the accommodation request.

N.12. May an employer voluntarily provide accommodations requested by an applicant or employee due to COVID-19, even if not required to do so under the ADA? *(12/14/21)*

Yes. Employers may choose to provide accommodations beyond what the ADA mandates. Of course, employers must provide a reasonable accommodation under the ADA, absent undue hardship, if the applicant or employee meets the definition of disability, requires an accommodation for the disability, and is qualified for the job with the accommodation. Accommodations might consist of schedule changes, physical modifications to the workplace, telework, or special or modified equipment. See, e.g., **WYSK Section D** or U.S. Department of Labor Blog, **Workers with Long COVID-19: You May Be Entitled to Workplace Accommodations (https://blog.dol.gov/2021/07/06/workers-with-long-covid-19-may-be-entitled-to-accommodations)** for more information.

Applicability of Definition of Disability

N.13. If an employer subjected an applicant or employee to an adverse action, and the applicant or employee is covered under any one of the three ADA definitions of disability, does that mean the employer violated the ADA? *(12/14/21)*

No. Having a disability, alone, does not mean an individual was subjected to an unlawful employment action under the ADA.

For example, the fact that an applicant or employee has a current disability, or a record of disability, does not mean that an employer violated the ADA by not providing an individual with a reasonable accommodation. As discussed in **Section D.**, there are several considerations in making reasonable accommodation determinations, including the employee's need for the accommodation due to a disability and whether there is an accommodation that does not pose an undue hardship to the employer.

Similarly, the fact that an employer regarded an applicant or employee as an individual with a disability does not necessarily mean that the employer engaged in unlawful discrimination. For example, the ADA does not require an employer to hire anyone who is not qualified for the job. Moreover, in some instances, an employer may have a defense to an employment action taken based on an actual impairment, such as where the individual poses a **direct threat (https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws)** to the health or safety of themselves or others in the workplace.

N.14. Do any ADA protections apply to applicants or employees who do not meet an ADA definition of disability? *(12/14/21)*

Yes. The ADA's requirements about disability-related inquiries and medical exams, **medical confidentiality**, **retaliation, and interference** apply to all applicants and employees, regardless of whether they have an ADA disability. By contrast, an individual must have a "disability" to challenge employment decisions based on disability, denial of reasonable accommodation (see **N.10**), or disability-based harassment.

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N. COVID-19 and the Definition of "Disability" Under the ADA/Rehabilitation Act (https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws#N)

MONTANA DEPARTMENT OF LABOR & INDUSTRY
EMPLOYMENT RELATIONS DIVISION
HUMAN RIGHTS BUREAU

[redacted], Charging Party, vs. [redacted], Respondent.	Final Investigative Report HRB Case No. 0220103

Recommendation: Based on my investigation, I find **reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

I. ISSUE PRESENTED

Did [redacted] ([redacted]) discriminate against [redacted] based on his vaccination status in violation of the Montana Human Rights Act (Title 49, Chapter 2, MCA) by threatening to terminate his employment unless he receives an influenza vaccine?

II. SUMMARY OF THE INVESTIGATION

This report constitutes a summary of the investigation conducted in this case. Content of this report is limited to witnesses, documents and other evidence relevant to the analysis of the issue presented. The case file may contain additional evidence not included in this report.

A. Charging Party's Position Statement:

[redacted] was working as a Flight Paramedic for [redacted] on October 7, 2021 when he received notice he was required to be vaccinated with the influenza vaccine. [redacted] believed the notice was sent in error until he received another notice on November 8, 2021 stating he would be removed from the work schedule unless he provided proof of vaccination by end of business day. Due to the impending threat to his employment, [redacted] quickly received the influenza vaccine and provided the required documentation to [redacted]. As a result, [redacted] maintains [redacted] discriminated against him due to his vaccination status by threatening to terminate his employment if he did not receive an influenza vaccine.

B. Respondent's Position Statement:

[redacted] acknowledges it required employees to receive the influenza vaccine by November 8, 2021 due to a longstanding influenza vaccination policy. Although [redacted]

EXHIBIT 75
30(b)(6) Designee
Mon, Aug 22, 2022
Reported by:
Mary Sullivan, RMR, CRR

has since changed the policy and no longer enforces it for Montana employees, [redacted] did provide documentation he received the influenza vaccine.

C. Omissions:

The parties do not dispute the facts of this case. Accordingly, this report is presented in an abbreviated format.

III. ANALYSIS

[redacted] alleges [redacted] unlawfully discriminated against him in the area of employment because of his vaccination status. [redacted] establishes he filed a timely complaint. The Montana Human Rights Bureau has jurisdiction over the complaint.

Montana House Bill 702 was signed into law by Montana's Governor, Greg Gianforte, on May 7, 2021, and has since been codified as Mont. Code Ann. §§ 49-2-312 and 313.

Mont. Code Ann.§ 49-2-312(1)(b) makes it an unlawful discriminatory practice for:

> an employer to refuse employment to a person, to bar a person from employment, or to discriminate against a person in compensation or in a term, condition, or privilege of employment based on the person's vaccination status or whether the person has an immunity passport.

On, November 8, 2021, [redacted] was notified via text message from his supervisor he was required to provide proof of influenza vaccination by end of business day or be removed from the work schedule. By requiring an unvaccinated employee to receive a vaccine or be discharged, the text message establishes [redacted] took an adverse action against [redacted] and made a clear statement of overt discrimination.

In cases where there is no dispute the adverse act happened based on a party's protected class, the Bureau applies a direct evidence analysis. By rule, in a direct evidence analysis:

> If a charging party has established a prima facie case with direct evidence of unlawful discrimination or illegal retaliation, the respondent must prove by a preponderance of the evidence that an unlawful motive played no role in the challenged action or that that direct evidence of discrimination in not credible and is unworthy of belief.

Admin. R. Mont. 24.9.610(5).

Applying the above-cited rule, [redacted] bears the burden to prove by a preponderance of the evidence an unlawful motive played no role when it threatened to terminate [redacted] employment unless he came into compliance with [redacted] longstanding policy requiring vaccination against influenza.

The Bureau acknowledges [redacted] was clearly addressing difficult and necessary health and safety issues amidst unpresented circumstances created by the Covid-19

pandemic. Add to that, [redacted] was attempting to navigate the shifting legal terrain in Montana around the novel protected class of vaccination status. A resulting effect of HB 702 becoming law was that [redacted] longstanding influenza policy was suddenly a violation of Montana law. [redacted], when it conditioned [redacted] continued employment on his compliance with the vaccination policy, engaged in an unlawful discriminatory practice.

[redacted] is unable to prove by a preponderance of the evidence an unlawful motive played no role in its enforcement of an influenza vaccination policy.

CONCLUSION

Based on my investigation, I find **reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

Chad Day
Montana Human Rights Bureau

5/10/2022
Date

MONTANA DEPARTMENT OF LABOR & INDUSTRY
EMPLOYMENT RELATIONS DIVISION
HUMAN RIGHTS BUREAU

[redacted] Charging Party, vs. [redacted], Respondent.	Final Investigative Report HRB Case No. 0220164

Recommendation: Based on my investigation, I find **reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

I. ISSUE PRESENTED

Did [redacted][1] ([redacted]) discriminate against [redacted] in the area of public accommodation based on her vaccination status in violation of the Montana Human Rights Act (Title 49, Chapter 2, MCA) when it limited in-person attendance for an organizational retreat to include only persons vaccinated against COVID-19?

II. SUMMARY OF THE INVESTIGATION

This report constitutes a summary of the investigation conducted in this case. Content of this report is limited to witnesses, documents and other evidence relevant to the analysis of the issue presented. The case file may contain additional evidence not included in this report.

A. Charging Party's Position Statement:

On or about June 9, 2021, [redacted] contacted [redacted] in an attempt to sign up for the [redacted], being held [redacted], 2021, through [redacted], 2021. [redacted] informed [redacted] she needed to be vaccinated against COVID-19 in order to attend the retreat in person. [redacted] is unvaccinated and felt excluded by [redacted] requirement. [redacted] alleges [redacted] discriminated against her on the basis of her vaccination status by denying her access to the retreat.

B. Respondent's Position Statement:

[1] In her Charge of Discrimination, Charging Party named Respondent as [redacted]. Respondent provided its true and correct business name as [redacted], here within referred as such.

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30(b)(6) Designee
Mon, Aug 22, 2022
Reported by:
Mary Sullivan, RMR, CRR

Respondent denies the allegations of discrimination as set forth in [redacted] complaint.

[redacted] is a 501c3 nonprofit located in [redacted], Montana, offering over [redacted] programs and [redacted] events for individuals diagnosed [redacted], along with their family members – all free of charge.

On March 15, 2020, [redacted] shut its physical door to program participants due to the COVID-19 pandemic. On March 18, 2020, [redacted] began and continues to offer its programming via ZOOM for all Montana residents. [redacted] was fully aware of [redacted] virtual programing, since [redacted] had attended a virtual program on December 20, 2020. This was the only time [redacted] utilized [redacted] programing.

On June 9, 2021, [redacted] reached out to [redacted] employee, [redacted], via ZOOM to inquire about the [redacted] to be held [redacted] 2021, through [redacted] 2021. [redacted] inquired whether participants needed to be vaccinated against COVID-19 and [redacted] chief executive officer, [redacted], provided that under the guidance of the Centers for Disease Control, [redacted] would require in-person participants of the retreat to be vaccinated. The following day, on June 10, 2021, [redacted] emailed [redacted] and informed [redacted] that she no longer desired to participate in [redacted] programs and requested to be removed from the [redacted] mailing list.

[redacted] did not withhold, refuse or deny [redacted] the ability to participate in the [redacted] since all participants, to include [redacted] were provided an opportunity to participate via ZOOM, if requested. [redacted] did not request to attend via ZOOM.

C. Omissions:

Due to Respondent acknowledging the alleged adverse act, as alleged by Charging Party, this report is presented in an abbreviated format. Accordingly, witness statements, documents and comparative evidence are not presented herein.

III. ANALYSIS

[redacted] alleges [redacted] discriminated against her in the area of public accommodation because of her vaccination status. [redacted] establishes she filed a timely complaint. The Montana Human Rights Bureau has jurisdiction over the complaint.

Montana House Bill 702 was signed into law by Montana's Governor, Greg Gianforte, on May 7, 2021, and has since been codified as *Mont. Code Ann. §§ 49-2-312* and *313*.

Mont. Code Ann.§ 49-2-312(1)(c) makes it an unlawful discriminatory practice for:

> a public accommodation to exclude, limit, segregate, refuse to serve, or otherwise discriminate against a person based on the person's vaccination status or whether the person has an immunity passport.

[redacted] alleges—and [redacted] acknowledges—[redacted] required proof of COVID-19 vaccination in order to attend the [redacted] to be held [redacted], 2021, through [redacted], 2021, in person.

Additionally, [redacted] notes this mandate was implemented for the retreat beginning [redacted], 2021, subsequent to the date on which Montana's vaccination status law went into effect.

As a threshold matter, [redacted] must show that she has standing as an aggrieved party. Under the Montana Human Rights Act (MHRA), a complainant must be aggrieved.

The MHRA defines "aggrieved party" as "a person who can demonstrate a specific personal and legal interest, as distinguished from a general interest, and who has been or is likely to be specially and injuriously affected by a violation of this chapter."

Mont. Code Ann. 49-3-101(2)

Here, the parties acknowledge [redacted] is a past participant of [redacted] programs, having attended a program via ZOOM, in December 2020. The parties also acknowledge [redacted] contacted [redacted] on June 9, 2021, to inquire about the [redacted] scheduled to begin [redacted] 2021. During that interaction, [redacted] informed [redacted] that in-person attendance was only allowed for participants vaccinated against COVID-19. Because [redacted] is unvaccinated, she was not allowed to attend in-person. Accordingly, [redacted] establishes standing as an aggrieved party.

In cases where there is no dispute that the adverse act happened based on a party's protected class, the Bureau uses a direct evidence analysis. By rule, in a direct evidence analysis:

> If a charging party has established a prima facie case with direct evidence of unlawful discrimination or illegal retaliation, the respondent must prove by a preponderance of the evidence that an unlawful motive played no role in the challenged action or that that direct evidence of discrimination in not credible and is unworthy of belief.

Admin. R. Mont. 24.9.610(5).

Applying the above-cited rule, [redacted] bears the burden to prove by a preponderance of the evidence that an unlawful motive played no role in its requirement that only persons vaccinated against COVID-19 could attend the retreat. In response to [redacted] discrimination complaint, [redacted] asserts it followed the guidance of the Centers for Disease Control.

The Bureau acknowledges [redacted] was clearly addressing difficult and necessary health and safety issues amidst unprecedented circumstances created by the COVID-19 pandemic. Nonetheless, by limiting in-person attendance for the [redacted] to include only persons vaccinated against COVID-19 was a clear violation of the Montana Human Rights Act. Such a position could have been avoided by choosing to allow only virtual attendance (thereby treating vaccinated and unvaccinated attendees the same).

[redacted] is unable to prove by a preponderance of the evidence that an unlawful motive played no role in its requirement that only persons vaccinated against COVID-19 could attend the [redacted].

IV. CONCLUSION

Based on my investigation, I find **reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

Carla Lott
Montana Human Rights Bureau

May 19, 2022
Date

MONTANA DEPARTMENT OF LABOR & INDUSTRY
EMPLOYMENT RELATIONS DIVISION
HUMAN RIGHTS BUREAU

[redacted], Charging Party, vs. [redacted], Respondent.	Final Investigative Report HRB Case No. 0210440

Recommendation: Based on my investigation, I find **no reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

I. ISSUE PRESENTED

Did [redacted] discriminate against [redacted] on the basis of vaccination status in violation of the Montana Human Rights Act (Title 49, Chapter 2, MCA), by threatening her with termination of employment if she chose not to receive the COVID-19 vaccination?

II. SUMMARY OF THE INVESTIGATION

This report constitutes a summary of the investigation conducted in this case. Content of this report is limited to witnesses, documents, and other evidence relevant to the analysis of the issue presented. The case file may contain additional evidence not included in this report.

A. Charging Party's Position Statement:

[redacted] self-drafted a complaint based on vaccination status and submitted that complaint to the Human Rights Bureau (Bureau) on May 25, 2021. After submitting her complaint, the Bureau only received one more communication from [redacted] (an email dated August 19, 2021). In that email, [redacted] indicated she no longer wished to pursue her claim. The Bureau then provided Wrenfrow with a Request for Withdrawal form, but [redacted] failed to return the form and did not respond to any subsequent communications from the Bureau.

The body of [redacted] complaint, in its entirety, consisted of the following:

> [redacted] stated on March 31 that all [redacted] Employees would be mandated to be vaccinated by July 1, then on May 6 It was stated that only Senior Service Employees were required to be vaccinated by July 1. This was also stated again on May 19 and again on May 24. On March 14 I was told that If we were not vaccinated by July 1 that we would not get terminated, however it would be a voluntary Quit due to failure to follow policy. [sic all]

B. Respondent's Position Statement:

[redacted] denies it discriminated against [redacted].

As [redacted] vaccination policy was evolving as the law changed, and at all times remained compliant. To be clear, although [redacted] initially planned to require vaccination of all employees, once Montana law precluded this option, [redacted] altered its plan. As the plan was altered, it was communicated to all employees, including Charging Party. Once HB 702 passed, [redacted] altered its vaccination requirement to comply. It limited mandatory vaccinations only to senior services employees, in accordance with the exemption set forth in HB 702, since the CDC has recommended all health care workers be vaccinated.

In addition, employees at [redacted], like Charging Party, were also aware [redacted] was following a no lay off policy. In other words, not a single individual was laid off during the pandemic who wanted to continue working and performed in accord with [redacted] policies and procedures. More significantly, individuals working in senior services who chose not to get vaccinated have been moved to alternate positions.

C. Charging Party's Rebuttal:

On August 19, 2021, [redacted] sent the following email to the Bureau:

> I would like to start out by addressing the comment that if we chose not to get vaccinated we would be moved to alternate positions. I was at no time offered an alternate position nor was I ever spoken to about choices. As far as them saying that I was planning on getting vaccinated until [redacted] required it is false. I stated that I was considering it until they were forcing it in order to keep my job. I however did get vaccinated due to the fact that June 30th we would no longer be able to work in Senior Services if we were not fully vaccinated so yes I did get vaccinated to keep my job so as not to lose my house, my car, and be unable to pay my bills. My complaint is that they are mandating a vaccine that is still not FDA-approved and I feel it is my choice to not get a vaccination that is not approved. I will withdraw my complaint however I felt it important to get some of the facts straight, there was no communication to me whatsoever that I could transfer or change to a different location in order to not get vaccinated and if I chose to move elsewhere I would have to take a pay cut as our wage as a CNA is more in Senior Living than the hospital. When I did receive my vaccination I did sign the paper stating that I was getting the vaccine under duress because I could not afford to lose my job.
>
> Thank you for your time in this matter. I am unhappy that I was forced to get a vaccine that is not approved and is experimental in order to keep my current position that I love. I love working with the elderly in rehabilitation and want to keep working at a job I love. I unfortunately disagree with the covid vaccine mandate but chose to follow their rules to keep my position.

D. Documents:

- Centers for Disease Control and Prevention, COVID-19 Vaccines for Healthcare Personnel, updated May 27, 2021, reads, in part, as follows:

> Healthcare personnel continue to be on the front line of the nation's fight against COVID-19. By providing critical care to those who are or might be infected with the virus that causes COVID-19, some healthcare personnel are at increased risk of infection from COVID-19. All healthcare personnel are recommended to get vaccinated against COVID-19.

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/hcp.html

E. Omissions:

As noted above, [redacted] neither participated in the Bureau's investigation, nor submitted a request for withdrawal form after indicating her desire not to pursue her claim. The Bureau's communications with [redacted] include the following:

- On July 23, 2021, this investigator mailed [redacted] a copy of the response filed by Benefis and requested that [redacted] submit a rebuttal.
- On August 16, 2021, having not received a response to the previous letter, this investigator mailed [redacted] another copy of the response filed by [redacted] and requested that she submit a rebuttal. This letter also contained a Request for Withdrawal form along with an explanation that [redacted] could complete and return the form if she no longer wished to pursue her claim.
- On August 19, 2021, this investigator received an email from [redacted], the content of which is set forth in Charging Party's Rebuttal above.
- On September 3, 2021, this investigator sent [redacted] a reply email requesting that she either participate in the Bureau's investigation by submitting a rebuttal or return the completed Request for Withdrawal form.

As of the date of this report, [redacted] has not communicated further with the Bureau. As such, the Bureau has drafted a finding based on the limited information contained in the case file.

III. ANALYSIS

[redacted] alleges [redacted] discriminated against her on the basis of vaccination status. [redacted] establishes she filed a timely complaint. The Bureau has jurisdiction over the complaint.

The initial complaint filed by [redacted] does not clearly articulate an adverse act on which she based her claim. However, [redacted] August 19, 2021 email clarifies her claim as follows: "My complaint is that they are mandating a vaccine that is still not FDA-approved and I feel it is my choice to not get a vaccination that is not approved."

House Bill 702 was signed into law by the Governor on May 7, 2021, and has since been codified as Mont. Code Ann. §§ 49-2-312 and 313.

Mont. Code Ann. § 49-2-312(1)(b) makes it an unlawful discriminatory practice for:

> an employer to refuse employment to a person, to bar a person from employment, or to discriminate against a person in compensation or in a term, condition, or privilege of employment based on the person's vaccination status or whether the person has an immunity passport.

This statute also states that "an individual may not be required to receive a vaccine whose use is allowed under emergency use or authorization or any vaccine undergoing safety trials." *Mont Code Ann. § 49-2-312(4)*

[redacted] alleges disparate treatment. To establish a prima facie case for disparate treatment, must show:

1. She is a member of a protected class; and
2. [redacted] subjected her to an adverse action in circumstances raising a reasonable inference [redacted] treated her differently because of membership in a protected class.

This analysis will proceed directly to element two, which is dispositive of [redacted] claim.

In its defense, [redacted] asserts that Mont. Code Ann. §49-2-313 includes the following exemption:

> A licensed nursing home, long-term care facility, or assisted living facility is exempt from compliance with 49-2-312 during any period of time that compliance with 49-2-312 would result in a violation of regulations or guidance issued by the centers for medicare and medicaid services or the centers for disease control and prevention.

[redacted] was asked to rebut [redacted] assertions that her position in senior services falls within the above-cited exemption and that CDC guidance recommends vaccination against COVID-19 for all healthcare personnel. The Bureau notes it has concerns about the application of this section, specifically what constitutes "guidance" issued by the centers for medicare and medicaid. But, the Bureau cannot force participation by a party and [redacted] has chosen not to participate. As such, [redacted] mandatory vaccination policy for senior services employees, including [redacted], did not violate the Montana Human Rights Act as it appears to fall within the exemption.

Accordingly, [redacted] cannot show that [redacted] subjected her to an adverse act and cannot establish a prima facie case for disparate treatment.

IV. CONCLUSION

Based on my investigation, I find **no reasonable cause** to believe unlawful discrimination occurred as alleged in Charging Party's complaint.

Bre Koffman

Bre Koffman
Montana Human Rights Bureau

November 22, 2021
Date

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION

MONTANA MEDICAL ASSOCIATION, et al., Plaintiffs, and MONTANA NURSES ASSOCIATION, Plaintiff-Intervenors, v. AUSTIN KNUDSEN, et al., Defendants.	Case No. CV 21-00108-DWM PLAINTIFFS' RESPONSES TO DEFENDANTS' FIRST COMBINED DISCOVERY REQUESTS

Plaintiffs submit the following answers/responses to Defendants' First Combined Discovery Requests dated June 29, 2022.

REQUEST FOR ADMISSION NO. 1: Please admit that the individual Plaintiffs have visited Providence, or any other health care facility defined by MCA § 50-5-101, since May 7, 2021.

RESPONSE: Admit as to Mark Carpenter. Admit as to Cheyenne Smith. Admit as to Wally and Jo Page. Denied as to Pat Appleby, although she has attended other health care establishments during this time frame.

REQUEST FOR PRODUCTION NO. 13: Please produce all documents in your possession, custody, or control that support or substantiate your Answer to Request for Admission No. 1.

RESPONSE: Plaintiffs object that this request is vague, overly broad, unduly burdensome and not proportional to the needs of the case. It is unclear what documentation is sought to substantiate the response to the previous request for admission.

REQUEST FOR ADMISSION NO. 2: Please admit that WMC, FVU, PH&S, and other health care providers employ individuals unvaccinated for COVID-19 and other infectious diseases.

RESPONSE: Plaintiffs object to the reference to "other infectious diseases" as vague, overly broad and not sufficiently defined. As to the non-objectionable portion of this request, Plaintiffs admit Providence employs individuals unvaccinated against COVID-19 but who have an approved exemption

84-92 constitute Plaintiffs' Eighth Claim for Violation of CMS Regulations, and make reference to all applicable CMS Regulations. These allegations and this claim impacts all physicians (including but not limited to those MMA members and physicians employed or contracted at Five Valleys and Clinic) who are on the medical staffs of facilities subject to the CMS Conditions of Participation. Moreover, Five Valleys (while not directly subject to the CMS regulations at issue) is part owner in an ambulatory surgery center, to which the CMS Conditions of Participation apply.

REQUEST FOR PRODUCTION NO. 33: Please produce any and all documents in your possession, custody, or control, including communications to or from employees or members, plans, or policies related to vaccination requirements or recommendations for any disease since January 1, 2018.

RESPONSE: Plaintiffs object to the extent this request seeks information from the individual Plaintiffs or the MMA. Plaintiffs object that this request is overly broad and unduly burdensome as to every communication made to any employee, and further object that the request is vague as to what is meant by "members" and "plans." Providence currently has 2,838 employee positions in the Montana service area, Five Valleys has 40 employees, and the Clinic has 190 employees. Plaintiffs cannot possibly know or locate every communication with every person on this topic. To the extent this topic is limited to the last three years

and relates to official statements and bulletins made on behalf of Providence, Five Valleys, and the Clinic to employees and policies related to vaccination requirements and recommendation, please see the documents produced herewith.

REQUEST FOR PRODUCTION NO. 34: Please produce any and all documents in your possession, custody, or control, including communications to or from employees or members, plans, or policies related to minimizing the spread (as that term is used in Paragraph 25 of the Second Amended Complaint) of pathogens since January 1, 2018.

RESPONSE: Plaintiffs object to the extent this request seeks information from the individual Plaintiffs or the MMA. Plaintiffs object that this request is overly broad and unduly burdensome as to every communication made to any employee, and further object that the request is vague as to what is meant by "members" and "plans." Providence currently has 2,838 employee positions in the Montana service area, Five Valleys has 40 employees, and the Clinic has 190 employees. Plaintiffs cannot possibly know or locate every communication with every person on this topic. To the extent this topic is limited to the last three years and relates to official statements and bulletins made on behalf of Providence, Five Valleys, and the Clinic to employees and policies related to vaccination requirements and recommendation, please see the email communications and policies pertaining to Providence, Five Valleys and the Clinic produced herewith.

documents and information produced therewith and referenced therein.

DATED this 29th day of July, 2022.

Attorneys for Plaintiffs:

GARLINGTON, LOHN & ROBINSON, PLLP

By _____
Justin K. Cole

CERTIFICATE OF SERVICE

I hereby certify that on July 29, 2022, a copy of the foregoing document was served on the following persons by the following means:

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION

MONTANA MEDICAL ASSOCIATION, et al.,

Plaintiffs,

and

MONTANA NURSES ASSOCIATION,

Plaintiff-Intervenors,

v.

AUSTIN KNUDSEN, et al.,

Defendants.

Case No. CV 21-00108-DWM

PLAINTIFFS' FOURTH SUPPLEMENTAL RESPONSES TO DEFENDANTS' FIRST COMBINED DISCOVERY REQUESTS

Plaintiffs submit the following supplemental answers/responses to Defendants' First Combined Discovery Requests dated June 29, 2022.

These answers/responses are prepared and submitted in accordance with Federal Rules of Civil Procedure 26, 33, 34, and 36. Plaintiffs do not recognize or accept any obligation to supplement answers/responses to discovery requests except as required by Federal Rule of Civil Procedure 26(e). The preface included in these discovery requests is not within the express or implied provisions of the Federal Rules of Civil Procedure and, as such, has been disregarded in preparing these answers/responses.

In the event Plaintiffs inadvertently or otherwise produce copies of documents that are subject to protection from discovery under the doctrines of attorney-client privilege, work-product, trade secrets, confidentiality, proprietary or confidential business or commercial information, or are not relevant and not reasonably calculated to lead to the discovery of the admissible evidence, any production herewith shall not be deemed a waiver of such protection or any subsequent obligation to use for admissibility in any proceedings herein.

INTERROGATORY NO. 5: In Paragraph 25 of the Second Amended Complaint, Individual Plaintiffs allege that they must "avoid or minimize contact" with "persons who carry or may carry the COVID-19 virus" and must "avoid commercial and professional establishments" that "fail to take steps to minimize the spread of the virus and other common viruses and germs" and must avoid establishments that "employ unvaccinated workers" or are unable to "take

necessary measures to protect against preventable diseases." Please describe in detail how you define these quoted phrases from Paragraph 25 of the Second Amended Complaint.

ANSWER: The phrases quoted in the response are defined as to their ordinary meaning. As additional explanation, individuals who are vulnerable due to age, disability, or health condition are more at risk of contracting and being harmed by vaccine-preventable diseases. These individuals are required to take particular precaution to avoid contracting vaccine-preventable diseases. This applies not only to COVID during the current pandemic, but to all infectious diseases.

For Mark Carpenter specifically, as a kidney transplant patient, he was given a significant amount of guidance prior to the transplant and afterwards regarding the risks of infections because of immunosuppressants. This started back in 2016 when he applied for a kidney transplant and the guidance is ongoing. This included his entire transplant team at Virginia Mason Hospital in Seattle, his primary care physician in Missoula, his nephrologist in Missoula, his infectious disease specialist in Missoula, and the Missoula County Health Department where he received a large number of vaccinations strongly recommended by his various medical providers. People on immunosuppressants are given guidance to the extent of avoiding things like salad bars due to the risk of infection for diseases

like Hepatitis B. In order to protect himself during the pandemic, he did extensive research on his own following clinical studies at John Hopkins and elsewhere. This is how he discovered that the vaccines might not produce antibodies for him and what levels of antibodies are expected to provide protection. For these reasons, he has not attended large gatherings (conferences, trade shows, sporting events, festivals, concerts, or weddings) since the pandemic began. Since March 2020, he has lived at his remote cabin on Salmon Lake and kept his interactions to a very small group of friends and family who were fully vaccinated and exercised caution.

For Wally Page, he avoided seeing people and establishments who disregarded masking and vaccination recommended by health care professionals. Jo Page limited places she visited to healthcare establishments, where providers masked and followed distancing protocols.

Cheyenne Smith was pregnant during the pandemic and exercised caution when in public. Pat Appleby also exercised caution when leaving the house or going to the grocery store.

FIRST SUPPLEMENTAL ANSWER: Plaintiffs provide the following additional information from each individual Plaintiff.

Additional information for Wally and Jo Page

For Wally, frequent trips to health care providers are not optional and he expects that his medical providers do him no harm. They mask and keep a clean work environment and he naturally assumed their vaccinations were a work requirement. With his cancer diagnosis, he has had to be very cautious. He felt some of the times he was at most risk of catching something included going to the emergency care waiting room where very sick patients waited for treatment. He knew that many of the sickest with COVID ended up being treated at emergency care before admission to the hospital. He has had to visit the chemotherapy infusion room over 100 times. Not knowing whether all individuals were vaccinated, he has had to be very cautious and he feels lucky that he did not catch COVID from someone there while he was receiving those treatments (though did contract COVID later).

Jo was diagnosed with breast cancer in 2019. As she met with different doctors, including primary care, oncologist, surgeons, and radiologists, she learned from them how important it was to keep herself safe from crowds, public areas, and exposures to anything that could penetrate her immune compromised system. She has a very active family and once the pandemic surfaced, she and her family became isolationists. They did not attend athletic events, weddings, any organization meetings, concerts, or the like. Her family would come by and talk to Wally and Jo from the yard just so they could see them and vice versa. Then

Wally was diagnosed with Non-Hodgkin's Lymphoma and Multiple Myeloma. At this point, Jo did the shopping which was mostly done via the internet and curb side services at grocery stores. Her contact with friends and family was mostly by phone and social networking. She did get all the immunizations offered for COVID-19.

Jo and Wally were extremely cautious with masking and personal contact. Gradually, their families came to visit, still masking. As of late, they have started seeing friends in small groups and still masked. They finally felt comfortable attending some of their grandchildren's events. And then Jo and Wally both contracted COVID. They are thankful they were immunized and they both recovered from COVID. They did receive the antiviral treatments as part of their treatment for COVID. Then they went back to being more cautious again.

Additional information for Pat Appleby:

During 2020, Pat worked in Billings at a plant nursery job where +/- 90% of the work was outdoors and masks and social distancing were nonetheless required. That seasonal employment ended at the end of November, and she thereafter hunkered down at home in the Bitterroot Valley with family going out as little as possible. She has many friends in her age group with health concerns as well and they freely discussed the need for vaccinations and precautions.

During the spring of 2021, vaccinations became available and her and her family were all fully vaccinated. By the time vaccine waiting periods were complete they were continuing to restrict activity but feeling less intimidated about going out and about. They did have out of state friends visit during the summer, but they were vaccinated prior to travel.

Pat and her husband were working a combination of in person and at home throughout 2020 and 2021. Pat's husband's employer required staff to wear masks and reduced customer contact as much as possible. They also encouraged customers to wear masks when interacting with company employees. Many of his customers were unwilling to protect themselves and others. By November 2021, her husband tested positive for COVID, and she tested positive a few days later. Fortunately for her, the illness was not severe and she recovered. But as the months go on, she is feeling many symptoms of what is now being called "Long Covid."

As for Cheyenne Smith:

Cheyenne has been immunocompromised since her diagnosis of Juvenile Rheumatoid Arthritis since 1996. She has always been cautious of her surroundings. Relying on immunosuppressants to live day to day, she has always been advised that she was at higher risk for infections and illnesses. Growing up,

she was constantly reminded to wash her hands and avoid any children that might be sick in school.

She loves her work as a dental hygienist. Upon getting accepted into hygiene school she was required to receive many vaccinations in order to attend. She has always assumed that all healthcare workers are required to receive vaccinations to go through school. As a hygienist, she believes becoming vaccinated is a measure to protect herself, her family, as well as her patients.

COVID-19 brought upon a whole new level of terror into Cheyenne's life. COVID-19 was so new, scary and unknown that she was terrified to go back to work. In late fall 2020, she found out she was pregnant. She struggled to get pregnant and once she was able to conceive, she was advised to be extremely cautious by her OBGYN, and was strongly advised to get vaccinated against COVID19 by both her OBGYN and her rheumatologist.

Cheyenne got vaccinated for COVID-19 when cleared for emergency use for healthcare workers, and at 5 weeks pregnant. She got vaccinated to protect herself, her growing baby, her husband and her patients. She believes this is the right thing to do as a healthcare worker, you protect yourself and you protect those you are caring for.

Every rheumatology visit, every ultrasound, and every prenatal visit she masked and followed all the guidelines recommended by her medical professionals to avoid as best she could the possible risk of infection.

Following the birth of her child, she now had a newborn who had no immune system and was unable to get vaccinated against COVID-19. She evermore trusted the healthcare workers were getting vaccinated to protect their patients, even the littlest patients.

As for Mark Carpenter:

Mark's primary care doctor and nephrology teams were adamant pre- and post-transplant about being up to date on all vaccinations and other preventative healthcare tasks. Mark received many of his vaccinations at the Missoula County Health Department and they also strongly stressed how important vaccinations were. Other things Mark did to reduce risk:

- Ordered groceries online with a specific pickup time where you park and they bring groceries to your car.
- Order more things online as opposed to going to local stores.
- Ordered food online for pickup/delivery as opposed to dining in.
- Did not visit any family members or friends who were not fully vaccinated and didn't wear masks or take precautions to disinfect surfaces. When socializing most activities were outdoors and tried to implement social distancing whenever possible.
- Canceled pre-planned vacation travel like annual family ski trips.

INTERROGATORY NO. 12: Please explain in detail what steps, if any, individual Plaintiffs took prior to May 7, 2021 to assess the vaccination or

immunity status of employees or personnel at any commercial or professional establishment before entering it.

ANSWER: Plaintiffs object that this request is overly broad, unduly burdensome and not limited to a discreet timeframe. As to the non-objectionable portion of the request, in general, prior to the COVID pandemic, the individual plaintiffs did not believe vaccination was an issue, due to the fact that vaccinations were a common requirement for the military, public schools, and daycares. Individual plaintiffs were unaware of the magnitude of the anti-vaccination movement prior to the pandemic. Mark Carpenter, for example, assumed most individuals were vaccinated, as vaccination status had never previously been a political issue and vaccinations were a common requirement of people proceeding through the public school system. In healthcare settings, Mark Carpenter assumed vaccination was a requirement of employment to protect patients, given that vaccinations were mandated for public schools and daycares.

FIRST SUPPLEMENTAL ANSWER: Please see the first supplemental answer to Interrogatory No. 5.

REQUEST FOR ADMISSION NO. 8: Please admit that the Montana Department of Health and Human Services has never required staff vaccination as a condition of participation in Medicaid.

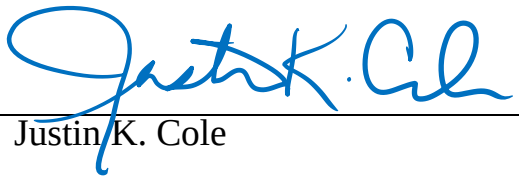
RESPONSE: Plaintiffs object that this request is overly broad, unduly burdensome, argumentative, assumes inaccurate facts, and seeks information not in the possession of Plaintiffs. Plaintiffs are unable to answer this request as Montana DPHHS is not responsible for establishing the conditions of participation for Medicaid.

FIRST SUPPLEMENTAL RESPONSE: Subject to the objections and response set forth in the initial response, Plaintiffs deny this request as written. The conditions for participation in Medicare and Medicaid are set by the Centers for Medicare and Medicaid Services, set forth in Title 42 of the Code of Federal Regulations ("CFR"). DPHHS may not set standards for the quality of care that are inconsistent with the requirements in Title 42 of the CFRs. *See* Mont. Code Ann. § 53-6-106(3). Furthermore, as a condition of participation in the Montana Medicaid program, all providers are required by DPHHS regulations to comply with all applicable state and federal statutes, rules and regulations, including but not limited to the federal regulations and statutes found in Title 42 of the CFR and the USC governing the Medicaid program. Admin. R. Mont. 37.85.401. As such, Montana regulation would, at a minimum, require participating facilities to comply with the CMS Conditions of Participation, and would specifically require hospitals to comply with 42 CFR 482.41 and 482.22.

DATED this 19th day of August, 2022.

Attorneys for Plaintiffs:

GARLINGTON, LOHN & ROBINSON, PLLP

By 
Justin K. Cole

CERTIFICATE OF SERVICE

I hereby certify that on August 19, 2022, a copy of the foregoing document was served on the following persons by the following means:

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UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION

MONTANA MEDICAL ASSOCIATION, ET. AL., PLAINTIFFS, AND MONTANA NURSES ASSOCIATION, PLAINTIFF-INTERVENORS, V. AUSTIN KNUDSEN, ET AL., DEFENDANTS.	CV-21-108-M-DWM **DEFENDANTS' RESPONSES TO PLAINTIFF'S FIRST COMBINED DISCOVERY REQUESTS**

judicial or administrative proceeding or investigation; the right to object on any ground to the use of the information or documents in this or any other court action or judicial or administrative proceeding or investigation; and the right to object at any time in any further response to this or any other requests for production of documents.

4. Defendants reserve the right to supplement and/or modify their responses to Plaintiff MMA's First Combined Discovery Requests to the extent further information becomes available and/or responsive documents are discovered.

Subject to the foregoing General Objections, Defendants submit these Responses to Plaintiff MMA's First Combined Discovery Requests as follows:

INTERROGATORY NO. 1: Please state the name and address of all persons and/or entities who provided information used in the preparation of your answers and responses to these discovery requests.

ANSWER: Marieke Beck, Tim Little, and Kim Cobos, Montana Department of Labor and Industry, with the assistance of counsel.

REQUEST FOR ADMISSION NO. 1: Please admit you intend to enforce Mont. Code Ann. § 49-2-312 against Offices of Private Physicians

("OPPs") as identified in Mont. Code Ann. § 50-5-101(26)(b), including but not limited to Plaintiffs Western Montana Clinic and Five Valleys Urology.

RESPONSE: Deny as stated. The state objects based on the ambiguity of the term "enforce." To the extent "enforce" is intended to encompass solely penalties and affirmative relief, no determination has yet been made to enforce against any OPP. To the extent "enforce" is intended more broadly to encompass pre-penalty activities, such as intake of complaints or investigations into filed complaints, admit.

REQUEST FOR ADMISSION NO. 2: Please admit you intend to enforce Mont. Code Ann. § 49-2-312 against Hospitals as identified in Mont. Code Ann. § 50-5-101(31), including but not limited to Plaintiff Providence Health & Services, related to vaccines other than the COVID-19 vaccine and immunity passports other than those related to COVID-19.

RESPONSE: Deny as stated. The state objects based on the ambiguity of the term "enforce." To the extent "enforce" is intended to encompass solely penalties and affirmative relief, no determination has yet been made to enforce against any Hospital. To the extent "enforce" is

intended more broadly to encompass pre-penalty activities, such as intake of complaints or investigations into filed complaints, admit.

Before Defendants may enforce § 49-2-312 against anyone, including Hospitals, there must be specific facts demonstrating that entity violated the law's strictures. As of the date of these responses, Defendants are not aware of any facts demonstrating a particular entity's violation. Defendants cannot speculate as to what factual showing would suffice to initiate enforcement of the law against Hospitals.

REQUEST FOR ADMISSION NO. 3: Please admit that if OPPs as identified in Mont. Code Ann. § 50-5-101(26)(b) treat staff differently in terms and conditions of employment based upon proof of vaccination status, such conduct would violate Mont. Code Ann. § 49-2-312.

RESPONSE: Deny. Plaintiff's use of the term "treat staff differently" is vague and ambiguous. Some conduct incorporated therein may constitute a violation of Mont. Code Ann. § 49-2-312, some may not. Absent fuller defining of terms and intent of the request, the State is unable clearly to admit or deny, and therefore denies.

REQUEST FOR ADMISSION NO. 4: Please admit the prohibited discriminatory practices prohibited by Mont. Code Ann. § 49-2-312 apply

accordance with the Federal Rules of Civil Procedure and the Court's scheduling order.

REQUEST FOR PRODUCTION NO. 4: Please produce a copy of each expert's file, including all communications (such as letters and e-mails) between the expert and you and/or your counsel related to compensation for the expert's study or testimony, that identify facts or data provided by you or your counsel that the expert considered in forming opinions, or that identifies assumptions that you or your counsel provided and that the expert relied upon in forming opinion; all notes; and, billing documentation.

RESPONSE: Defendants object to this request to the extent it exceeds the scope of Fed. R. Civ. P. 26(a)(2) and Fed. R. Civ. P. (a)(4). Subject to and without waiving this objection, Defendants have not yet identified the testifying expert and/or hybrid witnesses they intend to disclose in this case. Defendants will disclose such witnesses and the bases for their expert opinions in accordance with the Federal Rules of Civil Procedure and the Court's scheduling order.

INTERROGATORY NO. 8: Please provide a detailed explanation for the rationale and State interest regarding the different treatment of

licensed nursing homes, long-term care facilities, and assisted living facilities versus Hospitals (as defined in Mont. Code Ann. § 50-5-101(31)) in Mont. Code Ann. §§ 49-2-312 and 49-2-313.

ANSWER: At the time HB 702 passed, the Centers for Medicare & Medicaid ("CMS") has issued a series of regulations imposing COVID-19 requirements on Medicare and Medicaid certified nursing homes/long-term care facilities, including requirements to educate staff and residents about COVID-19 and COVID-19 vaccines and to make onsite COVID-19 vaccinations available. CMS and the Centers for Disease Control and Prevention (CDC) had issued guidance recommending vaccination requirements for nursing homes and long-term care facilities that participate in the Medicare and Medicaid programs. It was further expected that CMS would impose vaccination requirements on nursing homes/long-term care facilities because of the vulnerable populations they serve. Based on the unique populations served by each of those discrete types of health care facilities, the State of Montana chose to offer a limited exemption to these facilities that is tied in duration to the existence of CMS or CDC guidance or regulations. At the time HB 702 passed, only these types of health facilities were expected to be subject to

a CMS vaccine requirement; it was not until September 2021 that CMS announced that it would expand the planned emergency regulation requiring vaccination from nursing homes to all Medicare and Medicaid certified facilities.

Nursing homes, assisted living facilities, and long-term care facilities tend to be smaller facilities with fewer beds. They serve especially vulnerable elderly and/or disabled populations. Licensed nursing homes, long-term care facilities, and assisted living facilities also operate under different regulations than hospitals and are licensed separately and differently. *See, e.g.*, MCA § 50-5-101(7), (26), (31), (37), (56) (defining assisted living facilities, long term care facilities, nursing homes, physician offices, and hospitals); *see also* Mont. Admin. R. 37.106.4, 37.106.6, 37.106.28 (setting distinct minimum standards for hospitals, nursing facilities, and assisted living facilities).

INTERROGATORY NO. 9: Please provide a detailed explanation for the rationale regarding the different treatment of OPPs (as defined in Mont. Code Ann. § 50-5-101(26)(b)) versus Hospitals (as defined in Mont. Code Ann. § 50-5- 101(31)) in Mont. Code Ann. § 49-2-312.

ANSWER: Unlike hospitals, physician offices are not certified by CMS and are not subject to CMS Conditions of Participation or health and safety regulations. This is reflected in the CMS Omnibus Rule which does not cover physician offices. Likewise, the Montana Code Annotated exempts physician offices from the definition of "health care facility" and Montana health and safety regulations exempt physician offices from the definition for health-care facility. This reduces the regulatory and licensing burden on physician offices because the nature of their ordinary course of business does not require the same inspection, licensing, and oversight regime required of health-care facilities. The State of Montana drew a reasonable line at the exemption provided in MCA, § 49-2-312 between health-care facilities and other types of businesses, as is its prerogative. Physician offices do not qualify as health care facilities and Plaintiffs do not challenge that historic delineation.

INTERROGATORY NO. 10: Please provide a detailed explanation for the rationale and State interest regarding the different treatment of licensed nursing homes, long-term care facilities, and assisted living facilities versus OPPs (as defined in Mont. Code Ann. § 50-5-101(26)(b)) in Mont. Code Ann. §§ 49-2-312 and 49-2-313.

ANSWER: At the time HB 702 passed, CMS issued guidance recommending vaccination requirements for nursing homes and long-term care facilities. Based on the unique populations served by each of those discrete types of health care facilities, the State of Montana chose to offer a limited exemption to these facilities that is tied in duration to the existence of CMS or CDC guidance or regulations. While physicians and group practices may participate in the Medicare or Medicaid programs, they are not required to comply with CMS Conditions of Participation, Conditions for Coverage, or Requirements. At the time that HB 702 was adopted, there was no reason for the State to believe that CMS would impose vaccination requirements on OPPs—and indeed, CMS did not do so in the CMS Omnibus Rule. Thus, the reason for the limited exemption for the three listed types of facilities could not possibly apply to physician offices because they do not fall under a similar regulatory regime and indeed physician offices are not covered by the CMS Omnibus Rule.

This also reflects the fact that OPPs are different than licensed nursing homes, long-term care facilities, and assisted living facilities because OPPs are not residential facilities.

INTERROGATORY NO. 11: Please describe, with particularity, what constitutes "reasonable accommodation measures" as stated in Mont. Code Ann. § 49-2-312(3)(b).

ANSWER: Defendant objects to Interrogatory No. 11 because it is vague, ambiguous, confusing, and overbroad in that what constitutes "reasonable accommodation measures" varies greatly depending on the circumstances of any given situation. As propounded, Interrogatory No. 11 offers no facts as a premise for the inquiry. This places it outside the scope of Fed. R. Civ. P. 33(a)(2). Defendants cannot respond to a global request for what constitutes "reasonable accommodation measures" without knowing the facts and circumstances relevant to the Answer. The Federal Rules of Civil Procedure do not require Defendants to conceive of every set of facts by which an employee, patient, visitor, or other person could plausibly raise an accommodation issue, and then determine each and every reasonable accommodation based on this expansive universe of hypothetical facts.

DATED this 11th day of May, 2022.

As to the objections:

/s/ Christian Corrigan

CHRISTIAN B. CORRIGAN
Assistant Solicitor General
P.O. Box 201401
Helena, MT 59620-1401
christian.corrigan@mt.gov

Attorney for Defendants

As to the Responses:

LAURIE ESAU
Commissioner
Montana Department of Labor & Industry

CERTIFICATE OF SERVICE

I certify a true and correct copy of the foregoing was delivered by email to the following:

Justin K. Cole:
jkcole@garlington.com,
dvtolle@garlington.com

Kathryn Mahe:
ksmahe@garlington.com
kjpeterson@garlington.com

Raphael Graybill:
rgraybill@silverstatelaw.net

Date: May 11, 2022

Dia C. Lang

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA, MISSOULA DIVISION

MONTANA MEDICAL ASSOCIATION, ET. AL., PLAINTIFFS, and MONTANA NURSES ASSOCIATION, PLAINTIFF-INTERVENORS, v. AUSTIN KNUDSEN, ET AL., DEFENDANTS.	No. CV-21-108-M-DWM

VERIFICATION

STATE OF MONTANA)
:ss
County of Lewis and Clark)

Commissioner Laurie Esau states under oath that she is the authorized representative of the Defendants in the above-titled action; that she has read Defendants' Responses to Plaintiff Montana Medical Association's First Combined Discovery Requests; that the responses were prepared with the assistance and advice of counsel; that some of the information is accordingly outside the scope of her personal knowledge; and that the responses, subject to inadvertent or undiscovered errors, are based on and necessarily limited by the records and information still in existence, presently recollected, and thus far discovered in the course of the preparation of these responses. Consequently, Defendants reserve the right to make any changes in the responses if it appears at any time that omission or errors have been made or that more accurate information is

available. Subject to these limitations, the responses are true to the best of my knowledge, information, and belief.

I declare under penalty of perjury that the foregoing is true and correct.

DATED this 16th day of May, 2022.

Laurie Esau

OFFICE OF THE GOVERNOR
STATE OF MONTANA

GREG GIANFORTE
GOVERNOR

KRISTEN JURAS
LT. GOVERNOR

April 28, 2021

The Honorable Wylie Galt
Speaker of the House
State Capitol
Helena, MT 59601

The Honorable Mark Blasdel
President of the Senate
State Capitol
Helena, MT 59601

Dear Speaker Galt and President Blasdel:

"Vaccine passports" undermine individual liberty and threaten personal privacy, tenets Montanans hold dear. No person should be compelled to involuntarily divulge their personal health information as a condition of participating in everyday life, and so-called vaccine passports are one step down a dangerous path that erodes personal privacy. "Vaccine passports" are steeped in discrimination and have no place in our state.

I appreciate the Legislature's work to prohibit "vaccine passports" in Montana with House Bill 702, and I support the sponsor's efforts and intent. However, I believe this measure can be strengthened.

Therefore, in accordance with the power vested in me as Governor by the Constitution and the laws of the State of Montana, I hereby return with amendments House Bill 702: "A BILL FOR AN ACT ENTITLED: "AN ACT PROHIBITING DISCRIMINATION BASED ON A PERSON'S VACCINATION STATUS OR POSSESSION OF AN IMMUNITY PASSPORT; PROVIDING AN EXCEPTION; PROVIDING AN APPROPRIATION; AND PROVIDING EFFECTIVE DATES."

In line with Executive Order 7-2021, I firmly believe that "vaccine passports," or any documentation related to an individual's vaccination status, are an unwarranted infringement on our liberties.

Many Montanans have deeply held religious reasons for not obtaining a vaccine. Others have health conditions that prohibit them from getting one. Ultimately, the decision to receive a vaccine is voluntary, and Montanans should not face the threat of discrimination rooted in whether they decide to receive a vaccine. Furthermore, employers must not discriminate or take punitive action against employees who opt out of immunizations, but instead should work to provide well established, reasonable accommodations that protect the health and safety of all involved.

For these reasons, I am pleased to offer an amendment that strengthens HB 702 and promotes its proper enactment. Specifically, my amendment clarifies that an employer may ask an employee to volunteer their vaccination or immunization status under certain circumstances.

My amendment also makes clear that an employer's implementation of reasonable accommodation measures for persons who are not vaccinated or not immune to protect the safety and health of employees, customers, patients, visitors, and other persons from communicable diseases is not unlawful discrimination.

Additionally, my amendment would ensure that provisions of HB 702 do not put licensed nursing homes, long-term care facilities, or assisted living facilities in violation of regulations or guidance issued by the U.S. Centers for Medicare and Medicaid Services.

This is an important bill that can be reinforced to further protect Montanans, and I respectfully ask for your support of this amendment.

Sincerely,

Greg Gianforte
Governor

Enclosure

cc: Legislative Services Division
Christi Jacobsen, Secretary of State

Amendments to House Bill No. 702
Reference Copy

Requested by the Governor
For the (H) Committee of the Whole

Prepared by Todd Everts
04/28/2021, 08:10:50

1. Title, line 10.
Following: "EXCEPTION"
Insert: "AND AN EXEMPTION"

2. Page 2, line 12.
Following: "~~(3)~~ ~~(2)~~ (3)"
Insert: "(a)"

3. Page 2.
Following: line 13
Insert: "(b) A health care facility, as defined in 50-5-101, does not unlawfully discriminate under this section if it complies with both of the following:
(i) asks an employee to volunteer the employee's vaccination or immunization status for the purpose of determining whether the health care facility should implement reasonable accommodation measures to protect the safety and health of employees, patients, visitors, and other persons from communicable diseases. A health care facility may consider an employee to be nonvaccinated or nonimmune if the employee declines to provide the employee's vaccination or immunization status to the health care facility for purposes of determining whether reasonable accommodation measures should be implemented.
(ii) implements reasonable accommodation measures for employees, patients, visitors, and other persons who are not vaccinated or not immune to protect the safety and health of employees, patients, visitors, and other persons from communicable diseases."

4. Page 2.
Following: line 21
Insert: "NEW SECTION. **Section 2. Exemption**. A licensed nursing home, long-term care facility, or assisted living facility is exempt from compliance with [section 1] during any period of time that compliance with [section 1] would result in a violation of regulations or guidance issued by the centers for medicare and medicaid services or the centers for disease control and prevention."

Renumber: subsequent sections

5. Page 3, line 3.
Strike: "[Section 1] is"
Insert: "[Sections 1 and 2] are"

6. Page 3, line 4.
Strike: "[section 1]"
Insert: "[sections 1 and 2]"

Exhibit 41 - 3

7. Page 3, line 12.
Strike: "2"
Insert: "3"

- END -

Explanation - Note: Because the page and line numbers referred to in these amendment instructions are required to match the page and line numbers of the official bill version being amended, they will not necessarily match the page and line numbers shown in any related Amendments in Context document.

AN ACT PROHIBITING DISCRIMINATION BASED ON A PERSON'S VACCINATION STATUS OR POSSESSION OF AN IMMUNITY PASSPORT; PROVIDING AN EXCEPTION AND AN EXEMPTION; PROVIDING AN APPROPRIATION; AND PROVIDING EFFECTIVE DATES.

WHEREAS, as stated in section 50-16-502, MCA, the Legislature finds that "health care information is personal and sensitive information that if improperly used or released may do significant harm to a patient's interests in privacy and health care or other interests"; and

WHEREAS, the Montana Supreme Court in State v. Nelson, 283 Mont. 231, 941 P.2d 441 (1997), concluded that "medical records fall within the zone of privacy protected by Article II, section 10, of the Montana Constitution" and "are quintessentially private and deserve the utmost constitutional protection".

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Discrimination based on vaccination status or possession of immunity passport prohibited -- definitions. (1) Except as provided in subsection (2), it is an unlawful discriminatory practice for:

(a) a person or a governmental entity to refuse, withhold from, or deny to a person any local or state services, goods, facilities, advantages, privileges, licensing, educational opportunities, health care access, or employment opportunities based on the person's vaccination status or whether the person has an immunity passport;

(b) an employer to refuse employment to a person, to bar a person from employment, or to discriminate against a person in compensation or in a term, condition, or privilege of employment based on the person's vaccination status or whether the person has an immunity passport; or

(c) a public accommodation to exclude, limit, segregate, refuse to serve, or otherwise discriminate against a person based on the person's vaccination status or whether the person has an immunity passport.

(2) This section does not apply to vaccination requirements set forth for schools pursuant to Title 20, chapter 5, part 4, or day-care facilities pursuant to Title 52, chapter 2, part 7.

(3) (a) A person, governmental entity, or an employer does not unlawfully discriminate under this section if they recommend that an employee receive a vaccine.

(b) A health care facility, as defined in 50-5-101, does not unlawfully discriminate under this section if it complies with both of the following:

(i) asks an employee to volunteer the employee's vaccination or immunization status for the purpose of determining whether the health care facility should implement reasonable accommodation measures to protect the safety and health of employees, patients, visitors, and other persons from communicable diseases. A health care facility may consider an employee to be nonvaccinated or nonimmune if the employee declines to provide the employee's vaccination or immunization status to the health care facility for purposes of determining whether reasonable accommodation measures should be implemented.

(ii) implements reasonable accommodation measures for employees, patients, visitors, and other persons who are not vaccinated or not immune to protect the safety and health of employees, patients, visitors, and other persons from communicable diseases.

(4) An individual may not be required to receive any vaccine whose use is allowed under an emergency use authorization or any vaccine undergoing safety trials.

(5) As used in this section, the following definitions apply:

(a) "Immunity passport" means a document, digital record, or software application indicating that a person is immune to a disease, either through vaccination or infection and recovery.

(b) "Vaccination status" means an indication of whether a person has received one or more doses of a vaccine.

Section 2. Exemption. A licensed nursing home, long-term care facility, or assisted living facility is exempt from compliance with [section 1] during any period of time that compliance with [section 1] would result in a violation of regulations or guidance issued by the centers for medicare and medicaid services or the centers for disease control and prevention.

Section 3. Appropriation. There is appropriated $200 from the general fund to the department of labor and industry for the biennium beginning July 1, 2021, for the purposes of:

(1) notifying local boards of health of the requirements of [section 1] and requiring local boards of health to prominently display notice of the requirements of [section 1] on the home page of their website, if available, for at least 6 months after [the effective date of this act]; and

(2) requiring the department of public health and human services to prominently display notice of the requirements of [section 1] on the home page of the department's website for at least 6 months after [the effective date of this act].

Section 4. Codification instruction. [Sections 1 and 2] are intended to be codified as an integral part of Title 49, chapter 2, part 3, and the provisions of Title 49, chapter 2, part 3, apply to [sections 1 and 2].

Section 5. Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

Section 6. Effective date. (1) Except as provided in subsection (2), [this act] is effective on passage and approval.

(2) [Section 3] is effective July 1, 2021.

- END -

I hereby certify that the within bill,

HB 702, originated in the House.

_____

Chief Clerk of the House

_____

Speaker of the House

Signed this _____day

of_____, 2021.

_____

President of the Senate

Signed this _____day
of_____, 2021.

HOUSE BILL NO. 702

INTRODUCED BY J. CARLSON, D. SKEES, J. READ, D. LENZ, W. GALT, S. BERGLEE, J. HINKLE, M. NOLAND, V. RICCI, B. TSCHIDA, S. GUNDERSON, M. REGIER, L. SHELDON-GALLOWAY, J. TREBAS, D. BARTEL, C. KNUDSEN, B. USHER, J. PATELIS, S. VINTON, M. HOPKINS, F. FLEMING, J. FULLER, R. KNUDSEN, J. KASSMIER, T. MOORE, B. LER, B. PHALEN, F. NAVE, L. BREWSTER, B. MITCHELL, A. REGIER, S. KERNS, S. GALLOWAY, S. GIST, E. HILL, J. SCHILLINGER, K. SEEKINS-CROWE, M. STROMSWOLD, J. GILLETTE, C. HINKLE, M. BINKLEY, R. MARSHALL

AN ACT PROHIBITING DISCRIMINATION BASED ON A PERSON'S VACCINATION STATUS OR POSSESSION OF AN IMMUNITY PASSPORT; PROVIDING AN EXCEPTION AND AN EXEMPTION; PROVIDING AN APPROPRIATION; AND PROVIDING EFFECTIVE DATES.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

R.K., et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	**No. 3:21-cv-00725**
	)	
GOVERNOR BILL LEE, in his official capacity as GOVERNOR OF TENNESSEE, et al.,	)	**Chief Judge Crenshaw** **Magistrate Judge Newbern**
	)	
	)	
Defendants.	)	

DECLARATION OF JAY BHATTACHARYA
IN SUPPORT OF GOVERNOR BILL LEE'S OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Jay Bhattacharya, pursuant to 28 U.S.C. § 1746, declare as follows.

1. My name is Jay Bhattacharya, MD, PhD. I am over twenty-one years of age, of sound mind and body, and am otherwise competent to testify to the matters stated herein.

2. I am a Professor of Heath Policy at Stanford University School of Medicine and a research associate at the National Bureau of Economic Research. I direct Stanford's Center for Demography and Economics of Health and Aging. My recent research focuses on the epidemiology of COVID, including the lethality of COVID infection and the effects of lockdown policies. Before COVID, I studied the health and well-being of vulnerable populations, emphasizing the role of government programs, biomedical innovation, and health policy. I have published many articles in top peer-reviewed scientific journals in medicine, economics, health policy, epidemiology, statistics, law, and public health, among other fields. I have published to date six peer-reviewed publications on COVID, including some of the most highly cited pieces published during the pandemic. I hold an M.D. and Ph.D. in economics, both earned at Stanford University. A true and correct copy of my *curriculum vitae* is attached as Exhibit A.

Executive Summary

3. This declaration contains my assessments of the scientific evidence regarding the benefits and harms of mandating that children wear masks to attend school. I adopt an approach that contrasts the marginal benefits of required masking against the marginal harms. This stands in contrast to the approach that has characterized much decision-making during the pandemic, which typically ignores harms from interventions while at the same time assuming – even in the absence of high-quality scientific evidence – that the interventions will succeed in slowing disease spread. The primary findings I report in each section are as follows.
4. In "Public Health Decision-Making Principles," I outline some key and uncontroversial principles that public health ought to follow if it is to claim that it has a reasonable basis for the policies it is implementing, including the consideration of both costs and benefits of the policy in both short and long run, the strength and quality of scientific evidence underlying the policy, whether the policy is consistent with democratic norms and ethical principles, and a requirement that the policy treat all members of society equitably. The imposition of mandatory childhood masking fails on several grounds because the balance of harms outweighs the benefits, and the strength of scientific evidence on benefits is weak.
5. In "COVID-19 Infection Fatality Risk," I discuss the evidence on the risk of mortality posed by SARS-CoV-2 infection. For children, the mortality risk posed by infection is vanishingly low, with infection survival probabilities surpassing 99.99% in many studies. The risk of mortality after infection grows sharply with age. For elderly adults over 70, the survival probability after infection is 95%. The vaccination of the adult population has dramatically lowered the mortality risk faced by vaccinated individuals.
6. In "Children are unlikely to suffer serious side effects from COVID-19", I present further evidence on the low likelihood that children face lasting harm from COVID infection, including evidence that severe inflammatory outcomes, such as MIS-C, are rare.
7. In "Children are Inefficient Transmitters of the Virus," I present evidence from studies conducted worldwide that children are less efficient at spreading the disease than adults. Based on this evidence, which was available early in the epidemic, many countries opened their schools for in-person instruction during the 2020-21 academic year, in many places with no masks required for children or staff. The results from this natural experiment

yielded very low COVID-related mortality for children and COVID-infection rates for teachers and staff at lower rates than in the population at large.

8. In "No Randomized Evidence of Efficacy of Masking in Limiting Disease Spread," I present evidence of structured reviews of the literature on the effect of masking on slowing the spread of COVID and other respiratory viruses. The primary conclusion is that there are no high-quality randomized evaluations that establish that masks on children are particularly effective in slowing disease spread. The highest quality observational evidence from the U.S. suggests no correlation between mandating that children wear masks and disease outcomes.
9. Finally, in "Harms to Children from Mask Wearing in Schools," I present evidence from the scientific literature that masks can pose some harm to the emotional and social development of some children.
10. Overall, the evidence I present in this report shows that permitting parents to opt out of a mandated mask policy is unlikely to have a significant effect on COVID disease spread and may relieve some children from the harms of masking.

Public Health Decision-Making Principles

11. The justification for a benefit-harm approach is that it is consistent with the principles of good public health[1] and health policy[2] practice that predates the epidemic and is more likely to produce good decisions and better pandemic outcomes. Within the context of public health decisions, "decisions about which actions should be considered [during a pandemic] should take into account numerous factors, such as virus transmission parameters, severity of disease among different age and risk groups, availability and effectiveness of control measures and treatment options, and impact on health care, schools, business, and the community."[3] That is because mitigation policies—especially severe ones—have "potential social, economic, and political consequences that need to be fully considered by political leaders as well as health officials" before their

[1] Public Health Leadership Society (2002) Principles of the Ethical Practice of Public Health. American Public Health Association. https://www.apha.org/-/media/files/pdf/membergroups/ethics/ethics_brochure.ashx
[2] Bhattacharya J, Hyde T, Tu P. Health Economics, London: Palgrave-MacMillan, (2013).
[3] Rachel Holloway et al., *Updated Preparedness and Response Framework for Influenza Pandemics*, MORBIDITY & MORTALITY WEEKLY REP., Sept. 26, 2014, at 6.

implementation.[4] Those consequences are evident and well-illustrated by the economic, physical, and psychological harms that extreme COVID-19 mitigation measures inflicted and, in many places, continue to inflict.

12. While the topic is voluminous, there are a few principles that are particularly relevant to COVID-19 policy making, including the following guidelines for decision-makers:
    a. Consider both the costs *and* benefits of alternative policies, choosing policies that appropriately balance the two.
    b. Appropriately account for uncertainty in the projected costs and benefits of policy options.
    c. Account for the strength of the scientific evidence.
    d. Be constrained in policy making by democratic norms and ethical principles.
    e. Choose policies that treat people in society equitably, and in particular, eschew policies that disproportionately favor more affluent members of society over poorer members.
13. Sound health policy decision-making requires a careful evaluation of both the costs and benefits over both the long and short term. It is striking that public health officials rarely discuss the collateral harms or, in the case of masks, often assume that there are none. The costs considered should include medical and psychological harms as well as economic damage.
14. The costs and benefits of every potential policy involve some degree of uncertainty, including lockdowns and masking. Weighing the costs and benefits of a particular mitigation policy is, to be sure, a difficult task in the context of a pandemic. "[D]ata needed to make decisions might be limited," especially early in a pandemic, but "delaying action might weaken the effectiveness of the response."[5] But that does not justify taking blanket prophylactic action that may, in the end, cause significant harm with little benefit, which is precisely what occurred in the COVID-19 pandemic.
15. In the face of uncertainty, public health decision-making should be based on the best available evidence regarding the most likely outcomes from the imposition of the policy. Medicine and public health require the highest quality evidence – placebo-controlled randomized trials – for a good reason; too often, lower-quality evidence produces misleading conclusions. Public health decision-making should eschew decision-making

[4] Thomas V. Inglesby et al., *Disease Mitigation Measures in the Control of Pandemic Influenza*, 4 BIOSECURITY & BIOTERRORISM: BIODEFENSE STRATEGY, PRACTICE, & SCIENCE 366, 369 (2006).
[5] Rachel Holloway et al., *Updated Preparedness and Response Framework for Influenza Pandemics*, MORBIDITY & MORTALITY WEEKLY REP., Sept. 26, 2014, at 6.

based on worst-case or best-case assumptions about the outcomes that may happen if alternate policies are adopted. It is particularly bad practice to make decisions that assume worst-case scenarios regarding the costs of a policy and best-case assumptions regarding the benefits of a policy, or vice versa. So, for instance, it is poor public health practice to assume in the absence of high-quality evidence that masks, if mandated, will have a dramatic effect on disease transmission and mortality with no consideration of the harms associated with masking children.

16. In addition to the costs and benefits, public health policy must consider the strength of the scientific evidence regarding the measure in achieving the aims it proposes. Of course, without solid scientific evidence in favor of a policy – especially one with enormous costs – its imposition by a government on a population would be unethical. The greater the potential harms from the policy on some part of the population, the greater the evidentiary standard required to establish its necessity.

17. Finally, equity is a key principle of public health. Public health officials must consider whether the harms of a policy like lockdowns fall disproportionately on the poor, minority populations, or others of low socioeconomic status. Similarly, policies that accrue benefits disproportionately to the affluent, majority populations, and people of high socioeconomic status should be redesigned to comport with the requirement for equity in public health decision-making.

18. In summary, sound public-health practice adheres to key principles aimed at grounding policy in sound science, respecting human rights and democratic norms, appropriately accounting for costs and benefits of policies and uncertainty in outcomes, treating people equitably, as well as other principles not discussed here. Public health officials must make decisions within that framework to engage in non-arbitrary and non-capricious decision-making. That includes current decisions about COVID-19-related health policy, such as whether or not to mandate non-pharmaceutical interventions ("NPI's") like mask wearing for schoolchildren—the subject of this report. Instead, public health authorities should focus their resources on protecting the population of older, vulnerable people who have not yet been vaccinated and still face a high risk of death if infected. Direct protection through extended vaccination efforts for the vulnerable would more effectively reduce the direct

harms from COVID, without some of the adverse effects – both social and personal – induced by mask mandates for children.

COVID-19 Infection Fatality Risk

19. SARS-CoV-2, the virus that causes COVID-19 infection, entered human circulation some time in 2019 in China. The virus itself is a member of the coronavirus family of viruses, several of which cause typically mild respiratory symptoms upon infection. The SARS-CoV-2 virus, by contrast, induces a wide range of clinical responses upon infection. These presentations range from entirely asymptomatic infection to mild upper respiratory disease with unusual symptoms like loss of sense of taste and smell, hypoxia, or a deadly viral pneumonia that is the primary cause of death due to SARS-CoV-2 infection.
20. The mortality danger from COVID-19 infection varies substantially by age and a few chronic disease indicators.[6] For most of the population, including the vast majority of children and young adults, COVID-19 infection poses less of a mortality risk than seasonal influenza. By contrast, for older people – especially those with severe comorbid chronic conditions – COVID-19 infection poses a high risk of mortality, on the order of a 5% infection fatality rate.
21. The best evidence on the infection fatality rate from SARS-CoV-12 infection (that is, the fraction of infected people who die due to the infection) comes from seroprevalence studies. The definition of seroprevalence of COVID-19 is the fraction of people in a population who have specific antibodies against SARS-CoV-2 in their bloodstream. A seroprevalence study measures the fraction of a population who have antibodies that are produced specifically by people infected by the SARS-CoV-2 virus. The presence of specific antibodies in blood provides excellent evidence that an individual was previously infected.
22. Seroprevalence studies provide better evidence on the total number of people who have been infected than do case reports or positive reverse transcriptase-polymerase chain reaction (RT-PCR) test counts. PCR tests are the most common type of test used to check whether a person currently has the virus or viral fragments in their body (typically in the

[6] Public Health England (2020) Disparities in the Risk and Outcomes of COVID-19. August 2020. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf

nasopharynx). The PCR test should not be used to count the total number of people who have been infected to date in a population. Case reports and PCR test counts both miss infected people who are not identified by the public health authorities or who do not volunteer for RT-PCR testing. That is, they miss people who were infected but recovered from the condition without coming to the attention of public health authorities. Because they ignore unreported, fatality rate estimates based on case reports or positive test counts are substantially biased toward reporting a higher fatality rate.

23. According to a meta-analysis[7] by Dr. John Ioannidis of every seroprevalence study conducted to date of publication with a supporting scientific paper (74 estimates from 61 studies and 51 different localities worldwide), the median infection survival rate—the inverse of the infection fatality rate—from COVID-19 infection is 99.77%. For COVID-19 patients under 70, the meta-analysis finds an infection survival rate of 99.95%. A separate meta-analysis[8] by other scientists independent of Dr. Ioannidis' group reaches qualitatively similar conclusions.

24. A study of the seroprevalence of COVID-19 in Geneva, Switzerland (published in *The Lancet*)[9] provides a detailed age breakdown of the infection survival rate in a preprint companion paper[10] 99.9984% for patients 5 to 9 years old; 99.99968% for patients 10 to 19 years old; 99.991% for patients 20 to 49 years old; 99.86% for patients 50 to 64 years old; and 94.6% for patients above 65.

25. I estimated the age-specific infection fatality rates from the Santa Clara County seroprevalence study[11] data (for which I am the senior investigator). The infection survival rate is 100% among people between 0 and 19 years (there were no deaths in Santa Clara in that age range up to that date); 99.987% for people between 20 and 39 years; 99.84% for people between 40 and 69 years; and 98.7% for people above 70 years.

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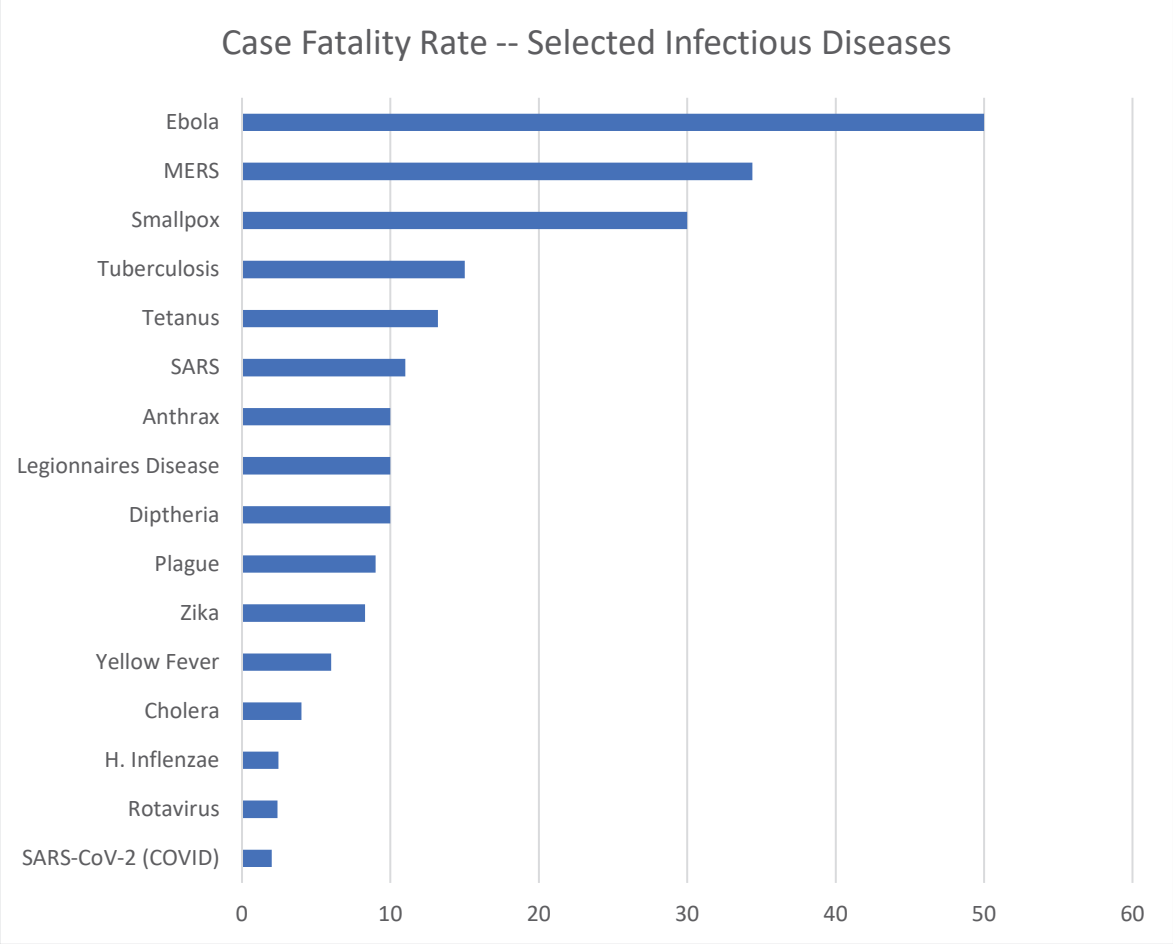
[7] John P.A. Ioannidis , *The Infection Fatality Rate of COVID- 19 Inferred from Seroprevalence Data*, Bulletin of the World Health Organization BLT 20.265892.
[8] Andrew T. Levin, et al., *Assessing the Age Specificity of Infection Fatality Rate for COVID- 19: Meta-Analysis & Public Policy Implications* (Aug. 14,2020)MEDRXIV, http://bit.ly/3gplolV.
[9] Silvia Stringhini, et al., *Seroprevalence of Anti-SARS-CoV-2 lgG Antibodies in Geneva, Switzerland (SEROCoV-POP): A Population Based Study* (June 11, 2020) THE LANCET, https://bit.ly/3187S13.
[10] Francisco Perez-Saez, et al. *Serology- Informed Estimates of SARS-COV-2 Infection Fatality Risk in Geneva, Switzerland* (June 15,2020) OSF PREPRINTS, http://osf.io/wdbpe/.
[11] Eran Bendavid, et al., *COVID- 19 Antibody Seroprevalence in Santa Clara County, California* (April 30,2020) MEDRXIV, https://bit.ly/2EuLIFK.

26. Those numbers are consistent with what the US CDC has reported. A US CDC report[12] found between 6 and 24 times more SARS-CoV-2 infections than cases reported between March and May 2020. Correspondingly, the CDC's estimate of the infection fatality rate for people ages 0-19 years is 0.003%, meaning infected children have a 99.997% survivability rate. For people ages 20-49 years, it was 0.02%, meaning that young adults have a 99.98% survivability rate. For people age 50-69 years, it was 0.5%, meaning this age group has a 99.5% survivability rate. Finally, for people ages 70+ years, it was 5.4%, meaning seniors have a 94.6% survivability rate. [13] There is thus no substantial qualitative disagreement about the infection fatality rate reported by the CDC and other sources in the scientific literature. This should come as no surprise since they all rely on seroprevalence studies to estimate infection fatality rates.

27. It is helpful to provide some context for how large the mortality risk is posed by COVID infection relative to the risk posed by other infectious diseases. Since seroprevalence-based mortality estimates are not readily available for every disease, in the figure immediately below, I plot case fatality rates, defined as the number of deaths due to the disease divided by the number of identified or diagnosed cases of that disease. The case fatality rate for SARS-CoV-2 is ~2% (though that number has decreased with the availability of vaccines and effective treatments). By contrast, the case fatality rate for SARS is over five times higher than that, and for MERS, it is 16 times higher than that.

[12] Fiona P. Havers, et al., *Seroprevalence of Antibodies to SARS-CoV-2 in 10 Sites in the United States, March 23-May 12, 2020* (Jul. 21, 2020) JAMA INTERN MED., https://bit.ly/3goZUgy.
[13] COVID- 19 Pandemic Planning Scenarios, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html.



28. Perhaps the most important implication of these estimates is that they identify two distinct populations of people who face a very different risk from COVID infection. One segment – the elderly and others with severe chronic disease – faces a higher risk of mortality if infected (especially if unvaccinated). A second segment – typically non-elderly people – face a very low risk of mortality if infected and instead face much greater harm from lockdowns, school closures, and other non-pharmaceutical interventions than from COVID infection itself. The right strategy, then, is focused protection of the vulnerable population by prioritizing them for vaccination while lifting lockdowns and other restrictions on activities for the rest since they cause harm without corresponding benefit for the non-vulnerable. The Great Barrington Declaration, of which I am a primary co-author, describes an alternate policy of focused protection. This policy would lead to fewer COVID-related deaths and fewer non-COVID-related deaths than universal lockdowns or a strategy that lets the virus rip through the population. My co-authors of this Declaration include Prof.

Martin Kulldorff of Harvard University and Prof. Sunetra Gupta of Oxford University. Over 12,000 epidemiologists and public health professionals and 35,000 medical professionals have co-signed the Declaration.[14]

29. These infection fatality rate estimates presented in this section are drawn from data before widespread vaccination in the U.S. and elsewhere. The COVID-19 vaccines approved for use in the U.S. are very effective in substantially reducing the infection fatality rate. According to the US Centers for Disease Control, the mRNA vaccines were 94% effective against COVID-19 hospitalization for patients 65 and older.[15] So infection fatality rates that I provide above are overestimated by at least one order of magnitude. Fully vaccinated, non-elderly teachers in classrooms face a vanishingly small risk of mortality even if the SARS-CoV-2 virus infects them.

Children are unlikely to suffer serious side effects from COVID-19 despite the delta variant

30. As the previous section indicates, COVID-19 is not a severe threat to schoolchildren, especially younger children—even if they contract the disease.[16] To begin, COVID-19 is almost never fatal for schoolchildren. According to Bravata et al., 2021 "[t]he CDC estimates that compared to adults 40 to 49 years of age, children 5 to 17 years of age have 160 times lower risk of death from COVID-19 and 27 times lower risk of hospitalization from COVID-19."[17] Since the start of the pandemic in the U.S. in January 2020 through Sept. 15, 2021, 439 children under 18 have died with a COVID-19 diagnosis code in their record. This is fewer children than die during a typical five-month influenza season each year.[18]

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[14] Bhattacharya J, Gupta S, Kulldorff M (2020) Great Barrington Declaration. https://gbdeclaration.org

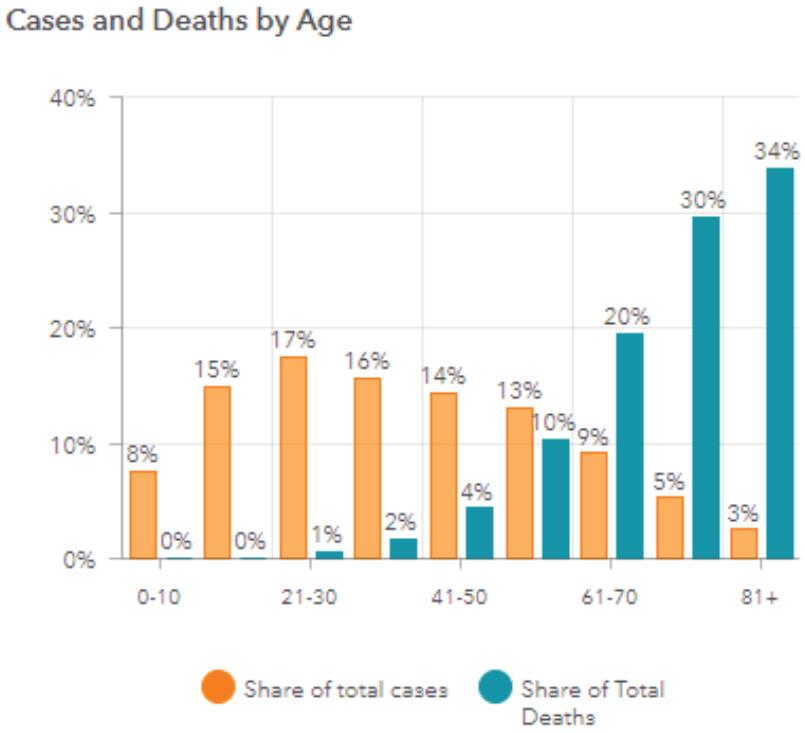
[15] Tenforde MW, Olson SM, Self WH, et al. Effectiveness of Pfizer-BioNTech and Moderna Vaccines Against COVID-19 Among Hospitalized Adults Aged ≥65 Years — United States, January–March 2021. MMWR Morb Mortal Wkly Rep 2021;70:674–679. DOI: http://dx.doi.org/10.15585/mmwr.mm7018e1external icon

[16] Especially children without preexisting conditions—"[i]t appears that children who become severely ill with acute Covid-19 often have one or more underlying conditions, including medical complexity, obesity, asthma, sickle cell disease, and immunosuppression." Jessica H. Rubens et al., *Acute COVID-19 and Multisystem Inflammatory Syndrome in Children*, BMJ: CLINICAL UPDATES, Mar. 1, 2021, at 2.

[17] Dena Bravata, et al. *Back to School: The Effect of School Visits During COVID-19 on COVID-19 Transmission* 9 (Nat'l Bureau of Econ. Research, Working Paper No. 28645, Apr. 2021).

[18] Marty Makary, Opinion, *The Flimsy Evidence Behind the CDC's Push to Vaccinate Children*, WALL ST. J. (July 19, 2021), https://on.wsj.com/2VYqit1. See also National Center for Health Statistics, "COVID-19 Data from the NCHS". Table 1. Table 1. Deaths involving coronavirus disease 2019 (COVID-19), pneumonia,

31. And in Tennessee, there have been almost no COVID-19 linked deaths among those under 30 years old.[19] The figure, taken from the University of Tennessee COVID-19 dashboard, plots a histogram of confirmed deaths by age in Tennessee using data from the pandemic's start through Sept. 27, 2021. It should not be surprising, given the evidence shown in the previous section, how uncommon mortality is for children relative to older people, especially those over the age of 70, where the bulk of the COVID-19 deaths have occurred.



32. This conclusion is also true at a county level, even in areas experiencing surges due to the delta variant. A survey of county health departments in Tennessee shows very few deaths among school age children. The Knox County Department of Health reports no COVID-19 deaths for children aged 17 and under.[20] Davidson County's Department of Health reports 1 COVID-19 death for children 17 and under.[21] Shelby County has reported a total

and influenza reported to NCHS by sex and age group. United States. Accessed September 24, 2021. https://www.cdc.gov/nchs/covid19/index.htm

[19] University of Tennessee COVID-19 Case Tracking https://myutk.maps.arcgis.com/apps/dashboards/72ce9fd4bee241. Data accessed September 27, 2021 and current through September 27, 2021.

[20] Knox County Health Department, https://covid.knoxcountytn.gov/case-count.html. Accessed September 27, 2021.

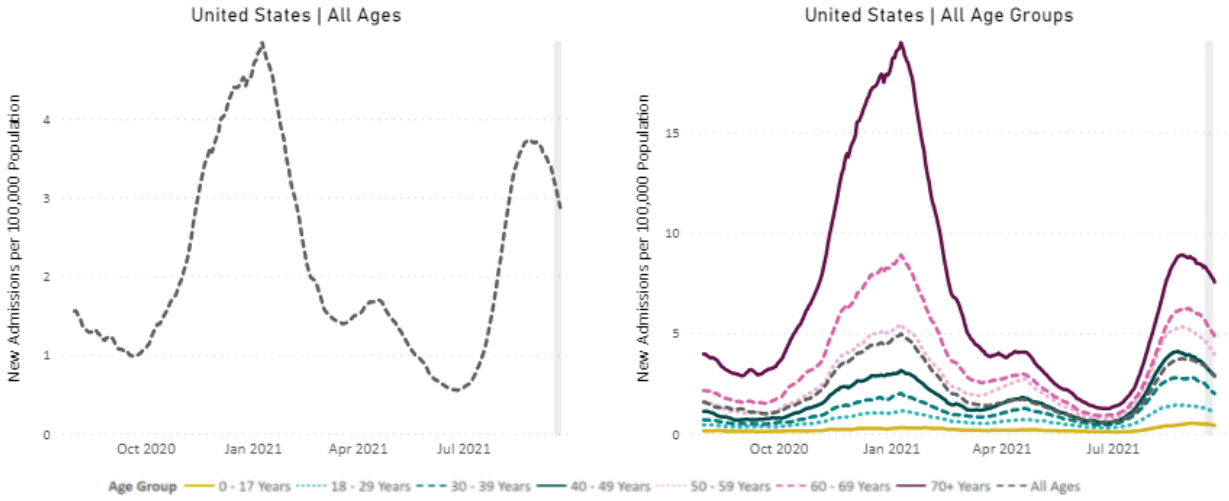
[21] Davidson County COVID-19 Dashboard, https://arcg.is/04LiWq. Accessed September 27, 2021.

of four deaths for children in that age group.[22] Hamilton County reports five deaths among those twenty and under.[23] In each county, deaths among these age groups were under one percent of total deaths in the count.

33. Indeed, data from the U.K. regarding fatality rates from the Delta variant show the case fatality rate from delta is lower than other variants. It is near 0.0% for those under fifty years old.[24] Given the death rate from COVID-19 is positively related to age, and the data from the U.K. indicate that the relationship still holds despite the new variant, the U.K. data show that the delta variant is *not* particularly lethal for schoolchildren.

34. The incidence of school-age children requiring hospitalizations due to COVID-19 is also rare. The latest data from the CDC, shown immediately below, plots hospitalization rates per 100,000 population for different age groups from September 2020 through Sept. 22, 2021. The rate of hospitalization for the 0-17 age group, even at the peak of the epidemic this past summer, was below five children per million population on any given date. Children make up by far the smallest share of the total hospitalized population at any given time, while the elderly make up the bulk of the hospitalized.[25]

[22] Shelby County Health Department, COVID-19 Fatalities, https://insight-editor.livestories.com/s/v2/1.5-fatalities/50ea216d-3e4e-4b86-995d-c3a390415953 . Accessed September 27, 2021.
[23] Hamilton County Health Department, Coronavirus Dashboard, https://health.hamiltontn.org/AllServices/Coronavirus(COVID-19).aspx. Accessed September 27, 2021.
[24] *See* Public Health England (2021) SARS-CoV-2 variants of concern and variants under investigation in England. Technical Briefiing 20. August 6, 2021. (showing that only 48 of the 147,612 unvaccinated people under 50 who were infected with the Delta variant died, or 0.03%). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1009243/Technical_Briefing_20.pdf.
[25] CDC COVID Data Tracker. United States at a Glance. https://covid.cdc.gov/covid-data-tracker/#new-hospital-admissions. Accessed September 24, 2021



35. Even those advocating for stricter non-pharmaceutical interventions in school settings acknowledge that COVID-19 "infection in children is generally characterized by mild illness. Only a minority of children require hospitalization… ."[26] The public health agency in the Netherlands similarly concludes, "Worldwide, relatively few children have been reported with COVID-19. . . Children become less seriously ill and almost never need to be hospitalized because of" COVID-19."[27]

36. Experience over the last year and a half bears this out. For example, in Sweden, "[f]rom March through June 2020, a total of 15 children with Covid-19 were admitted to an ICU (0.77 per 100,000 children in this age group)."[28] Furthermore, data published by Public Health England shows that hospitalization rates and case fatality rates from delta variant infections are lower than hospitalization and case fatality rates from the previously common alpha variant for the younger population.[29]

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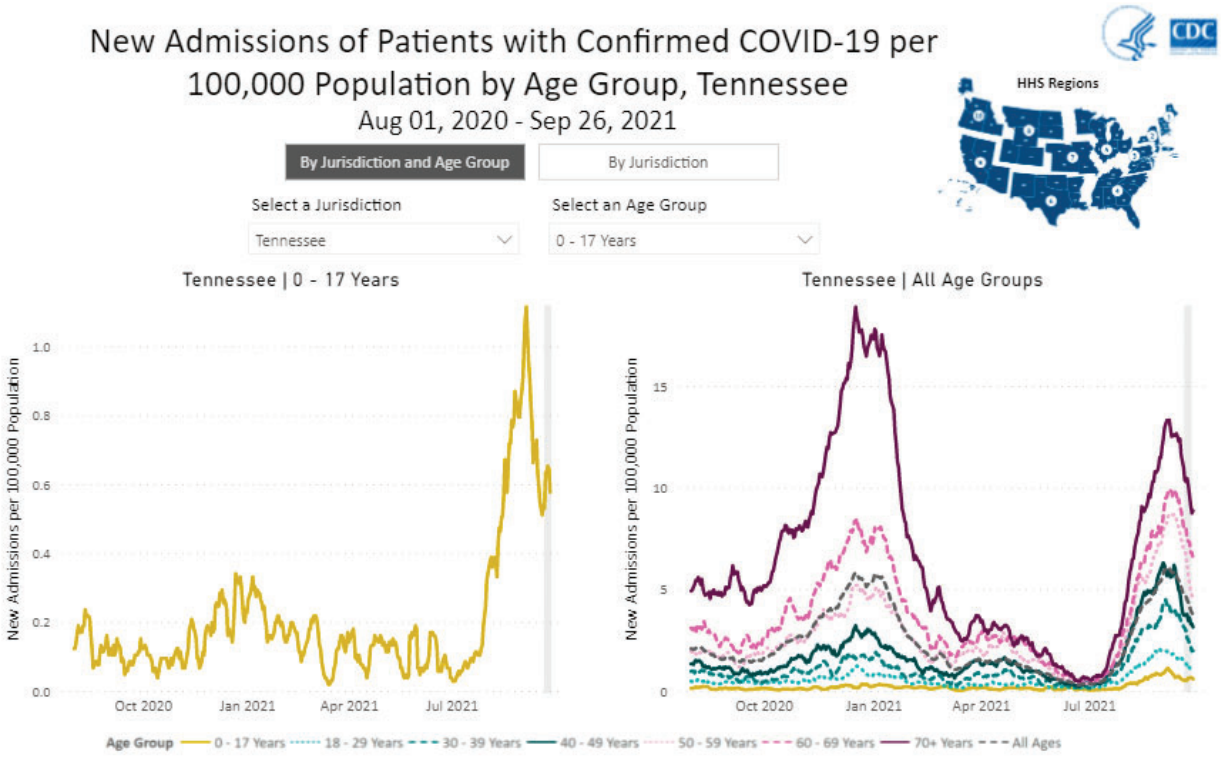
[26] Zoe Hyde, Perspective, *COVID-19, Children and Schools: Overlooked and at Risk*, 213 MED. J. AUSTL. 444, 444 (2020)

[27] *See Children, School and COVID-19*, NAT'L INST. PUB. HEALTH & ENV'T (last updated July 14, 2021), https://www.rivm.nl/en/coronavirus-covid-19/children-and-covid-19).

[28] Jonas F. Ludvigsson, Letter to the Editor, *Open Schools, Covid-19, and Child and Teacher Morbidity in Sweden*, 384 NEW ENG. J. MED. 669, 669 (2021)

[29] Public Health England. SARS-CoV-2 variants of concern and variants under investigation in England Technical briefing 23. 17 September 2021. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1018547/Technical_Briefing_23_21_09_16.pdf

37. And the data from the Tennessee Department of Health shows that, in Tennessee, children age 0-17 made up a minuscule fraction of new admissions over the whole epidemic and over the past three months:[30]

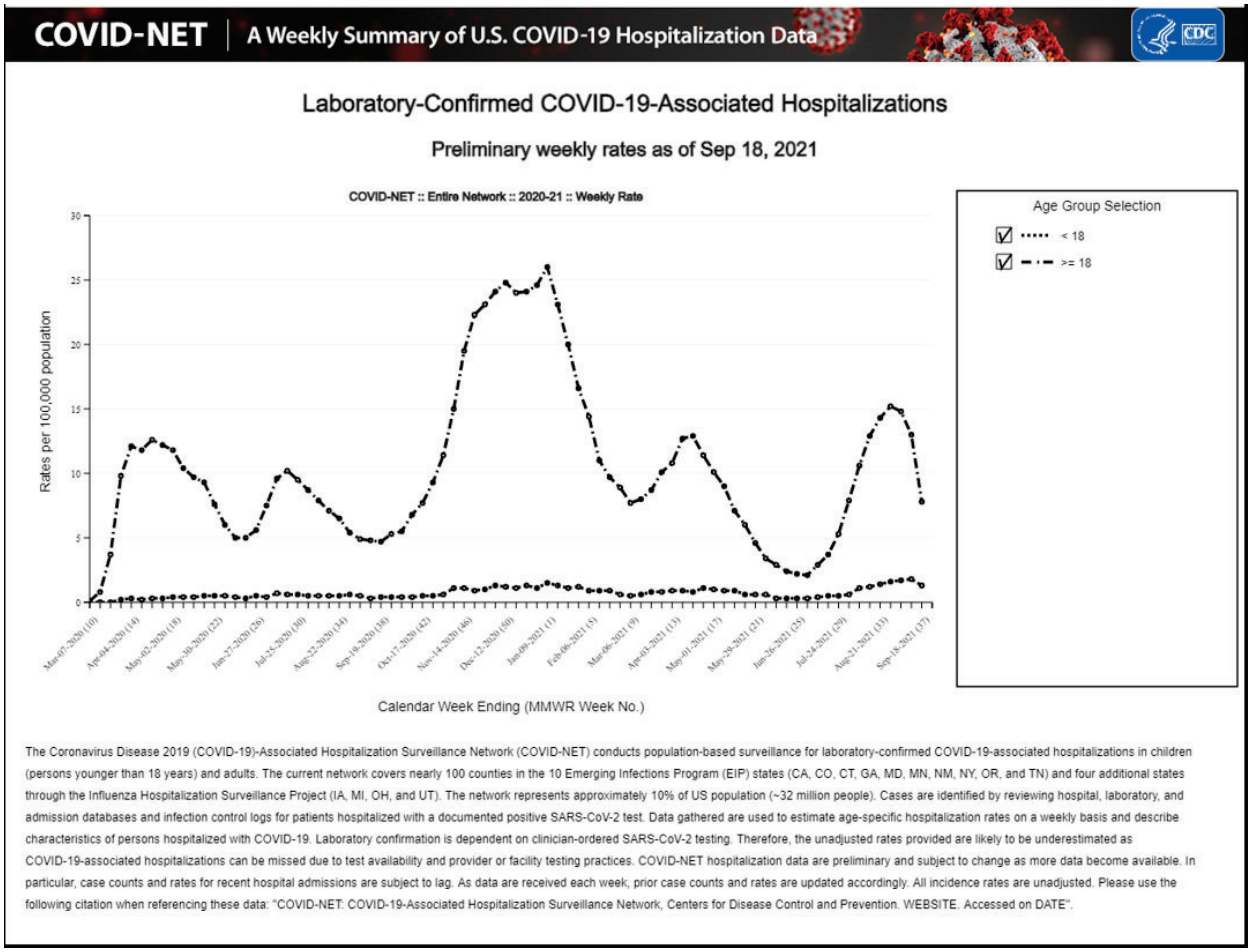


38. The chart on the left above does show a spike in hospitalizations that correspond to the prevalence of the Delta variant—but even that is low, approximately 1.2 admissions per 100,000 population. At least some part of the more recent spike is due to coinfection with Respiratory Syntical Virus (RSV), which had an out-of-season surge this summer in the U.S.[31] As the right-hand chart above reflects, it is still a tiny percentage of all hospital admissions. These data suggest outcomes for children infected with the delta variant are similar to outcomes from prior variants. Data from across the country confirm that

[30] *CDC. COVID Data Tracker.* https://covid.cdc.gov/covid-data-tracker/#new-hospital-admissions

[31] James Ducharme. Why the Respiratory Disease RSV is Having an Off-Season Surge. Time. July 22, 2021. https://time.com/6082836/rsv-spike-summer-2021/

conclusion, with the weekly admission rate for those under 18 years old much lower than those over 18.[32]



39. The U.K. has seen a similar pattern, with hospital admission rates for school-age children near their prior peak for each age cohort, though still much smaller compared to other age cohorts[33]. Two possible explanations for this include age prioritization of vaccination—which prioritized older individuals and hence protected them differentially— and a surge in RSV, rather than increasing virulence of the delta variant against children.

40. In addition to hospitalizations, severe health complications from COVID-19 are also rare. Long-lasting symptoms that persist after recovery from COVID-19 infections ("long COVID") and Multisystem Inflammatory Syndrome (MIS-C) are also rare among children.

[32] *COVID Data Tracker*, CDC (last visited Aug. 14, 2021), https://covid.cdc.gov/covid-data-tracker/#covidnet-hospitalization-network.

[33] *See Coronavirus (COVID-19) Latest Insights: Hospitals*, OFF. NAT'L STAT. (Aug. 13, 2021), https://bit.ly/3ALzikG.

As to the latter, "a small fraction of children can experience a severe post-infectious multisystem inflammatory syndrome."[34] The data from the CDC bears this out: in total, there have been 4,404 cases of MIS-C in children between the ages of 0 and 20 in the country since mid-May 2020.[35] That is roughly 0.1% of children identified as COVID-19 cases in that age group.[36] Rubens et al. confirm that MIS-C is rare: "Overall, MIS-C is a rare complication of SARS-CoV-2. A May 2020 systematic review from 26 countries reported an MIS-C incidence of 0.14% among all children with SARS-CoV-2 infection, but this estimated incidence may be imprecise because of potential underestimation of overall SARS-CoV-2 infections in children."[37]

41. As for long COVID, the evidence "suggests a very low prevalence of [it]" in children.[38] Indeed, "[s]eropositive children, all with a history of pauci-symptomatic SARS-CoV-2 infection, did not report long COVID more frequently than seronegative children."[39] Another study found that symptomatic COVID-19 infection in schoolchildren (5 to 17 years old) "is usually of short duration (6 days vs. 11 days in adults), with low symptom burden."[40] Further, the authors note that "[o]nly a small proportion of children had illness duration beyond four weeks, and their symptom burden decreased over time. Almost all children had symptom resolution by eight weeks."[41] This result is consistent with other studies showing that long COVID is rare among the general population. [42]

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[34] Hyde, *supra*, at 444; *see also* Ludvigsson, *Open Schools*, *supra*, at 669 ("[A] total of 15 children [between the ages of 1 and 16] with Covid-19 (*including those with MIS-C*) were admitted to an ICU (0.77 per 100,000 children in this age group).") (emphasis added).

[35] *Multisystem Inflammatory Syndrome*, CDC (last updated July 30, 2021), https://bit.ly/3xMxdTC.

[36] For data for total COVID-19 cases broken out by age, see *Demographic Trends of COVID-19 Cases and Deaths in the US Reported to CDC*, CDC (last updated Aug. 14, 2021), https://bit.ly/3iPfCpW. The number is a rough approximation due to the difference in reporting periods and because the CDC's age breakdown does not allow for totaling of cases in people aged 0 to 20. To approximate this number, the analysis totals cases for people aged 0 to 17, which would tend to increase the percentage presenting with MIS-C.

[37] Jessica H. Rubens et al., *Acute COVID-19 and Multisystem Inflammatory Syndrome in Children*, BMJ: CLINICAL UPDATES, Mar. 1, 2021, at 3

[38] Thomas Radtke et al., *Long-Term Symptoms After SARS-CoV-2 Infection in School Children: Population-Based Cohort with 6-Months Follow-Up* 6 (MedRxiv, Preprint, May 18, 2021)

[39] *Id.* at 6.

[40] Erika Molteni et al., *Illness Duration and Symptom Profile in Symptomatic UK School-Aged Children Tested for SARS-CoV-2*, LANCET ADOLESCENT HEALTH, Aug. 3, 2021, at 7.

[41] *Id.* at 2.

[42] *See* Alex J. Walker, *Clinical Coding of Long COVID in English Primary Care: A Federated Analysis of 58 Million Patient Records* In Situ *Using OpenSAFELY*, BRIT. J. GEN. PRAC., 2021, at 3 ("Up to 25 April 2021, there were 23,273 (*0.04%*) patients with a recorded code indicative of a long-COVID diagnosis.") (emphasis added).

42. The most reliable study was recently published by the Office of National Statistics in the U.K.[43] It is the most reliable study because of its large sample size and, notably, a control group of children who had no history of COVID-19 infection. Strikingly, among children age 2 – 11 years, the children in the control group (who had never previously had COVID) had a higher rate of "long-COVID" symptoms (4.1%) than the kids who had previously had COVID (3.2%) four months after recovery from infection. Among children 12-16, the rates of long-COVID symptoms at four months were similar and low in the control (1.3%) and COVID-recovered groups (3.0%). Among young adults age 17-24, the rates of "long-COVID" were identical in the control and COVID-recovered groups (3.6%).
43. To be sure, there is a chance that COVID-19 results in severe, adverse outcomes among children—as there is with any disease. But the evidence, thankfully, shows children infected with COVID-19 are overwhelmingly likely to recover fully with only mild illness while sick and no lingering effects.

Children are Inefficient Transmitters of the Virus

44. Even without masks, the overwhelming weight of scientific data suggests that the risk of transmission of the virus from children aged six and below to older people is negligible and from children between 7 and 12 to older people is small relative to the risk of transmission from people older than 18 to others. Data also show that the risk of child-to-child transmission in school settings is low.
45. The most important evidence on the childhood spread of the disease comes from a study conducted in Iceland and published in the New England Journal of Medicine[44]. The data for this study come from Iceland's systematic screening of its population to check for the virus. This is the most important study on this topic because it is the only study that definitively establishes the direction of the spread of the virus from contact to contact. The study reports on a population-representative sample and a sample of people who were

[43] Office of National Statistics, UK. Technical article: Updated estimates of the prevalence of post-acute symptoms among people with coronavirus (COVID-19) in the UK: 26 April 2020 to 1 August 2021. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/technicalarticleupdatedestimatesoftheprevalenceofpostacutesymptomsamongpeoplewithcoronaviruscovid19intheuk/26april2020to1august2021

[44] Daniel F. Gudbjartsson, Ph.D., Agnar Helgason, Ph.D., et al., *Spread of SARS-CoV-2 in the Icelandic Population,* The New England Journal of Medicine, https://www.nejm.org/doi/full/10.1056/NEJMoa2006100 (June 11, 2020).

tested because of the presence of symptoms consistent with COVID-19 infection. The study team isolated SARS-CoV-2 virus samples from every positive case, sequenced the virus's genome for every patient, and tracked the mutation patterns in the virus. This analysis, along with contact tracing data, allowed the study team to identify definitively who passed the virus to whom. There have been hundreds of minor mutations of the virus identified, which typically do not alter the function of the virus much, but which provide a unique fingerprint, of sorts, that makes it possible to tell whether two patients could possibly have passed the virus to one another. From this analysis, the senior author of the study, Dr. Kari Stefansson, concluded[45] that "even if children do get infected, they are less likely to transmit the disease to others than adults. We have not found a single instance of a child infecting parents. There is amazing diversity in the way in which we react to the virus."

46. Though the Iceland study is the only definitive study, many other studies use contact tracing methods to investigate the role of children in disease spread. The bulk of such studies conclude that children play a small role in disease spread, consistent with the Iceland data.

47. A French study[46], conducted by scientists at the L'Institut Pasteur, examined data from late April 2020 on schoolteachers, students, and their parents in Crepy-en-Valois in France. The schools in France were closed from the end of January on, at first because of the February holiday and then the late February lockdown. During this period, French schools implemented no restrictions on students – neither social distancing nor mask requirements. The authors found three cases among kids in January using antibody tests but found no evidence of virus spread to other kids or teachers from those early cases. Any spread between the end of January and April (when the authors collected samples) must have occurred during the lockdown. The authors' main conclusion[47] from these facts is that parents were the source of infections in school children; children were not the source.

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[45] Roger Highfield, *Coronavirus: Hunting Down COVID-10,* Science Museum Group, https://www.sciencemuseumgroup.org.uk/blog/hunting-down-covid-19/ (April 27, 2020).

[46] Arnaud Fontanet, MD, DrPH, Rebecca Grant, et al., *SARS-CoV-2 Infection in Primary Schools in Northern France: A Retrospective Cohort Study in an Area of High Transmission,* Institut Pasteur, https://www.pasteur.fr/fr/file/35404/download (last visited July 9, 2020).

[47] *COVID-19 In Primary Schools: No Significant Transmission among Children or From Students to Teachers,* Institut Pasteur, https://www.pasteur.fr/en/press-area/press-documents/covid-19-primary-schools-no-significant-transmission-among-children-students-teachers (June 23, 2020).

Those kids who tested antibody positive at the end of April, because of the circumstances of the lockdown, must have become positive from a source other than their school. The primary contacts of the young children were their parents, of whom 61% were positive, which is consistent with parent-to-child spread. This is also consistent with the results showing that only 6.9% of parents tested positive for the virus among antibody-negative kids in April. The authors' main conclusion mirrors the one reached in the Icelandic study showing that the disease spreads less easily from children to adults than from adults to adults, *even in the absence of masking requirements*.

48. Researchers in Ireland conducted a similar study[48] which analyzed 1,160 children and adults in Ireland who were physically present in a school at some time between March 1st and March 13th, where a COVID-19 case was identified. (Schools were closed in Ireland on March 12th). The authors found three children (between 10 and 15 years old) and three adults with COVID-19 infections. Their study followed students and families after the school closures to see if there was any evidence of disease spread from these identified cases. While the study authors mention physical distancing, hand hygiene, and cough etiquette as interventions implemented in Irish schools at the time, they do not mention required masking. All six patients had PCR confirmed COVID-19 disease but contracted the virus from contacts outside of school. Despite identifying 722 contacts, the study authors reported finding no instance of an infected child infecting another child. The infected adults, by contrast, had many fewer contacts – 102 – but did pass on the infection to a few adult contacts. This, even though the infected children engaged in "music lessons (woodwind instruments) and choir practice, both of which are reportedly high-risk activities for transmission." *Ibid.* As with the French study mentioned above, the Irish schools did not mandate masking at the time of the study, and they still do not require them for children under 13.[49]

49. Based on contact tracing data, a report[50] by the ministry of health in the Netherlands finds

[48] Laura Heavey, Geraldine Casey, et al., *No Evidence of Secondary Transmission of COVID-19 from Children Attending School in Ireland, 2020,* Eurosurveillance, https://www.eurosurveillance.org/content/10.2807/1560-7917.ES.2020.25.21.2000903#html_fulltext (May 28, 2020).
[49] Citizens Information Ireland. Face Coverings During COVID-19. https://www.citizensinformation.ie/en/health/covid19/face_coverings_during_covid19.html# (Sept. 25, 2021)
[50] *Children and COVID-19,* National Institute for Public Health and the Environment, https://www.rivm.nl/en/novel-coronavirus-covid-19/children-and-covid-19 (July 2, 2020).

almost no disease spread by infected patients 20 and under at all, and only limited spread by adults 20-25 to others outside their own age category. The authors of the study concluded: "Data from the Netherlands also confirms the current understanding: that children play a minor role in the spread of the novel coronavirus. The virus is mainly spread between adults and from adult family members to children. The spread of COVID-19 among children or from children to adults is less common." Hygiene standards in the Netherlands promulgated by its National Institute for Public Health and the Environment make no recommendation of masking for either primary school or secondary school students.[51]

50. A German[52] study reports a strikingly similar finding on the likelihood of pediatric disease spread. The German Society for Pediatric Infectious Diseases collected data on all children and adolescents admitted to a hospital for COVID-19 treatment between mid-March and early May 2020 – 128 patients were admitted to 66 different hospitals. The authors sourced the infection for 38% of these patients, which turned out to be a parent 85% of the time. Though the authors document a limitation of small sample size, they conclude that "In contrast to other epidemic viral respiratory infections, the primary source of infection with SARS-CoV-2 appears not to be other children." The authors reported a single death among these 128 pediatric patients.

51. A study of 23 family disease clusters in Greece, published on August 7, 2020, in the *Journal of Medical Virology*, found that in 91% of the clusters, an adult was the first person to be infected. Their contact tracing effort attempted to clarify the direction of disease spread by careful questioning about the relative timing of the development of symptoms. They found no evidence of either child to adult spread or even child to child spread. They concluded that "[w]hile children become infected by SARS-CoV-2, they do not appear to transmit the virus to others. Furthermore, children more frequently have an asymptomatic

[51] Hygiene Guideline for Primary Schools, National Institute for Public Health and the Environment. https://www.rivm.nl/hygienerichtlijnen/basisscholen (September 25, 2021); and General Hygiene Guideline. National Institute for Public Health and the Environment. https://www.rivm.nl/hygienerichtlijnen/algemeen (Sept. 25, 2021).

[52] Armann, J. P., Diffloth, N., Simon, A., Doenhardt, M., Hufnagel, M., Trotter, A., Schneider, D., Hübner, J., & Berner, R. (2020). Hospital Admission in Children and Adolescents With COVID-19. Deutsches Arzteblatt international, 117(21), 373–374. https://doi.org/10.3238/arztebl.2020.0373

or mild course compared to adults."[53]

52. A study by the Federal Office of Public Health of Switzerland analyzed 793 cases reported by Swiss doctors in late July 2020.[54] The reports included the place where each patient most likely contracted the infection. The most common source of infection was at home, with 27.2% tracing their disease there. School, by contrast, consisted of only 0.3% of the infections; exactly two of the 793 cases could be tracked to a school. This study has some limitations: first, it is a contact tracing study without genetic sequencing verification, so it is impossible to judge the direction of diseases spread with certainty (i.e., from adult to child or child to adult). Second, the report provides no details about the age of the cases, so it is not possible to separately glean the disease acquisition frequencies for children and adults; and third, only summer schools were in session during this period. Nevertheless, the results strongly suggest that schools are a minor source of community spread of the infection.

53. A large study of 1,900 children attending an urban summer school in Barcelona, Spain, found only 39 new index cases (30 pediatric) over five weeks.[55] (An index case is an initial person identified by a positive test for the virus, from whom close contacts are identified). The investigators chose this setting because they viewed it as a model for what to expect from school openings in the fall. Those 39 index cases interacted with another 253 children within their "cohabitation groups," of whom only 12 developed an infection"– a secondary attack rate of 4.7%. The low secondary attack rate was similar for children of all ages attending the programs, ranging up to 17 years old. The report does not mention masks as a disease prevention method. Rather, the investigators attributed the success in controlling the spread of the disease to frequent handwashing by the children and organizing the children into "bubbles" so that the kids interacted with the same group of children all day long.

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[53] Helena C. Maltezou Rengina Vorou Kalliopi Papadima, et al. (2020) "Transmission dynamics of SARS-CoV-2 within families with children in Greece: a study of 23 clusters" Journal of Medical Virology, https://doi.org/10.1002/jmv.26394 (accessed August 12, 2020).

[54] Office fédéral de la santé publique OFSP (2020) "Rectificatif : les lieux de contamination sont les contextes familiaux et non les boîtes de nuit" Aug. 2, 2020. available at https://www.bag.admin.ch/bag/fr/home/das-bag/aktuell/news/news-02-08-2020.html

[55] Oriel Guell (2020) *Major coronavirus study in Spanish summer camps shows low transmission among children*. El Pais. (Aug. 26, 2020) available at https://english.elpais.com/society/2020-08-26/major-coronavirus-study-in-spanish-summer-camps-shows-low-transmission-among-children.html

54. A comprehensive official report by Public Health England of the role of English schools, which were reopened on June 1, 2020, despite high community case numbers, in spreading the pandemic.[56] The author of this report found that cases and outbreaks were "uncommon across all educational settings" and that "[s]taff members had an increased risk of SARS-CoV-2 infections compared to students in any educational setting, and the majority of cases linked to outbreaks were in staff." In response to this study, U.K. education minister Gavin Williamson said: "The latest research, which is expected to be published later this year – one of the largest studies on the coronavirus in schools in the world – makes it clear there is little evidence that the virus is transmitted at school."[57]

55. Perhaps the best observational evidence (outside of the Iceland study) on the risk children pose to teachers comes from Sweden's COVID-19 policy. Swedish primary schools have been open for in-person instruction throughout the epidemic (high schools were closed briefly at the height of the epidemic), even when cases ran high in the community at large, with no masking required of its children.[58] In spring 2020, of the 1.8 million kids in school, ages 1-15, zero died from COVID.[59] Furthermore, there is no evidence the teachers were at greater risk of COVID infections than others, despite their pupils not wearing masks. On the contrary, the rate of COVID-19 infection among teachers was lower than the average rate of COVID-19 infection among other Swedish essential workers. This result is confirmed by studies of the effect of school closures in the U.S. and elsewhere on overall

[56] Sharif Ismail et al. (2020) "SARS-CoV-2 infection and transmission in educational settings: cross-sectional analysis of clusters and outbreaks in England" Public Health England, Aug. 12, 2020 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/911267/School_Outbreaks_Analysis.pdf

[57] Peter Walker (2020) "Little Evidence COVID Spreads in Schools, says Gavin Williamson" *The Guardian*, Aug. 10, 2020. https://www.theguardian.com/world/2020/aug/10/little-evidence-covid-spreads-in-schools-says-gavin-williamson

[58] Ludvigsson JF, Engerström L, Nordenhäll C, Larsson E. Open Schools, Covid-19, and Child and Teacher Morbidity in Sweden. N Engl J Med. 2021 Feb 18;384(7):669-671. doi: 10.1056/NEJMc2026670. Epub 2021 Jan 6. PMID: 33406327; PMCID: PMC7821981.

[59] Public Health Agency of Sweden (2020) "COVID-19 in Schoolchildren: A Comparison between Finland and Sweden" https://www.folkhalsomyndigheten.se/contentassets/c1b78bffbfde4a7899eb0d8ffdb57b09/covid-19-school-aged-children.pdf

excess mortality, which finds that school closures – much less mask mandates – on COVID risk were at best minimal.[60, 61]

56. The overwhelming bulk of scientific studies that have examined the topic – including the best studies, which take pains to distinguish correlation from causation – find that children play a limited role in spreading COVID-19 infection to adults. It is striking that this conclusion holds even in situations where children were not required to wear masks.

No Randomized Evidence of Efficacy of Masking in Limiting Disease Spread

57. There is by now a vast empirical literature purporting to evaluate the effectiveness of mask-wearing in limiting the spread of the SARS-CoV-2 virus. The question is complicated because it is unlikely that there is a single answer. The effectiveness of masks differ based on the type of mask (cloth vs. surgical vs. N95), protocols for replacing contaminated masks, how well trained the mask-wearer is in maintaining good mask fit, and a large number of other factors, including other non-pharmaceutical interventions such as hand washing, social distancing, and ventilation upgrades. The effectiveness of masks in protecting the wearer against infection (self-protection) will also differ from the effectiveness of masks in protecting people near the wearer from becoming infected (source control). Studies conducted in laboratories on mannequins, for instance, are unlikely to translate well into real-world settings, where conditions differ sharply from the laboratory. Many ecological studies also estimate the correlation between the imposition of mask mandates and the subsequent spread of COVID-19 disease in various locations rather than at the individual level. However, it is notoriously difficult to adjust for bias caused by factors that researchers do not observe in such studies.

58. The best guide to the effectiveness of masks – the highest quality evidence – are randomized controlled trials that reduce bias from many sources on the effectiveness estimates. Though some have argued that randomized evaluations of the effectiveness of

[60] Dena Bravata, Jonathan H. Cantor, Neeraj Sood & Christopher M. Whaley (2021) Back to School: The Effect of School Visits During COVID-19 on COVID-19 Transmission. NBER Working Paper # 28645. April 2021. https://www.nber.org/papers/w28645 DOI 10.3386/w28645

[61] Walsh S, Chowdhury A, Braithwaite V, et alDo school closures and school reopenings affect community transmission of COVID-19? A systematic review of observational studiesBMJ Open 2021;11:e053371. doi: 10.1136/bmjopen-2021-053371

masking are impossible in the context of respiratory virus spread, there were more than a dozen randomized evaluations of masking in the context of the flu published before the pandemic in peer-reviewed journals. It has been more than 18 months since the beginning of the pandemic and the imposition of lockdown orders, and the efficacy of masking has been of intense policy interest. Nevertheless, there is to date only a single peer-reviewed randomized study published on the effectiveness of masks in self-protection against COVID-19. The study, which did not enroll children, found no statistically significant difference between the treatment group and control group regarding the probability of infection.[62]

59. Shockingly, there are no randomized evaluations of the effectiveness of masks on children in source control for COVID-19 (that is, the effectiveness of masks in protecting others in the context of schools or children). In the context of adults, there is a preprint (not yet peer-reviewed) randomized study on the efficacy masking as source control. The study, conducted in Bangladesh, randomly assigned villages in that country to cloth masks, surgical masks, and control villages. In the villages chosen for masking, residents were offered masks for free, and various measures were implemented to encourage masking. Ultimately, about 40% of villagers in the villages chosen for masking wore masks, while about 10% wore masks in the control villages. Despite the sharp increase in masking, there was no statistically significant difference in the symptomatic seroprevalence of COVID-19 disease in the villages with cloth masks and the control villages. The villages assigned surgical masks had a slightly lower symptomatic seroprevalence rate than the control villages (0.76% vs. 0.69%), with a 95% statistical confidence bound that included zero effect and no measured difference in hospitalization or mortality. The study did not include children.

60. So in the context of COVID-19, there is no high-quality evidence supporting the notion that masks on children work to control disease spread, either self-protection or source

[62] Bundgaard H, Bundgaard JS, Raaschou-Pedersen DET, von Buchwald C, Todsen T, Norsk JB, Pries-Heje MM, Vissing CR, Nielsen PB, Winsløw UC, Fogh K, Hasselbalch R, Kristensen JH, Ringgaard A, Porsborg Andersen M, Goecke NB, Trebbien R, Skovgaard K, Benfield T, Ullum H, Torp-Pedersen C, Iversen K. Effectiveness of Adding a Mask Recommendation to Other Public Health Measures to Prevent SARS-CoV-2 Infection in Danish Mask Wearers : A Randomized Controlled Trial. Ann Intern Med. 2021 Mar;174(3):335-343. doi: 10.7326/M20-6817. Epub 2020 Nov 18. PMID: 33205991; PMCID: PMC7707213.

control. By contrast, in the context of the flu, there is considerable randomized evidence that masks are not effective in reducing disease spread for both source control and self-protection.[63]

61. The literature on the efficacy of masks to control respiratory viruses is vast, so it is fortunate that four prominent groups have conducted comprehensive literature reviews. I will reproduce here the key conclusions conducted by teams of researchers at the Cochrane Collaborative, at the European CDC, at the Oxford University Centre for Evidence-Based Medicine, and at the US Centers for Disease Control. All of the reviews acknowledge the lack of randomized evidence in this area. Each differs in their conclusions about the effectiveness of masks, but those conclusions rest on the relative weight each research group put on randomized studies showing no benefit in masking versus poor quality correlational evidence that provided mixed results on mask effectiveness based on the setting.

62. The Cochrane Collaborative is an organization of academics with a reputation for writing high-quality evidence summaries on a full range of important topics within medicine using a standardized approach to evidence evaluation. The Cochrane review of the mask literature separately evaluates the effectiveness of medical/surgical masks and N95 respirator masks.[64] Because there were no randomized studies in the context of COVID-19 when the study was published, the review focuses on the randomized studies in the influenza context. The authors conclude:

> **"Medical/Surgical Masks:** Seven studies took place in the community, and two studies in healthcare workers. Compared with wearing no mask, wearing a mask may make little to no difference in how many people caught a flu-like illness (9 studies; 3507 people); and probably makes no difference in how many people have flu confirmed by a laboratory test (6 studies; 3005 people). Unwanted effects were rarely reported, but included discomfort.
>
> **N95/P2 respirators:** Four studies were in healthcare workers, and one small study was in the community. Compared with wearing medical or surgical masks, wearing N95/P2 respirators probably makes little

[63] Jefferson T, Del Mar CB, Dooley L, Ferroni E, Al-Ansary LA, Bawazeer GA, van Driel ML, Jones MA, Thorning S, Beller EM, Clark J, Hoffmann TC, Glasziou PP, Conly JM. Physical interventions to interrupt or reduce the spread of respiratory viruses. Cochrane Database of Systematic Reviews 2020, Issue 11. Art. No.: CD006207. DOI: 10.1002/14651858.CD006207.pub5.
[64] *Ibid.*

> to no difference in how many people have confirmed flu (5 studies; 8407 people); and may make little to no difference in how many people catch a flu-like illness (5 studies; 8407 people) or respiratory illness (3 studies; 7799 people). Unwanted effects were not well reported; discomfort was mentioned."

63. In other words, according to a comprehensive evidence summary of mask effectiveness in the context of the flu – a virus that shares many physical properties with the SARS-CoV-2 virus and is transmitted similarly to SARS-CoV-2 – high-quality evidence finds no effect of masks on the spread of disease, even when the masks are employed by health care workers who are trained to use them properly.

64. The US CDC review, conducted last year, evaluates the randomized studies on the effectiveness of various personal protective measures, including face masks to protect against the spread of influenza.[65] The review's conclusion is straightforward:

> "In this review, we did not find evidence to support a protective effect of personal protective measures or environmental measures in reducing influenza transmission. Although these measures have mechanistic support based on our knowledge of how influenza is transmitted from person to person, randomized trials of hand hygiene and face masks have not demonstrated protection against laboratory-confirmed influenza, with one exception."

65. The one exception they note is a randomized study that found that regular hand washing may slow influenza spread in health care settings. The CDC review – conducted in mid-2020 – emphasizes the need for high-quality studies on masks and COVID-19. It is striking that there has only been two randomized evaluation published since this call for high-quality evidence last year (that is, the Danish and Bangladeshi mask studies I cite above) since the publication of this review by the CDC.

66. The review by the team at the Oxford University Centre for Evidence-Based Medicine – a group that (like the Cochrane Collaborative) is famous for its careful evidence summaries on a wide variety of health care topics – makes the same observations as the other groups.[66]

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[65] Xiao J, Shiu E, Gao H, et al. Nonpharmaceutical Measures for Pandemic Influenza in Nonhealthcare Settings—Personal Protective and Environmental Measures. Emerging Infectious Diseases. 2020;26(5):967-975. doi:10.3201/eid2605.190994.

[66] Tom Jefferson, Carl Heneghan (2020) Masking Lack of Evidence with Politics. Centre for Evidence Based Medicine working paper. Oxford University. https://www.cebm.net/covid-19/masking-lack-of-evidence-with-politics/

Namely, they lament the lack of high-quality evidence evaluating the effectiveness of masks in the context of COVID-19. Unlike the other groups, the CEBM review documents several randomized studies in progress (including the Danish mask study referenced above). Though the CEBM study was published in July 2020, to my knowledge, none of these planned randomized studies have been completed or published beside the Danish and Bangladeshi mask studies referenced above.[67] The CEBM summary emphasizes the danger of making policy decisions (such as making masks mandatory) when the scientific evidence on the topic is so inadequate.

> "What do scientists do in the face of uncertainty on the value of global interventions? Usually, they seek an answer with adequately designed and swiftly implemented clinical studies as has been partly achieved with pharmaceuticals. We consider it is unwise to infer causation based on regional geographical observations as several proponents of masks have done. Spikes in cases can easily refute correlations, compliance with masks and other measures is often variable, and confounders cannot be accounted for in such observational research…The small number of trials and lateness in the pandemic cycle is unlikely to give us reasonably clear answers and guide decision-makers. This abandonment of the scientific modus operandi and lack of foresight has left the field wide open for the play of opinions, radical views, and political influence."

67. The literature review by the European CDC covers both the randomized evidence on masks and influenza spread that the other teams' review and the early observational evidence on masks and COVID-19.[68] The team evaluating this evidence places more weight on the low-quality observational studies than do some of the other teams. For this reason, I place less importance on the conclusions of this review than I do on the others. Still, they emphasize in their conclusions the need for more high-quality (i.e., randomized) evidence on the topic.

    i. "The evidence regarding the effectiveness of medical face masks for the prevention of COVID-19 in the community is compatible with a small to moderate protective effect, but there are still significant uncertainties about the size of this effect. Evidence for the effectiveness of non-medical face masks, face shields/visors and

[67] During a person conversation on August 14, 2021, Prof. Carl Heneghan (Oxford University) confirmed to me that none of the planned randomized studies listed in the CEBM review (except for the Danish mask study cited here) had been completed, released as a working paper, or published to date.
[68] European Centre for Disease Prevention and Control. Using face masks in the community: first update. 15 February 2021. ECDC: Stockholm; 2021.

> respirators in the community is scarce and of very low certainty. Additional high-quality studies are needed to assess the relevance of the use of medical face masks in the COVID-19 pandemic."

68. Since there is so little randomized data available to answer whether masks effectively protect the user or slow disease spread, it is natural to look to observational evidence. Observational data are most important when randomized evaluations are impossible for logistical or ethical reasons. However, this is not true for masks since there have been randomized studies on their effect on reducing transmission of respiratory viruses conducted – including one in the context of COVID-19. The problem with observational studies is that the adoption of a mask mandate (either in schools or in the community) is not a random decision and may be induced by the perceived threat of COVID cases near the time of adoption. Therefore, the correlation observed in observational data does not necessarily imply a causal relationship between a mask mandate and COVID outcomes.
69. That said, a comprehensive analysis of the correlation between COVID spread in the U.S. in the fall/winter wave of late 2020/early 2001, and the imposition of mask mandates found no correlation between them.[69] The authors of this peer-reviewed study concluded that "Earlier mask mandates were not associated with lower total cases or lower maximum growth rates. Growth rates and total growth were comparable between U.S. states in the first and last mask use quintiles during the Fall-Winter wave…We did not observe an association between mask mandates or use and reduced COVID-19 spread in U.S. states." If there is no correlation between mask mandates and COVID case growth, it seems unlikely that there is a causal relationship.
70. For mask mandates in schools, the observational evidence is mixed, with some studies finding correlations between mask requirements and cases and others finding no correlation.[70] No randomized studies have been conducted. Some studies given prominence by the CDC have been of particularly poor quality. For instance, the CDC cited one study conducted by Duke researchers in North Carolina as showing that masks on

[69] Damian D.Guerra, Daniel J.Guerra. Mask mandate and use efficacy for COVID-19 containment in US States.International Research Journal of Public Health, 2021; 5:55. DOI: 10.28933/irjph-2021-08-1005
[70] Gettings J, Czarnik M, Morris E, et al. Mask Use and Ventilation Improvements to Reduce COVID-19 Incidence in Elementary Schools — Georgia, November 16–December 11, 2020. MMWR Morb Mortal Wkly Rep 2021;70:779–784. DOI: http://dx.doi.org/10.15585/mmwr.mm7021e1external icon

children reduced disease spread.[71] However, the study includes only 11 school districts that required masks and *no* control districts that did not require masks. Writing in the *Wall Street Journal* about the study, Duke University researcher Tom Nicholson wrote:

> In an inversion of logic, the report concluded that the only nonvariable in the data set [masks] must be the cause of low transmission rates in North Carolina schools. It should be obvious that proving some components of a strategy as useless doesn't demonstrate that others are effective. Such a claim requires a control group or appropriate statistical methods. The researchers might as well have attributed the low Covid rate in schools to wearing shoes.

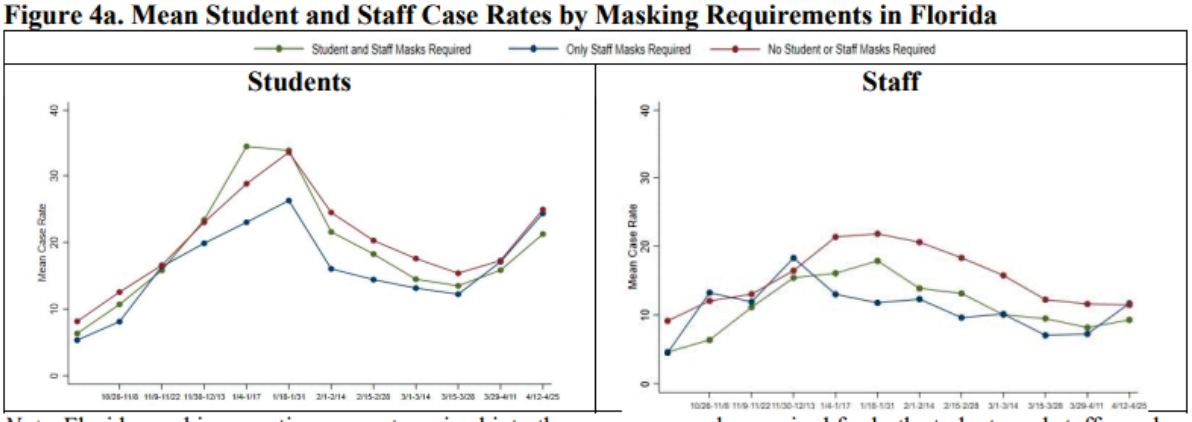
71. One particularly notable observational study—notable for its detailed measurement of masking policies at the school and district level, for its accounting for other factors such as school-level ventilation upgrades, and its consideration of outcomes throughout the 2020/21 school year – reported on the correlation between masking and COVID-19 case rates in Florida, New York, and Massachusetts.[72] In Florida, school mask policies fell into one of three categories: masks required for both staff and students; masks required only for staff; and no masks required. The figure (Figure 4, reproduced exactly from the paper) shows how case rates evolved over the school year (between October 2020 and April 2021) for each of the three groups. Through much of the school year, COVID case rates were

[71] US CDC. Science Brief: Transmission of SARS-CoV-2 in K-12 Schools and Early Care and Education Programs – Updated July 9, 2021. Accessed Sept. 25, 2021. https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/transmission_k_12_schools.html#in-person

[72] Emily Oster, Rebecca Jack, Clare Halloran, John Schoof, Diana McLeod (2021) "COVID-19 Mitigation Practices and COVID-19 Rates in Schools: Report on Data from Florida, New York and Massachusetts" medRxiv, May 21, 2021, doi: https://doi.org/10.1101/2021.05.19.21257467

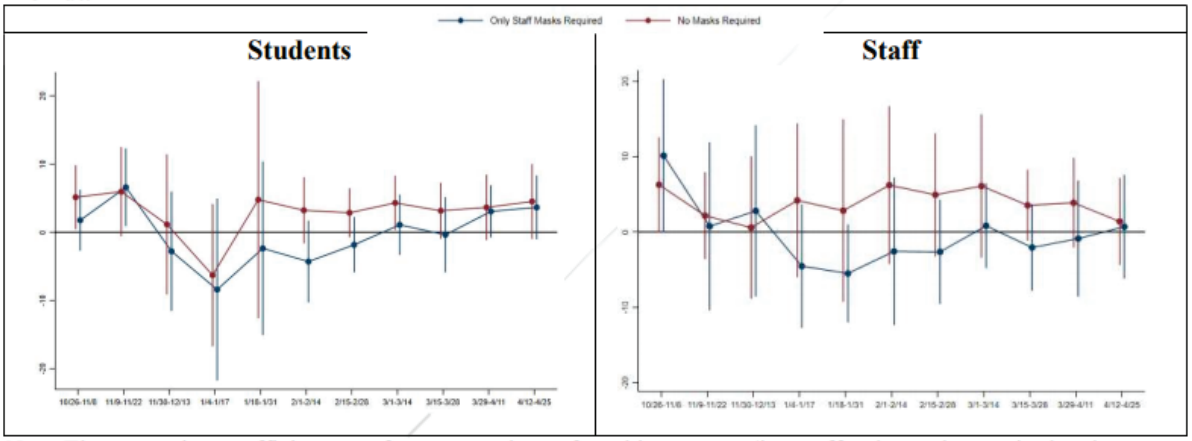
lowest among both staff and children for locations that required only staff to mask (top panel). In fact, there were no statistically significant differences in the case rates among the three groups; that is, locations with mask mandates on either staff or students did no better in case rates relative to locations with no mandates (bottom panel). The primary finding for Florida extends to the other states the authors analyzed: mask mandates for students are effectively uncorrelated with COVID-19 infection rates in either students or teachers.

Figure 4a. Mean Student and Staff Case Rates by Masking Requirements in Florida



Note. Florida masking practices are categorized into three groups: masks required for both students and staff, masks required for staff only, and no masks required for either students or staff. Case rates are reported as daily COVID-19 case rates per 100,000. Mean daily case rate is calculated by group per biweekly wave in the data. Means do not control for community case rates or population demographics.

Figure 4b. Regression Coefficients of Student and Staff Case Rates on Masking Requirements in Florida



Note. The regression coefficients are from regressions of masking groups (i.e. staff-only masks required and no masks required) interacted with each biweekly wave group on student and staff case rates. The comparison is masks required for both students and staff. Regressions control for community case rates, time fixed effects, racial demographics, density groups, ventilation upgrades, and school level. Regressions are weighted by total student enrollment and standard errors are clustered by school districts.

72. Given the negative evidence from high-quality randomized studies on the efficacy of masking in the context of the flu, the fact that the only two randomized trials on the efficacy of masking in adults both found minimal and statistically insignificant (Danish study) or barely statistically significant (Bangladeshi study) effects of masking on self-protection and source control, that there are no randomized trials in the contexts of masking children in schools, and that there is mixed evidence from observational studies, it is not correct to conclude that masking children in schools has limited the spread of COVID-19. The correct conclusion is that there is no established correlation, and hence no scientific basis for mandating the children be masked.

Harms to Children from Mask Wearing in Schools

73. In contrast with the poor quality evidence that masking children in schools has any effect whatsoever on COVID-19 disease spread, there is ample evidence of some physical and developmental harms to children that accrue from wearing masks.
74. The World Health Organization's guidance document on child masking says that up to age five, masking children may harm the achievement of "childhood developmental milestones."[73] For children between six and eleven, the same document says that mask guidance should consider the "potential impact of mask-wearing on learning and psychosocial development." The WHO explicitly recommends against masks during exercise because masks make breathing more difficult. The US CDC, which recommends masking toddlers as young as two years old, has not explained why its guidance departs from the WHO on this point.
75. A study surveying parents and pediatricians documents that a substantial fraction of children required to wear masks experience immediate physical side-effects, including speaking difficulties, changes in mood, discomfort breathing, headache, and cutaneous

[73] World Health Organziation. Advice on the use of masks for children in the context of COVID-19. Annex to the Advice on the use of masks in the context of COVID-19. Geneva, 2020. https://www.who.int/publications/i/item/WHO-2019-nCoV-IPC_Masks-Children-2020.1

disorders (i.e., face rashes).[74] In addition to these physical problems, masking children causes psychological stress in children and disrupts learning.

76. Covering the lower half of the face of both teacher and pupil reduces the ability to communicate.[75] In particular, children lose the experience of mimicking expressions, an essential tool of nonverbal communication. Positive emotions such as laughing and smiling become less recognizable, and negative emotions get amplified. Bonding between teachers and students is significantly and negatively affected. Masking exacerbates the chances that a child will experience anxiety and depression, which are already at pandemic levels themselves. Another review concludes: [76]

> "[C]overing the lower half of the face reduces the ability to communicate, interpret, and mimic the expressions of those with whom we interact. Positive emotions become less recognizable, and negative emotions are amplified. Emotional mimicry, contagion, and emotionality in general are reduced and (thereby) bonding between teachers and learners, group cohesion, and learning – of which emotions are a major driver."

77. One interesting study compares the hemoglobin content of blood collected before the pandemic led to lockdown versus blood collected during the pandemic through December 2020. The study analyzes a large sample size of over 19,500 blood donors.[77] The study's basic premise is that if masking creates hypoxia (sometimes experienced as difficulty breathing when masked), a donor's body will respond by making a larger quantity of hemoglobin to compensate. This is precisely what the researchers observe. They conclude that "prolonged use of face mask by blood donors may lead to intermittent hypoxia and consequent increase in hemoglobin mass." Of course, if this conclusion is true for blood donors, it is likely to be true for school children.

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[74] Assathiany R, Salinier C, Béchet S, Dolard C, Kochert F, Bocquet A, Levy C. Face Masks in Young Children During the COVID-19 Pandemic: Parents' and Pediatricians' Point of View. Front Pediatr. 2021 Jun 23;9:676718. doi: 10.3389/fped.2021.676718. PMID: 34249814; PMCID: PMC8260829.

[75] Carbon CC, Serrano M. The Impact of Face Masks on the Emotional Reading Abilities of Children-A Lesson From a Joint School-University Project. Iperception. 2021 Aug 19;12(4):20416695211038265. doi: 10.1177/20416695211038265. PMID: 34447567; PMCID: PMC8383324.

[76] Spitzer M. Masked education? The benefits and burdens of wearing face masks in schools during the current Corona pandemic. Trends Neurosci Educ. 2020;20:100138. doi:10.1016/j.tine.2020.100138 /

[77] Setia R, Dogra M, Handoo A, Yadav R, Thangavel GP, Rahman AE. Use of face mask by blood donors during the COVID-19 pandemic: Impact on donor hemoglobin concentration: A bane or a boon. Transfus Apher Sci. 2021 May 26:103160. doi: 10.1016/j.transci.2021.103160. Epub ahead of print. PMID: 34217601; PMCID: PMC8152240.

78. Finally, a perspective piece by the first author of the New England Journal of Medicine article on the Swedish experience with open schools (cited above) raises the likely possibility that children are less likely to comply with optimal mask-wearing protocols than adults.[78] The author's reasoning against the wisdom of masking children is worth quoting in full:

> "Face masks also have potential disadvantages, such as hindering verbal and non-verbal communication. There is a risk that children will keep touching their masks and actually increase the viral load on their hands. Using face masks also risks replacing social distancing, as some parents may be tempted to send their children to school or daycare wearing a mask if they have minor symptoms rather than keeping them at home. Finally, the commercially made masks that are currently available, especially the N95 masks that are said to offer greater protection, rarely fit children. Hence the use of such masks might lead to a false sense of safety, despite leaking viruses due to their poor fit. However, the most important drawback of face masks in children may well be that their use could reduce the focus from other measures that may be more important, such as hand washing, social distancing and staying at home when they are sick."

79. Good medicine is conservative about intervening when there is the possibility of harm. In the case of child masking, though some have asserted that it is proven that masking children never cause harm, that is clearly incorrect. The burden is not simply to prove that there exist children for whom masks never cause harm. Rather, the burden for someone advocating for mandated universal masking of children is to prove that no children are ever harmed. This is an impossible burden given the weight of the scientific evidence.

Conclusion

80. To summarize, the medical and epidemiological literature has documented conclusively that children face a vanishingly small risk of mortality from COVID-19 infection relative to other risks that children routinely face. Furthermore, the evidence also indicates that – even without masks – children are less efficient at spreading the disease to adults than adults are at spreading the infection to children or each other. There is no high-quality

[78] Ludvigsson JF. Little evidence for facemask use in children against COVID-19. Acta Paediatr. 2021 Mar;110(3):742-743. doi: 10.1111/apa.15729. Epub 2021 Jan 3. PMID: 33393117.

evidence that requiring children to wear masks has any appreciable effect on the likelihood that teachers or other school staff will acquire COVID-19 disease. On the contrary, empirical evidence from Sweden and elsewhere where masks were not required shows that schools are low-risk environments of disease spread. Finally, there is considerable evidence that requiring children to wear masks all day at school correlates with harms to their learning and development and with both physical and psychological harms.

I hereby declare under penalty of perjury that the foregoing is true and correct.

Executed on September 28, 2021
Stanford, California

Jayanta Bhattacharya

Digitally signed by Jayanta Bhattacharya
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Jayanta "Jay" Bhattacharya

Montana Medical Association, et al. v
Austin Knudsen, et al.

David B. King, MD
August 2, 2022

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION

MONTANA MEDICAL ASSOCIATION, ET AL.,
Plaintiffs,
and
MONTANA NURSES ASSOCIATION,
Plaintiff-intervenors,
vs.
AUSTIN KNUDSEN, ET AL.,
Defendants

Cause Number CV-21-108-M-DWM

VIDEORECORDED DEPOSITION UPON ORAL EXAMINATION OF DAVID B. KING, MD

BE IT REMEMBERED, that videorecorded deposition upon oral examination of DAVID B. KING, MD, appearing at the instance of Defendants, was taken at the offices of Fisher Court Reporting, 442 E. Mendenhall, Bozeman, Montana, on Tuesday, August 2nd, 2022, beginning at the hour of 9:00 a.m., pursuant to the Federal Rules of Civil Procedure, before Deborah L. Fabritz, Court Reporter - Notary Public.

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ALSO PRESENT: Nicole Tomac, videographer

I N D E X

E X H I B I T S

WHEREUPON, the following proceedings were had and testimony taken, to-wit:

* * * * * * *

THE VIDEOGRAPHER: This is the -- this is the videorecorded and videoconferenced deposition of Dr. David King, taken in the United States District Court for the District of Montana, Missoula Division. Cause Number CV-21-108-M-DWM. Montana Medical Association, et al., and Montana Nurses Association versus Austin Knudsen, et al.

Today is August 2nd, 2022. The time is 9:04 a.m. We are present with the witness at the offices of Fisher Court Reporting at 442 East Mendenhall Street in Bozeman, Montana.

The court reporter is Deb Fabritz, and the video operator is Nicole Tomac of Fisher Court Reporting. The deposition is being taken pursuant to notice.

I would now ask the attorneys to identify themselves, who they represent, and whoever else is present. For those appearing remotely, please note from where you are appearing.

MR. MEAD: This is Brent Mead, representing the defendants in this case, Austin Knudsen and Laurie Esau. And with me by Zoom are

imperfectly effective, as is natural immunity.

If you want really good natural immunity, I would make absolutely sure that you are on a vent for at least a couple of months so you can have months of fighting to generate a really robust immune response. If I can -- if I can -- if I can say, the one thing I would -- wish I had understood better prewriting this is that natural immunity does have a favorable role in those people who are not desperately ill from it.

So I think one of the things we should have done and could have done and probably will do, like some other countries do, is if you have a carefully documented, honestly documented case of COVID, you might think of that as equivalent to a booster. That's as far as I can go in supporting the natural immunity thing. And that's a newer understanding on my part as data has accumulated.

Q. Okay. So I want to just very briefly turn back to the opinion you expressed in paragraph 36 and your previous testimony on the Massachusetts Jacobson case.

So starting in Jacobson, are you aware that the vaccination mandate in that case came from the state government, not from a private

organization?

MS. MAHE: Objection. Asked and answered.

You can answer.

THE WITNESS: I did not read the case. I read the summary opinion or parts of the summary opinion. I don't even know that I read the whole thing.

BY MR. MEAD:

Q. Okay. So turning to page -- or to paragraph 36, when you say national standards of care, who -- who is -- who's creating that standard of care?

MS. MAHE: Objection. Calls for a legal conclusion.

You can answer.

THE WITNESS: You can have CDC recommendations. Medicare and Medicaid, as part of their funding, specify certain behaviors that are required. And those are the two main places that such things would come from.

We also have health requirements. USCIS has health requirements. They require -- interestingly, they have come to require COVID vaccination for any immigrant, as well as MMR and diphtheria, pertussis, tetanus, and the usual ones,

depending on the age of the applicant.

So there are several government agencies that have a role in setting national standards. It's not a single body. And then AMA has its own set of guidelines and so on and so forth. There are societies everywhere.

BY MR. MEAD:

Q. So you -- it might have been my microphone that cut out there. I wanted to clarify. You said MMA?

A. I'm sorry. AMA.

Q. AMA. Okay. Do -- do any of the relevant entities that create these standards of care -- are any of them in your opinion located at the state level in Montana?

A. I'm not knowledgeable enough about what Montana does. I -- I think childhood vaccinations are state controlled. Whether the federal government has oversight over that or has an overarching view, I don't know.

But I know as recently as 1973 Texas adopted belatedly childhood vaccination strategies. So one can infer that the government, at that point anyway, didn't have an overarching control of that.

Q. Okay. So in Montana you are a -- you are

a licensed physician?

A. Correct.

Q. Who -- who issues that license?

A. The State Department of Industry, I think. I don't know. I just fill out the form and send it back. I honestly don't know the -- the name of the entity.

Q. Okay. Are -- are you aware of any state entity that's sort of -- that investigates complaints against licensed physicians for, you know, failure to follow some standard of care?

A. Yeah. There's a board of medical examiners.

Q. Okay. And so I -- I want to turn to paragraph 39 and ask you a couple questions related to that first sentence. What do you mean by offices of private physicians?

A. If I can just rephrase the sentence, one of my patients -- let's just say it's somebody with an immune compromising condition. They're elderly. They're out of shape. They're diabetic. And they have heart failure, plus they have cancer and they're on chemo. We'll make it an open-and-shut thing.

I might see them in my clinic. They might be seen by the county public health department. They

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would certainly have been seen in the hospital. They may have been in rehab in a skilled nursing facility. They may be in a swing bed, waiting for that nursing home bed to open for rehab. They may even live in an assisted living facility. They may be in a town that has a critical care access hospital -- critical access hospital.

The same patient, the same medical problems cared for by providers in those different areas. And the reason for that sentence is because Montana has, in its wisdom, decided that the only ones that matter are nursing homes in terms of obeying the vaccine mandates.

Hospitals, doctors' offices, assisted living facilities, it's not required. So my point is it's silly to require that patient, my hypothetical patient, to be cared for by vaccinated people in one setting and none of the others. What -- what's that about?

Q. So --

A. Does that help you understand the sentence?

Q. Well, Dr. King, I'm wondering again, what do you mean by offices of private physician?

A. Offices of private physicians, so when I

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started -- now, I'm an employee now. So my office is Bozeman Health in big letters.

But up until 2011, from 1984, I was the founder and partner in a private physician office where I would see that patient, decide that that patient needed to be admitted to the hospital perhaps, take care of them at the hospital, and if they needed rehabilitation, took care of them at the skilled nursing facility before they were able to go home, as happens now.

Q. So let's -- let's talk about, I guess, skilled nursing facilities, then, for a second. In your opinion or experience, are there requirements that should be placed on the health care workers at those facilities, at skilled nursing facilities, that are not found at other types of health care settings?

A. Do I understand that you're asking is it okay to have different rules at a nursing home?

Q. Yes. That's a fair way to put it. Specific to the employees of the skilled nursing facility.

MS. MAHE: And I --

BY MR. MEAD:

Q. Can -- can those employees be subject to different requirements than employees at other health

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care settings?

MS. MAHE: And I have to object that that's vague. Are you -- I mean, he's not here to opine about the employment policies at a skilled nursing facility as far as what if they say you can't leave campus at lunch. You know, I -- I think that's so incredibly broad the way you asked it. Are you talking about a specific area?

BY MR. MEAD:

Q. So, Dr. King, again, in your experience working at -- in different health care settings, can or should in your opinion and experience employees of skilled nursing facilities -- should they be subject to different requirements than employees at other health care settings?

MS. MAHE: Object to the form.

You can answer if you can know what he's asking.

THE WITNESS: No. They all ought to be the same, but they're not based on House Bill 702, which separates them.

BY MR. MEAD:

Q. So -- so an employee at a private physician's office should be subject to the same health and safety regulations as an employee at a

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skilled nursing facility?

MS. MAHE: Object to the form.

You can answer.

THE WITNESS: They take care of the same patients. Why in the world would there not be the same requirements?

BY MR. MEAD:

Q. So, Dr. King, then it's -- the -- the requirement should be the same for -- if you treat a patient for a -- you know, a ten-minute in-office visit, the health and safety regulations should be the same as an employee at a skilled nursing facility that performs around-the-clock care for the population at a skilled nursing facility?

MS. MAHE: Object to the form.

You can answer.

THE WITNESS: Exactly. And the reason is that ten-minute visit of a -- well, let's make it even more obvious -- of an 18-year-old athlete -- and I never did ten-minute visits anyway -- is followed by the caregiver for that multiply ill patient who himself or herself has immune compromising conditions. So, of course, they should be the same.

BY MR. MEAD:

Q. So, Dr. King, then in -- in your

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experience are they the same?
MS. MAHE: Object to the form. That's vague.
You can answer if you understand what he's asking.
THE WITNESS: In my experience, yes, they are because of House Bill 702, which I think is ridiculous.
BY MR. MEAD:
Q. So, Dr. King, if prior to HB 702, were the requirements the same for health and -- were the health and safety requirements on employees -- were they the same?
MS. MAHE: Object to the form. Same for what? What entities are you talking about?
BY MR. MEAD:
Q. Were the health and safety requirements for employees at physician offices the same as employees for -- employees at skilled nursing facilities?
MS. MAHE: Object to the form.
You can answer.
THE WITNESS: Frankly, I don't know. But let's make this complete and ask if skilled nursing facilities, assisted living facilities, swing beds,

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hospitals, et cetera, because in my opinion they should have -- because they take care of the same patients, they should have the same rules.
And the answer is I don't know, although it strikes me that there's a more frequent ascertainment of tuberculosis status at skilled nursing facilities than there is in private practice, but that's -- that's not knowledge -- I think that's true. They may require TB testing more often.
BY MR. MEAD:
Q. Okay. So then that gets into my next question, that when we -- when you talk about -- in paragraph 39 that the facilities need to know the vaccination status of health care workers, what facts or studies are you relying on to form that opinion?
A. That is not subject to studies. That is truly my opinion based on my ethical sense of what my responsibility as a physician is to do no harm to anybody that I take care of.
Q. Okay. So I -- let's move down to paragraph 41. This is the paragraph in which you're discussing transferring patients to different facilities in the course of their care.
Can you describe -- your opinion is that you -- is it that you need to have actual knowledge

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of the vaccination status of health care workers at the facility you're transferring to? Is that your opinion?
MS. MAHE: Object to the form.
You can answer.
THE WITNESS: Yeah. So I'm sorry. I -- yes. That is my opinion, because my hypothetical patient who is now recovered from the physical therapy from her knee replacement, now goes to a less rigorous facility. She's got the same immune compromise. She's cared for by the same kind of people, nurses and aides and physicians and other providers. By moving to another facility, or perhaps she goes from the nursing home to the hospital, has not changed her immune status. So the rules should be the same.
BY MR. MEAD:
Q. So as a first question, when you -- when you say less rigorous, what do you mean by that?
A. So in order of rigor, we have the CCU. We have the hospital ward. We have swing beds and/or nursing homes. We have assisted living facilities. We have home care options. And that's in sort of descending order of the complicated nature of the care that's required.

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Q. Okay. So the -- the rigor you're referring to is related to the -- the normal, like, patient status being treated at that specific setting. So a patient being treated at the critical care unit is generally going to be a more complicated case than the patient at the rehab facility. Is that accurate to what you mean by rigor?
A. Yes.
Q. Okay. So when you go to transfer a patient, what is your -- in your experience, what is the process by which you're checking, you know, concerned your outline in paragraph 41. Like what checks are you doing of the facility you're transferring the patient to?
MS. MAHE: Object to the form.
You can answer.
THE WITNESS: I'm not sure what you're asking. I have presumably on many occasions used this, that, or the other facility as an adjunct to the care of my patient. What -- what would you have me be checking or what are you asking about?
BY MR. MEAD:
Q. So let's say the first time you transfer a patient to a facility to which you've never transferred someone before. What inquiries do you

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THE WITNESS: A skilled nursing facility is a place where you can get a higher level of care than an assisted living facility, whatever. A skilled nursing facility is often used for rehabilitation -- short-term rehabilitation after heart attack, stroke, injury, operation. Uniquely, a swing bed may be used for the same thing. But a skilled nursing facility has more nurses, better trained staff, therapists on staff, of various types and hugely more regulation than an assisted living facility.

BY MR. MEAD:

Q. Can you sort of expound on that last point? What -- what are -- what are the amounts of regulation that are different than an assisted living facility? And if you know why, please, you know, explain why those regulations exist.

MS. MAHE: Object to the form.

You can answer.

THE WITNESS: Just this quarter Bridger skilled nursing facility here in town received another 300 pages of new regulations from the government. I am not involved in reading those, reviewing those, and I only have any interaction with those when there's a quality concern and a regulation

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might be involved.

Somebody gets the wrong medicine, there's a book that you've got to follow about how to deal with that. The -- the reason nursing homes are going out of business is because between the regulatory environment, which is enabled by the fact that Medicare and Medicaid provide much of the funding for skilled nursing facilities -- if you've got enough money, you can go to an assisted living facility and regulations are much milder.

Because Medicare and Medicaid provide much of that funding, they get to write rules. So that answers part of your question.

Parenthetically, the reason we're closing is in part because Medicaid in this state with the governor's explicit approval -- I've talked to the owner of the nursing home I work at -- has refused to increase Medicaid rates, and -- and every Medicaid patient that this and every other nursing facility -- skilled nursing facility takes care of in this state loses over $100 a day every day, seven days a week on taking care of those Medicaid patients.

So that's why there's regulations. The regulations are onerous. I'm not going to tell you that they're wrong because I don't know the -- the

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words. I know that you would need a cart or perhaps a motorized vehicle to carry the paper regulations when you're getting several hundred pages of new ones several times a year.

Does that adequately answer your question about skilled nursing facilities?

BY MR. MEAD:

Q. So as a follow-up, I just want to kind of drill down on what -- what do the -- what's the characteristics of patients at a skilled nursing facility, and what does the care -- what is the care required? Is it inpatient? Is it outpatient? Is it around-the-clock care? Can you just describe like what does patient care at a skilled nursing facility entail?

MS. MAHE: Object to the form.

You can answer.

THE WITNESS: These are patients who are sometimes barely not sick enough to be in the hospital but too sick or too complicated to be anywhere else. So you will find in our nursing facility people who are recovering from strokes, people who are recovering from COVID pneumonia, people who are recovering from total joint repairs, people who are recovering from infections, plus

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people with Huntington's chorea which is a familial fatal degenerative disorder, people with multiple sclerosis who are wheelchair bound, people who are severely demented and can't take care of themselves. Those are the kind of people who are in skilled nursing facilities.

BY MR. MEAD:

Q. So, Dr. King, is it accurate that it is -- it's -- it's -- it's inpatient around-the-clock care?

A. I don't think inpatient can be used for this, because it's kind of been co-opted by the hospital. But these are people who live there and could not function elsewhere.

An assisted living facility, those patients are free. There are some who just have laundry and meals there. There are others -- because it's underregulated as compared to skilled nursing facilities, there are people there who would normally have been in a skilled nursing facility, but -- but through loopholes and regulatory sort of non sequiturs, they get to stay in a nicer building. But yeah. Anyway --

BY MR. MEAD:

Q. So, Dr. King, are patients transferred to a skilled nursing facility from, say, a hospital due

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to a need for more supervisory care --
MS. MAHE: Object to the form.
BY MR. MEAD:
Q. -- if that's the right word? But the idea that their treatment requires a much more supervised treatment compared to a hospital visit?
MS. MAHE: Object to the form.
You can answer.
THE WITNESS: No. Less supervised than a hospital visit. The hospital by definition has higher levels of staffing, higher levels of expertise, higher levels of therapies and imaging and lab and all that stuff.
So one goes from the hospital to a skilled nursing facility or to a swing bed. We're not even talking here about acute care facilities, you know, the rural sort of quasi hospitals.
The thing that's the same is that the basic underlying diseases may be entirely the same. They might be worse in the hospital or you might be dealing with something else in the hospital, but our patients with -- wheelchair bound patients with multiple sclerosis, whether they're in the hospital or in the nursing home or in my office, have the same medical problems. They have the same risks of

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exposure which is where I think we're getting around to.
BY MR. MEAD:
Q. Okay. So let me try and rephrase, just to help me understand this, that -- so is it accurate, then, that initial treatment is done at the hospital and then the sort of the full long-term care would be done at a skilled nurse facility.
MS. MAHE: Object to the form.
You can answer.
THE WITNESS: Yes and no. If you -- again compared to a couple decades again, more people are going to assisted living facilities who have money enough to do that. One can go directly to a skilled nursing facility from home if one doesn't have an acute condition that requires hospitalization first. That tends to be poorly paid for.
The usual pathway is somebody is in the hospital and ends up needing rehab, but there's a whole other component, and those are the permanent residents who may start there from any direction and are too sick to go anywhere else other than the hospital which we try to avoid if they don't need that level of care.
BY MR. MEAD:

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Q. So then, Dr. King, is that sort of -- is that permanent? Is -- is that one of the distinguishing factors between the settings, whether we're talking about skilled nursing facilities or assisted living facilities compared to hospitals, that the skilled nursing facility and assisted living facility are -- a slightly more permanent resident of the patient. Is that accurate?
MS. MAHE: Object to the form.
THE WITNESS: Ironically, the assisted living facility, that's true. The skilled nurse facility, for those who are there for rehab stays under Medicare -- almost all of them are Medicare because there aren't very many young people. Occasionally we'll get a motor vehicle accident victim or something. We hope to get them home. That's our goal, is to rehab them and get them to a less restrictive setting or back to an ALS.
BY MR. MEAD:
Q. Understood. Doctor, can you -- can you estimate like what is that time frame if you're successful? It will vary patient by patient, but like can you ballpark for me? Like what are we looking at for discharge or is it just too patient dependent?

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MS. MAHE: Object to form.
THE WITNESS: Weeks to months is entirely patient dependent.
BY MR. MEAD:
Q. Okay.
A. The one thing that limits is that once you get out to a certain number of days, your insurer will start to try to limit benefits. Whether it's Medicare, VA, or some sort of private policy, they will start saying we aren't going to pay for this anymore if you haven't -- so you have to show continued progress to justify more payment.
And we spend a lot of time fighting with them to get people covered because they can't afford to have the rehab if -- if they're not paying for it. That's a whole other story.
Q. Sure. So on the -- on the same line, when we're talking about physician offices, it's accurate that there's not going to be an overnight patient visit. Correct?
MS. MAHE: Object to the form.
You can answer.
THE WITNESS: It depends on where the physician office is. If you have a physician office -- well, it's actually more likely to be a PA or a

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the health care system, particularly in -- in Bozeman but pretty much everywhere. They can't find the bed they used to be able to find.

Q. And when you say that there are different rules, the rules that you are talking about are the conditions for participation for Medicare and Medicaid?

A. Yeah. Predominantly. Yeah.

Q. Yeah. And -- and so as I understand it -- and you can correct me if I'm wrong, but there are -- for hospitals, there are time lines for how long somebody can stay in the swing bed, and that was 72 hours. But that was gotten away with during COVID because of that. Is that what you're talking about?

A. Yes. The -- the -- again, I'm not really expert in swing beds, but -- but yeah. COVID has changed all kinds of things.

The frequency that -- because health care providers were not guaranteed to be vaccinated and could in theory bring in COVID to the nursing facilities, they actually reduced the frequency of required physician visits in skilled nursing facilities to eliminate that possible -- or partially eliminate the possibility that a health care provider might bring COVID into the facility.

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Q. So in a skilled nursing facility, can a patient that is in a skilled nursing facility leave the facility to be seen by a physician in an office of private physician?

A. Yes. If -- if they want to or if the service necessary can't be provided elsewhere, you -- you got to go follow up X-rays and visit your orthopedist. They could get the X-rays in the place. The orthopedist could come, but they don't -- they don't do that. And for that matter, the X-rays are better at the orthopedist's office.

So essentially it's a service that is better done there. Can't really be well done in a facility. For those reasons, they go out.

We have tried very hard to eliminate as a reason in our community that the doctor just doesn't want to come down to the facility. That's not allowed by Medicare as a reason to make them come to your office.

Q. And patients in a skilled nursing facility, do they ever get transferred to the hospital from the skilled nursing facility?

A. All the time. They catch COVID. They fall and break a hip. They have a seizure. They get a kidney infection. You name it.

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Q. So are the type of patients that are treated in a skilled nursing facility the same types of patients that are treated in hospitals?

A. The -- the only difference is theoretically one of acuity, how sick they are with their problems. The problems don't change.

And as I pointed out before, the risks -- diabetes, obesity, heart failure, lung failure, kidney failure, pancreas failure, autoimmune disorders, autoimmune -- immune modulating medications -- those transfer with the patient wherever they're seen. They're only in the hospital when one or some other problem mandates a higher level of care.

Q. And that -- I was going to ask that when you say acuity. So when they require more acute care, so more complex care is when they would go to the hospital?

A. Correct.

MS. MAHE: We can take a break for just two minutes, and then we should come back and should be able to finish up.

THE VIDEOGRAPHER: We are going off the record. The time is 1:38 p.m.

(Whereupon, a break was then

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taken.)

THE VIDEOGRAPHER: We are back on the record. The time is 1:40 p.m.

MS. MAHE: Dr. King, we'll reserve the rest of our questions. Thank you for your time today.

EXAMINATION

BY MR. MEAD:

Q. Dr. King, just a couple of questions based on that testimony. In your expert report did you cite any studies that are not directly related to COVID-19?

A. Yes.

Q. Can you -- which studies are those?

A. I'll have to leaf through. I can come -- first study would be the 1971 study from Texas. That may well be the only one.

MS. MAHE: Take your time and look through it.

THE WITNESS: I'm looking at the wrong one. I'm looking at Dr. Duriseti's. My suspicion is we won't find anything other than that one.

BY MR. MEAD:

Q. Okay.

MS. MAHE: Let him take the time to go

through it to make sure that that's accurate.
THE WITNESS: No. I make reference but not in context of any studies, only the Texas study.
BY MR. MEAD:
Q. Thank you. And so, Dr. King, on this question about populations at skilled nursing facilities, would you agree that the population at a skilled nursing facility is at a higher risk of COVID-19 infection and severity of disease if they are -- if they do contract COVID-19 than the general population?
MS. MAHE: Object to the form.
You can answer.
THE WITNESS: It is recognized itself as a risk factor for a worse outcome. So yes. I would -- I would say that you could also include other group living facilities along with that as a -- as a risk factor. They're not really any sicker. It has to do with closer confinement. Prisons, jails is also high risk.
BY MR. MEAD:
Q. So at -- at skilled nursing facilities and assisted living facilities, would you agree that one of the general risk factors is that the population at those facilities tend to be older?

A. Age is another risk factor. They tend to be older. They tend to have more chronic diseases. They tend to have more serious illnesses than young people do, yes.
Q. Okay. And then sort of a last question related to your testimony, would you agree that the prior administration, the Trump Administration, is the administration that launched operation warp speed to develop the COVID-19 vaccines. Correct?
A. Yes. I think our own Senator Daines was critical in that process.
MR. MEAD: With that, I -- I don't have any other questions.
EXAMINATION
BY MS. MAHE:
Q. I just have one quick follow-up. Dr. King, would you say that the patients in a skilled nursing facility are a higher risk population than the patients who are in a CCU within a hospital?
A. No.
MS. MAHE: We'll reserve the rest of our questions. Appreciate your time today.
THE WITNESS: Thank you.
THE VIDEOGRAPHER: All right.
THE WITNESS: It's nice to meet those of

you who I am meeting for the first time.
MS. MAHE: Oh, we can go off the record.
THE VIDEOGRAPHER: That concludes the deposition. The time is 1:45 p.m.
(Whereupon, the deposition concluded at 1:45 p.m.)
SIGNATURE RESERVED.
* * * * * * * *

DEPONENT'S CERTIFICATE

I, DAVID B. KING, MD, the deponent in the foregoing deposition, DO HEREBY CERTIFY, that I have read the foregoing - 155 - pages of typewritten material and that the same is, with any changes thereon made in ink on the corrections sheet, and signed by me a full, true and correct transcript of my oral deposition given at the time and place hereinbefore mentioned.

_____
DAVID B. KING, MD

Subscribed and sworn to before me this _____day of _____, 2022.

_____
PRINT NAME: _____
Notary Public, State of Montana
Residing at: _____
My commission expires: _____

C E R T I F I C A T E

STATE OF MONTANA)
: ss
COUNTY OF GALLATIN)

I, Deborah L. Fabritz, Registered Professional Reporter and Notary Public for the State of Montana, residing in Bozeman, do hereby certify:

That I was duly authorized to and did swear in the witness and report the deposition of DAVID B. KING, MD, in the above-entitled cause; that the foregoing pages of this deposition constitute a true and accurate transcription of my stenotype notes of the testimony of said witness, all done to the best of my skill and ability; that the reading and signing of the deposition by the witness have been expressly RESERVED.

I further certify that I am not an attorney nor counsel of any of the parties, nor relative or employee of any attorney or counsel connected with the action, nor financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal on this 17th day of August, 2022.